Remit a check of $100.00 to the Alabama Board of Medical Examiners when you submit your completed application.

ALABAMA BOARD OF MEDICAL EXAMINERS

848 Washington Avenue / Montgomery, AL 36104 / (334) 242-4116

APPLICATION FOR REGISTRATION OF PHYSICIAN ASSISTANT

PHYSICIAN TO COMPLETE:

Supervising Physician Name in Full _____

AL Medical License Number _____

Medical Specialty _____ Board Certified: Select One Board Eligible: Select One

Principal Practice Location Address _____

(If mailing address is different, please provide here) _____

Telephone Number: (_____) _____ FAX Number (_____) _____

1. Provide the name, practice site address and designated working hours per week of each physician assistant and/or CRNP and/or CNM **currently** registered to you.

NAME _____ _____ _____

ADDRESS _____ _____ _____

HOURS _____ _____ _____

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

YES ☐ NO ☐ **If the answer is NO**, Supplemental Certificate must be submitted.

PHYSICIAN ASSISTANT TO COMPLETE:

Physician Assistant Name in Full _____

AL P. A. License Number _____ *Place a "**N/A**" if you do not have an Alabama license.*

1. Is the P.A. **currently** certified or registered to any other primary certifying physician? **If the answer is YES, provide** the physician name, practice address, and the number of hours per week with each primary supervising physician. Attach separate sheets if necessary.

NAME _____

ADDRESS _____

HOURS per week _____

P. A./PHYSICIAN SUPERVISORY AGREEMENT
CORE DUTIES AND SCOPE OF PRACTICE

1. The P. A. may work in any setting consistent with the supervising physician's scope of practice and are customary to the Supervising Physician's scope of practice and are customary to the practice of the Physician. The P. A. scope of practice shall be defined as those functions and procedures for which the P. A. is qualified by formal education, clinical training, area of certification and experience.
2. The following skills and functions are the core duties which may be performed by the P. A.

a. Arrange inpatient hospital admissions, transfers, and discharges in accordance with established guidelines/standards developed within the practice of the supervising physician and P. A.; perform rounds and record appropriate patient progress notes; compile detailed narrative and case summaries; complete forms pertinent to patients' medical records.
b. Perform detailed and accurate health histories, review patient records, develop comprehensive medical status reports, and order laboratory, radiological, therapeutic and diagnostic studies or treatment appropriate for the complaint, age, race, sex and physical condition of the patient.
c. Perform comprehensive physical exams and assessments. Formulate medical diagnoses, including the interpretation and evaluation of patient data to determine patient management and treatment, including the institution of therapy and ordering of medical devices or referral of patients to appropriate care facilities and/or agencies and other resources of the community or other physicians.
d. Prescribe legend drugs authorized by the supervising physician and included on the formulary approved by the guidelines established by the Alabama Board of Medical Examiners for P. A.s.
e. Institute emergency measures and emergency treatment or appropriate stabilization measures in situations such as cardiac arrest, shock, hemorrhage, convulsions, poisoning and emergency obstetric delivery where indicated.
f. Provide instructions, education and guidance regarding healthcare and healthcare promotion to patients, family and caregivers.
g. Skills and functions that are taught in usual and standard PA academic education and do not require additional training or course documentation. The supervising physician and PA may document and validate that the PA has received education, training and competency to perform the core duty or skill.
h. The Board of Medical Examiners recognizes the following as examples of usual and customary core duties and skills that a Physician Assistant can perform, including, but not limited to, the following:
   (1) Perform the following example procedures/skills:
      (a) Surgical Assisting
      (b) Wound debridement, suturing and care of superficial wounds.
      (c) Skin biopsies (facial biopsies are to be requested).
      (d) Insert and removal of drains (excluding paracentesis, thoracentesis, thoracostomy tube insertion, ventriculostomy insertion, and placement of any percutaneous drain into a body cavity).
      (e) Suturing-single layer closure of the face.
      (f) Vein or artery cut-down for access.
      (g) Vein harvesting.
      (h) Surgical wound closure-may close the outermost layer of the fascia, subcutaneous tissue, dermis and epidermis on extremities; over thoracic or abdominal cavities approval to close subcutaneous, dermis and epidermis only.
      (i) Removal of superficial foreign body of the eyeball.
      (j) Incision and drainage of superficial skin infections or abscesses.
      (k) PICC line placement
      (l) Tracheostomy tube change
      (m) Thoracostomy tube removal
      (n) Enteric tube exchange
      (o) Groshong catheter removal
      (p) Infusaport (portacath) removal
      (q) Post pyloric feeding tube placement
      (r) Removal of pacing wires
      (s) Intubation
      (t) Escharotomy
      (u) Cardiac stress test monitoring.

