South Carolina Department of Labor, Licensing and Regulation

South Carolina Board of Medical Examiners

110 Centerview Dr • Columbia • SC• 29210

P.O. Box 11289 • Columbia • SC• 29211

Phone: 803-896-4500 • Medboard@llr.sc.gov • Fax: 803-896-4515

www.llronline.com/POL/Medical/

ANESTHESIOLOGIST'S ASSISTANT LICENSURE REQUIREMENTS AND INSTRUCTIONS

REQUIREMENTS FOR LICENSURE

In order to qualify for licensure as an Anesthesiologist's Assistant, a completed application must be filed on forms provided by this Board.

The following requirements must be met (Section 40-47-1240):

A. successful completion of an accredited degree program for Anesthesiologist's Assistants;
B. current National Commission for Certification of Anesthesiologist's Assistant (NCCAA) certification.

APPLICATION FORM

Include with your paper application:

- Check or money order in the amount of $300 made payable to LLR-Board of Medical Examiners Application fee is non-refundable. A returned check fee of up to $30, or an amount specified by law, **may** be assessed on all returned funds.
- Copy of your valid Drivers License, State Issued ID, Passport or Military ID
- Copy of your social security card
- A 2"x2" professional photo (Passport Photo)
- NCCAA Certificate
- Malpractice Claim Information Form, if applicable
- Legal documentation for name change
- Sponsoring Anesthesiologist's Form and Practice Protocol Form

Have submitted directly to the Board office address above from the issuing agent:

- Official Transcripts from Anesthesiologist Assistant School or Certification of Education Form
- License Verification from each state medical board that you are currently or have ever been licensed in.
- 3 Letters of Recommendation

REQUIRED INTERVIEW FOR LICENSURE:

After the completed application is received in the Board Office and all criteria met, the Anesthesiologist's Assistant and sponsoring Anesthesiologist will receive a letter stating details about a personal interview with a Board Member or Board designee. Each applicant and sponsoring Anesthesiologist must meet with an assigned Board Member or designee before a license can be issued. Original National Board Certificate,

Anesthesiologist's Assistant training certificate and other relevant documents must be presented and verified during the interview. When the sponsoring Anesthesiologist receives a copy of the approved application from the Board, a copy of the Board's approval letter and approved protocol must be furnished, by the sponsoring Anesthesiologist, to all hospitals and other offices where the Anesthesiologist's Assistant will be working.

SUPERVISING PHYSICIAN AND SPONSORING PHYSICIAN

Only an Anesthesiologist with a permanent SC medical license may serve as a supervising or sponsoring Anesthesiologist. A physician who is on probation with this Board may not serve as a sponsoring or supervising Anesthesiologist.

CHANGING SPONSORING PHYSICIAN/TERMINATING EMPLOYMENT

If at any time employment is terminated or a change of sponsoring Anesthesiologist is requested, the Anesthesiologist's Assistant and sponsoring Anesthesiologist must notify the Board in writing, stating the reasons for termination. If changing sponsoring Anesthesiologist, a new application, along with a fee of $25, must be submitted for Board approval. The interview process is the same as Section IV when changing a sponsoring Anesthesiologist.

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Application for Licensure as an Anesthesiologist's Assistant

Include with your application:

- Check or money order in the amount of $300 made payable to LLR-Board of Medical Examiners
  Application fee is non-refundable. A returned check fee of up to $30, or an amount specified by law, **may** be assessed on all returned funds.
- Copy of your valid Drivers License, State Issued ID, Passport or Military ID
- Copy of your social security card
- A 2"x2" professional photo (Passport Photo)
- NCCAA Certificate
- Malpractice Claim Information Form, if applicable
- Legal documentation for name change
- Sponsoring Anesthesiologist's Form and Practice Protocol Form

Have submitted directly to the Board office address above from the issuing agent:

- Official Transcripts from Anesthesiologist Assistant School or Certification of Education Form
- License Verification from each state medical board that you are currently or have ever been licensed in.
- 3 Letters of Recommendation

Note for SC Residents: To find your Congressional District you may go to: http://www.scstatehouse.gov/legislatorssearch.php

I. APPLICANT INFORMATION:

Last Name:____________________First:______________________Middle:_________________Suffix:________

Have you ever legally changed your name? ☐ Yes ☐ No Maiden Name:____________________________

If yes, please submit legal documentation supporting the change. (Marriage certificate, divorce decree, etc.)

