APA-1
6/93

TRANSMITTAL SHEET FOR NOTICE OF INTENDED ACTION

Control 540 Department or Agency Alabama State Board of Medical Examiners
Rule No. 540-X-7, Appendix E
Rule Title: Application for Registration of Anesthesiologist Assistant

_____ New ___X___ Amend _____ Repeal _____ Adopt by Reference

Would the absence of the proposed rule significantly harm or endanger the public health, welfare, or safety?	YES
Is there a reasonable relationship between the state's police power and the protection of the public health, safety, or welfare?	YES
Is there another, less restrictive method of regulation available that could adequately protect the public?	NO
Does the proposed rule have the effect of directly or indirectly increasing the costs of any goods or services involved and, if so, to what degree?	NO
Is the increase in cost, if any, more harmful tot he public than the harm that might result from the absence of the proposed rule?	NO
Are all facets of the rulemaking process designed solely for the purpose of, and so they have, as their primary effect, the protection of the public?	YES

****

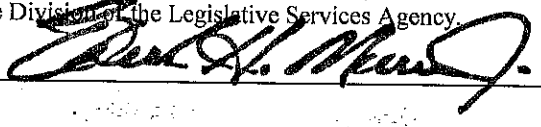
Does the proposed rule have an economic impact? NO

If the proposed rule has an economic impact, the proposed rule is required to be accompanied by a fiscal note prepared in accordance with subsection (f) of Section 41-22-23, Code of Alabama 1975.

****

Certification of Authorized Official

I certify that the attached proposed rule has been proposed in full compliance with the requirements of Chapter 22, Title 41, Code of Alabama 1975, and that it conforms to all applicable filing requirements of the Administrative Procedure Division of the Legislative Services Agency.

Signature of certifying officer 

Date: December 14, 2017

APA-2
6/93

ALABAMA STATE BOARD
OF MEDICAL EXAMINERS

NOTICE OF INTENDED ACTION

AGENCY NAME: Alabama State Board of Medical Examiners

RULE NO. & TITLE: 540-X-7, Appendix E, Application for Registration of Anesthesiologist Assistant

INTENDED ACTION: To amend the Rule Appendix.

SUBSTANCE OF PROPOSED ACTION: To modify the form for online completion and re-letter as Appendix C

TIME, PLACE, MANNER OF PRESENTING VIEWS: All interested persons may submit data, views, or arguments concerning the proposed new rule(s) and regulation(s) in writing to: Patricia E. Shaner, General Counsel, Alabama State Board of Medical Examiners, Post Office Box 946, Montgomery, Alabama 36101-0946, by mail or in person between the hours of 8:30 a.m. and 4:30 p.m., Monday through Friday, until and including February 2, 2018. Persons wishing to obtain copies of the text of this rule and submit data, views, or comments or arguments orally should contact Patricia E. Shaner, by telephone (334-242-4116) during said period in order to set up an appointment for a hearing respecting such oral data, views, or arguments. Additionally, proposed rules are posted to the Board's web site, www.albme.org.

FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE: February 2, 2018

CONTACT PERSON AT AGENCY: Patricia E. Shaner

Edward H. Munson, Jr., Acting Executive Director

540-X-7, APPENDIX ~~E~~C

Under Alabama law, this document is a public record and will be provided upon request.

ALABAMA BOARD OF MEDICAL EXAMINERS

P.O. Box 946 / Montgomery, AL 36101-0946 / (334) 242-4116

APPLICATION FOR REGISTRATION OF ANESTHESIOLOGIST ASSISTANT

PHYSICIAN TO COMPLETE:

Supervising ~~Physician~~Anesthesiologist Name in Full

~~Ala.~~AL Medical License Number ~~Date of Birth~~ ~~Social Security~~ No.*

~~*Pursuant to Ala. Code § 30-3-194, it is mandatory that we request and that you provide your social security number (SSN) on this application. The uses of your SSN are limited to the purpose of administering the state child support program and intra-agency for identification purposes. If your SSN is not provided, your application is not complete, and no license will be issued.~~

Medical Specialty

REQUIRED: Board Certified: YES NO Board Eligible YES NO

Principal Practice Location Name and Address

(If mailing address is different please provide here)

Telephone Number: ( ) FAX Number ( )

1. List the name, practice site address and designated working hours per week of each anesthesiologist assistant **currently** registered to you.

