ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802

APPLICATION FOR MEDICAL LICENSURE IN ARKANSAS
and Centralized Credentials Verification Service

www.armedicalboard.org

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✓ Medicine/Surgery ____ Osteopathic Medicine/Surgery ____ Education License

1. Name Scott J. Spear, MD (Legibly Print full Legal Name) Social Security # _

2. Name as listed on your Driver's License or Passport: Scott Jay Spear

Driver's License State and Number Wisconsin,

3. Address 3202 Bluff St, Apt 5; Madison, WI 53705-3435

4. Address you wish license to be mailed:
as above.

5. Phone (Work) 608-265-2009 (Fax) 608-262-9160 (email) _

6. Male ☑ Female ☐ Birth Date _ Austin, TX Race: Cauc.

If born outside of U.S., how long have you lived in U.S. ____ Years ____ Months. Are you a citizen of U.S. ___yes ___no
If yes, and foreign born, attach proof of citizenship. If no, indicate your status with U.S. Immigration ____
(Attach copy of Visa/Work Permit)

7. ECFMG Certificate # _____ Date Issued _____

8. Intended practice location in Arkansas Fayetteville Give name and address of hospital, clinic, group or private:
NW Arkansas Regional Health Center

9. Specialty Pediatrics Subspecialty _____
Board Certified (Date) 1984 Board Certified (Date) _____
Recertification _____ Recertification _____

10. Drug Enforcement Administration Number BS5974553 State _____ Expiration Date 2/28/2007
State Controlled Substance License Number N/A State _____ Expiration Date _____
State Controlled Substance License Number _____ State _____ Expiration Date _____
Submit a copy of your DEA Registration Card and State Controlled Substance License to this office.

11. UPIN # 134622519O Medicaid Provider # 136695002 * Medicare Provider # 405522283
Accept Medicaid Patients? ✓ Yes ____ No Accept Medicare Patients? ✓ Yes ____ No

12. Professional Liability Insurance (**CURRENT** Carrier Name) State of Wisconsin Attorneys General
Policy # N/A Date of Expiration _____ Amount of Coverage _____
Send enclosed form to your insurance carrier and have them return directly to this office.

13. Medical School. Date Graduate Nov. Mo 16 Day 1978 Yr Degree MD

	Name of Institution	Address	Date from	Date to
1st Year	Baylor College of Medicine	Houston, TX	7/1975	11/1978
2nd Year	BCM	"	"	"
3rd Year	BCM	"	"	"
4th Year				

Have Verification of Medical Education Form and an official Transcript mailed directly to this office.

* Please use the Medicare and Medicaid numbers of my employer. I will be applying for my own numbers.

FOR USE OF SECRETARY ONLY

License No. E-5207
Name Scott J. Spear, MD.
Application for License through endorsement by
Flex

Application received 11-28-06
Fees $500.00 Date 11-28-06
License issued 4/13/2007
Application Declined _____
Fees returned _____ 20____

NOTE: Application must be legible and completed in INK or Typed

14. Post Graduate Training (list chronologically). **Send Enclosed Verification Form – Refer to Instruction Sheet**

Name of Institution	Address	Type of Program	Dates From/To	Completed? Yes/No
Central TX Medical Foundation	Austin, TX	Pediatrics	12/78-5/79	Yes
Univ of CO Hospitals	Denver, CO	Pediatrics	6/79-6/81	Yes
Children Hosp. of SF	San Francisco, CA	Pediatrics	7/81-6/82	Yes

15. Fellowships (list chronologically). **Send Enclosed Verification Form – Refer to Instruction Sheet**

Name of Institution	Address	Type of Program	Dates From/To	Completed? Yes/No
UC San Francisco	San Francisco, CA	Adol. Medicine	7/82-6/84	Yes

16. Circle which licensing exam you have taken: **USMLE** **NBME** **(FLEX)** **NBOME** **COMLEX** **LMCC**

- or -

State Board Examination – State _____ **Year** _____ **(Taken prior to 1975 only)**

17. Have you taken the SPEX exam in the last five years? _____ Yes ✓ No **If yes, have certified copies of scores mailed directly to this office.**

18. Military Service? _____ Yes ✓ No If yes, which Branch? _____

Dates of Service _____ **Attach copy of separation papers and have records sent from Military Personnel Records Center. (See Instruction Sheet and Verification form.)**