Home Address: __________________________City:____________State:______Zip:__________District:_____

Congressional District (SC Residents Only)

Mailing Address: ______________________________________City:________________State:_____Zip:_______

(If different than above)

Phone: ___________________________ Email Address: ____

Date of Birth: _____________________ Social Security No.: ____________________________________

Place of Birth (City, State or Country): ____

Race: ____________________________ Gender: ☐ Female ☐ Male

(for statistical purposes only)

Sponsoring Anesthesiologist's Name: ____

License Number: _________________________ Phone: ______________________________

Business Address: ____

Name: ______________________________

II. PROFESSIONAL EDUCATION INFORMATION

List all Anesthesiologist's Assistant Schools attended and dates of attendance.

Institution/Program	LOCATION (City and State or Country)	Attendance Dates (MM/YR – MM/YR)	Degree Earned

III. RECORD OF EXAMINATION

List each NCCAA examination attempt(s) below.

NCCAA Certificate Number: ______________________________ Expiration Date: ____________________

Attempt (First, second, etc.)	LOCATION (State or Country)	Date of Exam	Passed/Failed Score

IV. RECORD OF LICENSURE

List all states in which you have been licensed in for any medical profession; regardless of status: Active, Inactive, Expired, Training etc. You will need to contact each State Board and request a License Verification to be mailed directly to the Medical Board at the above listed address. We provide a License Verification Form as a courtesy; however, we will accept a state board issued form. Attach additional sheet if needed.

State/Jurisdiction	License No.

State/Jurisdiction	License No.

State/Jurisdiction	License No.

V. MEDICAL PRACTICE EMPLOYMENT HISTORY

List all Anesthesiologist's Assistant related employment (include training) chronologically, most recent first.

FROM Month / Yr	TO Month / Yr	EMPLOYER NAME	OFFICE ADDRESS	TYPE OF PRACTICE

Name: ______________________________

VI. PERSONAL HISTORY INFORMATION

If you answer yes to any of the below questions, you must attach a full written explanation.

1. Has your Anesthesiologist's Assistant certificate/license ever been revoked, suspended, reprimanded, restricted, disciplined, or placed on probation by a medical licensing board or other entity? YES NO

2. Have you ever had an application to practice as an Anesthesiologist's Assistant denied or refused by another medical licensing board or other entity? YES NO

3. Have you ever had any hospital privileges denied, revoked, suspended or restricted in any way? YES NO

4. Have you ever voluntarily surrendered an Anesthesiologist's Assistant license? YES NO

5. Have you ever resigned from any hospital, institution or health care facility in lieu of disciplinary action? YES NO

6. Are you currently under investigation or the subject of pending disciplinary action by any medical licensing board, health care facility or other entity? YES NO

7. Have you ever had a malpractice lawsuit, judgment filed against you or settled a medical malpractice claim? If yes, how many? ________ (Complete a Malpractice Information Claim Form for each claim) YES NO

8. Are you currently being 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? YES NO

9. Do you currently have any mental illness (e.g. bipolar disorder, schizophrenia, paranoia or any other psychotic disorder) or any physical illness or condition that might interfere with your ability to competently and safely perform the essential functions of practice as an anesthesiologist's assistant? YES NO

10. Within the past two (2) years, has your ability to practice medicine been impaired by any physical or mental illness or by the use of alcohol and/or drugs? YES NO

11. Have you ever discontinued the practice of medicine for any reason for three consecutive months or more? YES NO

12. Was your medical education / residency training interrupted other than for vacation periods or military service? YES NO

13. Have you ever been convicted, pled guilty or pled nolo contendere to a felony of any kind or to a non-felony crime involving drugs or moral turpitude? YES NO

VII. LETTERS OF RECOMMENDATION

Please supply below the names and addresses of three individuals willing to write letters of recommendation to support your application for SC Anesthesiologist's Assistant licensure. Two of these three letters must be from physicians; the third may be from an Anesthesiologist's Assistant that is familiar with your work. **You must request that each physician listed below write directly to the Board** indicating that you are known to them, in what capacity and for how long, and outlining characteristics they believe qualify you for Anesthesiologist's Assistant licensure in SC. The letters must be signed by the physician writing on your behalf. Make note of the reference number and physician's name listed for when you check your application status later.

Reference 1.

Name: ____ Phone: ______________________________

Address: ____
Street, City, State, Zip

Reference 2.

Name: ____ Phone: ______________________________

Address: ____
Street, City, State, Zip

Reference 3.

Name: ____ Phone: ______________________________

Address: ____
Street, City, State, Zip

PRIVACY DISCLOSURE:

South Carolina Law requires that every individual who applies for an occupational or professional license provide a social security number for use in the establishment, enforcement and collection of child support obligations and for reporting to certain databanks established by law. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Social security numbers may also be disclosed to other governmental regulatory agencies and for identification purposes to testing providers and organizations involved in professional regulation. Your social security number will not be released for any other purpose not provided for by law.

