UA UNIFORM APPLICATION FOR LICENSURE

For State Board Use Only

Affidavit and Authorization for Release of Information

Applicant: In the presence of a notary public, sign this form with attached photo. If you are using FCVS for credentials verification, consider having that form notarized at the same time. Send the separate notarized FCVS form to FCVS. **Do not send this form to FCVS** as doing so will delay your licensure.

Please return to the Vermont Board of Medical Practice, 280 State Drive, Waterbury, VT 05671-8320
AHS.VDHMedicalBoard@vermont.gov

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Uniform Application for Physician State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

Applicant Photograph

Securely tape or glue a recent (per the board's instructions) front-view 2" x 2" passport-type color photo of yourself in this square.

_____
Applicant's signature (must be signed in the presence of a notary)

_____
Applicant's printed last name, first name, middle initial, and suffix (e.g., Jr.)

_____
Date of signature (must correspond to date of notarization)

[Please note: The Notary Public seal should overlap the bottom of the photo to the left.]

NOTARY

State of _____, County of _____,

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this _____ day of _____, 20____.

Notary Public Signature _____ My Notary Commission Expires _____

EMPLOYMENT CONTRACT FORM

I, _____, an applicant for
(Applicant's Name)

Certification of Anesthesiologist Assistant, am employed by

_____
(Employer's Name)

for the period beginning _____
(Month/Day/Year)

Termination of my contract will cause my certification to become null and void.

_____ _____
Signature of Anesthesiologist Assistant Date

_____ _____
Signature of Supervising Anesthesiologist Date

_____
Print Name of Anesthesiologist

NOTE: A contract from each separate employer is required.

STATE OF VERMONT
BOARD OF MEDICAL PRACTICE
280 State Drive, Waterbury, VT 05671-8320
AHS.VDHMedicalBoard@vermont.gov

APPLICATION BY PROPOSED PRIMARY SUPERVISING ANESTHESIOLOGIST

Name of Supervisor: _____
(Last) (First) (Middle)

Address where AA will be supervised:

_____
(Office Name)

_____
(Street)

_____ _____
(City, State, Zip Code) (Telephone Number)

Vermont Physician License Number: _____

Hospital(s) where you have privileges:

Hospital(s) Location Specialty

_____

_____

What arrangements have you made for supervision when you are not available:

_____

_____

List the name and addressed of all anesthesiologist assistants you currently supervise:

_____

_____

CERTIFICATE OF PROPOSED PRIMARY SUPERVISING ANESTHESIOLOGIST

I hereby certify that, in accordance with 26 VSA, Chapter 29, I shall be legally responsible for all professional activities of (Name of AA) _____, A.A. while under my supervision. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice. I further certify that notice will be posted that an anesthesiologist assistant is used, in accordance with 26 VSA, Chapter 29, Section 1657. I also affirm that I have read and will abide by all provisions of 26 VSA, Chapter 29, of the Statutes of the Vermont Board of Medical Practice.

I further certify that I have read the statutes and Board rules governing anesthesiologist assistants.

_____ _____
Signature of Primary Supervising Anesthesiologist Date

_____ _____
Signature of AA Applicant Date

Note: An AA who prescribes controlled drugs must obtain an ID number from DEA.
AA's DEA Number _____

STATE OF VERMONT
BOARD OF MEDICAL PRACTICE
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AHS.VDHMedicalBoard@vermont.gov

APPLICATION BY PROPOSED SECONDARY SUPERVISING ANESTHESIOLOGIST

Name of Supervisor: _____
(Last) (First) (Middle)

Address where AA will be supervised:

_____
(Office Name)

_____
(Street)

_____ _____
(City, State, Zip Code) (Telephone Number)

Vermont License Number: _____

Hospital(s) where you have privileges:

Hospital(s) Location Specialty

_____

_____

List the name and addressed of all anesthesiologist assistants you currently supervise:

_____

_____

CERTIFICATE OF PROPOSED SECONDARY SUPERVISING ANESTHESIOLOGIST

I hereby certify that, in accordance with 26 VSA, Chapter 29, I shall be legally responsible for all professional activities of (Name of AA) _____, A.A. while I am supervising them. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice and that in accordance with 26 VSA, Chapter 29, Section 1657. I also affirm that I have read and will abide by all provisions of 26 VSA, Chapter 29, of the Statutes of the Vermont Board of Medical Practice.

