DEPARTMENT OF HEALTH
ANESTHESIOLOGIST ASSISTANTS
P.O. Box 6330
Tallahassee, Florida 32399-6330
(850) 245-4131

APPLICATION FOR LICENSURE AS AN ANESTHESIOLOGIST ASSISTANT (INSTRUCTIONS)

Prior to completing the application, we strongly recommend that you carefully read Sections 458 and 459, Florida Statutes and Rule Chapters 64B8-31, and 64B15-7 Florida Administrative Code. 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 the following web-sites www.leg.state.fl.us/ (statutes) and www.flrules.org (Florida Administrative Code).

Please take personal responsibility for preparing your application. Carefully read and follow all instructions. If you have questions, call for clarification. Applicants are required to keep the application information updated during processing.

The Department strongly suggests that you refrain from making a commitment or accepting a position in Florida until you are licensed.

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 must be used for this purpose.

THE FOLLOWING ITEMS MUST ACCOMPANY YOUR APPLICATION FOR LICENSURE AS AN ANESTHESIOLOGIST ASSISTANT: Copies must be legible. It is acceptable, and preferred that large documents be reduced to 8 1/2" x 11".

1. Applications and Initial License Fee:
No application will be processed without the fees. Application and initial license fees must accompany the application. The application fee is non-refundable. The application fee is $150 and the initial license fee is $100 plus $5.00 unlicensed activity fee for any person applying for licensure as an Anesthesiologist Assistant as provided in Sections 458 and 459, F.S., Submit a check, money order or cashier's check made payable to the Florida Department of Health in the amount of $255. The biennial license period for Anesthesiologist Assistants is February 1 odd year through January 31 odd year.

2. Anesthesiologist Assistant Diploma: Submit a photocopy of your Anesthesiologist Assistant diploma. Additionally, you are responsible for mailing to your Anesthesiologist Assistants program the "Anesthesiologist Assistant Program Verification Form".

3. NCCAA: Submit a photocopy of your certificate issued to you by the National Commission on Certification of Anesthesiologist Assistants (NCCAA). If you have had a previous certificate that lapsed, please indicate the certification number. Chapters 458 and 459 require any person desiring to be licensed, as an Anesthesiologist Assistant, must have "satisfactorily passed a proficiency examination by an acceptable score established by the National Commission on Certification of Anesthesiologist Assistants (NCCAA). If an

applicant does not hold a current certificate issued by the NCCAA and has not actively practiced as an Anesthesiologist Assistant within the immediately preceding 4 years, the applicant must retake and successfully complete the entry-level examination of the NCCAA to be eligible for licensure." 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. Additionally, you are responsible for mailing the "NCCAA Verification Form" to NCCAA.

4. Advanced Cardiac Life Support (ACLS) Certificate: Submit a photocopy of your ACLS certificate issued by the American Heart Association.

5. United States Military and/or Public Health: Provide a copy of your discharge documents indicating type of discharge.

6. Name: List your name as it appears on your birth certificate and/or a legal name-change document. Nicknames or shortened versions are unacceptable. If you have a hyphenated last name, enter both names in the last name space. It will be recognized by the first letter of the first name; e.g., Diaz-Jones.

7. Financial Responsibility: Pursuant to Section 456.048(1), F.S., prior to licensure, the Anesthesiologist Assistant must provide a statement of liability coverage on forms approved by the Board**.**

8. Letters of Recommendation: Two current, original, personalized and individualized letters of recommendation from Anesthesiologists, (MD's or DO's) on his or her letterhead paper. Each letter must be addressed to the Board of Medicine and must have been written no more than six (6) months prior to the filing of the application. 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. 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, please have the physician clarify his/her association with you. Letters should expound on your clinical skills and abilities.

9. License Verifications: (AA, PA, LPN, RN, EMT, CNA, Paramedic, RT, TT, PT, etc.)
Provide verification of licensure as an Anesthesiologist Assistant **a**nd/or any other healthcare practitioner in any state. Some agencies charge a fee for license verifications. If you are, or have been, licensed in the United States, contact each state and have them forward licensure/registration/certification, (including temporary licenses/permits) verification directly to the Board of Medicine. If no license/registration/ certification was required during your employment, please request that the state board provide such statement directly to this office. A copy of your license is not acceptable in lieu of a written verification of licensure from the State Licensing Agency. You may want to request state licensure verifications as soon as possible; some states can take up to 6 weeks to complete and mail verifications. Additionally, you are responsible for mailing the "Licensure Verification Form" to all state Medical Boards where you have ever held a license as a health care provider. (Not limited to Anesthesiologist Assistant licensure)

10. Education, Training, Employment and Non-Employment History: Question 17 must contain and account for all non-medical periods of time, including vacations and non-employment during the past five years. Question 18 must contain and account for all medical related employment. Omission of this information will cause a delay in the application process. Do not leave off more than 30 days.