Other personal information collected by the Department for the licensing boards it administers is limited to such personal information as is necessary to fulfill a legitimate public purpose. The South Carolina Freedom of Information Act ensures that the public has a right to access appropriate records and information possessed by a government agency. Therefore, some personal information on the application may be subject to public scrutiny or release. The Department collects and disseminates personal information in compliance with The South Carolina Freedom of Information Act, the South Carolina Family Privacy Protection Act, and other applicable privacy laws and regulations. Additionally, the Department shares certain information on the application with other governmental agencies for various governmental purposes, including research and statistical services.

VIII. CERTIFYING STATEMENT

I, ____ being duly sworn, depose and say that I am the person described and identified, 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 anethesiologist'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 agents or representatives 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 reservations 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 an act shall constitute the cause for denial or revocation of my license to practice medicine 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 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.

____
Signature of Applicant

____
Print Name of Applicant

Subscribed and sworn to before me this ______ day

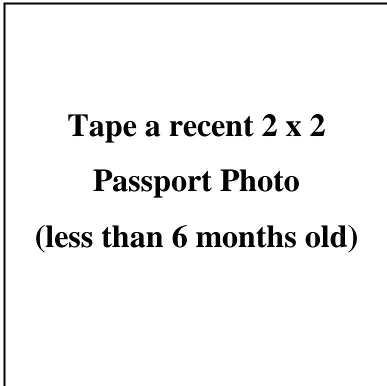
of ________________20________.

Notary Signature: _________________________________

Print Name: ______________________________________

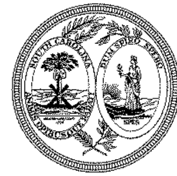
Notary for the State of: ___________________________

My Commission expires: __________________________



(Notary Seal)

STATE OF SOUTH CAROLINA
DEPARTMENT OF LABOR, LICENSING AND REGULATION
VERIFICATION OF LAWFUL PRESENCE IN THE UNITED STATES
AFFIDAVIT OF ELIGIBILITY



Pursuant to Section 8-29-10, *et seq.* of the South Carolina Code of Laws (1976, as amended), the Department of Labor, Licensing and Regulation must verify that any person who applies for a South Carolina license is lawfully present in the United States. Complete and sign this affidavit of eligibility. The information provided is subject to verification.

Section A: LAWFUL PRESENCE in the United States.

The undersigned ________________________________, of ________________________________
(Print clearly First, Middle, and Last name) (Home Address, City, State, and Zip Code)
being first duly sworn deposes and states as follows:

Check only one box:

1. ☐ I am a United States citizen; or
2. ☐ I am a Legal Permanent Resident of the United States eighteen years of age or older; or
3. ☐ I am a Qualified Alien or non-immigrant under the Federal Immigration and Nationality Act, Public Law 82-414, eighteen years of age or older, and lawfully present in the United States.
4. ☐ Other:____________________Please submit any documentation that supports this status.

Date of Birth: ____________________

Alien Number:______________________ I-94 Number: __________________

(**If you checked number 2, 3, or 4 you must attach a copy of your immigration documents**. See instruction sheet for a list of accepted immigration documents.)

Section B: ATTESTATION.

I understand that in accordance with section 8-29-10 of the South Carolina Code of Laws, a person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall, in addition to other sanctions imposed by this State or the United States, be guilty of a felony, and upon conviction must be fined and/or imprisoned for not more than 5 years (or both).

I understand that the representations made in this Affidavit shall apply through any license(s) or renewals issued, and that I shall have an affirmative duty to immediately advise the Department of Labor, Licensing and Regulation of any change of my immigration or citizenship status.

I swear and attest the information contained herein is true and correct to the best of my knowledge. I understand that under South Carolina law, providing false information is grounds for denial, suspension, or revocation of a license, certificate, registration or permit.

____
Signature of Affiant

SWORN to before me this________day of____________________, 20_______

____
Notary Signature

____
Print Name

Notary Public for ______________________________________

My Commission Expires: __________________________________

Rev: 02-02-2015

INSTRUCTION SHEET FOR COMPLETING AFFIDAVIT OF ELIGIBILITY

CHECK box 1:
If you are a United States Citizen by birth or naturalization

CHECK box 2:
If you are a Legal Permanent Resident and you are not a U.S. Citizen, but are residing in the U.S. under legally recognized and lawfully recorded permanent residence as an immigrant.
PROVIDE A COPY OF ALL IMMIGRATION DOCUMENTS.

