



New Mexico Medical Board
2055 S. Pacheco Street, Building 400
Santa Fe, New Mexico 87505

ANESTHESIOLOGIST ASSISTANT APPLICATION

GENERAL INFORMATION FOR ANESTHESIOLOGIST ASSISTANT LICENSURE

Fees

The applicant fee of \$100 is payable in U.S. funds by cashier's check, money order, check MasterCard or Visa. Applications will not be processed until the application fee has been received. **All fees are nonrefundable.**

Education Requirements

All applicants must have graduated from an Anesthesiologist Assistant program accredited by the Committee on Allied Health.

Education and Accreditation (CAHEA of the American Medical Association or its successor agency) and hold current NCCAA Certification. Anesthesiologist Assistants not currently certified by NCCAA have a one-time grace period of one-year from the date of licensure to become certified.

INSTRUCTIONS FOR COMPLETING THE PHYSICIAN ASSISTANT APPLICATION

Procedures

Complete the application in its entirety. Please **type or print in black or blue ink.**

1. **Board Application**

Complete all application pages. You must respond to **all** components of the application as instructed.

2. **Anesthesiologist Assistant Medical Education Certification**

You must have your Anesthesiologist Assistant Program verify your degree. Affix a recent (less than 6 months) passport quality photograph of yourself (alone) in the designated space. Photographs must be clear, front view, full face without a hat or dark glasses. Full-length photos, black and white or computer photos will not be accepted. **The completed verification must be sent directly to the Board office from the Anesthesiologist Assistant Program.**

3. **NCCAA**

You must have the National Commission on the Certification of Anesthesiologist Assistants verify certification or registration to sit for the Certificate Exam. **The completed verification must be sent directly to the Board office from NCCAA.**

4. **Verification of Licensure / Registration**

You must have each state licensing authority that has ever issued you a Anesthesiologist Assistant license or any other health related license/registration verify the standing of that license/registration directly to the Board. Use the enclosed form entitled "Verification of Licensure/Registration." Make photocopies as required. Complete the release on the top half of the form and send one copy to each jurisdiction. **These completed verifications must be sent directly to the Board office from the licensing authority.**

5. **Letters of Recommendation**

You must have two (2) Recommendation forms completed and sent directly to the Board from **physicians** who have supervised you for at least (6) months and are licensed to practice medicine in the United States. New graduates may obtain letters from their Anesthesiologist Assistant Program Director, Director's designee or Preceptors. **Forms of Recommendation must attest to your moral character and competence to practice.**

6. **Applicants Oath**

To allow the Board to make inquiries into your background, you must complete the form entitled "Applicant's Oath". Submit this form with your application.

7. **Supervising Physician Statement of Responsibility**

Upon employment, an Anesthesiologist Assistant together with a New Mexico licensed physician must Submit a Completed "Supervising Physician Statement of Responsibility Form" directly to the Board office.

8. **Submitting The Board Application**

Attach your payment to the front of the application. Make payment in U.S. funds to the New Mexico Medical Board. Do not send cash. Mail your application, appropriate fee, Applicant's Oath and any other Supporting documents to:

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9. **Personal Interview**

If you are required to schedule an appointment for a personal interview with the Board or the Board's Designee, you will be notified after your application and all required documents have been received and are complete in every detail.

10. **License**

Applicants whose applications are approved and who successfully complete an interview (if required) will be issued a license to practice in the state of New Mexico.



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ANESTHESIOLOGIST ASSISTANT EDUCATION CERTIFICATION

This is my authorization to release all information in your files, favorable, to the New Mexico Medical Board.

Print/Type Full Name

Date of Birth

Address

Signature

Date

City/State/Zip

Telephone Number

THE SECTION BELOW SHOULD BE COMPLETED BY PROGRAM DIRECTOR

I hereby certify that the Anesthesiologist Assistant Degree issued by, _____
Program Name

Was conferred upon _____, on _____ and
Date of Graduation

that the photograph which appears below is a true likeness of the applicant.

Program Director/Administrator (type or print)

Program Director/Administrator Signature

Date

Anesthesiologist Assistant Program Address

City/State/Zip

Telephone Number

Attach recent
Passport-Style
Photograph that
will fit in this space

INSTRUCTIONS TO ANESTHESIOLOGIST ASSISTANT PROGRAM OFFICIAL

This form will not be accepted if returned by the applicant. Please complete this certification and return directly to the above address.
Thank you for your cooperation.

School seal
must
partially
cover
photograph

Professional Practice Questions Please answer all of the following Yes or No questions. If you answer YES to any question, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.

