



South Carolina Department of Labor, Licensing and Regulation
Board of Medical Examiners
110 Centerview Drive, Suite 202
P.O. Box 11289
Columbia SC 29211-1289
(803) 896-4500

APPLICATION FOR ANESTHESIOLOGIST'S ASSISTANT CHANGE OF SPONSORING ANESTHESIOLOGIST

NOTE: Application must be fully completed with all requested information and documentation supplied. Appropriate fee must accompany application; **application fee is non-refundable: \$25.00**

I hereby make application to the State Board of Medical Examiners of South Carolina for Anesthesiologist's Assistant license in the State of South Carolina and submit the following statement of facts with the required supporting documents.
This application form itself is a public document obtainable under the Freedom of Information Act.

Applicant's Name: _____
Last First Middle

Home Address: _____
Street City State Zip

Home Phone: () _____

New Sponsoring Physician: _____
Last First Middle

Address: _____
Street City State Zip

Business Phone: () _____

I. EMPLOYMENT ACTIVITIES

1. List all activities chronologically:

Office address and Location	From Mo./Day/Yr.	To Mo./Day/Yr.
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. NCCAA Certificate Number: _____ (please attach copy) Expiration Date: _____

CONTROL # _____
CHECK # _____
AMOUNT \$ _____

II. PERSONAL DATA

Answer Yes or No

1. Has your Anesthesiologist's Assistant certificate/license ever been revoked, suspended, reprimanded, Restricted or placed on probation by any licensing board or any other entity? _____
2. Have you ever had an application to practice as an Anesthesiologist's Assistant denied or refused by another licensing board or entity? _____
3. Have you ever had hospital privileges denied, revoked, suspended or restricted in any way? _____
4. Have you ever resigned from any hospital, institute or health care facility in lieu of disciplinary action? _____
5. Are you currently under any investigation or the subject of pending disciplinary action by any licensing board or other entity? _____
6. Is your Anesthesiologist's Assistant certificate/license currently restricted in any way by any licensing board or other entity? _____
7. Have you ever had a malpractice lawsuit, judgment or settlement filed against you?
If so, how many? _____
8. Currently or within the last five years, have you been treated for any physical, mental, or emotional condition that might interfere with your ability to competently and safely perform the essential functions of practice as an Anesthesiologist's Assistant? _____
9. Has your ability to practice as an Anesthesiologist's Assistant ever been impaired by any physical or mental illness or by the use of alcohol or drugs? _____
10. Currently or within the last five years, have you developed any disease or conditions, physical, mental or emotional, (e.g. bipolar disorder, schizophrenia, paranoia or any other psychotic disorder) that might interfere with your ability to competently and safely perform the essential functions of practice as an Anesthesiologist's Assistant? _____
11. Have you ever discontinued practicing as an Anesthesiologist's Assistant for any reason for one month or more? _____
12. Have you ever been arrested, indicted or convicted, pled guilty, or pled nolo contendere for any violation of any federal, state or local law? (other than minor traffic violations) _____
13. Have you ever been known by any other name or surname? _____
14. Have you ever voluntarily surrendered an Anesthesiologist's Assistant certificate/license? _____

NOTE: If you answered "yes" to any of the above questions (1-14), you must attach a full written explanation pertaining to that particular question.

III. SPONSORING ANESTHESIOLOGIST

This information is to be completed by the Sponsoring Anesthesiologist:

1. Full Legal Name: _____ S.C. License No.: _____

2. Office Mailing Address: _____
Street City State Zip

Office Phone #: () _____

3. Home Address: _____
Street City State Zip

Home Phone #: () _____

4. Type of Practice: _____

5. Are you a diplomat of the ABA? _____

6. List name and location of any hospital or other offices (other than your own) where you request this Anesthesiologist's Assistant to assist you:

Hospital/Office:

Location:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I hereby certify that the foregoing is correct and true, and I assume responsibility for sponsoring my Anesthesiologist's Assistant and for ensuring that he/she is supervised by any other anesthesiologist, according to the approved written protocols for this Anesthesiologist's Assistant.

Supervising Sponsoring Signature

S.C. License No.

Date

PLEASE ATTACH A COPY OF YOUR WRITTEN PRACTICE PROTOCOLS. THESE PROTOCOLS MUST BE SIGNED BY YOU AND YOUR SPONSORING ANESTHESIOLOGIST.

