

**ATHLETIC TRAINER LICENSE/TEMPORARY PERMIT
PHYSICIAN DIRECTION FORM**

Athletic Trainer Name: _____ Social Security Number: _____

Address: _____ Phone: (work) _____

City/State/Zip: _____ (home) _____

Directions to Applicant: If practicing fully or partially in a non-clinical setting, please request your supervising/directing physician to complete the following form and return to the address listed above.

Ark. Code Ann S 17-93-411 of 1995 Act 1279 licenses athletic trainers and requires the following supervision of the athletic trainer.

1. In a non-clinical traditional setting, the athletic trainer may practice the art and science of athletic training under the direction of a physician licensed in the state of Arkansas.
2. In a clinical setting, the athletic trainer may practice athletic training in a hospital or outpatient clinic under the direct supervision of a physical therapist and upon the referral of a physician licensed in the state of Arkansas.

Directions to Physician: Please read the information below and complete the following.

Supervising / Directing Physician: a person holding a current unrestricted license to engage in the practice of medicine or osteopathy. Other physicians, who act on a referral basis with athletic trainers who hold a current unrestricted license to engage in the practice of chiropractic, optometry, and podiatry in the state of Arkansas.

PLEASE CHECK THE ACTIVITY OR ACTIVITIES FOR WHICH DIRECTION IS GIVEN:

- 1. Interscholastic (High School Athletics)
- 2. Intramural
- 3. Intercollegiate (College Athletics)
- 4. Professional
- 5. Sanctioned Recreational Sports Activities:
 - ___ a. Has officially designated coaches who have the responsibility for athletic activities of the organization.
 - ___ b. Has a regular schedule of practices or workouts which are supervised by the officially designated coaches.
 - ___ c. Is an activity generally recognized as having an established schedule of competitive events of exhibitions.
 - ___ d. Has a policy requiring documentation of having passed a preparticipation medical examination conducted by a licensed physician as a condition for participation in the athletic activities of the organization.

Physician's Name (please print) _____

Date _____

Physician's Signature _____

Physician's Address _____

City/State/Zip _____ Phone Number _____