NAME

ADDRESS

HOURS

2. ~~Have you ever had a anesthesiologist assistant certified or registered to you by the Alabama Board of Medical Examiners?~~

~~YES _____ NO _____ **If the answer is YES,** list the names of the assistant(s) in the spaces provided.~~

~~3.~~ Is the anesthesiologist assistant for whom registration is sought employed by you or by your group, partnership or professional corporation?

YES_____ NO _____ **If the answer is NO**, ~~Appendix G to Chapter 7~~ Supplemental Certificate must be submitted.

~~I hereby certify that the foregoing information is correct to the best of my knowledge, information and belief; and that I have reviewed and understand the current rules and regulations of the Alabama Board of Medical Examiners pertaining to anesthesiologist assistants and understand my responsibilities.~~

Date: _____ **Primary Supervising Physician Signature**:

~~In accordance with Rule 540-X-7-.51 confirmed receipt of this application will be sent by mail, unless a FAX number is provided where the confirmation can be transmitted by FAX. An anesthesiologist assistant previously approved to practice under the provisions of Chapter 7 of the Board of Medical Examiners Administrative Rules may continue in the supervised practice with this interim supervising physician and may continue until such time as this application is approved or denied, provided the supervising physician meets the qualifications established in Rule 540-X-7-.47.~~

ANESTHESIOLOGIST ASSISTANT ~~TO COMPLETE~~:

Assistant Name in Full

~~Ala.~~AL A. A. License Number _____ ~~Date of Birth_____~~ ~~Social Security No.*_____/_____/_____~~

~~*Pursuant to Ala. Code § 30-3-194, it is mandatory that we request and that you provide your social security number (SSN) on this application. The uses of your SSN are limited to the purpose of administering the state child support program and intra-agency for identification purposes. If your SSN is not provided, your application is not complete, and no license will be issued.~~

1. ~~Have you ever been certified or registered as a anesthesiologist assistant by the Alabama Board of Medical Examiners?~~

~~YES _____ NO _____ **If the answer is YES,** list the names of the physicians in the spaces provided.~~

2. ~~Are you~~ Is the A. A. **currently** certified or registered to any other primary certifying ~~physician~~anesthesiologist? **If the answer is YES,** in the space below give the ~~physician~~anesthesiologist name, ~~physician~~ practice ~~location~~address, ~~*assistant's* certification or registration number,~~ and ~~*assistant's*~~ number of hours per week ~~for~~with each primary supervising ~~physician~~anesthesiologist. ~~(There are spaces for three separate registrations.)~~

NAME
ADDRESS
REGISTRATION No.
HOURS per week

~~I hereby certify that the foregoing information is correct to the best of my knowledge, information and belief; and that I have reviewed and understand the current rules and regulations of the Alabama Board of Medical Examiners pertaining to anesthesiologist assistants and understand my responsibilities.~~

Date: _____ **Anesthesiologist Assistant Signature:**

I hereby certify that the foregoing information is correct to the best of my knowledge, information and belief; and that I have reviewed and understand the current rules and regulations of the Alabama Board of Medical Examiners pertaining to anesthesiologist assistants and understand my responsibilities.

Date: **Primary Supervising Anesthesiologist Signature:**

[OR]

[electronic signature]

I understand and agree that by typing my name, I am providing an electronic signature that has the same legal effect as a written signature pursuant to Ala. Code §§ 8-1A-2 and 8-1A-7. I attest that the foregoing information has been provided by me and is true and correct to the best of my knowledge, information and belief.