i. For additional skills requested outside the core duties of the P. A. by the supervising physician (i.e. diagnostic or surgical procedures requiring additional training), the supervising physician must provide documentation of the training and / or certification which qualifies the P. A.
The training for the additional duty/skill shall have been previously approved by the Board.
Please list each additional skill request.
See attached "Additional Skills Request Protocol" from the supervising physician.

j. Provide emergency medical services in the event of declared national emergency or natural disaster in accordance with the requirements of Board Rules.

3. List each practice site where this Job Description will be utilized and the number of hours this P. A. will be working weekly in each site. Must include name, address and phone number of each site:

PRACTICE LOCATION	_____	_____	_____
ADDRESS	_____	_____	_____
PHONE	_____	_____	_____
HOURS *Per Week*	_____	_____	_____

4. Is there a request for the P. A. to practice in a remote site? Yes ☐ No ☐
   If yes, attach a letter from the physician requesting approval to utilize the P. A. at a remote site and complete the following information:
   Name, address and telephone number of the remote site

   _____

   Number of hours and at what frequency will the supervising physician will visit the remote site _____

   Number of hours the P. A. will spend in the remote site weekly _____

   Number of hours both will be present together _____

   Provide (attach) a plan describing the practice location, facilities and arrangements for appropriate communication, consultation and review.

5. Provide a written plan for review of medical records and patient outcomes. The review should be documented and maintained at the practice location.

   What percentage of charts will be reviewed? _____

   Who will perform the review? _____

   How often will the review take place? _____

6. Will this P. A. be authorized to have prescriptive privileges? Yes ☐ No ☐
   If yes, attach a completed Formulary which is a list of the legend drugs which are authorized by the Physician to be prescribed by the P. A.. The formulary approved under the rules of the Board of Medical Examiners should be utilized and attached as the authorized legend drugs to be prescribed. The medication categories chosen should reflect the needs of the supervising physician's medical practice.

7. Will this P. A. be authorized to have prescriptive privileges to prescribe controlled substances as allowed under Alabama Code Section 20-2-60,et.seq.?
   Yes ☐ No ☐
   (Prerequisites for controlled substances prescribing by P.A.s are stated in Board Rules, Chapter 540-X-12)
   If yes, the application for a Qualified Alabama Control Substance Certificate can be found at our web site, www.albme.org.

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

Print Name	Signature of Primary Supervising Physician	Date
Print Name	Signature of Assistant to Physician	Date

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

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

SKILLS PROTOCOL TEMPLATE

(*Attach additional pages if necessary)*

PA NAME:
License Number:
Email Address:
Supervising Physician:
License Number:
Email Address:
Practice Specialty of Physician:

Practice Site: Name of Practice and Mailing Address

Procedure Name: List one procedure only

Purpose of Procedure:

Description of Procedure (Give comprehensive details including technique used, energy device to be used if applicable:
Medications to be injected if applicable:

Contraindications /Limits (for allowing Mid-Level practitioner to perform the procedure):

Plan for Supervised Practice:

Plan for Physician Availability:

Plan for Quality Assurance/Adverse Outcome review:

Supervising Physician: (Print Name): _____

Signature: _____Date: _____

PA (Print Name): _____

Signature: _____Date: _____

To: Alabama Board of Medical Examiners

As a covering (back-up) physician providing supervision for Physician Assistant_____, P. A., by signing this document, I hereby affirm that:

1. I am familiar with the current rules regarding Physician Assistants;

2. I am familiar with the job description filed by_____,M.D./D.O. (primary sponsoring physician), and_____, P. A., RA#_____;

3. I will be accountable for adequately supervising the medical care rendered pursuant to the job description; and

4. I will approve the drug type, dosage, quantity and number of refills of legend drugs which the assistant is authorized to prescribe in the job description.

