CCVS Organization-Specific
AUTHORIZATION AND RELEASE

I hereby authorize the Arkansas State Medical Board to provide my credentialing information gathered by the Board to New Directions Behavioral Health (a Credentialing Organization) with whom I am affiliating and seeking privileges.

This Authorization shall remain in effect for a period not to exceed two (2) years unless revoked by me in writing.

I understand that if I have provided this organization with permission to utilize my electronic signature for the purpose of obtaining my credentialing information from the Arkansas State Medical Board's CCVS, this is the legal equivalent of my signature on this form and is as valid as if I signed the form with pen and ink and it can be enforced in the same way.

Typed or Printed Name of Physician: _____

Licensure Number: _____

**Signature of Physician: _____ Date Signed: _____
(Stamped signature is not acceptable, Electronic signatures only acceptable if signed on this form)

**This document does not authorize the Arkansas State Medical Board to release information collected to third parties except as later authorized by the above physician and Arkansas law.*

***In no event shall the practitioner or healthcare organization utilizing the electronic signature hold the employees of the Arkansas State Medical Board and CCVS responsible or liable, either personally or in their official capacity, directly or indirectly, for any damage or loss caused or alleged to be caused by or in connection with the use of or reliance on the practitioner's electronic signature in providing the credentialing information requested to the credentialing organization identified on this document. This statement will serve as an attestation that the practitioner's electronic signature affixed to this Organization Authorization and Release is true and correct and represents the practitioner's true signature.*

ARKANSAS STATE MEDICAL BOARD

Centralized Credentials Verification Service

1401 West Capitol, Suite 340 • Little Rock, AR 72201 • (501) 296-1802 • Fax (501) 296-1806

CCVSMonitor@armedicalboard.org • www.armedicalboard.org

CCVS ATTESTATION & RENEWAL FORM

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

1. Do you currently maintain individual or group malpractice insurance coverage? ☐ Yes ☐ No

   If NO, list reason: _____

   Policy Number(s): _____ Coverage Amounts: _____

   Expiration Date: _____ Insurance Carrier Name(s): _____

   If Group Policy, list Group Name: _____

2. Will you be providing telemedicine services from another state (an act that is part of patient care through electronic means)? ☐ Yes ☐ No

3. *Since your last attestation*, has your primary practice location changed? ☐ Yes ☐ No

   If YES, list the following: Current location: _____

   Position/Title: _____ Specialty: _____ Effective Date: _____

4. *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 an attached page.* ☐ Yes ☐ No

5. *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 an attached page.* ☐ Yes ☐ No

6. *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, reprimanded, received a written warning, or otherwise sanctioned, or is any such action pending? *If YES, briefly explain on an attached page.* ☐ Yes ☐ No

7. *Since your last attestation*, have you been or are you presently being treated for alcoholism or substance abuse due to an Order of the Arkansas State Medical Board or an Order of the medical licensing authority of any other state? *If YES, briefly explain on an attached page.* ☐ Yes ☐ No

8. *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 an attached page.* ☐ Yes ☐ No

9. *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 or without 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 an attached page.* ☐ Yes ☐ No

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

11. *Since your last attestation*, have any malpractice claims or professional liability lawsuits been filed against you, or have you received notification of a suit alleging you have committed medical malpractice? *If YES, briefly explain on an attached page.* ☐ Yes ☐ No

    Claim Date: _____ Claimant's Initials: _____ (ASMB requirement per Medical Practices Act 17-95-103)

12. *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 an attached page.* ☐ Yes ☐ No

    Claim Date: _____ Claimant's Initials: _____ (ASMB requirement per Medical Practices Act 17-95-103)

I affirm and attest that I am the license holder and 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) **Arkansas Medical License Number (Required)**