1. Has your professional liability coverage ever been terminated by action of the insurance company?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Have you ever been denied professional liability insurance coverage?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Has your professional liability carrier ever excluded any specific procedures from your coverage?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5. Have you ever been excluded from or sanctioned by Medicare and/or Medicaid?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6. Have you ever been charged with, arrested for, convicted of, or pled no contest to a misdemeanor or felony, or have you ever been named as a defendant in any criminal proceedings or subject to investigation by a governmental entity that could result in sanctions or licensure adverse actions?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7. Have you ever been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8. Have your privileges at any healthcare entity ever been voluntarily or involuntarily suspended, restricted, diminished, revoked or not renewed, except for medical records?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9. Have you ever resigned from a healthcare entity to avoid modification, suspension, or termination of privileges?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
10. Has your application for licensure or license to practice in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, denied or are any currently held licenses pending investigation or being challenged?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
11. Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
12. Has your federal or state narcotics registration certificate in any jurisdiction ever been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
13. Have you ever been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please type on a separate sheet of paper for each case. <ul style="list-style-type: none"> • Name, age, sex of patient/claimant. • Date(s) and type of treatment and/or surgery, which led to the allegations against you. • Nature of allegations in claims/suits. Specify whether a suit was ever filed. • Names of other practitioners and hospital, if any, involved in claims or suit. • Disposition or current status of claim or suit (be specific). • Name of insurance carrier defending you. • Name of defense attorney. 	Yes <input type="checkbox"/>	No <input type="checkbox"/>
14. Do you know of any reason why you cannot perform the essential duties of the clinical privileges/functions for which you are requesting with or without a reasonable accommodation according to acceptable standards of professional performance and without posing a direct threat to patients?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
15. Do you use illegal drugs or have you illegally used drugs in the past five years?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If you answer YES to any question, please give details including name, address, and telephone number of significant parties on a separate sheet of paper



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APPLICANT'S OATH

Anesthesiologist Assistant I, _____, am the person named in this application for licensure as an anesthesiologist assistant. I hereby certify I have read and agree to the law and rules established for practice as an anesthesiologist assistant, including the requirement that the supervising anesthesiologist must be present in the operating room during the induction of a general or regional anesthetic and during emergence from a general anesthetic; the presence of the supervising anesthesiologist must be documented in the patient record, and the supervising anesthesiologist must be present within the operating suite and immediately available to the operating room when I am performing anesthesia procedures. I certify that _____, M.D. is the board certified anesthesiologist who will be providing supervision and that my license is void upon changing supervising anesthesiologist until the new supervising anesthesiologist is approved by the Board. I furthermore understand that I must register with the Board annually and I may only work at as an employee of the Department of Anesthesiology at UNM medical School.

I acknowledge and state that I have read the information and Instruction that accompanied and I have answered all questions truthfully. I understand that the fee I submitted is not refundable.

I authorize and request every person, hospital, clinic, community, governmental agency (local, state, federal, or foreign), court, association, institution or other organization having control of any documents, records, and other information pertaining to me, to furnish to the New Mexico Medical Board or any of their agents or representatives to inspect and make copies of such documents, records and other information, in connection with this application, subsequent licensure, and practice thereunder.

I hereby release, discharge, and exonerate the New Mexico Medical Board, and their agents or representatives, and any person furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records, other information, or the investigation made by the New Mexico Medical Board. I authorize the New Mexico Medical Board to release information, material, documents, orders, or the like relating to me or to this application to any other agency of the State of New Mexico or the appropriate licensing agency of any other state or Territory of the United States or any agency of the United States Government.

Applicant Signature

Date

Attach recent
Passport-Style
Photograph that
will fit in this space



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New Applicant Change of Supervising Physician

SUPERVISING ANESTHESIOLOGIST STATEMENT OF RESPONSIBILITY

THIS SECTION TO BE COMPLETE BY ANESTHESIOLOGIST ASSISTANT

Name: _____
Last First Mi Maiden

Home: _____
Number and Street

City State Zip/Postal Code

Office Telephone: () _____ Home Telephone: () _____

Fax Number: () _____ E-Mail Address: _____

Physician Assistant Signature: _____
NM License Number

THIS SECTION TO BE COMPLETED BY SUPERVISING ANESTHESIOLOGIST

Name: _____
Supervising Anesthesiologist (Print or Type) NM License Number Field of Practice

Business Name: _____

Address _____

City State Zip/Postal Code

Business Telephone: () _____ Fax Number: () _____

Supervision Beginning Date: _____ Supervision Ending Date: _____
(Board must approve) (If known)

Payment Information: Fee \$25 **(\$25 fee does not apply for new applicants)**

_____ Master Card _____ Visa _____ Check _____ Money Order

Credit Card #: _____ Exp Date: _____

ALTERNATE SUPERVISING PHYSICIAN:

In my Absence, the following physician (s) agrees to serve as alternate supervising physician (s) for the above-named anesthesiologist assistant. Copy if needed.

Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature
Physician Name	NM License Number	Field of Practice	Signature

I certify that I am the supervising physician named in this document and assume full responsibility for the supervision of the anesthesiologist assistant named above. I also acknowledge that I have read and understand the rules pertaining to the supervision of a anesthesiologist assistant. I further acknowledge that in submitting these forms to the New Mexico Medical Board. I agree that supervision will be in accordance with the New Mexico Medical Practice Act and Rules.

Signature of Supervising Physician _____ Date _____

Approved By: _____
Signature Title Date

Effective date of Supervision: ____/____/____

