Anesthesiologist Assistant Application for Licensure

Board *of* Medicine
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: https://flboardofmedicine.gov/
Email: BOM_InitialApps@flhealth.gov
Phone: (850) 245-4131
Fax: 850-488-0596

Are you an active duty member of the United States Armed Services?

Are you a veteran of the United States Armed Services?

Are you the spouse of a veteran of the United States Armed Services?

Are you the spouse of an active member of the United States Armed Services?

If you answered "Yes" to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health's commitment to serving members and veterans of the United States Armed Forces and their families online at http://www.flhealthsource.gov/valor

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Do Not Write in this Space For Revenue Receipting Only

Prior to completing the application, it is strongly recommended that you carefully read chapter (ch.) 458 Florida Statutes (F.S.) and ch. 459, F.S., and Rule ch. 64B8-31, Florida Administrative Code (F.A.C.), and ch. 64B15-7, F.A.C.

You must know and comply with the laws and rules as they pertain to your professional practice. Laws and rules are subject to change at any time. For updated information refer to www.leg.state.fl.us/ for Florida Statutes and www.flrules.org for Florida Administrative Code.

Anesthesiologist Assistant (1515) **$255.00**

Total fee of $255.00 includes the following:	
Application Fee (non-refundable)	$150.00
Initial License Fee	$100.00
Unlicensed Activity Fee	$5.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. Requests for a refund must be made in writing. Fees are refundable for up to three years from the date of receipt.

1. PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

_____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone (Input without dashes)

Physical Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website)

_____ _____ _____
Street (Place of Employment) Suite No. City

_____ _____ _____ _____
State ZIP Country Work/Cell Telephone (Input without dashes)

EQUAL OPPORTUNITY DATA:

We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender:	Male	Race:	Native Hawaiian or Pacific Islander	Hispanic or Latino	White
	Female		American Indian or Alaska Native	Black or African American	Asian
			Two or More Races		

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

Yes No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. SOCIAL SECURITY DISCLOSURE

This information is exempt from public records disclosure.

Pursuant to Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s). 456.013(1)(a), F.S., authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

Social Security Number: _____
(Input without dashes)

Social Security Information- * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code § 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, F.S. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.

Name: _____

3. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past. Attach additional sheets if necessary.

_____

B. Do you hold, or have you ever held a license to practice as an anesthesiologist assistant or any other regulated professional license(s)? Yes No

C. List all regulated professional licenses (active, inactive or lapsed). Include any temporary licenses or permits. Attach additional sheets if necessary.

License Type	License #	State/Jurisdiction or Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

Submit a "License Verification" form to **ALL** state(s) of licensure. License verifications must be received directly from the licensing authority regardless of the status of the license. A copy of your license **will not** be accepted in lieu of official verification.

If you have been employed as a health care practitioner in a state that did not require license/registration/ certification, you must request that the state board provide such statement directly to the board office.

D. Have you ever discontinued practice for any reason for a period of one month or longer? Yes No

E. Have you ever been named in a lawsuit for malpractice or has any settlement or claim been paid on your behalf in relation to a claim or malpractice? Yes No

If you responded "Yes," provide the following:

A copy of the **Complaint(s)**, **Amended Complaint(s)**, and **Judgement**. If litigation is pending, the attorney representing the case must submit a letter addressed to the Board of Medicine explaining the current litigation status.

A written self-explanation stating how many cases you have been named in and the details of your involvement.

F. If you have ever served in the United States (U.S.) Military or Public Health Service (PHS), have you ever been disciplined by any branch of the U.S. Military or PHS? Yes No N/A

If "Yes," provide the following:

A self-explanation on a separate sheet providing accurate details (including, but not limited to, the date(s), location(s), and specific circumstances).

Documentation from the U.S. Military/PHS regarding the disciplinary action and charge(s)/event(s).