III. SUPERVISING PHYSICIAN

I hereby certify that the foregoing is true and correct, and I assume responsibility for supervising all tasks performed by my physician assistant under my supervision. It is my responsibility to inform all approved alternate supervising physicians of the responsibilities of supervising my physician assistant.

_____ Supervising Physician Signature	_____ S.C. License No.	_____ Date
_____ Alternate Supervising Physician Signature	_____ S.C. License No.	_____ Date
_____ Alternate Supervising Physician Signature	_____ S.C. License No.	_____ Date

(Attach additional sheet, if needed.)

V. AFFIDAVIT

I, _____ being duly sworn, depose and say that I am the person described and identified, that I am of good moral character and that I am the person named in the documents presented in support of this application. By filing this application, I hereby authorize and consent to an investigation of my fitness and qualifications to practice as an Anesthesiologist’s Assistant in South Carolina.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, and federal) to release to this licensing Board any information, files or records requested by the Board for its evaluation of my professional, ethical and other qualifications for licensure in South Carolina. I hereby release, discharge and exonerate the State Board of Medical Examiners of South Carolina, its agent or representative and any person or organization furnishing information from any and all liability of every nature and kind arising out of the furnishing of documents, records or other information, or arising from the investigation made by the State Board of Medical Examiners of South Carolina.

I have carefully read the questions in the foregoing application and have answered them completely, without reservation of any kind, and I declare that all statements made by me herein are true and correct. Should I furnish any false or incomplete information in this application, I hereby agree that such act shall constitute the cause for denial or revocation of my license to practice as an Anesthesiologist’s Assistant in South Carolina. Further, if licensed, I agree to keep the Board informed of any future changes in my address.

I hereby authorize the Board of Medical Examiners of South Carolina to utilize my Social Security Number in making necessary reports to the Federation of State Medical Boards’ Physician Data Center for compilation of information about applicants and licensees in order to coordinate licensure and disciplinary activities between the individual States’ licensing boards.

Applicant’s Signature: _____ Date: _____

Subscribed and sworn to before me this _____ day of _____, _____.

Notary Public Signature: _____ (L.S.) For: _____

My Commission Expires: _____

THIS SPACE FOR BOARD USE ONLY

Interviewed/approved by Board Member:
Date approved
Board Member Signature

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PRACTICE PROTOCOL FOR ANESTHESIOLOGIST'S ASSISTANTS (AA)

As approved by the South Carolina Board of Medical Examiners, and the AA Committee of the Board, Anesthesiologist's Assistants may perform duties within written practice protocols and under the supervision of an anesthesiologist. Any duties not covered by the following must be individually considered and approved by the AA Committee and the Board before the AA may perform those duties.

1. There shall be at all times a direct, continual and close supervisory relationship between the AA and the supervising anesthesiologist, who shall at all times be responsible for the activities of the AA.
2. The AA shall provide delegated medical services within the scope of the education, training and experience of the AA. These services include gathering of preoperative data and perioperative patient evaluations, as well as delegated teaching and research functions, as appropriate.
3. Perioperative patient evaluation and care may include the following:
 - a. Administer anesthesia under the direction of the supervising anesthesiologist.
 - b. Initiate multiparameter monitoring prior to or during anesthesia or other acute care settings. The AA may use data from central venous, pulmonary artery and intracranial catheters as well as other monitors or devices that are indicated.
 - c. Manage pre and post anesthesia care, including ventilatory support of patients as assigned by the supervising anesthesiologist.
 - d. Initiate acute cardiopulmonary resuscitation in life threatening situations according to CPR/ACLS protocols.

Anesthesiologist's Assistant:

Sponsoring Anesthesiologist:

Print Name

Print name

Address

Address

City, State & Zip

City, State & Zip

Signature

Signature

Date

SC License #

Date

Date protocols developed

Date of annual review

Date protocols amended

PRACTICE PROTOCOLS FOR ANESTHESIOLOGIST'S ASSISTANT

Signature page for Alternate Supervising Anesthesiologists

Anesthesiologists supervising an AA, must review the protocol submitted by the AA, and must sign below:

Practice Name

Address

Supervising Anesthesiologist(s):

License #	Printed Name	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____