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 must then 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

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.
APPLICATION BY PROPOSED PRIMARY SUPERVISING ANESTHESIOLOGIST

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

<table>
<thead>
<tr>
<th>Name of Supervisor:</th>
<th>(Last)</th>
<th>(First)</th>
<th>(Middle)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address where AA will be supervised:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Office Name)</td>
</tr>
<tr>
<td>(Street)</td>
</tr>
<tr>
<td>(City/State, Zip Code)</td>
</tr>
<tr>
<td>(Telephone Number)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vermont Physician License #:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Hospital(s) where you have privileges:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital(s)</td>
</tr>
<tr>
<td>-------------</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What arrangements have you made for supervision when you are not available:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>List the names and addresses of all anesthesiologist assistants you currently supervise:</th>
</tr>
</thead>
</table>

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.

<table>
<thead>
<tr>
<th>(Date)</th>
<th>Signature of Primary Supervising Anesthesiologist</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Date)</td>
<td>Signature of AA Applicant:</td>
</tr>
</tbody>
</table>

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

AA's DEA Number
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 ___________________________, certify that

State Board of ___________________________, (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)
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
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.

<table>
<thead>
<tr>
<th>The basic medical knowledge to be expected in a AA:</th>
<th>Poor</th>
<th>Fair</th>
<th>Average</th>
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<tr>
<td>Professional judgement:</td>
<td>______</td>
<td>______</td>
<td>______</td>
<td>______</td>
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<td>Sense of responsibility:</td>
<td>______</td>
<td>______</td>
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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 an 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: ____________________________
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.

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PAGE TWO OF TWO

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Yes ☐ No ☐

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