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6/93

TRANSMITTAL SHEET FOR NOTICE OF INTENDED ACTION

Control 540 Department or Agency Alabama State Board of Medical Examiners
Rule No. 540-X-7, Appendix E
Rule Title: Application for Registration of an Anesthesiologist Assistant
_____ New __X__ Amend _____ Repeal _____ Adopt by Reference

Would the absence of the proposed rule significantly harm or endanger the public health, welfare, or safety?	YES
Is there a reasonable relationship between the state's police power and the protection of the public health, safety, or welfare?	YES
Is there another, less restrictive method of regulation available that could adequately protect the public?	NO
Does the proposed rule have the effect of directly or indirectly increasing the costs of any goods or services involved and, if so, to what degree?	NO
Is the increase in cost, if any, more harmful tot he public than the harm that might result from the absence of the proposed rule?	NO
Are all facets of the rulemaking process designed solely for the purpose of, and so they have, as their primary effect, the protection of the public?	YES

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Does the proposed rule have an economic impact? NO

If the proposed rule has an economic impact, the proposed rule is required to be accompanied by a fiscal note prepared in accordance with subsection (f) of Section 41-22-23, Code of Alabama 1975.

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Certification of Authorized Official
I certify that the attached proposed rule has been proposed in full compliance with the requirements of Chapter 22, Title 41, Code of Alabama 1975, and that it conforms to all applicable filing requirements of the Administrative Procedure Division of the Legislative Reference Service.

Signature of certifying officer _____

Date: December 16, 2011

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6/93

ALABAMA STATE BOARD
OF MEDICAL EXAMINERS

NOTICE OF INTENDED ACTION

AGENCY NAME: Alabama State Board of Medical Examiners

RULE NO. & TITLE: 540-X-7, Assistants to Physicians, Appendix E, Application for Registration of Anesthesiologist Assistant

INTENDED ACTION: To amend the rule

SUBSTANCE OF PROPOSED ACTION: To add a statement concerning the statutory authority for requesting, requirement for requesting, uses of and consequences of not supplying an applicant's social security number.

TIME, PLACE, MANNER OF PRESENTING VIEWS: All interested persons may submit data, views, or arguments concerning the proposed new rule(s) and regulation(s) in writing to: Patricia E. Shaner, General Counsel, Alabama State Board of Medical Examiners, Post Office Box 946, Montgomery, Alabama 36101-0946, by mail or in person between the hours of 8:30 a.m. and 4:30 p.m., Monday through Friday, until and including Friday, February 3, 2012. Persons wishing to obtain copies of the text of this rule and submit data, views, or comments or arguments orally should contact Patricia E. Shaner, by telephone (334-242-4116) during said period in order to set up an appointment for a hearing respecting such oral data, views, or arguments.

FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE: February 3, 2012

CONTACT PERSON AT AGENCY: Patricia E. Shaner

Larry D. Dixon, Executive Director

ALABAMA BOARD OF MEDICAL EXAMINERS

P.O. Box 946 / Montgomery, AL 36101-0946 / (334) 242-4116

APPLICATION FOR REGISTRATION OF ANESTHESIOLOGIST ASSISTANT

PHYSICIAN TO COMPLETE:

Supervising Physician Name in Full _____

Ala. Medical License Number _____ Date of Birth _____ Social Security No.* _____

*Pursuant to Ala. Code § 30-3-194, it is mandatory that we request and that you provide your social security number (SSN) on this application. The uses of your SSN are limited to the purpose of administering the state child support program and intra-agency for identification purposes. If your SSN is not provided, your application is not complete, and no license will be issued.

Medical Specialty _____ Board Certified: YES NO Board Eligible YES NO

Principal Practice Location Address _____

(If mailing address is different please provide here) _____

Telephone Number: (_____) _____ FAX Number (_____) _____

1. List the name, practice site address and designated working hours per week of each anesthesiologist assistant **currently** registered to you.

NAME _____

ADDRESS _____

HOURS _____

2. Have you ever had a anesthesiologist assistant certified or registered to you by the Alabama Board of Medical Examiners?

YES _____ NO _____ **If the answer is YES**, list the names of the assistant(s) in the spaces provided.

_____

_____

3. Is the anesthesiologist assistant for whom registration is sought employed by you or by your group, partnership or professional corporation?

YES_____ NO _____ **If the answer is NO**, Appendix **G** to Chapter 7 must be submitted.

I hereby certify that the foregoing information is correct to the best of my knowledge, information and belief; and that I have reviewed and understand the current rules and regulations of the Alabama Board of Medical Examiners pertaining to anesthesiologist assistants and understand my responsibilities.

Date: _____ **Primary Supervising Physician Signature**: _____

In accordance with Rule 540-X-7-.51 confirmed receipt of this application will be sent by mail, unless a FAX number is provided where the confirmation can be transmitted by FAX.

A anesthesiologist assistant previously approved to practice under the provisions of Chapter 7 of the Board of Medical Examiners Administrative Rules may continue in the supervised practice with this interim supervising physician and may continue until such time as this application is approved or denied, provided the supervising physician meets the qualifications established in Rule 540-X-7-.47.

ANESTHESIOLOGIST ASSISTANT TO COMPLETE:

Assistant Name in Full _____

Ala. A. A. License Number _____ Date of Birth_____ Social Security No.* _____/_____/_____

*Pursuant to Ala. Code § 30-3-194, it is mandatory that we request and that you provide your social security number (SSN) on this application. The uses of your SSN are limited to the purpose of administering the state child support program and intra-agency for identification purposes. If your SSN is not provided, your application is not complete, and no license will be issued.

1. Have you ever been certified or registered as a anesthesiologist assistant by the Alabama Board of Medical Examiners?

   YES _____ NO _____ **If the answer is YES**, list the names of the physicians in the spaces provided.

_____

_____

2. Are you **currently** certified or registered to any other primary certifying physician? **If the answer is YES,** in the space below give the physician name, physician practice location, *assistant's* certification or registration number, and *assistant's* number of hours per week for each primary supervising physician. (There are spaces for three separate registrations.)

NAME _____

ADDRESS _____

REGISTRATION No. _____

HOURS per week _____

I hereby certify that the foregoing information is correct to the best of my knowledge, information and belief; and that I have reviewed and understand the current rules and regulations of the Alabama Board of Medical Examiners pertaining to anesthesiologist assistants and understand my responsibilities.

Date: _____ **Anesthesiologist Assistant Signature:** _____

Office Use ▼	**PLEASE NOTE & RESPOND TO THE FOLLOWING AS APPROPRIATE FOR THIS REGISTRATION REQUEST.**
	FEE: Each new registration requires submission of a $100.00 fee. Please attach check payable to Alabama Board of Medical Examiners.
	JOB DESCRIPTION: Please attach a completed job description signed by the physician and the assistant.
	APPENDIX G : If assistant is employed by an entity **other than** the physician, the physician's group or professional corporation please include a completed Appendix G. Include a separate sheet for responses if required.
	COVERING PHYSICIAN LETTERS: The absence of "covering physician" letter(s) indicates that when the primary physician is not working, the assistant is not working. (A "sample" form was included in the registration package.)