19. List all states/countries in which you have or have had a medical license. **Have verification of each license mailed directly to this office. Send enclosed verification of Licensure Form. (Form may be copied if necessary.)**

State/Country	License #	Date Issued	Active Y/N
Wisconsin	36224-020	11/1/05	Y
Texas	F3348	1979	N
California	C039857	1981	N

State/Country	License #	Date Issued	Active Y/N

20. Professional References/Recommendations: **Have three physician (M.D. or D.O.) reference/recommendation letters mailed from their offices directly to this office.** These cannot be current partners or related to you. They must have worked with you and directly observed your professional performance in the recent past. At least one of these references/ recommendations must have had organizational responsibility for supervising your performance (i.e. department chief, service chief or training program director).

Name	Address	Association
Richard P. Keeling, MD	453 Hudson St, Apt 3 New York, NY 10014	Fmr. Exec. Director
James A. Lindblade, MD	1542 Courouche Glen Madison, WI 53704	Colleague
Martin Lancaster, MD	Dept of Family & Preventive Med 521 Jack Stephens Dr., #530 Little Rock, AR 72205	Colleague

21. Professional Activities

List in chronological order all your professional activities, institutional affiliations or places of employment since graduation from Medical School. This includes hospitals, teaching institutions, HMO's, private practice, corporations, military assignments, government agencies, and Locum Tenens assignments. Exclude Residency and Fellowship. You may attach additional sheets after completing this section, if space is not sufficient. *Do not submit curriculum vitae (CV) in lieu of completing this section.*

From	To	Status	Location & Complete Address	Position
12/78	5/79	Inactive	Central Texas Medical Foundation 601 E. 15th Street - Suite L-503 Austin, TX 78701	Resident in Pediatrics
6/79	6/81	Inactive	University of Colorado Hospital 1056 E. 19th Ave, B-065 Denver, CO 80218	Resident in Pediatrics
7/81	6/82	Inactive	Children's Hospital of San Francisco 3700 California St. San Francisco, CA 94118	Resident in pediatrics
7/82	6/84	Inactive	Univ. of CA San Francisco 3333 California St., Box 0503 San Francisco, CA 94143-0503	Fellow in Adolescent Medicine
8/84	1/85	Inactive	Student Health Center Univ. of Tx at Austin 100 W. Dean Keeton St Austin, TX 78712	Staff Physician
1/85	2/06	Inactive	University Health Service 1552 University Ave Madison, WI 53726	Director of Clinical Services
2/06	present	current	University Health Service 1552 University Ave Madison, WI 53726	Assoc. Prof of Pediatrics
6/04	present	Active	UW Hospital and Clinics 600 Highland Ave H4/831 Madison WI 53792-8320	Pediatrics General

- Please review this list carefully. If there are gaps in your chronological history you are required to provide a brief explanation. **Send enclosed Verification Hospital/Clinic forms to each facility. (See Instruction Sheet)**
- **Complete all forms in black or blue ink ONLY.**

Attach explanation of any "yes" answers. Refer to Instruction Sheet for the following questions.