When the primary supervising physician is off duty, out of town, or not on call and not immediately available to respond to patient medical needs, the physician assistant is not authorized to perform any act or render any treatments unless another qualified physician **in the same partnership, group, medical professional corporation or physician practice foundation or with whom the primary supervising physician shares call is on call and is immediately available to supervise the physician assistant** and has previously filed with the Board this letter stating that he or she assumes all responsibility for the actions of the physician assistant during the temporary absence of the primary supervising physician.

I will assume all responsibility for the actions of the assistant during the temporary absence of the primary supervising physician.

Relationship with primary supervising physician: **(CHECK ONE BELOW)**

☐ Partnership ☐ Professional Group
☐ Medical Professional Corporation ☐ Physician Practice Foundation
☐ Physician sharing call

Medical specialty of covering physician _____

_____ _____
Print Physician name License number

_____ _____
Physician signature Date

Covering physician's telephone number_____ Fax _____

APPROVED FORMULARY for
Physician Assistant Registered to Physician
(Adopted by the Alabama Board of Medical Examiners March 15, 1995)

I authorize _____, PA to prescribe and/or administer medications in the categories* below. *[You must complete each line with **YES, NO,** or **RESTRICTED.** If restricted, state restrictions below.]*

* ***Authorized categories of drugs should reflect the needs of the medical practice*** **in which the Physician Assistant is working**.

All written prescriptions will adhere to the standard, recommended doses of legend drugs, as identified in the Physician Desk Reference or Product Information Insert, not to exceed the recommended treatment regimen periods.

* **Botox, Restylane, Collagen and Mesotherapy are not approved for PA prescriptive privileges nor are they to be administered by a PA.**

* The category, *Radioactive Agents*, shall be approved by the Alabama Board of Medical Examiners only for a PA certified to a supervising physician who holds a current license from the Alabama Public Health Department for prescribing / administering / dispensing radioactive pharmaceuticals. If the category, Radioactive Agents, is requested, please attach a copy of the physician's current license from the Public Health Department.

