

**ARKANSAS DEPARTMENT OF HEALTH**  
Perfusionist Licensure Program

Initial License Application fee is \$150.00. Initial Provisional License fee is \$150.00.

Renewal of license for two years is \$100.00. Renewal of Provisional License for one year is \$150.00.

Make check payable to the Arkansas Department of Health.

Please address any questions or concerns to Mary Fuller at 501-661-2771.

**Place the check on top of the completed application and mail/FedEx to:**

**Mary Fuller, Administrator  
Arkansas Department of Health  
Health Facility Services  
5800 West 10<sup>th</sup> St., Suite 400  
Little Rock, AR 72204-1704**

**ARKANSAS DEPARTMENT OF HEALTH**  
Perfusionist Licensure Program

**APPLICATION FOR LICENSURE**  
Perfusionist or Provisional Perfusionist

Date Received \_\_\_\_\_ 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. Do you possess a professional license, certificate, or registration as a perfusionist issued by another state, jurisdiction, or territory? \_\_\_\_ Yes \_\_\_\_ No

If yes, give license, certification, or registration number and the same name and address of the agency or jurisdiction issuing the license, certificate, or registration: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Have you ever had your license, certificate, or registration revoked, canceled, or suspended? Yes \_\_\_\_ No \_\_\_\_

If yes, briefly state the reason(s):  
\_\_\_\_\_  
\_\_\_\_\_

8. In order to facilitate the board's review of your application materials, 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.

**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: \_\_\_\_\_

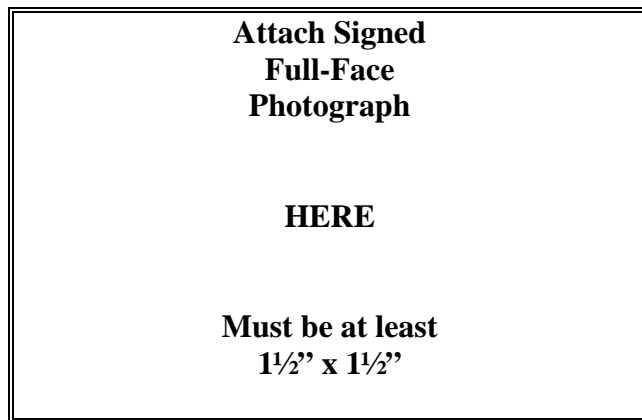
Inclusive dates attended: \_\_\_\_\_

Degree awarded and major field: \_\_\_\_\_

**PHOTOGRAPH SUBMISSION**

All applicants for licensure must complete this page.

1. Attach a full-faced, wallet sized photograph (minimum size 1½” x 1½”) of applicant’s head and shoulders only. Use tape to secure the photograph to the page.
2. This photograph will be used in connection with your application for licensure and for the purposes of complaint or violation investigation(s). It will not be made available to any person who grades your examination nor to any person who makes decisions concerning your employment.
3. Photograph must have been taken within the two-year period prior to application.
4. Cutouts, newspaper or magazine clippings, photocopies, etc. will not be accepted.
5. Sign the photograph on the backside. Sign and date this page as indicated.
6. Failure to follow these instructions will result in a deficiency notice and no action will be taken on your file until the deficiency is resolved.



Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_

Social Security No: \_\_\_\_\_ Date: \_\_\_\_\_

**Perfusionist Licensure Application Affidavit & Agreement**

In making application to the State of Arkansas Perfusionists Advisory Committee for the issuance of a license or provisional license as a perfusionist, I have read and agree to abide by the Licensed Perfusionist Act and the rules of the State of Arkansas Perfusionists Advisory Committee. 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 Committee 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 agree to hold the State of Arkansas Perfusionists Advisory Committee, its members, officers and examiners, free from any damage or claim for damage or complaint by reason of any action they or any one of them take in connection with this application, the attendant examination (if applicable), the grades with respect to any examination, the failure of the Committee to issue me a license and any other aspect of licensing. I hereby grant permission to the Committee 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.

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.

Date: \_\_\_\_\_ Perfusionist Signature: \_\_\_\_\_

Subscribed and sworn to before me on this the

\_\_\_\_\_ day of \_\_\_\_\_ month, \_\_\_\_\_ year

Notary Public Signature \_\_\_\_\_ Print Name \_\_\_\_\_

Notary Public in and for \_\_\_\_\_ County, Arkansas or \_\_\_\_\_

My Commission expires \_\_\_\_\_

**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

\_\_\_\_\_  
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