	YES	NO
22. Have you ever failed a licensing exam? Where?_____ Explain.		✓
23. Has your application for examination or licensure ever been rejected, denied or withdrawn?		✓
24. Has any medical licensing board ever placed your license on probation, suspension or has it revoked a license or certificate it had granted you? If yes, list name and address of board. _____		✓
25. Have you ever been ordered to appear before a state medical board for any reason other than licensure?		✓
26. Have disciplinary procedures ever been initiated toward you by either a medical board or hospital? Explain.		✓
27. Have your privileges at any hospital been denied, suspended, diminished, voluntarily or involuntarily relinquished, revoked or not renewed, or is any such action pending?		✓
28. Have you ever voluntarily surrendered your license in any state?		✓
29. Have you ever been charged or convicted (including a plea of nolo contendere) of a misdemeanor or felony? (NOTE: Applicants must answer affirmatively if records, charges, or convictions have been pardoned, expunged, plead down, released or sealed.)		✓
30. Have you ever been denied provider participation in any state or Federal Medicaid program?		✓
31. Have you ever previously made application to the Arkansas State Medical Board?		✓
32. Have you ever been warned, censured by, or requested to withdraw from, any hospital in which you have trained, been a staff member or held hospital privileges? If yes, explain.		✓
33. Have you ever been disciplined or dismissed from any professional activity or training program? Have you ever received a warning, reprimand, or been placed on probation during an internship, residency or fellowship program? If yes, explain.		✓
34. Have you ever, voluntarily or involuntarily, left a training institution program before completing it? If yes, explain.	✓	
35. Have you ever been reported to the National Practitioners Data Bank or subject to NPDB adverse action report?		✓
36. Have you resigned or surrendered clinical privileges from any medical staff while under investigation for possible incompetence or improper professional conduct, or in return for such an investigation not being conducted?		✓
37. Have you ever been denied membership, renewal thereof, or been subject to disciplinary action in any medical organization, or is any such action pending?		✓
38. Have you ever been terminated, sanctioned, penalized or had to repay money to any State Medicaid or Federal Medicaid programs? If yes, name state _____		✓
39. Have any malpractice claims been filed against you? If yes, provide official documentation from your attorney or insurance company.		✓
a. How many? _____ b. How many were dismissed with settlement? _____ c. How many were dismissed or dropped? _____ d. How many are pending? _____		
40. Have you ever been cited by a peer review organization? Explain Give the name and address of the organization _____		✓
41. Have you ever had to discontinue practice for any reason for a period longer than one month? If yes, explain.	✓	
42. Have you been, or are you presently, being treated for alcoholism, or substance abuse? If yes, was this voluntary or the result of a medical board action? Explain.		✓
43. Do you currently, or have you had, 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?		✓

	YES	NO
44. Have you ever had a DWI? How many? _____ Date(s) occurred _____	____	✓
45. Have you ever been treated for drug or substance abuse outside a hospital setting? Explain.	____	✓
46. Have you ever been treated for drug or substance abuse in a treatment center or hospital? Give name of institution, date and length of stay? _____	____	✓
47. Are you currently being, or have you ever been, monitored by a Physician Health Committee in any state? If yes, give state(s) _____ Ask your treating physician to send documentation of your status.	____	✓
48. Have you ever been rejected by a medical society?	____	✓
49. Has your license to practice medicine or Drug Enforcement Administration registration in any jurisdiction been denied, reduced, limited, suspended, revoked, placed on probation, not renewed voluntarily, or involuntarily relinquished, or is any such action pending? If yes, explain.	____	✓
50. Have you ever defaulted on any Health Education Assistance Loan? If yes, explain.	____	✓
51. To your knowledge, are you currently the subject of an investigation by any licensing board as of the date of this application? If yes, explain.	____	✓

If, during the application process, you become aware of any such investigation, you are required to report it to this office.

34. From 12/78 until 5/79, I pursued a sub-internship with the Central Texas Medical Foundation in Pediatrics after my early graduation from Baylor College of Medicine in 11/78.
I left the Univ. of CO Hospitals Pediatric Residency program in 6/81 after completing two years of training so as to work in a program that was geared more towards primary care – my eventual area of practice.
I completed my third year of Pediatrics training at Children's Hospital of San Francisco from 7/81-6/82.

41. I was on full-pay administrative leave from 11/04-1/05 while under investigation by the campus office of Equity and Diversity for allegations of harassment made by a disgruntled former employee. This was done to protect me from his on-going allegations. It did not involve patient care; it involved management and administrative concerns. As a result of the investigation, I was exonerated and returned to my position without diminution of pay or status.

AFFIDAVIT OF APPLICANT

I, Scott J. Spear, MD, certify after being sworn, that all of the information supplied in the foregoing application is true, correct, current and complete to the best of my knowledge, that the photograph submitted herein is a true likeness of myself and was taken within sixty (60) days prior to the date of this application. I acknowledge that any false or untrue statement or representation made in this application may result in the revocation or denial of any license to practice medicine granted to me, and criminal prosecution to the fullest extent of the law.

Scott J. Spear

Applicant's Signature (in INK)

11/06/06

Date Signed

Sworn to and subscribed before me this 16 **day of** November, 20 06.

My Commission Expires: 07/08/07

Lynn Sullivan

Signature of Notary Public

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

Rev. 5/2/06 ljm
Form cannot be copied.