11. Activities: You are required to update your application by providing the Board office with a written statement of your activities within 30 days of the Committee meeting to which your application is being considered.

12. Supplemental Documents: If any of the questions numbered 20-23 and 25-40 on the application are answered "Yes", you must submit a detailed statement, composed by you, explaining the circumstances. Should any of the questions in the “YES/NO” portion of the application fail to provide sufficient space for the requested information, use an additional page and number the additional information with the corresponding number in the application.

- For Questions 33-38: * Reports from all treating physicians/hospitals/institutions/agencies, including admission and discharge summary regarding treatment on conduct assessment(s); mental or physical conditions. Reports must include all DSM III R/DSM IV, Axis I and II diagnoses and codes and Axis III condition and prescribed medications. Applicants, who have any history of those listed above, may be required to undergo a current conduct assessment through Florida’s Professionals Resource Network (PRN). Also see “Supplemental Documents”.

- For Questions 23, 25-29, and 39-40: * Submit court copies of charges/arrest report(s), indictments(s) and judgment(s) and satisfaction of judgment(s) Submit copies of any litigation or any other proceedings in any court of law or equity, any criminal court, any arbitration Board or before any governmental Board or Agency, to which you have been a party, either as a plaintiff, defendant, co-defendant, or otherwise. Also see “Supplemental Documents”.

- For Questions 20-22 and 32: * Submit Copies of supporting documentation. Also see “Supplemental Documents”.

- For Questions 30: * Submit court copies of complaint(s), amended complaint(s), and judgment(s). If litigation is pending, the attorney representing the case must submit a letter addressed to the Committee on Anesthesiologist Assistants explaining the current litigation status. Submit a statement, composed by you, stating how many cases you have been named in and the details of your involvement. Also see “Supplemental Documents”.

∗Section 456.013(3)(c), Florida Statutes, permits the Board to require your personal appearance.

The Total Fee (includes Application, License, and Unlicensed Activity Fees) **$255** Return all pages of the application. (Excluding instruction pages) Application must be typed or printed legibly.	**DEPARTMENT OF HEALTH** **BOARD OF MEDICINE** **P.O. Box 6330** **Tallahassee, Florida 32399-6330** **(850) 245-4131** **APPLICATION FOR LICENSURE AS AN ANESTHESIOLOGIST ASSISTANT**	**For Deposit/Receipt Only** **CLIENT 1515**

1. Today's Date:

2.Name:_____
(First) (Middle) (Last)

3. List all legal name changes including marriage, maiden, or other:

4. Mailing Address:
_____
(No. & Street) (City , State) (Zip)

5. Permanent Address:
_____
(No. & Street) (City, State) (Zip)

6. Date of Birth: (Month, Day, Year)

7a. Primary Telephone Number:	7b. Alternate Telephone Number:

OPTIONAL: E-mail Address:

ACCREDITED ANESTHESIOLOGIST ASSISTANT PROGRAM:

8. Name and location of program:

9. Dates of Attendance: (Month/Day /Year)

From **To**

CERTIFICATION HISTORY:	
10a. Have you ever taken the examination of the National Commission on Certification of Anesthesiologist Assistants? YES ☐ NO ☐	10b. Initial NCCAA exam dates; month and year.
11a. Have you ever failed the examination of the National Commission on Certification of Anesthesiologist Assistants? YES ☐ NO ☐	11b. If yes, list all failed exam dates; month / year.
12a. Are you re-certified by the NCCAA? YES ☐ NO ☐	12b. List all NCCAA re-certification exam dates.
13. Have you completed the Advanced Cardiac Life Support program administered by the American Heart Association? YES ☐ NO ☐	14. List ACLS completion date; month and year.

