ALABAMA BOARD OF MEDICAL EXAMINERS

P.O. Box 946 / Montgomery, AL 36101-0946 / (334) 242-4116

APPLICATION FOR REGISTRATION OF ANESTHESIOLOGIST ASSISTANT

PHYSICIAN TO COMPLETE:

Supervising Physician Name in Full _____

Ala. Medical License Number _____ Date of Birth _____ Social Security No.* _____

*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.

Medical Specialty _____ Board Certified: ☐ YES ☐ NO Board Eligible: ☐ YES ☐ NO

Principal Practice Location Address _____

(If mailing address is different please provide here) _____

Telephone Number: _____ FAX Number _____

1. List the name, practice site address and designated working hours per week of each anesthesiologist assistant **currently** registered to you.

NAME _____

ADDRESS _____

HOURS _____

2. Have you ever had a anesthesiologist assistant certified or registered to you by the Alabama Board of Medical Examiners?

YES ☐ NO ☐ **If the answer is YES**, list the names of the assistant(s) in the spaces provided.

_____

_____

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

YES ☐ NO ☐ **If the answer is NO**, Appendix **G** to Chapter 7 must be submitted.

I hereby certify that the foregoing information is correct to the best of my knowledge, information and belief; and that I have reviewed and understand the current rules and regulations of the Alabama Board of Medical Examiners pertaining to anesthesiologist assistants and understand my responsibilities.

Date: _____ **Primary Supervising Physician Signature**: _____

In accordance with Rule 540-X-7-.51 confirmed receipt of this application will be sent by mail, unless a FAX number is provided where the confirmation can be transmitted by FAX.

A anesthesiologist assistant previously approved to practice under the provisions of Chapter 7 of the Board of Medical Examiners Administrative Rules may continue in the supervised practice with this interim supervising physician and may continue until such time as this application is approved or denied, provided the supervising physician meets the qualifications established in Rule 540-X-7-.47.

ANESTHESIOLOGIST ASSISTANT TO COMPLETE:

Assistant Name in Full _____

Ala. A.A. License No. _____ Date of Birth _____ Social Security No.* _____

*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.

1. Have you ever been certified or registered as a anesthesiologist assistant by the Alabama Board of Medical Examiners?

   YES ☐ NO ☐ **If the answer is YES**, list the names of the physicians in the spaces provided.

_____

_____

2. Are you **currently** certified or registered to any other primary certifying physician? **If the answer is YES,** in the space below give the physician name, physician practice location, *assistant's* certification or registration number, and *assistant's* number of hours per week for each primary supervising physician. (There are spaces for three separate registrations.)

NAME _____

ADDRESS _____

REGISTRATION No. _____

HOURS per week _____

I hereby certify that the foregoing information is correct to the best of my knowledge, information and belief; and that I have reviewed and understand the current rules and regulations of the Alabama Board of Medical Examiners pertaining to anesthesiologist assistants and understand my responsibilities.

Date: _____ **Anesthesiologist Assistant Signature**: _____

Office Use ▼	**PLEASE NOTE & RESPOND TO THE FOLLOWING AS APPROPRIATE FOR THIS REGISTRATION REQUEST.**
	FEE: Each new registration requires submission of a $100.00 fee. Please attach check payable to Alabama Board of Medical Examiners.
	JOB DESCRIPTION: Please attach a completed job description signed by the physician and the assistant.
	APPENDIX G : If assistant is employed by an entity **other than** the physician, the physician's group or professional corporation please include a completed Appendix G. Include a separate sheet for responses if required.
	COVERING PHYSICIAN LETTERS: The absence of "covering physician" letter(s) indicates that when the primary physician is not working, the assistant is not working. (A "sample" form was included in the registration package.)