DEPARTMENT OF HEALTH
ANESTHESIOLOGIST ASSISTANTS
P.O. Box 6320
Tallahassee, Florida 32399-6320
(850) 245-4131

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR LICENSURE AS AN ANESTHESIOLOGIST ASSISTANT

Prior to completing the application, we strongly recommend that you carefully read Sections 458 and 459, Florida Statutes and Rules 64B8-31, and 64B15-7 Florida Administrative Code. You must know and comply with the laws and rules as they pertain to your professional practice. Laws and rules are subject to change at any time. For updated information refer to the following web-sites www.leg.state.fl.us/ (statutes) and www.fac.dos.state.fl.us (Florida Administrative Code).

IMPORTANT NOTICE:

Effective July 1, 2009, section 456.0635, Florida Statutes, provides that health care boards or the department **shall refuse** to issue a license, certificate or registration and shall refuse to admit a candidate for examination if the applicant has been:

(a) Convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, chapter 893, 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, unless the sentence and any subsequent period of probation for such conviction or pleas ended more than 15 years prior to the date of the application;
(b) Terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5 years;
(c) Terminated for cause, pursuant to the appeals procedures established by the state or Federal Government, from any other state Medicaid program or the federal Medicare program, unless the applicant has been in good standing with a state Medicaid program or the federal Medicare program for the most recent 5 years and the termination occurred at least 20 years prior to the date of the application.

Please take personal responsibility for preparing your application. Carefully read and follow all instructions. If you have questions, call for clarification. Applicants are required to keep the application information updated during processing.

The Department strongly suggests that you refrain from making a commitment or accepting a position in Florida until you are licensed.

Upon employment as an Anesthesiologist Assistant, you must notify the Florida Department of Health, Board of Medicine, Anesthesiologist Assistants within 30 days of beginning such employment or after any subsequent changes in the supervising physician(s) and any address changes. An Anesthesiologist Assistant Protocol must be used for this purpose and will be supplied to you upon licensure.

THE FOLLOWING ITEMS MUST ACCOMPANY YOUR APPLICATION FOR LICENSURE AS AN ANESTHESIOLOGIST ASSISTANT: Copies must be legible. It is acceptable, and preferred that large documents be reduced to 8 1/2" x 11".

1. Applications and Initial License Fee:

No application will be processed without the fees. APPLICATION & LICENSE FEES MUST ACCOMPANY THE APPLICATION. THE APPLICATION FEE IS NON-REFUNDABLE. The application fee is $300 and the initial license fee is $500 plus $5.00 unlicensed activities fee for any person applying for licensure as an Anesthesiologist Assistant as provided in Sections 458 and 459, F.S., Submit a check, money order or cashiers check made payable to the Florida Department of Health in the amount of $805. The biennial license period for Anesthesiologist Assistants is February 1 odd year through January 31 odd year.

2. Anesthesiologist Assistant Diploma: Submit a photocopy of your Anesthesiologist Assistant diploma. Additionally, you are responsible for mailing to your Anesthesiologist Assistants program the "Anesthesiologist Assistant Program Verification Form".

3. NCCAA: Submit a photocopy of your certificate issued to you by the National Commission on Certification of Anesthesiologist Assistants (NCCAA). If you have had a previous certificate that lapsed, please indicate the certification number. Chapters 458 and 459 require any person desiring to be licensed, as an Anesthesiologist Assistant, must have "satisfactorily passed a proficiency examination by an acceptable score established by the National Commission on Certification of Anesthesiologist Assistants (NCCAA). If an applicant does not hold a current certificate issued by the NCCAA and has not actively practiced as an Anesthesiologist Assistant within the immediately preceding 4 years, the applicant must retake and successfully complete the entry-level examination of the NCCAA to be eligible for licensure." By Board rule, the Board may require an applicant who does not pass the NCCAA exam after five or more attempts to complete additional remedial education or training. Additionally, you are responsible for mailing the "NCCAA Verification Form" to NCCAA.

4. Advanced Cardiac Life Support (ACLS) Certificate: Submit a photocopy of your ACLS certificate issued by the American Heart Association.

5. Military: For active military status, submit a photocopy of current military orders. For in-active military, submit a copy of your military discharge orders (DD214 indicating type of discharge) from all military service performed as a member of the Armed Forces of the United States or the Public Health Service.