I further certify that I have read the statutes and Board rules governing anesthesiologist assistants.

_____ _____
Signature of Proposed Secondary Supervising Anesthesiologist Date

PROTOCOL REQUIREMENTS FOR ANESTHESIOLOGIST ASSISTANTS

ln order to practice, a certified Anesthesiologist Assistant shall have completed a protocol with a Vermont licensed Anesthesiologist signed by both the anesthesiologist assistant and the supervising anesthesiologist. The original shall be filed with the Board and copies shall be kept on file at each of the anesthesiologist assistant's practice sites. All applicants and certificatees shall demonstrate that the requirements for certification are met.

The Protocol document shall be signed by the primary supervising anesthesiologist and the AA, and shall cover at least the following:

- Narrative: A description of the practice setting, patient population common to the practice and, a general overview of the role of the anesthesiologist assistant in that practice.
- A detailed description of the manner in which on-site and off-site Anesthesiologist supervision and communication will occur;
- A detailed description of the manner in which secondary supervising anesthesiologists will be utilized, and the means by which communication with them will be managed
- A detailed description of the manner in which emergency conditions will be handled in the absence of an on-site anesthesiologist, including
    - Plans for immediate care,
    - Means of accessing emergency transport;
    - A detailed description of the physician's supervision plan for the AA's practice; and
    - A detailed description of the physician's plan for retrospective review of AA charts which must at least include the following:
        - The frequency with which these reviews will be conducted;
        - The minimum number or percentage of charts that will be reviewed;
        - The method by which charts will be selected for review; and
        - The methods by which the review will be documented;
- Sites of Practice: Name, physical address and type of facility for each practice site.
- Duties: A list of the tasks and duties delegated to the AA, which shall include only activities within the supervising anesthesiologists' scope of practice. The supervising anesthesiologist may only delegate those tasks for which the anesthesiologist assistant is qualified by education, training, and experience to perform.
- Authorization To Prescribe. An AA may prescribe only those drugs that are within the scope of practice of both the AA and the primary supervising anesthesiologist as documented in the protocol. If authorized to prescribe prescription drugs and/or devices, the protocol must address all of the following (if applicable): 27.3.5.1 Whether the AA is authorized to prescribe controlled substances;
    - The AA’s DEA number; and
    - The specific schedules authorized

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ANESTHESIOLOGIST ASSISTANT

VERIFICATION OF LICENSURE OR CERTIFICATION

This section must be completed by the regulatory authority in the states in which you now hold or have ever held a license or certification to practice as a medical practitioner.

I, _____ on behalf of the _____

State Board of _____, certify that
(or other authority)

_____ was granted Certificate/License Number _____

to practice as an _____ in the State of _____

on the _____ day of _____, _____ and that

said certificate or license has never been revoked, suspended, or conditioned in any way, or the certificate holder or licensee have never been disciplined by this authority in any way.

_____
(Authorized Representative)

[AFFIX SEAL]

_____
(Date)

Vermont Department of Health
Board of Medical Practice
280 State Drive, Waterbury, VT 05671-8320
AHS.VDHMedicalBoard@vermont.gov
802-657-4220

CERTIFICATE OF ANESTHESIOLOGIST ASSISTANT EDUCATION

I hereby certify that, _____ was admitted to the
(Name)

_____ Anesthesiologist Assistant Program in

_____ on _____
(City, State) (Date)

and completed all requirements for graduation on _____.
(Date)

A _____ was granted on _____
(Specify Certificate/Diploma/Degree) (Date)

Is this program CAHEA or successor agency approved? ☐ Yes ☐ No

Date: _____

[AFFIX SEAL]

Signed: _____
(Authorized Officer of the School)

TO PROGRAM: Return to above address

Vermont Department of Health
Board of Medical Practice
280 State Drive
Waterbury, VT 05671-8320
Email: AHS.VDHMedicalBoard@vermont.gov Phone: 802-657-4220

REFERENCE FORM TO BE COMPLETED BY AN ACTIVE PHYSICIAN STAFF MEMBER

Name of applicant: _____

The Applicant named above has applied to the Vermont Board of Medical Practice for a license to practice medicine. The applicant has listed your name as one who has requisite knowledge through recent observation of the applicant's current clinical competence, ethical character, and ability to work cooperatively with others. In this regard, please complete the following reference form. Thank you for your cooperation.

