Application for Appointment
AMS Representative to the Arkansas State Medical Board

Personal Information

Name: _____
Last First Middle

Business Address: _____
Street Suite #

_____
P.O. Box City State Zip Code

Are you actively practicing medicine full-time? ____Yes ____ No
(Physician must remain in full-time, active practice for the term of the appointment.)

How many hours or days per week do you practice?_____

Contact Info: _____
Home # Office # Fax#

_____
Mobile# Email Address

Date of Birth: _____ Medical Specialty:_____

Are you a registered voter in the county of your residence? ____Yes ____ No
(Note: This is required to receive any appointment.)

Education

Medical School: _____
Name Location Year Graduated

Residency: _____
Name Location Year Completed

Experience

State your experiences, interests and/or elements of your personal history that qualify you for this appointment:

Have you ever been disciplined or cited for a breach of ethics or unprofessional conduct by or been the subject of a complaint to any court, administrative agency, professional association, disciplinary committee or any other professional group? ____ Yes ___ No
If yes, please explain:

Have you ever been convicted of a violation of any federal, state, county or municipal law, regulation or ordinance (including traffic violations for which a fine of $150 or more was imposed, this includes driving under the influence of alcohol and/or drugs)? ____ Yes ___ No
If yes, please explain:

Have you ever been affiliated (as an officer, owner, director, trustee, partner, advisor or consultant) with any institutions (corporations, firms, partnerships, business enterprises, non-profit organizations, etc.) within the past five years that might present a potential conflict of interest or appearance of conflict of interest with your requested appointment? ____Yes ___ No
If yes, please explain:

Do you know anyone who might take any steps, overtly or covertly, to attack your appointment?____ Yes ___No
If yes, please explain:

Is there anything in public records that, if discovered, would be embarrassing to you, the state, or the administration? ____Yes ___ No
If yes, please explain

References

List two physicians that have known you well within the past five (5) years. Include a current, complete address and telephone number:

Name Mailing Address Zip Code Area Code / Phone Number

1.

2.

I certify that the facts contained in this application are true and correct to the best of my knowledge. I agree that any misstatement, misrepresentation, or omission of a fact may result in my disqualification for appointment.

Signature: Date:

Return to the Arkansas Medical Society by fax or email no later than October 1, 2012.

P.O. Box 55088 | Little Rock, AR 72215 | 501-224-8967 | 501-224-6489 fax | boardappointments@arkmed.org