4. DISASTER

Would you be willing to provide health services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? Yes No

Name: _____

5. EDUCATION / TRAINING HISTORY

A. List the accredited anesthesiologist assistant program you completed.

School Name	Address	Attendance Dates: From-To (MM/DD/YYYY)
		to

All applicants must provide the following:

The **"Anesthesiologist Assistant Program Verification Request" form** (found at the back of the application) must be sent **directly from the anesthesiologist assistant program** you attended to the board office.

B. List all undergraduate, graduate, and professional education. Starting with undergraduate education, list in chronological order all schools, colleges, and universities attended, whether completed or not. Attach a separate sheet if necessary.

School Name	School Address	Dates of Attendance: From-To (MM/DD/YYYY)	Degree Awarded
		to	
		to	
		to	
		to	

C. Have you completed the Advanced Cardiac Life Support (ACLS) program administered by the American Heart Association (AHA)? Yes No

If "Yes," provide the program completion date: _____
MM/YYYY

All applicants must **submit a copy of the ACLS certificate** issued by the AHA to the board office.

D. List in chronological order any other relevant training you have received.

Program Name	Program Location	Dates of Training: From-To (MM/DD/YYYY)	Diploma/Certificate Awarded
		to	
		to	
		to	
		to	

All documentation must be sent directly to the board office at BOM_InitialApps@flhealth.gov or mailed to:

Board *of* Medicine
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3253

Name: _____

This information is exempt from public records disclosure

6. EXAMINATION HISTORY

A. Have you ever taken the examination of the National Commission on Certification of Anesthesiologist Assistants (NCCAA)? Yes No

If you responded "Yes," list all exam dates, whether passed or failed. Attach additional sheets if necessary.

Exam Date (MM/YYYY)	Result
	Pass Fail
	Pass Fail
	Pass Fail
	Pass Fail

By board rule, the board may require an applicant who does not pass the NCCAA exam after five or more attempts to complete additional remedial education or training.

All applicants certified by the NCCAA must provide the following:

The **"National Commission on Certification of Anesthesiologist Assistants Verification Request" form** (found at the back of the application) must be sent to the board office **directly from the NCCAA**.

B. Do you have a previous NCCAA certificate that has lapsed? Yes No

If "Yes," provide the certification number: _____

C. Are you re-certified by the NCCAA? Yes No

If you responded "Yes," list all NCCAA re-certification dates, whether passed or failed. Attach additional sheets if necessary.

Exam Date (MM/YYYY)	Result
	Pass Fail
	Pass Fail
	Pass Fail
	Pass Fail

Name: ______________________________

7. EMPLOYMENT HISTORY

Non-Medical Employment History

Account for all periods of time during the **past five years** during which you were **not** employed in a medical-related setting, including time taken off for vacations. Do not leave off more than 30 days.

In chronological order list all **non-medical employment** and **non-employment** during the past five years to the present. List the full name and address of the facility. Attach additional copies of this page if necessary.

Facility Name/Address		Employment Dates: From-To (MM/YYYY)
		to
Position Title	**Reason for Leaving**	

Facility Name/Address		Employment Dates: From-To (MM/YYYY)
		to
Position Title	**Reason for Leaving**	

Facility Name/Address		Employment Dates: From-To (MM/YYYY)
		to
Position Title	**Reason for Leaving**	

Facility Name/Address		Employment Dates: From-To (MM/YYYY)
		to
Position Title	**Reason for Leaving**	

Facility Name/Address		Employment Dates: From-To (MM/YYYY)
		to
Position Title	**Reason for Leaving**	

Facility Name/Address		Employment Dates: From-To (MM/YYYY)
		to
Position Title	**Reason for Leaving**	

Name: ______________________________

Medical Employment History

Account for **all** periods of time you have been employed in a **medical-related setting.** Do not leave off more than 30 days.

In chronological order list **all medical-related employment.** List the full name and address of the facility. Attach additional copies of this page if necessary.

