Arkansas Department of Health
Arkansas State Board of Athletic Training
4815 W. Markham ST., Slot 73 • Little Rock, AR 72205-3867
(501) 683-4076 • aratb@arkansas.gov

ATHLETIC TRAINERS REINSTATEMENT APPLICATION

To reinstate your license:

1. Complete and return the reinstatement application to the Arkansas State Board of Athletic Training at 4815 W. Markham St., Box 73, Little Rock, AR 72205-3867 along with the reinstatement fee of $125.00.

2. Submit a current Physician Direction Form signed by your directing physician if you are partially or fully practicing in a non-clinical setting or physician'.

3. Submit a current Direct Supervision Form signed by your supervising physical therapist if you are partially or fully practicing in a free-standing rehabilitation clinic.

4. **A current BOC certification is required.** The Board office will verify your BOC certification online.

ADVANCED SKILLS:

Have you completed training in Advanced Skills that were not part of your college/university curriculum? (I.E. Dry needling, administration of IVs, suturing)

Yes: _____ No: _____

If you answered "Yes", proof of training (See below footnote) should be submitted to the board office via postal service or e-mail attachment at:

ARATB
4815 W. Markham Street, Slot 73
Little Rock, AR 72205

or

ARATB@arkansas.gov

Proof of training should include a copy of the course completion certificate showing the course title, course date, & BOC or CME number.

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ATHLETIC TRAINERS REINSTATEMENT APPLICATION

ATHLETIC TRAINER REINSTATEMENT FEE - $125.00

License #		**NPI (National Provider Identifier) #**			
Last Name					
First Name					
Middle Name					
Mailing Address					
City		**State**		**Zip**	
Residence County					
Home Phone		**Work Phone**			
Email					

Are you an active member of the Military being stationed in AR?	Yes ☐ No ☐
Are you a former member of the Military?	Yes ☐ No ☐
If yes, what is the discharge date?	
Is your spouse an active member of the Military being stationed in AR?	Yes ☐ No ☐
Is your spouse a former member of the Military?	Yes ☐ No ☐
If yes, what is the discharge date?	
Do you practice fully or partially in a non-clinical setting?	Yes ☐ No ☐

If the answer is yes to the above, please complete and submit the Physician Direction Form.

List all states where you hold or previously held an athletic trainer's license:

List the name of each facility where you provide athletic training. Attach additional sheet if necessary.

Facility Name	
Facility City & State	
Facility Name	
Facility City & State	
Facility Name	
Facility City & State	

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Physician Direction Form

Directions to Applicant: If practicing fully or partially in a nonclinical setting or physician's office, please request your directing physician to complete the form and return it to the address listed above.

Arkansas Code § 17-93-411 requires the following direction of the athletic trainer.

1. In a nonclinical setting an athletic trainer may practice the art and science of athletic training under the direction of a physician licensed in the state of Arkansas.
2. In a physician's office, an athletic trainer may practice under the direction or consultation of a physician licensed in the state of Arkansas.

Arkansas Code § 17-93-402 defines a "Clinical Setting" as follows.

1. "Clinical setting" means a hospital or outpatient clinic;

A nonclinical setting is a setting other than a hospital or outpatient clinic.

Directing Physician	**Athletic Trainer**
Name:_____	Name:_____
Address: _____	Address: _____
City: _____	City: _____
State/Zip:_____	State/Zip: _____
Phone:_____	Phone: _____
Business Name: _____	AT Employer: _____

I, the above-named Directing Physician, agree to be the Directing Physician for the Athletic Trainer named above, under the Rules of the Arkansas State Board of Athletic Training. I understand and agree to abide by the following standing orders:

I agree to be readily available for consultation for the care of the athlete but not necessarily on the premises. I must submit an annual Physician Direction Form to the Arkansas State Board of Athletic Training with the Athletic Trainer's licensure request, permit request, or licensure renewal request to the State of Arkansas.

I shall allow the Athletic Trainer to perform independently only those functions for which the Athletic Trainer has training and experience, as outlined in the 5 Domains from the Board of Certification's Practice Analysis, 8Th Edition and additional education as approved by the Board.

- **D1:** Injury & Illness Prevention and Wellness Promotion
- **D2:** Examination, Assessment and Diagnosis
- **D3:** Immediate & Emergency Care
- **D4:** Therapeutic Intervention
- **D5:** Healthcare Administration & Professional Responsibility

_____ _____

Directing Physician's Signature Date

I, the above-named Athletic Trainer, shall adhere to the Arkansas State Board of Athletic Training Rules and applicable Standards of Practice for the profession.

In the event of termination of this Agreement, I shall notify the Board in writing. I will not provide services until documentation of an appropriate Directing Physician is approved by the Board.

Any changes in this agreement shall be submitted in writing within ten (10) days to the Board.

_____ _____

Athletic Trainer's Signature Date

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Direct Supervision Form

Directions to Applicant: If practicing fully or partially in a freestanding rehabilitation clinic setting, please request your supervising physical therapist to complete the form and return it to the address listed above.

Arkansas Code § 17-93-411 requires the following direct supervision of the athletic trainer.

1. The athletic trainer may practice athletic training in a freestanding rehabilitation clinic under the direct supervision of a physical therapist licensed in the state of Arkansas and upon the referral of a physician licensed in the state of Arkansas.

Arkansas Code § 17-93-402 defines a "Freestanding rehabilitation clinic" as follows.

1. "Freestanding rehabilitation clinic" means a rehabilitation clinic that is not located on the campus of a hospital or healthcare system.
2. "Freestanding rehabilitation clinic" does not include a physician's office.

Supervising Physical Therapist	**Athletic Trainer**
Name:_____	Name:_____
Address: _____	Address: _____
City: _____	City: _____
State/Zip:_____	State/Zip: _____
Phone:_____	Phone: _____
Business Name: _____	AT Employer: _____

I, the above-named Physical Therapist, agree to be the designated supervisor for the Athletic Trainer named above, under the Rules of the Arkansas State Board of Athletic Training. I understand and agree to abide by the following standing orders:

I agree to be on the premises and readily available for consultation for the care of the athlete. I must submit an annual Direct Supervision Form to the Arkansas State Board of Athletic Training with the Athletic Trainer's licensure request, permit request, or licensure renewal request..

I shall allow the Athletic Trainer to perform independently only those functions for which the Athletic Trainer has training and experience, as outlined in the 5 Domains from the Board of Certification's Practice Analysis, 8Th Edition and additional education as approved by the Board.
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- **D1:** Injury & Illness Prevention and Wellness Promotion
- **D2:** Examination, Assessment and Diagnosis
- **D3:** Immediate & Emergency Care
- **D4:** Therapeutic Intervention
- **D5:** Healthcare Administration & Professional Responsibility

_____ _____
Supervising Physical Therapist Signature Date

I, the above-named Athletic Trainer, shall adhere to the Arkansas State Board of Athletic Training Rules and applicable Standards of Practice for the profession.

In the event of termination of this agreement, I shall notify the Board in writing. I will not provide services until documentation of an appropriate Supervising Physical Therapist is approved by the Board.

Any changes in this agreement shall be submitted in writing within ten (10) days to the Board.

_____ _____
Athletic Trainer's Signature Date