1. Antihistamine and Decongestant Drugs ☐ Yes ☐ No ☐ Restricted

2. Antineoplastic Agents (If Yes, specify circumstances) ☐ Yes ☐ No ☐ Restricted

3. Blood Derivatives ☐ Yes ☐ No ☐ Restricted

4. Coagulation Agents ☐ Yes ☐ No ☐ Restricted

5. Central Nervous System Agents (Nonscheduled) ☐ Yes ☐ No ☐ Restricted

6. Agents of Electrolytic, Caloric and Water Balance ☐ Yes ☐ No ☐ Restricted

7. Expectorants and Cough Preparation(Nonscheduled) ☐ Yes ☐ No ☐ Restricted

8. Gastrointestinal Drugs ☐ Yes ☐ No ☐ Restricted

9. Local Anesthetics ☐ Yes ☐ No ☐ Restricted

10. Radioactive Agents (See note at top of form) ☐ Yes ☐ No ☐ Restricted

11. Spasmolytics ☐ Yes ☐ No ☐ Restricted

12. Vitamins ☐ Yes ☐ No ☐ Restricted

13. Anti-Infective Agents ☐ Yes ☐ No ☐ Restricted

14. Autonomic Drugs ☐ Yes ☐ No ☐ Restricted

15. Blood Formation ☐ Yes ☐ No ☐ Restricted

16. Cardiovascular Drugs ☐ Yes ☐ No ☐ Restricted

17. Diagnostic Agents ☐ Yes ☐ No ☐ Restricted

18. Enzymes ☐ Yes ☐ No ☐ Restricted

19. Ophthalmic drugs ☐ Yes ☐ No ☐ Restricted

20. Hormone and Synthetic Substitutes ☐ Yes ☐ No ☐ Restricted

21. Oxytocics (If yes, specify circumstances) ☐ Yes ☐ No ☐ Restricted

22. Serums, Toxoids, Vaccines ☐ Yes ☐ No ☐ Restricted

23. Birth Control Drugs and Devices ☐ Yes ☐ No ☐ Restricted

24. Analgesics and Antipyretics (Nonscheduled) ☐ Yes ☐ No ☐ Restricted

25. Prosthetics / Orthotics ☐ Yes ☐ No ☐ Restricted

26. Pulmonary Drugs ☐ Yes ☐ No ☐ Restricted

27. Anti-inflammatory Drugs ☐ Yes ☐ No ☐ Restricted

28. Other (If yes, specify circumstances) ☐ Yes ☐ No ☐ Restricted

THE PHYSICIAN ASSISTANT NAMED IN THIS DOCUMENT IS NOT AUTHORIZED TO PRESCRIBE CONTROLLED DRUGS.

Physician signature _____ Date _____ Physician Assistant Signature _____ Date _____

THE SUPERVISING PHYSICIAN SHALL BE HELD LIABLE OR RESPONSIBLE FOR ANY ACT OR OMISSION OF THE ASSISTANT ARISING OUT OF THE ASSISTANT'S PRESCRIBING TO PATIENTS.

SUPPLEMENTAL CERTIFICATE TO APPLICATION
FOR REGISTRATION AS A PHYSICIAN ASSISTANT

To: _____
(Name and Address of Hospital or Corporate Employer)

The State Board of Medical Examiners has been presented with an application from _____ for certification as a physician assistant to _____ M.D./D.O. Information available to the Board indicates that _____, M.D./D.O., is an employee of _____ (legal entity), and that _____, Physician Assistant, is an employee of _____ (legal entity).

To assist the Board in evaluating this application, it is requested that this questionnaire be filled out and executed by the President, Chairman, Chief Executive Officer or Chief Administrative Officer of the corporation or other legal entity that employs the physician and/or the physician assistant. These questions relate directly to the supervisory relationship contemplated by Board Rules, Chapter 540-X-7.
When an additional explanation is to be provided, please attach additional information on separate pages.

1. Is the physician whose name appears above, employed by you to engage in the full-time practice of medicine? Select one **If the answer to this question is NO, please provide the Board with details of the employment agreement between your corporation and the physician**.

2. Does the physician whose name is stated above have the unqualified authoritv to terminate the employment of the physician assistant registered to him? Select one **If the answer to this question is NO, please set out in detail the steps required to terminate the employment of the physician assistant and identify the officer or officers of the corporation authorized to make that decision**.

3. Does the physician whose name is stated above, have the unqualified authority to determine the levels of compensation to be paid to the physician assistant registered to him? Select one **If the answer to this question is NO, please set forth in detail the manner in which the compensation of the physician assistant is established and the identification of the officer or officers of the corporation who are authorized to establish increase or reduce the compensation of the physician assistant.**

4. Does the physician whose name appears above have the unqualified authority in matters relating to patient care to enforce compliance with orders and directives issued to the physician assistant? Select one
Please describe in detail the manner in which such orders and directives may be enforced.

5. Is the physician assistant whose name appears above subject to the supervision, direction or control of any officer, director, supervisor or employee of the corporation other than the physician to whom he is registered? Select one
If the answer to this question is YES, please explain in detail, identifying the individual exercising the supervision, direction or control and the circumstances in which such supervision, direction and control would be exercised.

6 In matters relating to patient care, is the physician assistant whose name appears above subiect to the immediate supervision, direction or control of any non-physician? Select one
If YES, explain the relationship.

7 Will the physician assistant whose name appears above be expected or required to perform any part of his or her duties at any time when the physician to whom he or she is registered is not on duty and physically present on the premises of the hospital, clinic, or facility where the physician's assistant services will be rendered? Select one
If the answer to this question is YES, please explain in detail all such circumstances.

