Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

Affidavit
And
Authorization For Release of Information

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 Application for Physician 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's Signature (must be signed in the presence of a notary)

_____
Applicant's Printed Last Name

_____
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

_____
Date of Signature

Applicant Photograph

Securely tape or glue in this square a current front-view 2" x 2" passport-type color photograph of yourself.

NOTARY

Dated_____ Signed _____

State of_____ County of _____

SUBSCRIBED AND SWORN TO before me this_____ day of, _____ 20____.

My commission expires:_____ (NOTARY PUBLIC SIGNATURE & SEAL)

Applicant Name: _____ Date _____

EMPLOYMENT CONTRACT FORM

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

Certification as a 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
108 CHERRY STREET
BURLINGTON, VT 05401
(802) 657-4220

APPLICATION BY PROPOSED PRIMARY SUPERVISING ANESTHESIOLOGIST

Please print. Incomplete applications will be returned. Attach additional sheets as needed

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

Address where AA will be supervised:

_____
(Office Name)

_____
(Street)

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

Vermont Physician License #: _____

Hospital(s) where you have privileges:

Hospital(s)	Location	Specialty

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

_____

_____

List the names and addresses 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.

_____ _____
(Date) Signature of Primary Supervising Anesthesiologist

_____ _____
(Date) Signature of AA Applicant:

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
108 CHERRY STREET
BURLINGTON, VT 05401
(802) 657-4220

APPLICATION BY PROPOSED SECONDARY SUPERVISING ANESTHESIOLOGIST

Please print. Incomplete applications will be returned. Attach additional sheets as needed.

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

Address where AA will be supervised:

_____
(Office Name)

_____
(Street)

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

Vermont License #: _____

Hospital(s) where you have privileges:

Hospital(s)	Location	Specialty

List all the names and addresses of 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) _____, AA while I am supervising him/her. 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.

_____ _____
(Date) (Signature of Proposed Secondary Supervising Anesthesiologist)

Protocol requirements for Anesthesiologist Assistants

In 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.

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401
(802) 657-4220

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 has never been disciplined by this authority in any way.

(AFFIX SEAL) _____ _____
(Authorized Representative) (Date)

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401
(802) 657- 4220

CERTIFICATE OF ANESTHESIOLOGIST ASSISTANT EDUCATION

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

_____ Anesthesiologist Assistant

Program in _____ on _____
(City and 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

(AFFIX SEAL)

Date: _____

Signed: _____
(Authorized Officer of the School)

TO PROGRAM: Return to above address

Reference Form #1 Return Directly to the Board

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401
(802) 657- 4220

Name of applicant: _____
The person named above has applied to the Vermont Board of Medical Practice for a certification to practice as an anesthesiologist assistant in Vermont. 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 _____ was at _____

from _____ to _____. During that time, he/she

was (list status in 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.

The basic medical knowledge to be expected in a AA:	_____ 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 skills in the tasks delegated:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Cooperativeness ability to work with others:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Willingness to accept directions and limitations in role:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
History & physical exam:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Record keeping:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
AA-Patient relationship:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Track record in adhering to scope of practice:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Ability to communicate in reading, writing and speaking the English language:	_____ Poor	_____ Fair	_____ Average	_____ Above Average

Return Directly to the Board

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401
(802) 657- 4220

REFERENCE FORM TO BE COMPLETED BY PHYSICIAN WORKED WITH MOST RECENTLY
PAGE TWO OF TWO

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 emotional disturbance, mental illness, organic illness, alcohol or drug problem, which might impair the applicant's ability to practice as a anesthesiologist assistant?	____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?	____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 training program(s)?	____Yes	____ No

In addition to the information provided on the previous page, 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 his/her 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 anesthesiologist assistant, he/she was competent to practice as an anesthesiologist assistant and he/she was not the subject of any disciplinary action.

I recommend _____ for certification in Vermont.

Signed: _____ Date: _____

Print or Type Name and Title: _____

Reference Form #2 Return Directly to the Board

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401
(802) 657- 4220

Name of applicant: _____
The person named above has applied to the Vermont Board of Medical Practice for a certification to practice as an anesthesiologist assistant in Vermont. 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 _____ was at _____

from _____ to _____. During that time, he/she

was (list status in 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.

The basic medical knowledge to be expected in a AA:	_____ 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 skills in the tasks delegated:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Cooperativeness ability to work with others:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Willingness to accept directions and limitations in role:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
History & physical exam:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Record keeping:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
AA-Patient relationship:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Track record in adhering to scope of practice:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Ability to communicate in reading, writing and speaking the English language:	_____ Poor	_____ Fair	_____ Average	_____ Above Average

Reference Form #2
Continued

Return Directly to the Board

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401
(802) 657- 4220

REFERENCE FORM TO BE COMPLETED BY PHYSICIAN WORKED WITH MOST RECENTLY
PAGE TWO OF TWO

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 emotional disturbance, mental illness, organic illness, alcohol or drug problem, which might impair the applicant's ability to practice as a anesthesiologist assistant?	____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?	____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 training program(s)?	____Yes	____ No

In addition to the information provided on the previous page, 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 his/her 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 anesthesiologist assistant, he/she was competent to practice as an anesthesiologist assistant and he/she was not the subject of any disciplinary action.

I recommend _____ for certification in Vermont.

Signed: _____ Date: _____

Print or Type Name and Title: _____