

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

Required demographic information:

Name in full (First, Middle, Last, M.D./D.O.)

Alternate name(s) used

Address (Street, City, State, Zip)

Email address

Place of birth

Date of birth

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.)

Sex

Telephone (H or C)

Telephone (W)

Required background information:

If your answer is "yes," please provide a detailed explanation in the space provided.

Legal:

1. Have you ever been arrested for, cited for, charged with, or convicted of any crime, offense, or violation of any law, felony, or misdemeanor, including, but not limited to, offenses related to the practice of medicine or state or federal controlled substances laws?

\* This question excludes minor traffic violations such as speeding and parking tickets but includes felony and misdemeanor criminal matters that have been dismissed, expunged, sealed, subject to a diversion or deferred prosecution program, or otherwise set aside.

2. Have you ever been arrested for, cited for, charged with, or convicted of any sex offender laws or required to register as a sex offender for any reason?

3. Have you ever had a judgment rendered against you or action settled relating to an action for injury, damages, or wrongful death for breach of the standard of care in the performance of your professional service ("malpractice")?

4. To your knowledge, as of the date of this application, are you the subject of an investigation or proposed action by any law enforcement agency?

Administrative/Regulatory:

5. Have you ever had any Drug Enforcement Administration registration and/or state controlled substances registration denied, voluntarily surrendered while under investigation, or subject to any discipline, including, but not limited to revocation, suspension, probation, restriction, conditions, reprimand, or fine?

6. Have you ever been denied prescription privileges for non-controlled or legend drugs by any state or federal authority?

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in any state or jurisdiction or has your application for a license to practice as an assistant to physicians been withdrawn under threat of denial?

8. Has your certification or license to practice as an assistant to physicians in any state or jurisdiction ever been subject to any discipline, including but not limited to revocation, suspension, probation, restrictions, conditions, reprimand, or fine?

9. Have your privileges at any hospital or health care facility ever been revoked, suspended, curtailed, limited, or placed under conditions restricting your practice?

10. To your knowledge, as of the date of this application, are you the subject of an investigation or proposed action by any federal agency, any licensing board/agency, or any hospital or health care facility?

Health:

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

12. Within the past five years, have you 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 during 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?

13. Within the past five years, have you been 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?

14. Are you currently\* engaged in the excessive use of alcohol or controlled substances or in the use of illegal drugs, or receiving any therapy or treatment for alcohol or drug use, sexual boundary issues, or mental health issues?

\*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 that the condition referred to may have an ongoing impact on one's functioning as an assistant to physicians within the past two years.

Notice: If you are an anonymous participant in the Alabama Professionals Health Program and are in compliance with your contract, you may answer "No" to this question. Such an answer for this purpose, upon certification, will not be deemed as providing false information to the Alabama Board of Medical Examiners.

14.a. 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. Licensees are expected to address their health concerns and ensure patient safety. Options include anonymously self-referring to the Alabama Professionals Health Program (334-954-2596), an 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 assistant to physicians.

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

Education/Training/Experience:

15. Has your medical education, training, or medical practice been interrupted or suspended, or have you ceased to engage in direct patient care, for a period longer than 60 days for any reason other than a vacation or for the birth or adoption of a child?

When entering attendance dates below, you may use the first date of the month instead of the exact date. (Ex: attended August 1990 - July 1994, enter 08/01/1990 - 07/01/1994)

**Education (beginning with undergraduate degree)**

Upload a copy of your diploma(s) reflecting graduation from an Anesthesiologist Assistant Program  
School Name Start  
Date End Date  
School Address

**Activities Since Beginning Undergraduate Degree (cover all time periods)**

Place of Employment or Activity Start Date  
End Date  
Address

**Examination**

Have you successfully completed the Anesthesiologist Assistant National Certifying Examination?  
If YES, upload verifying documentation from the National Commission on Certification of Anesthesiologist Assistants (NCCAA).  
If NO, have you ever taken the examination?  
Are you registered to take the examination?  
If YES upload verifying documentation from the NCCAA. Test date:

**Current Practice**

Are you currently registered, certified to or working for any other primary supervising physician in another state? i.e., 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 physician to whom you are certified. In addition, state your designated working hours per week for each physician listed.

**Certification of Licensure in Other States**

List all states where you have been certified/registered/licensed as an assistant to physicians. Primary source verification is required from any state that does not report anesthesiologist assistant data to the Federation of State Medical Boards.

**Certification and Release:**

I, [full name], certify that all of the information supplied in the submitted application is true and correct to the best of my knowledge, and that the photograph submitted herein is a true likeness of me 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 denial of this application or revocation of any certification/licensure granted.

I further consent to and 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 consent to and 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.

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.

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Anesthesiologist Assistant's Signature