

APA-2

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 D, Application for Licensure of Anesthesiologist Assistant

INTENDED ACTION: To amend the rule/appendix

SUBSTANCE OF PROPOSED ACTION: Amend for online completion

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: Carla H. Kruger, Office of the 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 Aug. 3, 2018. Persons wishing to obtain copies of the text of this rule and submit data, views, or comments or arguments orally should contact Carla H. Kruger, 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, the intended action is available at the Board's web site, www.albme.org.

FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE: Aug. 3, 2018

CONTACT PERSON AT AGENCY: Carla H. Kruger



Amy T. Dorminey, Board Secretary

ALABAMA BOARD OF MEDICAL XAMINERS
 P.O. Box 946 / Montgomery, AL 36101-0946 / (334) 242-4116

APPLICATION FOR LICENSURE OF ANESTHESIOLOGIST ASSISTANT

I. Anesthesiologist Assistant's Name in Full _____

 Home Address _____ City _____ State _____ Zip _____
 Place of Birth _____ Date of Birth _____ Sex _____
 Social Security #Number* _____

*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.

- Place of Birth
- Country of Birth
- City of Birth
- State/Providence of Birth
- Gender/Sex (at birth)
- Date of Birth

Contact Information

The address and contact methods provided should be how the Board or Commission can contact the license applicant directly. Please DO NOT provide contact information for office managers, assistance, or license assistant companies.

- Home Address
- Country
- Street
- Apt/Suite
- City
- State
- Zip
- County

II. If you answer yes to any of the following questions, please provide a detailed explanation and provide the complete address of any psychiatrist/psychologist, state board, hospital, etc., if appropriate:

	YES	NO
1. Have you ever been convicted of a felony?	_____	_____
2. Have you ever been convicted of a crime or offense (felony or misdemeanor) related to the practice of	_____	_____
3. Have you ever been convicted of any violation of a state or federal law relating to controlled	_____	_____
4. Have you ever been denied a state or federal controlled substance certificate?	_____	_____
5. Have you ever been denied prescription privileges for non-controlled or legend drugs by any state or	_____	_____
6. Has your certification or license to practice as an anesthesiologist assistant in any state been suspended, revoked, restricted, curtailed, or voluntarily surrendered while under investigation in any state?	_____	_____
7. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited, placed under conditions restricting your practice, or voluntarily surrendered while under investigation?	_____	_____

8. Have you ever been denied a certification or license to practice as an anesthesiologist assistant in any state or has your application for certification or for a license to practice as an anesthesiologist assistant been withdrawn under threat of denial?

9. Have you ever had a judgment rendered against you or action settled relating to the performance of your professional service?

10. Have you successfully completed the Anesthesiologist Assistant National Certifying Examination?

If YES, PROVIDE VERIFYING DOCUMENTATION You answered Yes, upload verifying documentation from the National Commission on Certification of Anesthesiologist Assistants (NCCAA).

If NO, ~~h~~ Have you ever taken the examination? YES NO

Are you registered to take the examination? YES NO

If YES ATTACH VERIFYING DOCUMENTATION

You answered Yes, upload verifying documentation

from the NCCAA.

Test Date

~~11. Are you currently registered, certified to or working for any other primary supervising anesthesiologist either in Alabama or another state? ie Are you presently working as an anesthesiologist assistant? If so, answer yes.~~

~~If YES, provide the name and principal practice location of each primary supervising anesthesiologist to whom you are certified. In addition, state your designated working hours per week for each physician listed.~~

~~12. Have you ever been certified as an anesthesiologist assistant by the Alabama Board of Medical Examiners in the past?~~

~~If YES, please provide names of anesthesiologists.~~

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13. 11. Within the past five years, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority?

14. 12. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?

15. 13. Are you currently* engaged in the excessive use of alcohol, controlled substances, or the use of illegal drugs, or received any therapy or treatment for alcohol or drug use, sexual boundary issues or mental health issues? (If you are an anonymous participant in the Alabama Physician Health Program and are in compliance with your contract, you may answer "No" to this question, such answer for this purpose will not be deemed upon certification as providing false information to the Alabama Board of Medical Examiners)

*The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the condition referred to may have an ongoing impact on one's functioning as an assistant to an anesthesiologist within the past two years.