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

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

Name of the Corporation	Title of Officer Signing Certificate
Printed Name of Officer Signing Certificate	Signature

PA/CRNP Critical Care Skill Requirements

- The training requirement for the skills you have requested and for which you have been approved is noted in the table below. 50% of the CVL: Internal Jugular and Femoral and Arterial Line, Radial and Femoral may be done in the simulation lab.
- Documentation of supervised practice upon completion should be submitted to the Board of Medical Examiners (PA and CRNP) and to Board of Nursing (CRNP) for approval and all documentation must identify the anatomical site, and whether the procedures were performed on a live patient or in the simulation lab.
- Documentation of Supervised Procedures for Annual Maintenance as below. Keep a copy at your practice location. ***Supervised Practice must be submitted within 1 year of approval to train.***

Skill	Total number required for certification*	50% allowed to be in Simulation Lab	Annual Maintenance Requirement
Central Venous Lines: Internal Jugular	10	5	5
Central Venous Lines: Femoral	10	5	5
Central Venous Line: Subclavian (**physician must be present**)	50	N/A	25
Central Venous Line, Remove and Replace over Guide Wire ***(Only for practitioners who have previously been approved or are requesting CVL placement, IJ and Femoral)***	5	N/A	5
Removal of percutaneous Central Venous Line	10	0	5
Removal of Tunneled Central Venous Lines-**Insertion of Tunneled catheters is NOT approved**	10	0	5
Arterial Line Insertion: Radial **(PA Only)**	10	5	5
Arterial Line Insertion: Femoral	10	5	5
Intra-Aortic Balloon insertion	20	N/A	10
Radial Artery Harvest **(Cardiac Surgery Only)**	20	N/A	10
Sternal Closure **(Cardiac Surgery Only)**	50	N/A	25
Primary Sternotomy **(Cardiac Surgery Only)**	50	N/A	25
Primary Thoracotomy **(Cardiac Surgery Only)**	50	N/A	25
Thoracostomy tube insertion **(Intra-operative only)**	30	N/A	15
Removal of Pacing Wires **(CRNP Only)**	30	N/A	15
Removal of Left Atrial Catheter	30	N/A	15
Removal of Mediastinal Chest Tubes	15	N/A	8
Removal of Pulmonary Artery Catheter (Swan-Ganz catheter)	30	N/A	15
Removal of Intra-Aortic Balloon Pump	10	N/A	5

Standard for Approval of Central Venous Lines: Adult central venous access obtained through a percutaneous method by way of the internal jugular vein or femoral vein. The Seldinger method is recommended, which refers to the use of a guidewire placed into a vessel to provide a conduit for intravascular catheter placement. ***A non-cuffed catheter no larger than 9 French may be used*.** **Insertion of tunneled catheters is not approved.**

ALABAMA BOARD OF MEDICAL EXAMINERS

Request to Train for Critical Care Specialty Protocol Skills

Complete this page with the required attachments to request approval to train the CRNP/PA to perform the skills indicated below.
Protocol Request is for (please print) _____CRNP/PA

☐ **This PA has been previously trained in the skills checked below and we wish to transfer the approval to perform these skills to our Registration Agreement. (Include copies of previously approved supervised practice)**

☐ **This PA has been previously approved to train and is requesting to transfer this approval.**

1. Choose the procedures you wish to train your APP to perform (# needed for certification)

2. ***Attach protocols*** including any contraindications and limits to the CRNP/PA being allowed to perform these procedures. Also include description of techniques and any energy device utilized during the performance of these procedures if applicable.

