

ALABAMA BOARD OF MEDICAL EXAMINERS

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

EMERGENCY APPLICATION FOR REGISTRATION OF ANESTHESIOLOGIST ASSISTANT

ANESTHESIOLOGIST TO COMPLETE:

| | |
|---|--|
| Supervising Physician Name in Full _____ | |
| AL Medical License Number _____ | |
| Medical Specialty _____ | Board Certified: YES <input type="checkbox"/> NO <input type="checkbox"/> Board Eligible: YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Principal Practice Location Address _____ | |
| County of Principal Practice Location _____ | |
| Telephone Number: (_____) _____ | FAX Number (_____) _____ |

ANESTHESIOLOGIST ASSISTANT TO COMPLETE:

| |
|--|
| Anesthesiologist Assistant Name in Full _____ |
| <i>Place a "N/A" if you <u>do not</u> have an Alabama license.</i> |
| AL A. A. License Number _____ |

- List each practice site where this Job Description will be utilized. Must include name, address and phone number of each site:

| | | | | |
|--------------------------|-------|-------|-------|-------|
| Practice Location | _____ | _____ | _____ | _____ |
| Address: | _____ | _____ | _____ | _____ |
| Phone: | _____ | _____ | _____ | _____ |

- Anesthesiologist Assistants practicing within a licensed healthcare facility, shall be authorized to perform all skills as authorized in the licensed health care facility's protocols as may be necessary to provide health care to patients.

Is the A.A. practicing within a licensed healthcare facility? Yes No

If no, this registration agreement shall be limited to the applicable standard protocol approved by the Alabama Board of Medical Examiners.

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.

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.

Knowingly providing false information to the Alabama Board of Medical Examiners or Medical Licensure Commission of Alabama could result in disciplinary action.

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 PAAADept@albme.org. Acknowledgment of receipt and approval letter will be provided via return email.

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