Facility Name/Address		Employment Dates: From-To (MM/YYYY)
		to
Position Title	**Reason for Leaving**	

Facility Name/Address		Employment Dates: From-To (MM/YYYY)
		to
Position Title	**Reason for Leaving**	

Facility Name/Address		Employment Dates: From-To (MM/YYYY)
		to
Position Title	**Reason for Leaving**	

Facility Name/Address		Employment Dates: From-To (MM/YYYY)
		to
Position Title	**Reason for Leaving**	

Facility Name/Address		Employment Dates: From-To (MM/YYYY)
		to
Position Title	**Reason for Leaving**	

Facility Name/Address		Employment Dates: From-To (MM/YYYY)
		to
Position Title	**Reason for Leaving**	

8. OTHER ITEMS REQUIRED

Letters of Recommendation- All applicants must submit two current, original, personalized and individualized letters of recommendation from anesthesiologists (MD's or DO's) on the anesthesiologist's letterhead paper, expounding on your clinical skills and abilities. Each letter must be addressed to the Board of Medicine and must have been written no more than six months prior to the filing of the application.

If you are a recent graduate, your recommendation letters must be from your faculty anesthesiologists.

If you were employed as an anesthesiologist assistant, your recommendation letters must be from supervising anesthesiologist.

If clinical rotations are completed in a state other than your program and your preceptor physician is submitting a recommendation letter, the physician must clarify their association with you.

Letters addressed only "To Whom It May Concern" and/or containing a signature stamp **will not be accepted.** Identical letters that appear to have been composed by the same person, or from family members, **will not be accepted.**

All supporting documentation not submitted with the application should be sent to the board office at BOM_InitialApps@flhealth.gov or mailed to:

Board *of* Medicine
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3253

Name: _____

This information is exempt from public records disclosure.

9. HEALTH HISTORY

The board and the department, as part of its responsibility to protect the health, safety, and welfare of the public, must assess whether an applicant manifests any physical, mental health, or substance use issue that impairs the applicant's ability to meet the eligibility requirements for a health care practitioner as defined in chapter (ch.) 456, F.S., and the applicable statutory practice acts.

The board and the department support applicants seeking treatment and views effective treatment by a licensed professional as enhancing the applicant's ability to meet the eligibility requirements to practice a health care profession.

Seeking assistance with stress, mild anxiety, situational depression, family or marital issues will not adversely affect the outcome of a Florida health care practitioner application. The board and the department do not request that applicants disclose such assistance.

1. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or impairs your ability to practice? Yes No
2. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or impairs your ability to practice? Yes No

If a "Yes" response was provided to any of the questions in this section, provide the following documents directly to the board office:

A letter from a licensed health care practitioner, who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

A written self-explanation, identifying the medical condition(s) or occurrence(s); and current status.

Name: _____

10. DISCIPLINE HISTORY

A. Have you ever had a license to practice as a anesthesiologist assistant revoked, suspended, placed on probation, received a citation, or other disciplinary action taken in any state, territory, or country?
Yes No

B. Have you ever had any application for a license to practice a regulated profession, including medicine, denied by any state board or the licensing authority of any state, territory, or country? Yes No

If you responded "Yes" in questions A-B, you must provide the following:

A written self-explanation, describing in detail the circumstances surrounding the disciplinary action.

A copy of all pertinent information including **Administrative Complaint(s), Final Order(s), and current disposition**.

C. Are you currently under investigation or prosecution in any jurisdiction for an act that would constitute a violation under s. 456.072, F.S., or s. 458.331, F.S.? Yes No

If you responded "Yes" in question C, you must provide the following:

A written self-explanation, describing in detail the circumstances surrounding the disciplinary action.

A letter from the state board/entity explaining the results of the investigation.

If you responded "Yes" in questions A-C, complete the following:

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				Y N
				Y N
				Y N
				Y N

If you responded "Yes" to any of the questions in this section, you must provide the following:

A written self-explanation, describing in detail the circumstances surrounding the disciplinary action.