LICENSURE HISTORY:
15. In what states are/were you licensed/registered as a healthcare provider? (AA, EMT, CNA, RN, etc.) Include all temporary certificates/licenses. List the states, the license number, issue date and type of license. If non-applicable, indicate N/A or none. (see #9 on page 3 of the instructions)

EDUCATION HISTORY:
16. List, undergraduate, graduate and professional education – Starting with undergraduate education, list in chronological order all schools, colleges and universities attended, whether completed or not. Submit on a separate sheet if needed.
COLLEGE OR UNIVERSITY: List the name, location of school, dates of attendance and degrees earned.
OTHER TRAINING:

NON-MEDICAL EMPLOYMENT HISTORY:		
17. In CHRONOLOGICAL order list all non-medical employment during the past 5 years until present. Give full name and address of the facility, dates of employment (month and year), positions / titles held, and reason for leaving. Failure to provide all required information will delay processing the application. Add additional sheets if necessary.		
NAME & ADDRESS OF FACILITY FOR NON-MEDICAL EMPLOYMENT DURING LAST 5 YRS	**Dates of Employment (Month and Year)**	**Title of position held & reason for leaving**

MEDICAL EMPLOYMENT HISTORY:

18. In CHRONOLOGICAL order list all medical related employment. Give full name and address of the facility, dates of employment (month and year), positions / titles held, and reason for leaving. Failure to provide all required information will delay processing the application. Add additional sheets if necessary.

Name and Address of Employer	Dates of Employment (Month and Year)	Title of position held & reason for leaving

MILITARY HISTORY:

19. Have you ever been in the United States Military and or Public Health Service? If yes, please list below the branch of service, rank and all dates of service. Provide a copy of your discharge document.

YES ☐ NO ☐

THE FOLLOWING QUESTIONS MUST BE ANSWERED YES OR NO. ALL AFFIRMATIVE ANSWERS MUST BE PERSONALLY EXPLAINED TO THE COUNCIL IN DETAIL ON AN ADDITIONAL SHEET. DOCUMENTATION SUBSTANTIATING THE EXPLANATION IS REQUIRED.

20. Have you ever been denied a license as an Anesthesiologist Assistant or health care practitioner by any state board or other governmental agency of any state or country? YES ☐ NO ☐

21. Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature, including, but not limited to, a charge of violation of the medical practice act, unprofessional or unethical conduct? YES ☐ NO ☐

22 Have you ever had a license to practice as an Anesthesiologist Assistant or other health care practitioner revoked, suspended, or other disciplinary action taken in any state, territory or country? YES ☐ NO ☐

23. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if the court withheld adjudication so that you would not have a record of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question YES ☐ NO ☐

24. 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. YES ☐ NO ☐

25. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? (If you responded "no", skip to #26.) YES ☐ NO ☐

25a. If "yes" to 25, 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 ☐

25b. If "yes" to 25, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes.) YES ☐ NO ☐

25c. If "yes" to 25, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation? YES ☐ NO ☐

25d. If "yes" to 25, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or charges dismissed? (If "yes", please provide supporting documentation.) YES ☐ NO ☐

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

26a. If "yes" to 26, 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 ☐

27. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If "No", do not answer 27a.) YES ☐ NO ☐

27a. 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 ☐

28. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? (If "No", do not answer 28a or 28b.) YES ☐ NO ☐

28a. Have you been in good standing with a state Medicaid program for the most recent five years? YES ☐ NO ☐

28b. Did the termination occur at least 20 years before the date of this application? YES ☐ NO ☐

29. Are you currently listed on the United States Department of Health and Human Services Office of 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 29.a., is the student loan default or delinquency the only reason you are listed on the LEIE? YES ☐ NO ☐

30. 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 of malpractice? YES ☐ NO ☐
31. Have you ever discontinued practice for any reason for a period of one month or longer? YES ☐ NO ☐
32. Have you ever had employment terminated for cause? YES ☐ NO ☐
33. In the last five years, have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years? YES ☐ NO ☐
34. In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or YES ☐ NO ☐
35. During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice medicine within the past five years? YES ☐ NO ☐
36. During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine? YES ☐ NO ☐
37. In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years? YES ☐ NO ☐
38. During the last five years, have you been treated for or had a recurrence of a diagnosed substance- related (alcohol/drug) disorder that has impaired your ability to practice medicine within the last five years? YES ☐ NO ☐
39. Have you had any felony convictions? YES ☐ NO ☐
40. Have you had any license revoked or denied? YES ☐ NO ☐

AFFIDAVIT: (Applicable to questions 22, 39 and 40 only)

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.

Name of Notary:_____(typed, printed or stamped)

Signature of Notary:_____

Date Notary Commission Expires: _____

We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Male ☐ Female ☐ Black ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other ☐

Statement of Applicant:

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 459, and sections 766.301-306, F.S. and Chapters 64B8-31, and 64B15-7, Florida Administrative Code.