6. Name Changes: (including marriage) Proof of legal name change – If marriage or other legal proceeding has changed your name, a copy of your marriage certificate or a copy of the court order for each legal change of name must be submitted. If the name change document is not in the English language, it must be accompanied by a copy of a translation prepared by a certified translator or faculty member of the Modern Language or Linguistics Department of a United States College or University. If change of name was made during naturalization, proof of name change must be submitted from the Department of Immigration and Naturalization. IF A NAME OTHER THAN YOUR LEGAL NAME APPEARS ON ANY DOCUMENTATION SUBMITTED, YOU MUST PROVIDE A WRITTEN EXPLANATION.

7. Financial Responsibility: Pursuant to Section 456.048(1), F.S., prior to licensure, the Anesthesiologist Assistant must provide a statement of liability coverage on forms approved by the Board**.**

8. Letters of Recommendation: Two current, original, personalized and individualized letters of recommendation from Anesthesiologists, (MD's or DO's) on his or her letterhead paper. Each letter must be addressed to the Board of Medicine and must have been written no more than six (6) months prior to the filing of the application. Letters addressed only "TO WHOM IT MAY CONCERN" and/or containing a signature stamp will not be accepted. Identical letters that appear to have been composed by the same

person, or from family members, will not be accepted. If you are a recent graduate, your recommendation letters must be from your faculty anesthesiologists. If you were employed as an Anesthesiologist Assistant, your recommendation letters must be from supervising anesthesiologist. If clinical rotations are completed in a state other than your program and your preceptor physician is submitting a recommendation letter, please have the physician clarify his/her association with you. Letters should expound on your clinical skills and abilities.

9. Photograph: Submit a current photograph of yourself (head and shoulders) taken within the last 60 days - preferably no smaller than 2" x 2".

10. License Verifications: (AA, PA, LPN, RN, EMT, CNA, Paramedic, RT, TT, PT, etc.)
Provide verification of licensure as an Anesthesiologist Assistant **a**nd/or any other healthcare practitioner in any state. Some agencies charge a fee for license verifications. If you are, or have been, licensed in the United States, contact each state and have them forward licensure/registration/certification, (including temporary licenses/permits) verification directly to the Board of Medicine. If no license/registration/ certification was required during your employment, please request that the state board provide such statement directly to this office. A copy of your license is not acceptable in lieu of a written verification of licensure from the State Licensing Agency. You may want to request state licensure verifications as soon as possible; some states can take up to 6 weeks to complete and mail verifications. Additionally, you are responsible for mailing the "Licensure Verification Form" to all state Medical Boards where you have ever held a license as a health care provider. (Not limited to Anesthesiologist Assistant licensure)

11. Prevention of Medical Errors Continuing Medical Education: Submit a copy of your Prevention of Medical Errors certificate. Section 456.013(7), Florida Statutes, requires, as a condition of granting a license, each Anesthesiologist Assistant shall complete a 2-hour course on Prevention of Medical Errors. You will be required to submit confirmation on the enclosed form of having completed said course. Your license will not be issued unless you have completed this requirement. The course shall be a minimum of two (2) hours, approved for Category I AMA.

12. Education, Training, Employment and Non-Employment History: Question 18 part one must contain and account for **all non-medical periods of time, including vacations and non-employment during the past five years.** Question 18 part two must contain and account for all medical related employment. Omission of this information will cause a delay in the application process. Do not leave off more than 30 days.

13. Activities: You are required to update your application by providing the Board office with a written statement of your activities within 30 days of the Committee meeting to which your application is being considered.

14. Supplemental Documents: If any of the questions numbered 21– 36 on the application are answered "Yes", you must submit a detailed statement, composed by you, explaining the circumstances. Should any of the questions in the "YES/NO" portion of the application fail to provide sufficient space for the requested information, use an additional page and number the additional information with the corresponding number in the application.

- For Questions 29-43: * Reports from all treating physicians/hospitals/institutions/agencies, including admission and discharge summary regarding treatment on conduct assessment(s); mental or physical conditions. Reports must include all DSM III R/DSM IV, Axis I and II diagnoses and codes and Axis III condition and prescribed medications. Applicants, who have any history of those listed above, may be required to undergo a current conduct assessment through Florida's Professionals Resource Network (PRN). Also see "Supplemental Documents".

- For Questions 24, 25, 26 and 42: * Submit court certified copies of charges/arrest report(s), indictments(s) and judgment(s) and satisfaction of judgment(s) Submit copies of any litigation or any other proceedings in any court of law or equity, any criminal court, any arbitration Board or before any governmental Board or Agency, to which you have been a party, either as a plaintiff, defendant, co-defendant, or otherwise. Also see “Supplemental Documents”.