IMPORTANT: The Board recognizes that licensees encounter health conditions, including those involving mental health and substance use disorders, just as their patients and other health care providers do. The Board expects its licensees to address their health concerns and ensure patient safety. Options include anonymously self-referring to the Alabama Physician Health Program (334-954-2596), a physician advocacy organization dedicated to improving the health and wellness of medical professionals in a confidential manner. The failure to adequately address a health condition, where the licensee is unable to practice with reasonable skill and safety to patients, can result in the Board taking action against the license to practice as an anesthesiologist assistant.

 Please initial certifying that you understand and acknowledge your duty as a licensee to address any such condition as stated above.

*The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the condition referred to may have an ongoing impact on one's functioning as an assistant to an anesthesiologist within the past two years.

- 46. 14. Have you been, within the past five years, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving?
- 47. 15. Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation?

APPLICANT'S EDUCATION (since graduating from high school): (provide a copy of your diploma(s) reflecting graduation from an Anesthesiologist Assistant program.)

Education Information

When entering dates attended in the education sections if you do not know the exact date use the first date of the month. (Example: you attended from August 1990 – July 1994, enter 08/01/1990 – 07/01/1994)

Applicant's Education (since graduating from high school)

Upload a copy of your diploma(s) reflecting graduation from an Anesthesiologist Assistant Program

- School Name
- Start Date
- End Date
- School Address

	Dates attended	Name of school	Address
1.	From _____ to _____	_____	_____
2.	From _____ to _____	_____	_____
3.	From _____ to _____	_____	_____

IV. APPLICANT'S ACTIVITIES since graduation from high school: (cover all time periods)

	Date	Place of employment or activity	Address
1.	From _____ to _____	_____	_____
2.	From _____ to _____	_____	_____
3.	From _____ to _____	_____	_____
4.	From _____ to _____	_____	_____
5.	From _____ to _____	_____	_____

Applicant's Activities since graduating from high school (cover all time periods)

- Place of Employment or Activity
- Start Date
- End Date
- Address

v. **CERTIFICATION of LICENSURE:** (list all states where you have been certified/registered/licensed as an Anesthesiologist Assistant). It is a requirement that each state provide directly to the Board a verification. Copies via facsimile or email are accepted (see instructions). It is your responsibility to make the request to each state.

It is a requirement that each state provide a verification of licensure and return it directly to this agency where it will be added to your application for licensure. It is your responsibility to make the request to each state.

State

VI. Affidavit and Release:

I, _____ certify after being duly sworn, that all of the information supplied in the foregoing submitted application is true and correct to the best of my knowledge, that the photograph submitted ~~herein~~ is a true likeness of the assistant and was taken within sixty 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 of any certification / licensure granted.

I further authorize the release of this application and any information submitted with it or information collected by the Alabama Board of Medical Examiners in connection with this application, including derogatory information, to any person or organization having a legitimate need for the information and release of the Alabama Board of Medical Examiners from all liability for the release of this information.

I further authorize the release of information, including derogatory information, which may be in the possession of other individuals or organizations to the Alabama Board of Medical Examiners and release this person or any organization from any liability for the release of information.

Anesthesiologist Assistant's Signature

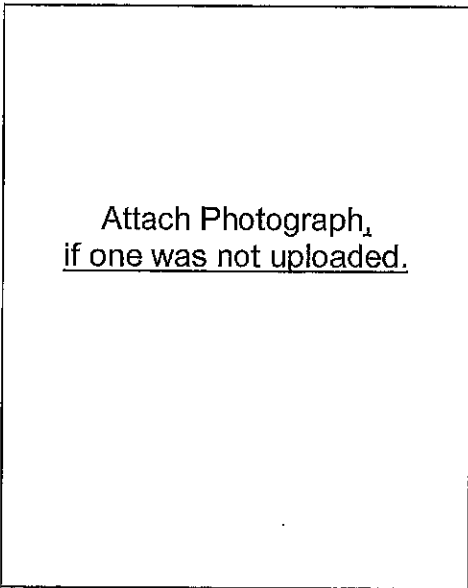
Date: _____ County of _____

State of _____

SWORN to and subscribed before me this _____ day of

Notary Public Signature

My Commission Expires: _____



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

The Alabama Board of Medical Examiners will enforce the Board's rules and options for the issuance of Non-Disciplinary Citation and Administrative Charge when an applicant falsifies an application.

Print application affidavit and release, sign in presence of Notary Public, attach color picture if not uploaded, and return mail original to the Alabama Board of Medical Examiners.