A copy of all pertinent information including **Administrative Complaint(s), Final Order(s), and current disposition**.

D. Have you ever had employment terminated for cause? Yes No

If you responded "Yes," provide a written self-explanation.

Name: _____

11. CRIMINAL HISTORY

A. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld.

Reckless driving, driving while license suspended or revoked (DWSLR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question. Yes No

B. Have you had any felony convictions? Yes No

If you responded "Yes" in this section, complete the following:

Offense	Jurisdiction	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				Y N
				Y N
				Y N

If you responded "Yes," you must provide the following:

A written self-explanation, describing in detail the circumstances surrounding each offense; including date, city and state, charges and final results.

Final Dispositions and **Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.

Completion of Sentence Documents. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

12. CRIMINAL AND MEDICAID / MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), F.S.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under ch. 409, F.S. (relating to social and economic assistance), ch. 817, F.S. (relating to fraudulent practices), ch. 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? Yes No

If you responded "No" to the question above, skip to question 2.

a. If "Yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence, and completion of any subsequent probation? Yes No

b. If "Yes" to 1, for the felonies of the third degree, has it been more than ten years from the date of the plea, sentence, and completion of subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), F.S.)? Yes No

c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), F.S., has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation? Yes No

d. If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed (if "Yes," provide supporting documentation)? Yes No

Name: _____

2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? Yes No

   If you responded "No" to the question above, skip to question 3.

   a. If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended? Yes No

3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to s. 409.913, F.S.? Yes No

   If you responded "No" to the question above, skip to question 4.

   a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? Yes No

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? Yes No

   If you responded "No" to the question above, skip to question 5.

   a. Have you been in good standing with a state Medicaid program for the most recent five years? Yes No

   b. Did termination occur at least 20 years before the date of this application? Yes No

5. Are you currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities (LEIE)? Yes No

   a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? Yes No

   b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? Yes No

If you responded "Yes" to any of the questions in this section, you must provide the following:

A written self-explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation.

Supporting documentation including court dispositions or agency orders where applicable.

Documentation for sections 9 and 10 must be sent to the board office at BOM_InitialApps@flhealth.gov or mailed to:

Board *of* Medicine
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3253

Documentation for sections 11 and 12 must be sent to MQA.BackgroundScreen@flhealth.gov or mailed to:

Background Screening Unit
Florida Department of Health
4052 Bald Cypress Way, Bin BSU-01
Tallahassee, FL 32399

Name: _____

13. LIVESCAN PRIVACY STATEMENT

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation (found in the forms following this application).

The board will not receive your Livescan results if you do not confirm the above statement by checking the box.

Electronic Fingerprinting: (Required for ALL applicants)

All applicants, including out-of-state applicants, are required to submit their fingerprints electronically. The Department of Health accepts electronic fingerprinting offered by Livescan service providers that are approved by the Florida Department of Law Enforcement. For a list of approved vendors, visit: http://www.flhealthsource.gov/background-screening/.

Typically background results submitted by Livescan are received by the board within 24-72 hours of being processed. The board's ORI number is **EDOH4510Z**. The board cannot accept hard fingerprint cards or results. All results must be submitted electronically by the Livescan service provider.

The Florida Department of Health retains fingerprints on any applicant in the Care Provider Clearinghouse. One of the requirements for your Livescan to be retained in the Care Provider Clearinghouse is a photograph must be taken by the Livescan service provider at the time of fingerprinting. Your background screening results will be retained for five years. You will be notified when your retention date is approaching and will be provided with instructions on how to retain your fingerprints to avoid having to submit a new background screening.

14. APPLICANT SIGNATURE

I have carefully read the questions in the application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me are true and correct. I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to s. 456.067, F.S.

Florida law requires me to immediately inform the board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed.

I authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 45 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Section 456.013(1)(a), F.S., provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant Signature _____ Date _____

You may print this application and sign it or sign digitally. MM/DD/YYYY

It is strongly suggested that applicants **refrain from** making a commitment or accepting a position in Florida until a Florida Anesthesiologist Assistant license has been issued.

Upon employment as an Anesthesiologist Assistant, you must notify the Florida Department of Health, Board of Medicine, Anesthesiologist Assistants **within 30 days** of beginning such employment **or** after any subsequent changes in the supervising physician(s) and any address changes. An **"Anesthesiologist Assistant Protocol" form** must be used for this purpose.

This form is required for ALL applicants.

Board *of* Medicine
Anesthesiologist Assistant
Financial Responsibility

Name: _____

The Financial Responsibility options are divided into two categories: coverage and exemptions.
Choose only ONE option that best describes your situation, unless you choose **option 3** in the **"Financial Responsibility Coverage"** section. Not making a choice or choosing more than one option will make this form invalid. Staff is unable to advise you on which option to choose. If you have questions regarding an option, consult your legal counsel, insurance company or financial institution.

FINANCIAL RESPONSIBILITY COVERAGE

1. I have established an irrevocable letter of credit or an escrow account in an amount of $100,000/ $300,000, in accordance with ch. 675, F.S., for a letter of credit and s. 625.52, F.S., for an escrow account.

2. I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F.S., from a surplus lines insurer as defined under s. 626.914(2), F.S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F.S., or through a plan of self-insurance as provided in s. 627.357, F.S.

3. I am exempt from financial responsibility coverage. ***(If you choose this option you must choose one option from the exemption category below.)***

EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILTY COVERAGE

1. I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.

2. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals.

3. I have no malpractice exposure, because I do not practice in the state of Florida.

Section 456.067, F.S., Penalty for giving false information. - In addition to, or in lieu of, any other discipline imposed pursuant to s. 456.072, F.S., the act of knowingly giving false information in the course of applying for or obtaining a license for the department, or any board thereunder, with intent to mislead a public servant in the performance of his or her duties, or the act of attempting to obtain or obtaining a license from the department, or any board thereunder, to practice a profession by knowingly misleading statements or knowing misrepresentations constitutes a felony of the third degree, punishable in s. 775.082, F.S., s. 775.083, F.S., or s. 775.084, F.S.

Applicant Signature _____ Date _____
MM/DD/YYYY

This form is required for ALL applicants.

Board *of* Medicine
Anesthesiologist Assistant Affidavit

Applicant Name: _____

Answer the following questions and sign this form before a notary public.
Submit the completed form with your application.

A. Have you ever had a license to practice as an anesthesiologist assistant or other license to practice any regulated profession revoked, suspended, received a citation, or otherwise acted against, including denial of licensure? Yes No

B. Have you had any license revoked or denied? Yes No

C. Have you had any felony convictions? Yes No

Applicant Signature _____ Date _____
MM/DD/YYYY

State of _____ County of _____

The foregoing instrument was sworn before me this_____ day of _____, 20_____

by _____ who is personally known to me or who has produced as

identification _____ and did take an oath.

Printed Name of Notary _____

Notary Signature _____

Date Notary Commission Expires: _____
MM/DD/YYYY

[NOTARY SEAL]

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR ALL APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL REOCRDS RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREEING CLEARINGHOUSE

NOTICE OF:

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record to be employed, licensed, work under contract, or serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes. "Specified agency" means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Person with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearinghouse will be notified if FDLE receives Florida arrest information on you.

Your Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies' duties in distinguishing your identity from that of other persons whose identification information may be the same or similar to yours.

Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of your record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in S. 943.056, F.S., and Rule 11C-8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.

Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

The FBI's Privacy Statement follows on a separate page and contains additional information.

US Department of Justice
Federal Bureau of Investigation
Criminal Justice Information Services Division

PRIVACY STATEMENT

Authority: The FBI's acquisition, preservation and exchange of information requested by this form is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub. L.92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L.94-29; Pub.L.101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion of approval of your application.