- For Questions 21, 22, 23, 27, 28, 29, 30, and 31: * Submit Copies of supporting documentation. Also see “Supplemental Documents”.

- For Questions 32 and 33: * Submit court certified copies of complaint(s), amended complaint(s), and judgment(s). If litigation is pending, the attorney representing the case must submit a letter addressed to the Committee on Anesthesiologist Assistants explaining the current litigation status. Submit a statement, composed by you, stating how many cases you have been named in and the details of your involvement. Also see “Supplemental Documents”.

∗Section 456.013(3)(c), Florida Statutes, permits the Board to require your personal appearance.

The Total Fee (includes Application, License, and Unlicensed Activity Fees) **$805** Return all pages of the application. (Excluding instruction pages) Application must be typed or printed legibly.	**DEPARTMENT OF HEALTH** **BOARD OF MEDICINE** **P.O. Box 6320** **Tallahassee, Florida 32399-6320** **(850) 245-4131** **APPLICATION FOR LICENSURE AS AN ANESTHESIOLOGIST ASSISTANT**	**For Deposit/Receipt Only** **CLIENT 1515**

1. Today's Date:

2.Name:_____
(First) (Middle) (Last)

3. List all legal name changes including marriage, maiden, or other and provide legal documentation of each name change.

4. Mailing Address:
_____
(No. & Street) (City , State) (Zip)

5. Permanent Address:
_____
(No. & Street) (City, State) (Zip)

6. Place of Birth: (City/State/ or Country)	7. Date of Birth: (Month, Day, Year)
8a. Home Telephone Number:	8b. Work Telephone Number:

OPTIONAL: E-mail Address:

ACCREDITED ANESTHESIOLOGIST ASSISTANT PROGRAM:

9. List the name and location of the Anesthesiologist Assistant program you attended.

10. Dates of Attendance: (Month/Day/Year)

From **To**

CERTIFICATION HISTORY:	
I1a. Have you ever taken the examination of the National Commission on Certification of Anesthesiologist Assistants? YES ☐ NO ☐	11b. Initial NCCAA exam dates; month and year.
12a. Have you ever failed the examination of the National Commission on Certification of Anesthesiologist Assistants? YES ☐ NO ☐	12b. If yes, list all failed exam dates; month / year.
13a. Are you re-certified by the NCCAA? YES ☐ NO ☐	13b. List all NCCAA re-certification exam dates.
14. Have you completed the Advanced Cardiac Life Support program administered by the American Heart Association? YES ☐ NO ☐	15. List ACLS completion date; month and year.

LICENSURE HISTORY:
16. In what states are/were you licensed/registered as a healthcare provider? (AA, EMT, CNA, RN, etc.) Include all temporary certificates/licenses. List the states, the license number, issue date and type of license. If non-applicable, indicate N/A or none. (see #10 on page 3 of the instructions)

EDUCATION HISTORY:
17. Give name and location of Institution, dates of attendance (month and year), at each school, college, university, program and degree received. Failure to provide at least month, year and location will delay processing the application. Add supplemental sheet if necessary
COLLEGE OR UNIVERSITY: List the name, location of school, dates of attendance and degrees earned.
OTHER TRAINING:

NON-MEDICAL EMPLOYMENT HISTORY:

18. **Part One:** In CHRONOLOGICAL order list all non-medical employment during the past 5 years until present. Give full name and address of the facility, dates of employment (month and year), positions / titles held, and reason for leaving. Failure to provide all required information will delay processing the application. Add additional sheets if necessary.

NAME & ADDRESS OF FACILITY FOR NON-MEDICAL EMPLOYMENT DURING LAST 5 YRS	Dates of Employment (Month and Year)	Title of position held & reason for leaving

MEDICAL EMPLOYMENT HISTORY:

18. **Part Two:** In CHRONOLOGICAL order list all medical related employment. Give full name and address of the facility, dates of employment (month and year), positions / titles held, and reason for leaving. Failure to provide all required information will delay processing the application. Add additional sheets if necessary.

