

**ARKANSAS BOARD OF PODIATRIC MEDICINE**

**APPLICATION FOR LICENSE TO PRACTICE PODIATRIC MEDICINE**

*Must be filled out completely or your application will be considered incomplete.*

*Enter "N/A" if not applicable.*

1. Legal Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

2. Mailing Address: \_\_\_\_\_

3. County of Residence: \_\_\_\_\_

4. Address you wish License to be mailed: \_\_\_\_\_

5. Telephone: \_\_\_\_\_ (Work) \_\_\_\_\_

(Fax) \_\_\_\_\_ (Email) \_\_\_\_\_

**The Board is required to collect the following demographic information per Arkansas State Law.**

*(Act 670 of 1995; Act 1489 of 2009; Act 970 of 2017)*

6. Date of birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

7. Race: \_\_\_\_\_ Ethnicity:  Hispanic /  Non-Hispanic

8. Gender:  Male  Female

9. Are you a U.S. citizen?  Yes  No If no, please attach a copy of your Visa/Work permit.

10. Intended practice location in Arkansas: \_\_\_\_\_

Intended county of practice in Arkansas: \_\_\_\_\_

Name and address of hospital, clinic, group or private: \_\_\_\_\_

11. Board Certified: \_\_\_\_\_ Board Certified Specialty: \_\_\_\_\_

*(Date)*

*(Date)*

Recertification: \_\_\_\_\_ Recertification Specialty: \_\_\_\_\_

*(Date)*

*(Date)*

12. Do you have a Drug Enforcement Administration (DEA) #:  Yes  No

DEA #: \_\_\_\_\_ State: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

*If yes, submit a copy of your DEA registration number to this office.*

13. NPI: \_\_\_\_\_

Medicaid Provider Number: \_\_\_\_\_ Medicare Provider Number: \_\_\_\_\_

14. Have you completed at least 90 hours of undergraduate studies?  Yes  No

Name of Institution	Date From	Date To

15. Podiatric Medical Education

Date Graduated: \_\_\_\_\_

*(Month/Day/Year)*

Name of Institution	Address	Date From	Date To

*\*Have all official transcripts mailed directly to this office.*

**16. Residency/Fellowship:**

Date Graduated: \_\_\_\_\_  
 (Month/Day/Year)

Name of Institution	Address	Date From	Date To

*\*Have verification of education mailed directly to this office.*

**17. Have you successfully completed all parts of the National Board of Podiatric Medical Examiners?**

Yes  No *If yes, have official scores sent directly to this office.*

**18. Have you ever taken the Arkansas State Board Examination?  Yes  No**

Where: \_\_\_\_\_ When: \_\_\_\_\_

**19. Military Service  Yes  No**

If yes, which Branch? \_\_\_\_\_ Dates of Service: \_\_\_\_\_

**20. Professional Licenses - List all states/countries in which you have had a medical or professional license.**

State	License Number	Date Issued	Active Y/N

**21. Professional References: \*Have three (3) reference letters mailed directly to this office.**

These three (3) references may not be current partners or related to you. They must have worked with you and directly observed your professional performance in the recent past. At least one of these references must have had an organizational responsibility for supervising your performance (i.e., department chief, service chief, or training program director).

Name	Address

**Pertaining to the following section, attach an explanation of any "yes" answers.**

22. Has your application for examination or licensure in any state ever been rejected, denied, or withdrawn?  
 Yes  No
23. Has any medical licensing board ever placed your license on probation, suspension or has it revoked a license or certificate it had granted you?  Yes  No  
If yes, list name and address of board. \_\_\_\_\_
24. Have disciplinary procedures ever been initiated toward you by any licensing board?  Yes  No
25. Have you ever been convicted of a misdemeanor or felony?  Yes  No
26. Have you ever been disciplined or dismissed from any professional activity or training program?  Yes  No  
Explain. \_\_\_\_\_
27. Have you ever been addicted to alcohol or drugs?  Yes  No
28. Have you ever been treated for drug or substance abuse?  Yes  No
29. Are you currently being, or have you ever been monitored by a Physician Committee in any state?  
 Yes  No *If yes, ask your attending physician to send documentation of your status.*

***If during this application process, you become aware of any such investigation, you are required to report it to this office.***

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**AFFIDAVIT OF APPLICANT**

I, \_\_\_\_\_, certify that after being duly sworn, that all the information supplied in this application is true and correct to the best of my knowledge. I acknowledge that any false or untrue statement or representation made in this application may result in criminal prosecution to the fullest extent of the law and in the revocation or denial of any license to practice podiatric medicine granted to me.

Applicant's Signature \_\_\_\_\_

Date: \_\_\_\_\_