Social Security Account Number (SSAN): Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal Agencies to use this number to help identify individuals in agency records.

Principal Purpose: Certain determinations, such as employment, security, licensing and adoption, may be predicated on fingerprint-based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as may be relevant to the activity for which this application is being submitted, the FBI may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

Routine Uses: The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as many be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice, FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosure to: appropriate governmental authorities responsible for civil or criminal law enforcement counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law, treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing the application, they may have additional routine uses.

Additional information: The requesting agency and/or the agency conducting the application investigation will provide additional information to the specific circumstances of this application, which may include identification of other authorities, purposes, uses and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice.

Board *of* Medicine
Anesthesiologist Assistants
Electronic Fingerprinting

Take this form with you to the Livescan service provider. Check the service provider's requirements to see if you need to bring any additional items.

- Background screening results are obtained from the Florida Department of Law Enforcement and the Federal Bureau of Investigation by submitting a fingerprint scan using the Livescan method.
- You can find Livescan service providers at: http://www.flhealthsource.gov/background-screening/.
- Failure to submit background screening will delay your application.
- Applicants may use any Livescan service provider approved by the Florida Department of Law Enforcement to submit their background screening to the department.
- If you do not provide the correct Originating Agency Identification (ORI) number to the Livescan service provider, the board office will not receive your background screening results.
- The ORI number for the Board of Medicine is **EDOH4510Z**.
- You must provide accurate demographic information to the Livescan service provider at the time your fingerprints are taken, **including your Social Security number (SSN)**.
- Typically background screening results submitted through a Livescan service provider are received by the board within 24-72 hours of being processed.
- If you obtain your Livescan from a service provider who does not capture your photo you may be required to be reprinted by another agency in the future.

Name: _____ SSN#: _____
Last First Middle

Aliases: _____

Address: _____ Apt. Number: _____

City: _____ State: _____ ZIP: _____

Date of Birth: _____ Place of Birth: _____
MM/DD/YYYY

Weight: _____ Height: _____ Eye Color: _____ Hair Color: _____

Race: _____ Sex: _____
(W-White/Latino(a); B-Black; A- Asian; NA-Native American; U-Unknown) (M= Male; F=Female)

Citizenship: _____

Transaction Control Number (TCN#): _____
(This will be provided to you by the Livescan service provider.)

Keep this form for your records.

Complete verifications must be sent directly from the licensing agency to the board office at BOM_InitialApps@flhealth.gov, or mailed to:

Board *of* Medicine
Anesthesiologist Assistants
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3257

Board *of* Medicine License Verification Request

Part I: To be completed by applicant (Florida requires verification of all your current and previously held licenses.)

Name: _____

Address: _____

Name original license was issued under: _____

License Number: _____ State: _____

I hereby authorize release of any information regarding my licensure status to the Florida Board of Medicine.

Applicant Signature: _____ Date: _____
MM/DD/YYYY

Part II: To be completed by state licensing agency

All verifications must be in English and include the following criteria:

* Typed on an official state form or letterhead
* Include an official board seal
* Signature and title of state board official

The following information must be included in all verifications:

* Licensee name
* License number
* State or jurisdiction of licensure
* Licensure status
* Is license in good standing?
* Date of issuance/expiration
* Licensure method (examination or reciprocity/endorsement)
* Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)?
* If this license has ever been encumbered, please provide certified copies of documentation regarding the action with the completed license verification.

Complete verifications must be mailed directly from the verifying agency to:

Board *of* Medicine
Anesthesiologist Assistants
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3253

Board *of* Medicine
Anesthesiologist Assistant Program Verification Request

Applicant Name: _____ Date of Birth: _____
MM/DD/YYYY

Anesthesiologist Assistant Program Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

The individual listed above has applied to the Florida Board of Medicine for licensure as an anesthesiologist assistant. A diploma was submitted as proof of having completed educational prerequisites for licensure in Florida. Please authenticate by completing the following. This form must include a signature and seal.