Name and Address of Employer	Dates of Employment (Month and Year)	Title of position held & reason for leaving

MILITARY HISTORY:

19. Have you ever been in the United States military? If yes, please provide below the branch of service, rank and all dates of service. _____	YES ☐ NO ☐

CONTINUING MEDICAL EDUCATION:

20. I state that I have completed a minimum of two (2) hours of Preventing Medical Errors CME as defined by s.456.013(7), F.S.	YES ☐ NO ☐

THE FOLLOWING QUESTIONS MUST BE ANSWERED YES OR NO. ALL AFFIRMATIVE ANSWERS MUST BE PERSONALLY EXPLAINED TO THE COUNCIL IN DETAIL ON AN ADDITIONAL SHEET. DOCUMENTATION SUBSTANTIATING THE EXPLANATION IS REQUIRED..	
21. Have you ever been denied a license as an Anesthesiologist Assistant or health care practitioner by any state board or other governmental agency of any state or country?	YES ☐ NO ☐
22. Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature, including, but not limited to, a charge of violation of the medical practice act, unprofessional or unethical conduct?	YES ☐ NO ☐
23. Have you ever had a license to practice as an Anesthesiologist Assistant or other health care practitioner revoked, suspended, or other disciplinary action taken in any state, territory or country?	YES ☐ NO ☐
24. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if the court withheld adjudication so that you would not have a record of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question	YES ☐ NO ☐
25. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, Chapter 817, or Chapter 893, Florida Statutes; or 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396? (If no, do not answer 26.)	YES ☐ NO ☐
26. Has it been more than 15 years prior to the date of this application since the sentence and completion of any subsequent period of probation for each such conviction?	YES ☐ NO ☐
27. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If no, do not answer 28.).	YES ☐ NO ☐
28. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?	YES ☐ NO ☐
29. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state or federal government, from any other state Medicaid program or the federal Medicare program? (If no, do not answer 30 and 31)	YES ☐ NO ☐
30. Have you been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years?	YES ☐ NO ☐
31. Did the termination occur at least 20 years prior to the date of this application?	YES ☐ NO ☐
32. Have any civil judgments ever been entered against you?	YES ☐ NO ☐
33. Have you ever been named in a lawsuit for malpractice or has any settlement or claim been paid on your behalf in relation to a claim of malpractice?	YES ☐ NO ☐
34. Have you ever discontinued practice for any reason for a period of one month or longer?	YES ☐ NO ☐
35. Have you ever had employment terminated for cause?	YES ☐ NO ☐
36. In the last five years, have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?	YES ☐ NO ☐
37. In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?	YES ☐ NO ☐
38. During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice medicine within the past five years?	YES ☐ NO ☐
39. During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine?	YES ☐ NO ☐

40. In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?	YES ☐ NO ☐
41. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice medicine within the last five years?	YES ☐ NO ☐
42. Have you had any felony convictions?	YES ☐ NO ☐
43. Have you had any license revoked or denied?	YES ☐ NO ☐
44. Are you a United States citizen? If no, please list your alien number	YES ☐ NO ☐

AFFIDAVIT: (Applicable to questions 23, 42 and 43 only)

The foregoing instrument was sworn before me this _____day of _____, 200_____,

By_____who is personally known to me or who has produced as identification _____and did take an oath.

Name of Notary:_____ (typed, printed or stamped)

Signature of Notary:_____

Date Notary Commission Expires: _____

We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only
and does not in any way affect your candidacy for licensure.

Male ☐ Female ☐ Black ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other ☐

Color of Eyes: Color of Hair: Weight: Height:

OTHER MEANS OF IDENTIFICATION (if any)

Statement of Applicant:

I state that these statements are true and correct. I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084 F.S. I declare that I have read Chapters 456, 458 and 459, and sections 766.301-306, F.S. and Chapters 64B8-31, and 64B15-7, Florida Administrative Code. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure. I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days. I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR, and cannot be disclosed without my written consent unless otherwise provided in the regulations.

_____

SIGNATURE OF APPLICANT: **DATE:**

Affix 2X2 Photo Here

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

Florida Department of Health
Board of Medicine
Anesthesiologist Assistant License Application

Name: _____
Last First Middle

Social Security Number: _____

*This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCS § 666 (a)(13). For all professions regulated under chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013 (1)(a), Florida Statutes.

ANESTHESIOLOGIST ASSISTANT FINANCIAL RESPONSIBILITY FORM

(Please Print the Following Information)

NAME:

MAILING ADDRESS:

CITY: **STATE:** **ZIP:**

Mailing address will not be published on the Internet.

PRACTICE LOCATION:

CITY: STATE: ZIP:

Practice locations will be published on the Internet.