~~Office Use ▼~~	~~**PLEASE NOTE & RESPOND TO THE FOLLOWING AS APPROPRIATE FOR THIS REGISTRATION REQUEST.**~~
	~~FEE: Each new registration requires submission of a $100.00 fee. Please attach check payable to Alabama Board of Medical Examiners.~~

	~~JOB DESCRIPTION: Please attach a completed job description signed by the physician and the assistant.~~
	~~APPENDIX G : If assistant is employed by an entity **other than** the physician, the physician's group or professional corporation please include a completed Appendix G. Include a separate sheet for responses if required.~~
	~~COVERING PHYSICIAN LETTERS: The absence of "covering physician" letter(s) indicates that when the primary physician is not working, the assistant is not working. (A "sample" form was included in the registration package.)~~

Under Alabama law, this document is a public record and will be provided upon request.

ANESTHESIOLOGIST ASSISTANT JOB DESCRIPTION

Name of Anesthesiologist Assistant:
Name of Primary Supervising Anesthesiologist
Anesthesiologist's Principal Practice Location Name and Address:

Telephone Number

Listed below are duties approved by the Board as a basic job description. Any additional duties requested must be listed. Any additional duties must be individually considered and approved by the Board before performing them.

The following list includes the basic roles and functions to be performed by the Anesthesiologist Assistant. The list includes the acts, tasks and functions which the AA will be allowed to perform under supervision of an anesthesiologist, as well as those limited actions to be taken in life-threatening emergency conditions.

1. Administers anesthesia under the supervision of an anesthesiologist.
2. Performs initial acute cardio-pulmonary resuscitation in life-threatening situations as directed by a physician.
3. Establishes multi-parameter monitoring of patients prior to, during and after anesthesia or in other acute care situations. This may include invasive / non-invasive monitoring under the direct supervision of an anesthesiologist. Also, other monitoring as may be developed for anesthesia and intensive care use may be incorporated.
4. Manages perioperative anesthetic care, including ventilary support and other respiratory care parameters as directed by an anesthesiologist.
5. Assists in research projects as carried out by an anesthesiologist.
6. Instructs others in principles and practices of anesthesia, respiratory care and cardio-pulmonary resuscitation as directed by the anesthesiologist.
7. Assists an anesthesiologist in gathering routine perioperative data.
8. Provide emergency medical services in the event of declared national emergency or natural disaster in accordance with the requirements of Board Rules.
9. The choice of anesthesia and drugs to be employed are prescribed by an anesthesiologist for each patient except:

(a) where standard orders for the conduct of specified anesthetic are prescribed; and

(b) where life threatening emergencies arise necessitating the utilization of standard therapeutic or resuscitation procedures. An anesthesiologist will be immediately available for consultation regarding changes from standard procedures.

10. ADDITIONAL DUTIES REQUESTED FOR THE ANESTHESIOLOGIST ASSISTANT (i.e. procedures requiring additional training). Provide, as an attachment to this Job Description, documentation of the training and / or certification which qualifies the anesthesiologist assistant to perform each additional duty / procedure which is requested. Training for the additional duty/procedure shall have been previously approved by the Board pursuant to Board Rules.

11. List each practice site where this Job Description will be utilized, including name, address and phone number

12. List the name and designated working hours per week of each anesthesiologist assistant at the practice site where this Job Description will be utilized (a Supervising Anesthesiologist may supervise a maximum of four Anesthesiologist Assistants):

We hereby certify under penalty of law of the State of Alabama that the foregoing information in this Anesthesiologist Assistant Job Description is correct to the best of our knowledge and belief. We certify that we have reviewed the current rules and regulations of the State of Alabama pertaining to anesthesiologist assistants and understand our responsibilities. We understand that we are equally responsible for the actions of the Anesthesiologist Assistant.