I hereby 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 have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice Medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

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, 42CFR 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.

SIGNATURE OF APPLICANT: **DATE:**

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

Florida Department of Health
Board of Medicine
Anesthesiologist Assistant License Application

Name: _____
Last **First** **Middle**

Social Security Number: _____

*This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCA § 666 (a)(13). For all professions regulated under chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013 (1)(a), Florida Statutes.

Department of Health, Board of Medicine
ANESTHESIOLOGIST ASSISTANT FINANCIAL RESPONSIBILITY FORM
(Please Print the Following Information)

NAME:

MAILING ADDRESS:

CITY: **STATE:** **ZIP:**

Mailing address will not be published on the Internet.

PRACTICE LOCATION:

CITY: STATE: ZIP:

Practice locations will be published on the Internet.

Financial Responsibility options are divided into two categories, coverage and exemptions.
Choose only one option provided pursuant to s.456.048, Florida Statutes.

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 Chapter 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.

FINANCIAL RESPONSIBILITY EXEMPTIONS:

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

☐ **4.** I do not practice medicine in the State of Florida.

☐ **5.** I practice only in conjunction with my teaching duties at an accredited school or its main teaching hospitals.

Signature of Anesthesiologist Assistant Date

National Commission for Certification of Anesthesiologist Assistants contact@nccaa.org	From: Department of Health Board of Medicine 4052 Bald Cypress Way, Bin #C03 Tallahassee, Florida 32399-3253

Name:	

First Middle Last

Date of Birth:	/ /

NCCAA Certificate #:		Previous NCCAA Certificate # if applicable	

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

Dates of exams:	

Original issue date:	/ /

Expiration date:	/ /

SEAL

Comments if any

Signature and title: Date:

LICENSE VERIFICATION FORM

(Mail to each state where you were/are licensed)

To:	FROM: Department of Health Board of Medicine Anesthesiologist Assistants 4052 Bald Cypress Way BIN #C03 Tallahassee, Florida 32399-3253

The Anesthesiologist Assistant listed below has submitted an application for licensure in Florida. He/she states that he/she is/was licensed or registered in your state as a healthcare practitioner. Please complete and return this form as soon as possible. Thank you for your cooperation.

***Completed by applicant**

_____ First Middle LAST		
	*DOB:	/ /

Completed by Medical Board

Profession:		License #:	
Issue date:		Expiration Date	

Was a temporary certificate issued prior to full licensure? YES☐ NO☐

License #	Issue date:	Expiration Date:

Has any disciplinary action ever been taken against this license? YES☐ NO☐
If yes, please explain.

_____
Verified by: (signature)

SEAL

_____
Name: (please print)

_____
Title:

ANESTHESIOLOGIST ASSISTANT PROGRAM VERIFICATION FORM

To: (Anesthesiologist Assistant program address)	From: **Department of Health** **Board of Medicine** **Anesthesiologist Assistants** **4052 Bald Cypress Way** **Bin #C03** **Tallahassee, Florida 32399-3253**

The individual listed below has applied to the Florida Department of Health, Board of Medicine for licensure as an Anesthesiologist Assistant. A diploma from your school was submitted as proof of having completed educational prerequisites for licensure in Florida. Please authenticate by signature and seal that the following is true and correct.

Name:	_____ First Middle Last

DOB:	/ /

Profession:	**Anesthesiologist Assistant**	Degree issue date:	/ /

Comments (if any):_____

_____

_____
Verified by: (signature)

_____
Name: (please print)

_____
Title:

SEAL

ANESTHESIOLOGIST ASSISTANT PROTOCOL

INSTRUCTIONS AND INFORMATION

- ✓ Always submit pages 18 - 21 of the Protocol. (Do not return the instruction page.)
- ✓ The Anesthesiologist MUST sign page 20 and the Anesthesiologist Assistant MUST sign page 21.
- ✓ A separate Protocol form must be submitted for each individual practice setting. (Satellite offices DO NOT require separate forms but DO need to be listed.)
- ✓ If you do not receive your stamped copy of the Protocol form within 30 days, please call us at (850) 245-4131.
- ✓ Please maintain a copy of your signed Protocol form for credentialing purposes.
- ✓ Failure to submit any changes or up-dates within 30 days of the occurrence will result in disciplinary action. (mailing / practice locations, adding / deleting supervising physicians)
- ✓ With the exception of practicing in a government facility, only anesthesiologists with an unrestricted Florida license, and whose license is not on probation, is qualified to employ and supervise anesthesiologist assistants.
- ✓ Licensees are required to keep his/her protocol and licensure information current at all times.

