



SUPERVISING ANESTHESIOLOGIST STATEMENT

State Form 57723 (3-25)

INDIANA PROFESSIONAL LICENSING AGENCY

MEDICAL LICENSING BOARD OF INDIANA PROFESSIONAL LICENSING AGENCY

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Indianapolis, IN 46204

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- INSTRUCTIONS:**
1. Complete this form in its entirety.
 2. This form can be mailed to the office address shown above.
 3. Visit www.pla.in.gov for more information.

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

Email 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 Assistants at any given time.

Signature of supervising physician

Date (month, day, year)