Print Name Signature of Primary Supervising Anesthesiologist Date

Print Name Signature of Anesthesiologist Assistant Date

This form must be printed, signed, and emailed/faxed/mailed to the Board. Email address is provided on instructions page.

Under Alabama law, this document is a public record and if requested it will be provided in its entirety.

SUPPLEMENTAL CERTIFICATE TO APPLICATION FOR REGISTRATION AS AN **ANESTHESIOLOGIST ASSISTANT**

To: _____

(Name and Address of Hospital or Corporate Employer)

The State Board of Medical Examiners has been presented with an application from _____ for registration as an anesthesiologist assistant to _____ M.D. Information available to the Board indicates that _____, M. D., is an employee of _____ (legal entity), and that _____, Anesthesiologist Assistant, is an employee of _____ (legal entity).

To assist the Board in evaluating this application, it is requested that this questionnaire be filled out and executed by the President, Chairman, Chief Executive Officer or Chief Administrative Officer of the corporation or other legal entity that employs the

physician and the anesthesiologist assistant. These questions relate directly to the supervisory relationship contemplated by Board Rules, Chapter 540-X-7. When an additional explanation is to be provided, please attach additional information on separate pages.

1. Is the anesthesiologist whose name appears above, employed by you to engage in the full-time practice of anesthesiology? If the answer to this question is no, please provide the Board with details of the employment agreement between your corporation and the anesthesiologist.
2. Does the anesthesiologist whose name is stated above have the unqualified authority to terminate the employment of the anesthesiologist assistant registered to him/her? If the answer to this question is no, please set out in detail the steps required to terminate the employment of the anesthesiologist assistant and identify the officer or officers of the corporation authorized to make that decision.
3. Does the anesthesiologist whose name is stated above, have the unqualified authority to determine the levels of compensation to be paid to the anesthesiologist assistant registered to him/her? If the answer to this question is no, please set forth in detail the manner in which the compensation of the anesthesiologist assistant is established and the identification of the officer or officers of the corporation who are authorized to establish increase or reduce the compensation of the anesthesiologist assistant.
4. Does the anesthesiologist whose name appears above have the unqualified authority in matters relating to patient care to enforce compliance with orders and directives issued to the anesthesiologist assistant? Please describe in detail the manner in which such orders and directives may be enforced.
5. Is the anesthesiologist assistant whose name appears above subject to the supervision, direction or control of any officer, director, supervisor or employee of the corporation other than the anesthesiologist to whom he or she is registered? If the answer to this question is yes, please explain in detail, identifying the individual exercising the supervision, direction or control and the circumstances in which such supervision, direction and control would be exercised.
6. In matters relating to patient care, is the anesthesiologist assistant whose name appears above subject to the immediate supervision, direction or control of any non-physician? If yes, explain the relationship.
7. Will the anesthesiologist assistant whose name appears above be expected or required to perform any part of his or her duties at any time when the anesthesiologist to whom he or she is registered is not on duty and physically present on the premises of the hospital, clinic, or facility where the anesthesiologist assistant services will be rendered? If the answer to this question is yes, please explain in detail all such circumstances.

I understand that the information submitted herein is to be used by the Board of Medical Examiners as the basis for certification of an anesthesiologist assistant and that the furnishing of false or misleading information or the future occurrence of substantial departures from or violations of the standards and procedures outlined in this response, may be considered by the Board as grounds for termination of the certification of the anesthesiologist assistant.

The undersigned hereby certifies that the foregoing information is true and correct to the best of my knowledge, information and belief.

Name of the Corporation

Title of Officer Signing Certificate

Printed Name of the Officers Signing Certificate

Signature

This form should be completed, printed, and provided directly to the Alabama Board of Medical Examiners. Facsimile and email of this form are accepted.

Author: Alabama Board of Medical Examiners
Authority: Ala. Code § 34-24-303
History: Amended/Approved: November 16, 2017