Please complete all parts of this form. If more room is needed, please attach additional information.

Name (applicant) _____was at (Institution)_____

From _____to _____. During that time, the applicant

Was (list Position at the institution): _____

IMPORTANT NOTE: If you rate the applicant "poor" or "fair" in a particular category, please elaborate on this aspect of the reference in as much detail as possible.

Basic medical knowledge:	☐ Poor	☐ Fair	☐ Average	☐ Above Average
Professional judgement:	☐ Poor	☐ Fair	☐ Average	☐ Above Average
Sense of responsibility:	☐ Poor	☐ Fair	☐ Average	☐ Above Average
Moral character/ethical conduct:	☐ Poor	☐ Fair	☐ Average	☐ Above Average
Competence and skill:	☐ Poor	☐ Fair	☐ Average	☐ Above Average
Cooperativeness ability to work with others:	☐ Poor	☐ Fair	☐ Average	☐ Above Average
History & physical exam taking:	☐ Poor	☐ Fair	☐ Average	☐ Above Average
Record keeping:	☐ Poor	☐ Fair	☐ Average	☐ Above Average
Patient management:	☐ Poor	☐ Fair	☐ Average	☐ Above Average
Case presentations:	☐ Poor	☐ Fair	☐ Average	☐ Above Average
Relationship with patients:	☐ Poor	☐ Fair	☐ Average	☐ Above Average
Participation in Medical Staff Affairs:	☐ Poor	☐ Fair	☐ Average	☐ Above Average
Competence in being able to communicate in reading, writing and speaking the English language:	☐ Poor	☐ Fair	☐ Average	☐ Above Average

Name of applicant: _____

To the best of your knowledge, does/did the applicant carry out the duties and responsibilities of the position at your institution in a satisfactory manner?	☐ Yes	☐ No
Do you know of any reason that this person cannot currently practice medicine safely?	☐ Yes	☐ No
Do you know of any pending professional misconduct proceedings or medical malpractice claims?	☐ Yes	☐ No
Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses? (Note: DWI is not minor)	☐ Yes	☐ No
Do you know of any suspension, restriction or termination of training or professional privileges for reasons related to mental or physical impairment, incompetence, misconduct or malpractice?	☐ Yes	☐ No
Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures?	☐ Yes	☐ No
Do you know of any confirmed quality concern (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere?	☐ Yes	☐ No
Do you know of a failure of the applicant to complete a residency training program(s)?	☐ Yes	☐ No
Does the applicant call upon consults when needed?	☐ Yes	☐ No

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please check the appropriate response. If you answer "yes" to either question, please provide a short explanation.

Do you know of any leaves of absence or interruptions in applicant's medical education?	☐ Yes	☐ No
Do you know of any limitations or special requirements imposed on the applicant during medical education because of questions of academic or technical competence?	☐ Yes	☐ No

Please use the space below and the reverse side for elaboration on the above and any additional information you have available to aid the Board in evaluating this applicant. Of particular value to us in evaluating any applicant are comments regarding their notable strengths and/or weaknesses. We would appreciate such comments from you. Any additional information should be attached to this form.

The above report is based on:
☐ Close personal observation
☐ General impression
☐ A composite of previous evaluations
☐ Other – Specify: _____

I further certify that at the time of completion of the above training, or during my association with the applicant, the applicant was competent to practice as a medical practitioner and was not the subject of any disciplinary action.

I recommend (Applicant)_____ for licensure in Vermont.

Signed: _____ Date: _____

Print or Type Name and Title: _____