APPLICATION FOR LICENSURE AS AN ANESTHESIOLOGIST ASSISTANT

State Form 55969 (R4 / 1-21)

MEDICAL LICENSING BOARD OF INDIANA
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2060
E-mail: pla3@pla.IN.gov
www.pla.IN.gov

INSTRUCTIONS:

1. *The fee for this application is $100.00, payable to the Indiana Professional Licensing Agency, in accordance with 844 IAC 15-1-6.*
2. *Completed application and fees should be mailed to the address listed in the upper right hand corner of this form.*
3. *All fees are non-refundable and non-transferable.*
4. *Please refer to the instructions on our website, www.pla.in.gov, for the licensing requirements.*

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is mandatory and this record cannot be processed without it.
** This information is being requested for workforce statistical purposes only; disclosure is voluntary.

FOR OFFICE USE ONLY		
Application fee	Date fee paid *(month, day, year)*	Receipt number
Application number	License number issued	Date license issued *(month, day, year)*

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION		
Name of applicant (*last, first, middle*)		
Social Security number *	Date of birth (*month, day, year*)	Gender ** ☐ Male ☐ Female
Address of applicant (*number and street or rural route*)	City, state, and ZIP code	
Telephone number (*daytime*) ( )	E-mail address *(required)*	
Pursuant to IC 12-32-1-5 and IC 12-32-1-6, I swear under the penalty of perjury that: *(Please select ONLY ONE of the following.)* ☐ I am a United States Citizen. ☐ I am a qualified alien (as defined under 8 USC § 1641). ☐ I am authorized by the Federal government to work in the United States.		
Are you the spouse of a member of the military who is assigned to a duty station in Indiana? *(Optional)* ☐ Yes ☐ No	Are you an active duty member of the military? *(Optional)* ☐ Yes ☐ No	

POST SECONDARY EDUCATION

NAME OF SCHOOL	LOCATION	DATES ATTENDED *(month, year)*

ANESTHESIOLOGIST ASSISTANT PROGRAM

An anesthesiologist assistant program must be accredited by the Commission on Accreditation of Allied Health Education Program standards at the time of graduation.

NAME OF SCHOOL	LOCATION	DATES ATTENDED *(month, year)*

LIST ALL STATES, INCLUDING INDIANA, IN WHICH YOU HAVE BEEN LICENSED TO PRACTICE ANY REGULATED HEALTH OCCUPATION, REGARDLESS OF STATUS.				
STATE	TYPE OF LICENSE, CERTIFICATE, REGISTRATION OR PERMIT	NUMBER	DATE ISSUED *(month, day, year)*	CURRENT STATUS

QUESTIONS

If your answer is "Yes" to questions 1 - 10, explain fully in a signed written statement, including all related details, and provide copies of all relevant arrest or court documents. Describe the event including the location, date and disposition. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit you hold or have held? ☐ Yes ☐ No
2. Have you ever been denied a license, certificate, registration or permit to practice as an anesthesiologist assistant or any regulated health occupation in any state *(including Indiana)* or country, or surrendered your license? ☐ Yes ☐ No
3. Do you have any condition or impairment *(including a history of alcohol or substance abuse)* that currently interferes, or if left untreated may interfere, with your ability to practice medicine in a competent and professional manner? ☐ Yes ☐ No
4. Have you ever been the subject of an investigation by a regulatory agency concerning your license? ☐ Yes ☐ No
5. Except for minor violations of traffic laws resulting in fines, and arrests or convictions that have been expunged by a court.
   (1) have you ever been arrested; ☐ Yes ☐ No
   (2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state; ☐ Yes ☐ No
   (3) have you ever been convicted of any offense, misdemeanor, or felony in any state; ☐ Yes ☐ No
   (4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; ☐ Yes ☐ No
   (5) have you ever pled *nolo contendre* to any offense, misdemeanor, or felony in any state? ☐ Yes ☐ No
6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations? ☐ Yes ☐ No
7. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant? ☐ Yes ☐ No
8. Have you ever had a malpractice judgment against you or settled any malpractice action? ☐ Yes ☐ No
9. Have you ever surrendered your DEA registration at any time or had any limitations placed on your DEA registration? ☐ Yes ☐ No
10. Have you ever been terminated or disciplined by your employer while practicing as an anesthesiologist assistant or resigned in lieu of discipline? ☐ Yes ☐ No
11. Have you practiced as an anesthesiologist assistant either clinically or administratively in the last three (3) years? ☐ Yes ☐ No

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Professional Licensing Agency any files, documents, records or other information pertaining to the undersigned requested by the Agency, or any of its authorized representatives in connection with processing my application for licensure.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any information.

I further authorize the Professional Licensing Agency to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions any information which is material to my application, and I hereby specifically release the Agency from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I affirm, under penalties for perjury, that the foregoing representations are true.

Signature of applicant	Date (*month, day, year*)

SUPERVISING ANESTHESIOLOGIST STATEMENT

If there is more than one (1) supervising anesthesiologist, please provide a separate list with the name, license number, specialty and Board Certification of each supervising anesthesiologist.

Name of supervising anesthesiologist *(last, first, middle)*		License number
Residence address *(number and street or rural route, city, state, and ZIP code)*		
Address of practice *(number and street or rural route, city, state, and ZIP code)*		
Residence telephone number ( )	Office telephone number ( )	E-mail address
Specialty		Board certification

PRACTICE PROTOCOL FOR THE ANESTHESIOLOGIST ASSISTANT

INSTRUCTIONS: ON AN ATTACHED SHEET, give a detailed description of the exact privileges and tasks the anesthesiologist assistant shall be performing under the physician's supervision. In addition, please give a detailed description of the process maintained for evaluation of the anesthesiologist assistant's performance. THIS PRACTICE PROTOCOL MUST BE ON COMPANY LETTERHEAD (including address, telephone number, and fax number), BE PERSON SPECIFIC, AND BE SIGNED BY BOTH THE ANESTHESIOLOGIST ASSISTANT AND THE SUPERVISING PHYSICIANS.

CERTIFICATION OF SUPERVISION

Please indicate by signing your name below that the anesthesiologist assistant named in this application will be under your supervision in accordance with IC 25-3.7-2-4 and 844 IAC 15. This includes a restriction on supervising no more than four (4) Anesthesiologist Assistant's at any given time.

Signature of supervising physician	Date *(month, day, year)*