Financial Responsibility options are divided into two categories, coverage and exemptions.
Choose only one option of the five provided pursuant to s.458, Florida Statutes.

FINANCIAL RESPONSIBILITY COVERAGE:

☐ **1.** I have established an irrevocable letter of credit or an escrow account in an amount of $100,000/ $300,000, in accordance with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐ **2.** I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F.S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F.S.

FINANCIAL RESPONSIBILITY EXEMPTIONS:

☐ **3.** I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.

☐ **4.** I do not practice medicine in the State of Florida.

☐ **5.** I practice only in conjunction with my teaching duties at an accredited school or its main teaching hospitals.

Signature of Anesthesiologist Assistant Date

National Commission on Certification of Anesthesiologist Assistants 1500 Sunday Drive, Suite 102 Raleigh, NC 27607	From: Department of Health Board of Medicine 4052 Bald Cypress Way, Bin #C03 Tallahassee, Florida 32399-3253

Name:	_____ First Middle Last

Date of Birth:	/ /

NCCAA Certificate #:		Previous NCCAA Certificate # if applicable	

Number of times NCCAA exam was taken:		Number of times NCCAA exam was failed:	

Dates of exams:	

Original issue date:	/ /

Expiration date:	/ /

SEAL

Current status:	

_____
Comments if any
_____

_____
Signature and title: Date:

LICENSE VERIFICATION FORM

(Mail to each state where you were/are licensed)

To:	**FROM: Department of Health** **Board of Medicine** **Anesthesiologist Assistants** **4052 Bald Cypress Way** **BIN #C03** **Tallahassee, Florida 32399-3253**

The Anesthesiologist Assistant listed below has submitted an application for licensure in Florida. He/she states that he/she is/was licensed or registered in your state as a healthcare practitioner. Please complete and return this form as soon as possible. Thank you for your cooperation.

***Completed by applicant**

_____ First Middle LAST		
	*DOB:	/ /

Completed by Medical Board

Profession:		License #:	
Issue date:		Expiration Date	

Was a temporary certificate issued prior to full licensure? YES☐ NO☐		
License #	Issue date:	Expiration Date:

Has any disciplinary action ever been taken against this license? YES☐ NO☐
If yes, please explain.

_____
Verified by: (signature)

_____ SEAL
Name: (please print)

_____
Title:

ANESTHESIOLOGIST ASSISTANT PROGRAM VERIFICATION FORM

To:	From: **Department of Health** **Board of Medicine** **Anesthesiologist Assistants** **4052 Bald Cypress Way** **Bin #C03** **Tallahassee, Florida 32399-3253**
(Anesthesiologist Assistant program address)	

The individual listed below has applied to the Florida Department of Health, Board of Medicine for licensure as an Anesthesiologist Assistant. A diploma from your school was submitted as proof of having completed educational prerequisites for licensure in Florida. Please authenticate by signature and seal that the following is true and correct to your records.

Name:	_____ First Middle Last

DOB:	/ /

Profession:	**Anesthesiologist Assistant**	Degree issue date:	/ /

Comments (if any):_____

_____

_____

_____
Verified by: (signature)

_____
Name: (please print)

_____
Title:

SEAL

ANESTHESIOLOGIST ASSISTANT PROTOCOL

INSTRUCTIONS AND INFORMATION

- ✓ Always submit pages 17 - 21 of the Protocol. (Do not return the instruction page.)
- ✓ The Anesthesiologist MUST sign page 20 and the Anesthesiologist Assistant MUST sign page 21.
- ✓ A separate Protocol form must be submitted for each individual practice setting. (Satellite offices DO NOT require separate forms but DO need to be listed.)
- ✓ If you do not receive your stamped copy of the Protocol form within 30 days, please call us to confirm we have received it; (850) 245-4131.
- ✓ Please maintain a copy of your signed Protocol form for credentialing purposes.
- ✓ Failure to submit any changes or up-dates within 30 days of the occurrence will result in disciplinary action. (mailing / practice locations, adding / deleting supervising physicians)
- ✓ With the exception of practicing in a Government facility, only anesthesiologists with an unrestricted Florida license, and whose license is not on probation, is qualified to employ and supervise anesthesiologist assistants.
- ✓ Licensees are required to keep his/her protocol and licensure information current at all times.

PERFORMANCE OF SUPERVISING ANESTHESIOLOGIST(S):

Sections 458.3475 and 459.023, Florida Statutes, states that "an Anesthesiologist who directly supervises an anesthesiologist assistant must be qualified in the medical areas in which the anesthesiologist assistant performs and is liable for the performance of the anesthesiologist assistant."