Profession: Anesthesiologist Assistant Degree Issued Date: _____
MM/DD/YYYY

Comments (if any): _____

_____

_____

_____

Verified by:

Name of Verifier: _____

Signature of Verifier: _____

Date: _____ Title of Verifier: _____
MM/DD/YYYY

[SEAL]

Complete verifications must be mailed directly from the verifying agency to:

Board *of* Medicine
Anesthesiologist Assistants
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3253

Board *of* Medicine

National Commission on Certification of Anesthesiologist Assistants Verification Request

Part I: To be completed by applicant

Name: _____ Date of Birth: _____
MM/DD/YYYY

National Commission on Certification
of Anesthesiologist Assistants (NCCAA)

contact@nccaa.org

Part II: To be completed by NCCAA

NCCAA Certificate #: _____ Previous NCCAA Certificate # (if applicable): _____

Number of times NCCAA exam was taken: _____ Number of times NCCAA exam was failed: _____

Dates of Exam (MM/DD/YYYY)	Dates of Exam (MM/DD/YYYY)	Dates of Exam (MM/DD/YYYY)

Original Issue Date: _____ Expiration Date: _____
MM/DD/YYYY MM/DD/YYYY

Current Status: _____

Comments (if any): _____

_____

Verified by:

Name of Verifier: _____

Signature of Verifier: _____

Date: _____ Title of Verifier: _____
MM/DD/YYYY

[SEAL]

Board *of* Medicine
Anesthesiologist Assistants
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3257

Board *of* Medicine Anesthesiologist Assistant Protocol

- **Always** submit **all pages** of the protocol.
- A **separate** protocol form must be submitted for **each** individual practice setting, i.e., working full-time in one practice and part-time in an additional practice with different supervising anesthesiologist(s) would require two completed protocols. (**Satellite offices** within the same practice do not constitute multiple practices, but **must be documented** on a single protocol. Satellite offices **do not** require separate forms.)
- Maintain a copy of your signed protocol form for credentialing purposes.
- Licensees are required to keep their protocol and licensure information current **at all times.**
  *Failure to submit any changes or updates (mailing/practice locations, adding/deleting supervising physicians, etc.) within 30 days of the occurrence **will** result in disciplinary action.*
- With the exception of practicing in a government facility, **only** an anesthesiologist with an unrestricted Florida license, and whose license is not on probation, is qualified to employ and supervise anesthesiologist assistants.

1. ANESTHESIOLOGIST ASSISTANT (AA) INFORMATION

Name: _____ **Florida License #:** AA_____
Last/Surname First Middle

Address Change? Yes No **Employment Start Date:** _____
MM/DD/YYYY

Mailing Address: _____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone

Practice Address: _____ _____ _____
Street/P.O. Box Suite No. City

_____ _____ _____ _____
State ZIP Country Practice Telephone

Email Address*: _____

*Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. PURPOSE OF PROTOCOL *(It is the responsibility of the AA to keep the protocol current.)*

Section (s.) 458.3475, Florida Statutes (F.S.) and s. 459.023, F.S., and Rules 64B8-31 and 64B15-7, Florida Administrative Code, require that "Upon employment as an Anesthesiologist Assistant, a licensed Anesthesiologist Assistant must notify the board office prior to such employment and/or after any subsequent changes in the supervising Anesthesiologist(s). **Such notification shall include the full name, Florida license number and address of the supervising Anesthesiologist(s) as appropriate.**"

Indicate the information being updated using this protocol form.			
Primary Supervising Physician	Adding	Deleting	No Change
Alternate Supervising Physician	Adding	Deleting	No Change
Practice Location	Adding	Deleting	No Change
Satellite Location	Adding	Deleting	No Change

AA Name: ______________________________ Florida License #: AA______________

3. ADDING SUPERVISING ANETHESIOLOGIST(S) INFORMATION

Section 458.3475, F.S., and s. 459.023, F.S., state that "an Anesthesiologist who directly supervises an anesthesiologist assistant must be qualified in the medical areas in which the anesthesiologist assistant performs and is liable for the performance of the anesthesiologist assistant."

