ARKANSAS DEPARTMENT OF HEALTH

Perfusionist Licensure Program
5800 West Tenth, Suite 400
Little Rock, AR 72204
(501) 661-2201

APPLICATION FOR LICENSURE
Perfusionist or Provisional Perfusionist

Perfusionist License No.: _____ ADH Customer No.: _____

Please type or write legibly. All mail will be sent to the address listed in item #3 without regard to any other address which may appear on this completed application or on the envelope in which it was mailed.

APPLICANT INFORMATION (Check one) Perfusionist _____ Provisional Perfusionist _____

1. Name: _____
   Last First Middle or Maiden
2. Social Security Number: _____ Date of Birth: _____
3. Mailing Address: _____
4. Telephone: Home: _____Work: _____Cell: _____
5. E-mail Address: _____
6. Identify all professional licenses, certifications or registrations issued by jurisdiction or territory on back of this page or provide copy.
7. Have you ever had your license, certificate, or registration revoked, canceled, or suspended?
   Yes ____ No ____ If yes, briefly state the reason(s) on back of this page or attach report.
8. Please place a checkmark by the type of license for which you are applying:

____ **Licensed Perfusionist**
Applicant must hold a current certification as a Certified Clinical Perfusionist (CCP) issued by the American Board of Cardiovascular Perfusion (ABCP). Enclose a copy of the certificate or submit a verification letter from the ABCP. Enclose an official transcript or copy of certificate of completion from an approved education program.

____ **Provisional Licensed Perfusionist**
Applicant must have successfully completed an approved education program and shall be under the supervision and direction of a currently licensed perfusionist who resides in the state of Arkansas. Enclose *a copy of the certificate of completion from the education program.* Complete and enclose the ***Statement of Supervision*** form, page 4 of application.

EMPLOYMENT INFORMATION

9. Primary Employment Setting:

   Position: _____ Dates of Employment: _____

   Place of Employment: _____
   Address (include zip code): _____
   Telephone Number: _____

10. Secondary Employment Setting:

    Position: _____ Dates of Employment: _____

    Place of Employment: _____
    Address (include zip code): _____
    Telephone Number: _____

11. Work Experience:

    List positions held, type of work performed, employer's name, address, and dates of employment for previous work experience in the field of perfusion:

    _____

    _____

ACADEMIC INFORMATION

Applicants must submit official transcripts from an approved program or from a program with requirements as stringent as those established by the Accreditation Committee for Perfusion Education (AC-PE) and approved by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or their successors. If submitting an equivalent program, the burden is on an applicant to establish that program requirements are as stringent as those by the AC-EP and approved by the CAAHEP or their successors.

12. List all colleges, universities, and educational programs attended. Attach additional sheets if necessary.

    A. Perfusion education program: _____
       Location: _____
       Inclusive dates attended: _____

    B. College or university: _____
       Location: _____
       Inclusive dates attended: _____
       Degree awarded and major field: _____

PERFUSIONIST LICENSURE APPLICATION AFFIDAVIT & AGREEMENT

In making application to the State of Arkansas for a license or provisional license as a perfusionist, I have read and agree to abide by the Perfusionist Licensure Act and the *Rules and Regulations for Perfusionists in Arkansas*. I also agree to complete all application requirements and take all examinations necessary for the processing of my application. Upon issuance of a license, I agree to be bound by the Code of Ethics. I further understand that the fee submitted with this application is non-refundable and that the materials submitted for consideration become the property of the State and are non-refundable. I am aware of the schedule of fees and understand that additional fees must be paid to keep the license current. I have read and fully understand the Section relating to changes of name and address within 30 days of that change.

I hereby grant permission to the State of Arkansas to seek any information or references it deems fit in securing my credentials pertinent to this application.

I further agree that if issued a license, upon the revocation, suspension or cancellation of that license, I shall return the license certificate and license identification card to the Committee.

As an applicant for a Perfusionist license in Arkansas, I swear or affirm on oath and under penalty of Arkansas law the following:

____ I am a United States citizen or a legal permanent resident 18 years of age or older.

OR

____ I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act; I am 18 years of age or older; I am lawfully present in the United States; and my alien or admission number is: _____

(Print alien or admission number (required)

A front and back copy of one of the following documents must be attached:

1. Valid Foreign Passport with I-94; or
2. Temporary Resident Alien Card (I-688); or
3. Employment Authorization Card (I-766 or I-688B); or
4. Employment Authorization Document (I-688B); or
5. Refugee Travel Document (I-571)

The disclosure of a social security number is required under the Federal Code. Social Security numbers are used for identification purposes and are confidential except as to the child support enforcement division of the Office of the Attorney General.

The information which I have provided in this application is truthful. I understand that providing false information of any kind may result in the voiding of this application, and my failing to be granted a license or provisional license, or the revocation of my license.

Please include a check for $150.00 made out to Arkansas Department of Health.

Failure to include requested certificates, transcripts, and original* signed application *will cause application to be returned for completion.

Date: _____ Perfusionist Signature: _____

STATEMENT OF SUPERVISION FOR PROVISIONAL LICENSED PERFUSIONIST

The supervising licensed perfusionist must sign the application for a provisional license and the application for renewal of the provisional license.

Applicant Under Supervision Supervising Licensed Perfusionist

_____	_____
Name	Name
_____	_____
Address	Address
_____	_____
City, State, Zip	City, State, Zip
_____	_____
Telephone	Telephone
_____	_____
Provisional License Number	License Number

1. Applicant's number of cases worked per week: _____

2. _____
   Primary location and setting of services rendered

3. _____
   Address/City/State/Zip

4. _____
   Description of services rendered by applicant

5. _____ _____
   Date employment will begin Date supervision will begin

_____	_____
Signature of Supervisee	Signature of Supervisor
_____	_____
Date	Date