



Arkansas State Medical Board
Centralized Credentials Verification Service

Phone: (501) 296-1951
Fax: (501) 296-1806
www.armedicalboard.org

PLEASE fax back to CCVS
AT YOUR EARLIEST
OPPORTUNITY!

DO NOT MAIL

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?
2. Yes \_\_\_ No \_\_\_ Since your last attestation, have you been charged or convicted of (including a plea of guilty or nolo contendere) a felony?
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?
4. Yes \_\_\_ No \_\_\_ Since your last attestation, have you been or are you presently being treated for alcoholism or substance abuse?
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?
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?
7. Yes \_\_\_ No \_\_\_ Since your last attestation, are you presently involved in the use of any illegal substance?
8. Yes \_\_\_ No \_\_\_ Since your last attestation, have any malpractice claims or professional liability lawsuits been filed against you?
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?
10. Yes \_\_\_ No \_\_\_ Have you participated in continuing medical education related to your area of practice since your last AR license renewal?
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) (No Rubber Stamps)

Date Signed (Month/Day/Year - Required)

Licensee's Printed/Typed Name (Required)

AR License Number (Required)