Arkansas State Medical Board
Centralized Credentials Verification Service
Phone: (501) 296-1951
Fax: (501) 296-1806
www.armedicalboard.org

DO NOT ALTER THE QUESTIONS ON THIS ATTESTATION FORM!!!

Yes ____ No ____ Do you currently maintain individual or group malpractice insurance coverage? *If NO, list reason: ________________________________

Policy number (s): ______________________ Coverage amounts: ______________________ Expiration date: ______________________

Insurance Carrier(s)Name: ______________________ If Group (List Group Name Policy is under): ______________________
________________________________________________________________________________________________________________________________

If you answer YES to any of the following questions, provide an explanation of the circumstances on an attached page.

1. Yes ____ No ____ Since your last attestation, 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? * If YES, briefly explain on attached page.

2. Yes ____ No ____ Since your last attestation, have you been charged or convicted of (including a plea of guilty or nolo contendere) a felony? (NOTE: Applicants must answer affirmatively if records, charges, or convictions have been pardoned, expunged, plead down, released or sealed.) * If YES, briefly explain on attached page or attach copies of your documents.

3. Yes ____ No ____ Since your last attestation, has your license or certificate to practice medicine or Drug Enforcement Administration registration in any jurisdiction (state or country) been challenged, denied, reduced, limited, suspended, revoked, placed on probation, not renewed, voluntarily or involuntarily relinquished, or is any such action pending? * If YES, briefly explain on attached page.

4. Yes ____ No ____ Since your last attestation, 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? * If YES, briefly explain on attached page.

5. Yes ____ No ____ Since your last attestation, have you been advised or required by the Arkansas State Medical Board or any other licensing board to seek treatment for a physical or mental health condition? * If YES, briefly explain on attached page.

6. Yes ____ No ____ Since your last attestation, do you currently, or have you had since your last renewal, any physical or mental health condition, including alcohol or drug dependency, which, with accommodation, affects or is reasonably likely to affect your ability to practice medicine or to perform professional or medical staff duties appropriately? * If YES, briefly explain on attached page.

7. Yes ____ No ____ Since your last attestation, are you presently involved in the use of any illegal substance? * If YES, briefly explain on attached page.

8. Yes ____ No ____ Since your last attestation, have any malpractice claims or professional liability lawsuits been filed against you? * If YES, briefly explain on attached page. CLAIM DATE / / CLAIMANT’S INITIALS , ASMB Requirement (Medical Practices Act 17-95-103)

9. Yes ____ No ____ Since your last attestation, have any malpractice judgments been entered against you, or settlements been agreed to, in professional liability lawsuits or malpractice claims? * If YES, briefly explain on attached page or attach documents. CLAIM DATE / / CLAIMANT’S INITIALS

10. Yes ____ No ____ Have you participated in continuing medical education related to your area of practice since your last AR license renewal? * If NO, list reason: ________________________________

11. How many CME credits have you acquired since your last AR license renewal? _______ How many relate to your practice specialty? _______

ATTESTATION – ALL QUESTIONS MUST BE ANSWERED (if not applicable, put N/A in blank)

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 or updates.

__________________________________________________       _________________________
Licensee’s Signature (Required)       Date Signed (Month/Day/Year - Required)
(No Rubber Stamps)

Licensee’s Printed/Typed Name (Required)       AR License Number (Required)

*JCAHO; NCQA application/attestation intent – 2006 Standards

PLEASE fax back to CCVS AT YOUR EARLIEST OPPORTUNITY!

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DO NOT MAIL