PERFORMANCE OF SUPERVISING ANESTHESIOLOGIST(S):
Sections 458.3475 and 459.023, Florida Statutes, 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."

Keep a copy of these frequently used phone numbers and Web sites

- **Anesthesiologist Assistant Website**: www.flhealthsource.com (Applications, Protocols, renewal forms, CME requirements, address changes,)
  - **MQA Services** (Look-up License, request an application, request license certification for another state medical board.
- **Laws & Rules:** www.leg.state.fl.us/ and www.flrules.org
- **Web Board Address:** www.flboardofmedicine.gov
- **American Medical Association (AMA):** (312) 464-5000
- **American Academy of Anesthesiologist Assistants (AAAA):** (678) 222-4221
- **American Osteopathic Association (AOA):** (800) 621-1773
- **NCCAA:** (919) 573-5439
- **Medicaid:** (877) 267-2323 **Medicare:** (877) 267-2323 http://www.cms.gov

ANESTHESIOLOGIST ASSISTANT PROTOCOL FORM

Department of Health
4052 Bald Cypress Way, Bin #C03
Tallahassee, Florida 32399-3253
(850) 245-4131

IT IS THE RESPONSIBILITY OF THE ANESTHESIOLOGIST ASSISTANT TO KEEP THE PROTOCOL CURRENT.

Sections 458.3475 and 459.023, Florida Statutes, and Rules 64B8-31 and 64B15-7, Florida Administrative Code, require that "Upon employment as a 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."** A separate Protocol is required for each distinct practice, i.e., working full-time in one practice and then working part-time in an additional practice with different supervising Anesthesiologist (s) and would require two (2) completed Protocols. Satellite offices within the same practice do not constitute multiple practices, but must be documented on a single Protocol.

ANESTHESIOLOGIST ASSISTANT DATA:

Name:	**FL License #: AA**
Address Change? Yes ☐ No ☐	Employment Date: / /
Mailing Address:	
Practice Address:	
Home telephone #:	Practice telephone #:
E-mail Address:	

PLEASE INDICATE BELOW THE REASON (S) FOR SUBMITTING THIS FORM:		
Adding ☐	Deleting ☐	Primary Supervising Physician
Adding ☐	Deleting ☐	Alternate Supervising Physician
Adding ☐	Deleting ☐	Practice Location
Adding ☐	Deleting ☐	Satellite Location

DUTIES AND PROCEDURES PERFORMED BY THE AA

Duties and functions of the Anesthesiologist Assistant:

ADDING SUPERVISING ANESTHESIOLOGIST(S) DATA:				
Name and Practice Address of all Supervising Anesthesiologist(s) PLEASE PRINT	Supervising Physician(s) DEA Number	Physician's Florida Medical License #	Signature of Supervising Anesthesiologist	Beginning Date of Supervision

Signature of primary supervising anesthesiologist.

DELETING SUPERVISING ANESTHESIOLOGIST(S)

NAME OF SUPERVISING ANESTHESIOLOGIST (S) YOU ARE DELETING	FLORIDA MEDICAL LICENSE NUMBER	DELETION DATE

DELETION OF PRACTICE LOCATION(S)

	DELETION DATE

I declare that these statements are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.072, 458.327, 458.331, 459.013, 459.015, 775.082, 775.083 and 775.084, Florida Statutes.

_____Date: _____

Signature of Anesthesiologist Assistant

Electronic Fingerprinting

Take this form with you to the Livescan service provider. Please 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 to a fingerprint scan using the Livescan method;
- You can find an approved Livescan Service Provider at: http://www.flhealthsource.gov/background-screening/ (Select Locate a Provider).
- 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: _____ Social Security Number: _____

Aliases: _____ Date of Birth: _____
(MM/DD/YYYY)

Citizenship: _____ Place of Birth: _____

Race: _____ Sex: _____

White/Latino(a); **B**-Black; **A**-Asian; **NA**-Native American; **U**-Unknown) (**M**=Male; **F**=Female)

Weight: _____ Height: _____

Eye Color:_____ Hair Color: _____

Address:_____Apt. Number: _____

City:_____State:_____Zip Code: _____

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

Keep this form for your records.

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORD RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING 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 national criminal history record that may pertain to you to the Specified Agency or Agencies from which you are seeking approval to be employed, licensed, work under contract, or to 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 Persons 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 as 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 the 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, disclosures 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 you additional information pertinent 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.