CHECK box 3:
If you are a Qualified Alien. You are a Qualified Alien if you are:
An alien who is lawfully admitted for residence under the INA.
An alien who is granted asylum under Section 208 of the INA.
A refugee who is admitted to the United States under Section 207 of the INA.
An alien who is paroled into the United States under Section 212(d)(5) of the INA for a period of at least 1 year.
An alien whose deportation is being withheld under Section 243(h) of the INA (as in effect prior to April 1, 1997) or whose removal has been withheld under Section 241(b)(3).
An alien who is granted conditional entry pursuant to Section 203(a)(7) of the INA as in effect prior to April 1, 1980.
An alien who is a Cuban/Haitian Entrant as defined by Section 501(e) of the Refugee Education Assistance Act of 1980.
An alien who has been battered or subjected to extreme cruelty, or whose child or parent has been battered or subject to extreme cruelty.
PROVIDE A COPY OF ALL IMMIGRATION DOCUMENTS.

ACCEPTED IMMIGRATION DOCUMENTS:
Unexpired Reentry Permit (I-327)
Permanent Resident Card or Alien Registration Receipt Card With Photograph (I-551)
Unexpired Refugee Travel Document (I-571)
Unexpired Employment Authorization Card Which Contains a Photograph (I-766)
Machine Readable Immigrant Visa (with Temporary I-551 Language)
Temporary I-551 Stamp (on passport or I-94)
I-94 (Arrival/Departure Record) in Unexpired Foreign Passport
I-20 (Certificate of Eligibility for Nonimmigrant, F-1, Student Status)
DS2019 (Certificate of Eligibility for Exchange Visitor, J-1, Status)

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MALPRACTICE CLAIM INFORMATION

This form must be completed if you have ever been named as a defendant in a malpractice lawsuit, verdict or settlement.

____ _________________________
Physician Name Office Telephone No.

____
Address City State Zip

MALPRACTICE COMPLAINT:
Include name of patient, age, sex, date of occurrence and location, i.e., office or name and address of hospital.

Patient's Name: ____

Age: _________ Sex: _________ Date of Occurrence: _______________________

Place of Occurrence: ____

Indicate your position in case (i.e., resident, primary physician, etc.): _______________________

FILED AGAINST: ( ) Individual Doctor ( ) Group ( ) Hospital

List names of other defendant-doctors and/or hospitals:

____

____

____

DISPOSITION: ( ) Pending ( ) Jury Verdict ( ) Settled ( ) Dismissed ( ) Dropped

If there has been a verdict or settlement, please provide the following information:

Legal outcome: ____

Total amount paid (if any): ________________________ Date paid: ______________

Amount attributable to you: ____

1. On a separate sheet, provide a detailed written explanation of the background and medical issues involved in the case.
2. Attach copies of the complaint, answer, release, settlement documents and all other relevant legal documents.
3. Form may be duplicated as needed. <u>A separate report must be completed for each malpractice claim</u>.

Date: ____________________ Signature: ____

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SPONSORING ANESTHESIOLOGIST FORM
FOR ANESTHESIOLOGIST'S ASSISTANT

Submit with the Practice Protocol Form.

ANESTHESIOLOGIST ASSISTANT:

Last Name:___________________Suffix:___________First:_________________Middle:_________________

SPONSORING ANETHESIOLOGIST INFORMATION:

SC License Number: ____________________________

Last Name:___________________Suffix:___________First:_________________Middle:_________________

Phone: __________________________ Email Address: ______________________________________

Business Name: _____________________________________Type of Practice: ________________________

Business Address: ____________________________________City:_______________State:____ Zip:______

Are you a diplomat of the ABA? YES NO

LOCATION INFORMATION:

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

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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 Signature	Sponsoring Anesthesiologist Signature
______________________________	______________________________
Print Name	Print Name
______________________________	______________________________
Date	Date
	______________________________
	License Number

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CERTIFICATION OF ANESTHESIOLOGIST'S ASSISTANT EDUCATION

You may have the school fill this form out or have an official set of transcripts sent to the Medical Board at the above address.

Applicant's Name: ____

I am applying for a license to practice as an Anesthesiologist's Assistant in South Carolina. Please complete this form bearing the institution's official seal to the address above.

_______________________________ Applicant's Signature

_______________________________ Date

CERTIFICATION OF ANESTHESIOLOGIST'S ASSISTANT EDUCATION INFORMATION

It is hereby certified that ____

of (home town, state and country) ______________________________________

attended (full name of program) ____

from ____________________ to _______________________ and received a diploma

conferring the degree of ________________________________ and said diploma bears

the following date ____.

(Seal)

____
(Dean, Registrar, AA Program Director)

____
Current Date