You do not need to complete this form if you have provided one to the
Arkansas State Medical Board's CCVS within the last 120 days.

Arkansas State Medical Board

Centralized Credentials Verification Service
Phone: (501) 603-3574
(501) 296-1966
Fax: (501) 296-1806
www.armedicalboard.org

FAX back to ASMB within 10 days of receipt

DO NOT MAIL

SINCE YOUR LAST ATTESTATION

Yes _____ No _____ Do you currently maintain malpractice insurance coverage? ***CVO 5.1; 5.2****

Policy number:________________Coverage amounts:______________________Expiration date:_________________

If you answer yes to any of the following, please provide a complete explanation of the circumstances. All explanations should be provided on an attached page.

1. Yes_____ No_____ Have your privileges or medical staff membership at any hospital or other healthcare organization been denied, suspended, diminished, voluntarily or involuntarily relinquished, revoked or not renewed, or is any such action pending? ***MS5.5.2* (intent); CR7.5.3**; CVO5.1.4****
2. Yes_____ No_____ Have you been charged or convicted of (including a plea of guilty or nolo contendere) a felony? ***CVO5.1.3****
3. Yes_____ No_____ Has your license or certificate to practice medicine or Drug Enforcement Administration registration in any jurisdiction been challenged, denied, reduced, limited, suspended, revoked, placed on probation, not renewed, voluntarily or involuntarily relinquished, or is any such action pending? ***MS5.5.1****
4. Yes_____ No_____ Have you been or are you presently being treated for alcoholism or substance abuse? If Yes, was this voluntary or the result of a Medical Board action? ***MS5.4.3*; CR7.5.2**; CVO5.1.1****
5. Yes_____ No_____ Have you been or are you presently being treated for a mental health condition? If Yes, was this voluntary or the result of a Medical Board action? ***MS5.4.3*; CR7.5.2**; CVO5.1.1****
6. Yes_____ No_____ Do you currently, or have you had since your last renewal, any physical or mental health condition, including alcohol or drug dependency, which, with or without accommodation, affects or is reasonably likely to affect your ability to practice medicine or to perform professional or medical staff duties appropriately? ***MS5.4.3*; CR7.5.1**; CVO5.1.1****
7. Yes_____ No_____ Are you presently involved in the use of any illegal substance? ***CR7.5.2**; CVO5.1.2****
8. Yes_____ No_____ Have any claims or damages arising out of medical malpractice been made against you, or has any professional liability lawsuit been filed against you? ***ASMB*** (Medical Practices Act 17-95-103)***
9. Yes_____ No_____ Have any judgments been entered against you, or settlements been agreed to, in professional liability cases? ***MS5.5.3.1****

***MS** – Joint Commission on Accreditation of Healthcare Organizations Standard
****CR; CVO** – National Committee for Quality Assurance Standard
*****ASMB** – Arkansas State Medical Board Requirement

ATTESTATION

I affirm that all information contained in the original application or most recent update is true, correct, current, and complete in all respects to the best of my ability. I accept the responsibility to keep the Arkansas State Medical Board advised of any change or appropriate addition to any information contained in this form between now and the time such information is updated by subsequent renewals.

____

Licensee's Signature ***(No Rubber Stamps)*** **Date**

______________________________ ______________________

Licensee's Printed Name **License Number**