☐ Central Venous Line Insertion –Internal Jugular (10)
☐ Central Venous Line Insertion –Femoral (10)
☐ Central Venous Line Insertion-Subclavian (physician must be present) (50)
☐ Central Venous Line, Remove and Replace over Guide Wire (5) ***(Only for those practitioners who have previously been approved or are requesting CVL placement, IJ and Femoral)***
☐ Central Venous Line, Removal- Percutaneous (10)
☐ Central Venous Line, Removal- Tunneled (10) **
☐ Arterial Line Insertion-Femoral (10)
☐ Arterial Line Insertion –Radial (10) (**PA Only**)
☐ Intra-Aortic balloon insertion (20)
☐ Radial Artery harvest (Cardiac Surgery Only) (20)
☐ Sternal Closure (Cardiac Surgery Only) (50)
☐ Thoracostomy tube insertion (Intra-operative only) (30)
☐ Primary Sternotomy (Cardiac Surgery Only) (50)
☐ Primary Thoracotomy (Cardiac Surgery Only) (50)
☐ Removal of Pacing Wires (30) (**CRNP Only**)
☐ Removal of Left Atrial Catheter (30)
☐ Removal of Mediastinal Chest Tubes (15)
☐ Removal of Pulmonary Artery Catheter (Swan-Ganz catheter) (30)
☐ Removal of Intra-Aortic Balloon Pump (10)

3. Upon Completion of the required number of supervised procedures: Submit the final documentation of training on the required form to BME (for CRNP and PA) and to ABN (for CRNP) for final approval to perform the skills independently.

MD (print):_____License_____

MD Signature: _____Date: _____

CRNP/ PA (print): _____License # _____

CRNP/PA Signature: _____ Date: _____

Training may not begin until you have been approved to train by the Alabama Board of Medical Examiners (PA and CRNP) and by Alabama Board of Nursing (CRNP). Supervised practice must be submitted within one (1) year of being approved to train

**** Insertion of Tunneled Central Lines is NOT approved.**

Orthopedic Specialty Protocol

JOINT	INCLUDED	EXCLUDED
SHOULDER	Acromioclavicular Joint Subacromial bursa	Bicipital Tendon Glenohumeral joint aspiration and injection
ELBOW	Olecranon Bursa	Ulnar Collateral Ligament Biceps Tendon Biceps Muscle Annular Ligament of Radius Muscle and Tendon attachments at the Medial and Lateral Epicondyles
GREATER TROCHANTERIC BURSA	Iliopsoas Bursa Gluteous Medius Bursa Ischiogluteal Bursa	Hip Joint
KNEE	Pes anserine bursa	Suprapatellar bursa Prepatellar bursa Infrapatellar bursa Patellar Tendon Sartorius Tendon Gracilis Tendon Semitendinosus Tendon
WRIST, HAND	**EXCLUDED**	PAs are not authorized to perform injections in the wrist or hand
ANKLE	**EXCLUDED**	PAs are not authorized to perform injections in the ankle
FOOT	**EXCLUDED**	PAs are not authorized to perform injections in the foot

No injections of tendons, ligaments, or muscle groups

"For the purpose of this approval the mid-level practitioner is allowed to perform aspirations of joints [limited to shoulder, elbow (olecranon bursa only), knee, and greater trochanteric bursa according to the above grid], with Board approved documentation of training under direct physician supervision. Allowed to perform injections to joints [limited to shoulder, elbow (olecranon bursa only), knee, and greater trochanteric bursa], with Board approved documentation of training under direct physician supervision. Mid-Levels are approved to perform joint injections at remote site locations after approval of documented training and upon request to and approval by, the Board. Total of 25 supervised injections with no less than three (3) of each joint to be considered for approval". Supervised practice must be submitted within one (1) year of being granted the approval to train or the approval to train expires. **Effective March 20, 2018**

ALABAMA BOARD OF MEDICAL EXAMINERS

Orthopedic Specialty Protocol - Request to Train

Before beginning to train a PA to perform Joint Injections the physician must request permission to do so from the Board of Medical Examiners. Complete this page to request approval to train the PA to perform Joint Injections as part of the Orthopedic Specialty Protocol Request, **must include protocols as requested in Item 2 for:**

_____PA

Please Print

1. Check the procedures you wish to train the physician assistant to perform:

☐ **Arthrocentesis**
☐ **Injections of the Shoulder**
☐ **Injections of the Elbow (Olecranon Bursa only)**
☐ **Injections of the Knee**
☐ **Injections of Greater Trochanteric Bursa**

Complete the section below ONLY if you are requesting to transfer a previously approved skill(s).