Attach additional copies of this page as necessary. All dates must be in MM/DD/YYYY format.

Name of Supervising Anesthesiologist	DEA #	Florida Medical License #
Practice Address		Supervision Start Date
Signature:		

Name of Supervising Anesthesiologist	DEA #	Florida Medical License #
Practice Address		Supervision Start Date
Signature:		

Name of Supervising Anesthesiologist	DEA #	Florida Medical License #
Practice Address		Supervision Start Date
Signature:		

Name of Supervising Anesthesiologist	DEA #	Florida Medical License #
Practice Address		Supervision Start Date
Signature:		

Name of Supervising Anesthesiologist	DEA #	Florida Medical License #
Practice Address		Supervision Start Date
Signature:		

AA Name: ________________________________ Florida License #: AA______________

4. DELETING SUPERVISING ANETHESIOLOGIST(S) INFORMATION

Attach additional copies of this page as necessary. All dates must be in MM/DD/YYYY format.

Supervising Anesthesiologist to be Deleted	Florida Medical License #	Deletion Date

Supervising Anesthesiologist to be Deleted	Florida Medical License #	Deletion Date

Supervising Anesthesiologist to be Deleted	Florida Medical License #	Deletion Date

Supervising Anesthesiologist to be Deleted	Florida Medical License #	Deletion Date

Supervising Anesthesiologist to be Deleted	Florida Medical License #	Deletion Date

Supervising Anesthesiologist to be Deleted	Florida Medical License #	Deletion Date

5. DELETING PRACTICE LOCATION(S) INFORMATION

Attach additional copies of this page as necessary. All dates must be in MM/DD/YYYY format.

Practice Location to be Deleted	Deletion Date

Practice Location to be Deleted	Deletion Date

Practice Location to be Deleted	Deletion Date

Practice Location to be Deleted	Deletion Date

Practice Location to be Deleted	Deletion Date

Practice Location to be Deleted	Deletion Date

AA Name: _____ Florida License #: AA_____

6. ANESTHESIOLOGIST ASSISTANT DUTIES AND PROCEDURES

A. **List all duties and functions to be performed by the AA.**

B. **Describe procedures to be followed in the event of an anesthetic emergency.**

AA Name: _____ Florida License #: AA_____

7. ANESTHESIOLOGIST ASSISTANT AND PRIMARY SUPERVISING PHYSICIAN SIGNATURE

The protocol must be on file with the board before the anesthesiologist assistant may practice with the anesthesiologist or group. An anesthesiologist assistant may not practice unless a written protocol has been filed for that anesthesiologist assistant.

The anesthesiologist assistant may only practice under the **direct** supervision of an anesthesiologist who has signed the protocol. "Direct supervision" means the on-site, personal supervision by an anesthesiologist who is present in the office when the procedure is being performed in that office, or is present in the surgical or obstetrical suite when the procedure is being performed in that surgical or obstetrical suite and who is in all instances immediately available to provide assistance and direction to the anesthesiologist assistant while anesthesia services are being performed.

The protocol must be updated biennially.

I declare that all statements provided on this form are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to s. 456.072, F.S., s. 458.327, F.S., s. 458.331, F.S., s. 459.013, F.S., s. 459.015, F.S., s. 775.082, F.S., s. 775.083, F.S., and s. 775.084, F.S.

_____ _____
Anesthesiologist Assistant Signature Date (MM/DD/YYYY)

_____ _____
Primary Supervising Physician Signature Date (MM/DD/YYYY)

_____
Primary Supervising Physician Name (print)

If you do not receive your stamped copy of the protocol form within 30 days, contact the board office at (850) 245-4131.