Reset Form

APPLICATION FOR CHANGE OR ADDITION OF SUPERVISING ANESTHESIOLOGIST FOR ANESTHESIOLOGIST ASSISTANT

State Form 56172 (11-16)

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

* 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.

FOR OFFICE USE ONLY	
Date received (*month, day, year*)	Date approved (*month, day, year*)

DO NOT WRITE ABOVE THIS LINE

TO BE COMPLETED BY THE ANESTHESIOLOGIST ASSISTANT (*Please print clearly in ink.*)			
Name (*last, first, middle*)			Anesthesiologist Assistant license number
Address (*number and street or rural route*)			
City		State	ZIP code
Social Security number *	Date of birth (*month, day, year*)	E-mail address	Telephone number (*daytime*) ( )
Are you applying for a change of supervising physician? ☐ Yes ☐ No		Are you adding a supervising physician? ☐ Yes ☐ No	
Name of supervising physician prior to completion of this application			
Name of new supervising physician		Date of discontinuation of supervision of physician (*month, day, year*)	
Office address of new supervising physician (*number and street, city, state, and ZIP code*)			
I hereby swear or affirm under the penalties of perjury, that the statements made in this application are true, complete and correct.			
Signature of Anesthesiologist Assistant			Date (*month, day, year*)

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 as an Anesthesiologist Assistant.

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 such information.

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

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

AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to same.

Signature of Anesthesiologist Assistant	Date (*month, day, year*)

SUPERVISING PHYSICIAN'S STATEMENT

Name of supervising physician (*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 FACILITY ADDRESS TELEPHONE NUMBER AND FAX NUMBER, BE PERSON SPECIFIC, AND BE SIGNED BY BOTH THE ANESTHESIOLOGIST ASSISTANT AND THE SUPERVISING PHYSICIAN.

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.

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