Keep a copy of these frequently used phone numbers and Web sites

- **Anesthesiologist Assistant Website**: http://www.flboardofmedicine.gov/licensing/anesthesiologist-assistant-licensure (Applications, Protocols, renewal forms, CME requirements, address changes,)
  - **MQA Services** (Look-up License, request an application, request license certification for another state medical board.
- **Laws & Rules:** www.leg.state.fl.us/ and www.fac.dos.state.fl.us
- **Web Board Address:** www.flboardofmedicine.gov
- **American Medical Association (AMA):** (312) 464-5000
- **American Academy of Anesthesiologist Assistants (AAAA):** (703) 836-2272
- **American Osteopathic Association (AOA):** (800) 621-1773
- **NCCAA:** (919) 573-5439 , Toll Free (877) 558-0411
- **Medicaid:** (850) 414-2759 **Medicare:** (877) 267-2323 http://cms.hhs.gov

ANESTHESIOLOGIST ASSISTANTPROTOCOL FORM

Department of Health
4052 Bald Cypress Way, Bin #C03
Tallahassee, Florida 32399-3253
(850) 245-4131

IT IS THE RESPONSIBILITY OF THE ANESTHESIOLOGIST ASSISTANT TO KEEP THE PROTOCOL CURRENT.

Sections 458.3475 and 459.023, Florida Statutes, and Rules 64B8-31 and 64B15-7, Florida Administrative Code, require that "Upon employment as a Anesthesiologist Assistant, a licensed Anesthesiologist Assistant must notify the Board office prior to such employment and/or after any subsequent changes in the supervising Anesthesiologist(s)". **Such notification shall include the full name, Florida license number and address of the supervising Anesthesiologist(s) as appropriate."**
A separate Protocol is required for each distinct practice, i.e., working full-time in one practice and then working part-time in an additional practice with different supervising Anesthesiologist (s) and would require two (2) completed Protocols. Satellite offices within the same practice do not constitute multiple practices, but must be documented on a single Protocol.

ANESTHESIOLOGIST ASSISTANT DATA:

Name:	**FL License #: AA**
Address Change? Yes ☐ No ☐	Employment Date: / /
Mailing Address:	
Practice Address:	
Home telephone #:	Practice telephone #:
E-mail Address:	

PLEASE INDICATE BELOW THE REASON (S) FOR SUBMITTING THIS FORM:		
Adding ☐	Deleting ☐	Primary Supervising Physician
Adding ☐	Deleting ☐	Alternate Supervising Physician
Adding ☐	Deleting ☐	Practice Location
Adding ☐	Deleting ☐	Satellite Location

DUTIES AND PROCEDURES PERFORMED BY THE AA

Duties and functions of the Anesthesiologist Assistant:
The procedures to be followed in the event of an anesthetic emergency:

The protocol must be on file with the board before the anesthesiologist assistant may practice with the anesthesiologist or group. An anesthesiologist assistant may not practice unless a written protocol has been filed for that anesthesiologist assistant. The anesthesiologist assistant may only practice under the direct supervision of an anesthesiologist who has signed the protocol. Direct supervision means the on-site, personal supervision by an anesthesiologist who is present in the office when the procedure is being performed in that office, or is present in the surgical or obstetrical suite when the procedure is being performed in that surgical or obstetrical suite and who is in all instances immediately available to provide assistance and direction to the anesthesiologist assistant while anesthesia services are being performed. The protocol must be updated biennially.

ADDING SUPERVISING ANESTHESIOLOGIST(S) DATA:

Name and Practice Address of all Supervising Anesthesiologist(s) PLEASE PRINT	Supervising Physician(s) DEA Number	Physician's Florida Medical License #	Signature of Supervising Anesthesiologist	Beginning Date of Supervision

_____

Signature of primary supervising anesthesiologist.

DELETING SUPERVISING ANESTHESIOLOGIST(S)

NAME OF SUPERVISING ANESTHESIOLOGIST (S) YOU ARE DELETING	FLORIDA MEDICAL LICENSE NUMBER	DELETION DATE

DELETION OF PRACTICE LOCATION(S)

	DELETION DATE

I declare that these statements are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.072, 458.327, 458.331, 459.013, 459.015, 775.082, 775.083 and 775.084, Florida Statutes.

_____ Date: _____

Signature of Anesthesiologist Assistant