☐ **This PA has been previously trained in the skills checked above and we wish to transfer the approval to perform these skills to our Registration Agreement. (Include copies of previously approved supervised practice)**

☐ **This PA has been previously approved to train and is requesting to transfer this approval.**

2. **Include your protocol** for training as well as performance by the physician assistant. (See the Orthopedic Specialty Protocol Grid for Inclusions and Exclusions).

3. Upon completion of the required number of supervised procedures (25 cumulative), submit the documentation of training on the required form to the Alabama Board of Medical Examiners for final approval to perform the skills independently. **

MD printed name: _____License # _____

MD Signature: _____Date: _____

PA Signature: _____Date: _____

**Training may not begin until you have been approved to train by the Alabama Board of Medical Examiners. *APPROVAL TO TRAIN WILL LAPSE IF DOCUMENTATION OF SUPERVISED PRACTICE IS NOT RECEIVED WITHIN ONE (1) YEAR!*

Revised 05/28/2019

STATEWIDE CRITERIA FOR MID-LEVEL PRACTITIONERS
Otolaryngology Procedures

Procedures included:

1. Flexible Fiberoptic Diagnostic Laryngoscopy/Stroboscopy
2. Flexible Nasopharyngoscopy
3. Diagnostic Nasal Endoscopy (flexible and rigid)

Initial Requirements:

- Restricted to Otolaryngology practice
- CRNP or PA must have been working in the clinical setting of otolaryngology for no less than 6 months prior to making a request to train
- Observation of no less than 150 procedures (including normal /abnormal tissue distinction) of each procedure ***before*** requesting to train to perform the procedure
- Collaborating (CRNP) or Supervising (PA)Physician completes a request to train after observation period completed

Supervised Practice Requirements:

- CRNP or PA will perform and document 25(each) proctored procedures for initial certification**
- CRNP or PA will perform and document no less than 25 procedures (each) for yearly to maintain certification (keep copies at your facility).

****Supervised practice must be submitted within one (1) year from being granted the approval to train.**

Supervised Practice Requirements:

Procedure	Number for Initial Certification	Number for annual maintenance of certification
Flexible Fiberoptic Diagnostic Laryngoscopy/Stroboscopy	25	25
Flexible nasopharyngoscopy	25	25
Diagnostic nasal endoscopy(flexible and ridged)	25	25

ALABAMA BOARD OF MEDICAL EXAMINERS

Otolaryngology Specialty Protocol Request to Train

CRNP Name: _____License Number: _____

PA Name: _____License Number: _____

Collaborating or Supervising Physician must certify that the **Initial Requirements** have been met as follows:

☐ Practitioner has practiced in the clinical setting of otolaryngology for 6 months or greater

☐ Observation of no less than 150 procedures (including normal /abnormal tissue distinction) of **each procedure *before*** requesting to train to perform the procedure

In signing this form, I the Collaborating /Supervising Physician certify the ***Initial Requirements*** have been met and I am requesting to train the above named mid-level practitioner to perform the following skills in accordance with the State-wide criteria adopted by the Alabama Board of Medical Examiners:

☐ Flexible Fiberoptic Diagnostic Laryngoscopy/Stroboscopy (25)

☐ Flexible Nasopharyngoscopy (25)

☐ Diagnostic Nasal Endoscopy (flexible and rigid) (25)

Mid-level practitioner will submit documentation of supervised practice on the forms provided with the approval notice of 25(each skill) proctored procedures for initial certification.

X_____ _____
Printed Name License Number
X_____ _____
Signature Date

Training may not begin until you have been approved to train by both the Alabama Board of Medical Examiners and the Alabama Board of Nursing. ***APPROVAL TO TRAIN WILL EXPIRE IF DOCUMENTATION OF SUPERVISED PRACTICE IS NOT RECEIVED WITHIN ONE (1) YEAR!*