VERMONT

State of Vermont
Department of Health
Medical Practice Board
108 Cherry Street – PO Box 70
Burlington, VT 05402-0070
www.HealthyVermonters.info

[phone] 802-657-4220
[toll-free] 800-745-7371
[fax] 802-657-4227

Agency of Human Services

Memorandum

TO: Anesthesiologist Assistant

FROM: Medical Practice Board

DATE: October 31, 2005

RE: 2006 Anesthesiologist Assistant Certification Renewal Instructions

Enclosed is your 2006 Anesthesiologist Assistant Certification Renewal Application. Please follow the instructions below and return the completed application with documentation and payment to this office no later than January 13, 2006. If you have any questions or need additional information do not hesitate to contact us at 802 657-4220, 800 745-7371 or medicalboard@vdh.state.vt.us. ***Your certification will lapse if we have not received your completed application and fee by January 31, 2006.***

INSTRUCTIONS

- ☐ enter, correct or update all information
- ☐ print legibly or type your answers
- ☐ answer all questions completely, even if you believe the information is already on file with the Board
- ☐ use the enclosed Form A to provide explanations to "yes" answers in Parts II -IV
- ☐ write your name and certificate number on each attachment
- ☐ make a copy of the completed forms and all attachments for your own records
- ☐ do not delegate this important task to any other person. False statements on this form may be grounds for charges of unprofessional conduct

Be sure to enclose:

- ☐ completed application and appropriate attachments, e.g. Form A, Primary and Secondary Supervising Anesthesiologist Applications, NCCAA Certificate, Scope of Practice, etc.
- ☐ completed *Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions,* whether or not you have children
- ☐ completed ***clinical practice questions*** and any other attachments
- ☐ a check for $100 for primary certification payable to the Vermont Department of Health
  - ***LATE FEE***: Applications post-marked or received after 1/31/06 will be assessed a $25 late fee plus $5 for every additional month or fraction of a month.

Please return the completed application, attachments and fee no later than January 13, 2006 to facilitate timely processing and avoid an interruption in your ability to practice because of a lapsed certification.

Please Note:
Certificatees have a continuing obligation during each two-year renewal period to promptly notify the Board of any change or new information including, but not limited to, disciplinary or other action limiting or conditioning their certificate or ability to practice in any jurisdiction. Failure to do so may subject the certificatee to disciplinary action by the Board.

Thank you.

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
108 Cherry Street, PO Box 70
Burlington VT 05402-0070
802 657-4220 or 800-745-7371

2006 ANESTHESIOLOGIST ASSISTANT CERTIFICATION RENEWAL APPLICATION

PART I

Certificate # AAA-00000

1. Name: _____

2. Other Name(s), if any, under which you were certified or licensed in Vermont and elsewhere:

_____

3. Home Address:

_____

City, State, Zip Code: _____

4. Work Address:

_____

City, State, Zip Code:

_____

Please check your preferred mailing address: □ Home □ Work
(This address will be public and listed on the Board's website)

5. Email Address

_____

6. Daytime Telephone Number: Area Code: (_____)

_____

7. Date of Birth: Month: _____ Day _____ Year _____

8. Place of Birth: _____

9. Do you have hospital privileges in Vermont? ☐ Yes ☐ No

Hospital Name(s) and Location(s):

_____
_____
_____
_____

10. In what year did you start working as an anesthesiologist assistant in Vermont? _____

11. Did you practice in Vermont during the past 12 months? ☐ Yes ☐ No

12. Other states where you now hold an active certification or license to practice:

_____
_____

13. States where you previously were certified or licensed to practice:

_____

_____

14. Specialty: _____ DEA Number: _____ _____

15. Name and office address of current EMPLOYER:

Name Address

_____ _____

16. Please list (use additional sheet if necessary) name(s) and address(es) of physicians who currently serve as your PROPOSED PRIMARY and SECONDARY SUPERVISING ANESTHESIOLOGIST(S).

Proposed Primary Supervising Anesthesiologist (s):

Name Address

_____

_____

Proposed Secondary Supervising Anesthesiologist (s):

Name Address

_____

_____

17. Scope of Practice: The Board of Medical Practice requires that you and your primary supervising physician(s) review the most current scope of practice for your practice setting, paying attention to any additions or deletions in duties and procedures. Please review, date and sign your scope of practice and have your PROPOSED PRIMARY SUPERVISING ANESTHESIOLOGIST sign it as well. Attach a copy of your signed scope of practice to this application.

    a. Has there been a change in your scope of practice which has not been reviewed by the Board?
    ☐ Yes ☐ No

18. Please provide a letter from your Supervising Anesthesiologist attesting to the fact that you have practiced as an Anesthesiologist Assistant within the past twelve months.

19. Continuing Medical Education (CME) requirements:

    NCCAA certified Anesthesiologist Assistant: Attach proof of current NCCaA certification; this will serve as adequate proof of CME completion.

20. Proposed Primary Supervising Anesthesiologist and Proposed Second Supervisory Anesthesiologist forms are provided. They must be completed and returned with this application.

PART II

"Yes" answers to Questions 21 - 44 require an explanation on Form A.

21. Have you ever applied for and been denied a certificate to practice medicine or any other healing art?
    □ yes □ no

22. Have you ever withdrawn an application for a certificate to practice medicine or any other healing art?

□ yes □ no

23. Have you ever voluntarily suspended, surrendered or resigned a certificate to practice medicine or any other healing art in lieu of disciplinary action?

□ yes □ no

24. Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?

□ yes □ no

25. Have you ever been denied the privilege of taking an examination before any state medical examining board?

□ yes □ no

26. Have you ever discontinued your education, training, or practice for a period of more than three months for reasons other than a family need?

□ yes □ no

27. Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion?

□ yes □ no

28. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you?

□ yes □ no

29. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?

□ yes □ no

30. Are you presently or have you ever been a defendant in a criminal proceeding?

□ yes □ no

PART III

(Unless otherwise ordered by a court, your responses to the questions in Part III are considered exempt from public disclosure.)

Any "yes" response to the questions below must be fully explained on the enclosed Form A.

31. To your knowledge, are you the subject of an investigation by any other licensing board as of the date of this application? □ yes □ no

32. To your knowledge, are you presently the subject of a criminal investigation? □ yes □ no

The following definitions are provided to assist you in answering questions 33 through 35.

"Ability to practice medicine" - This term includes:
The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments, and to learn and keep abreast of medical developments; and
The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" - Includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, hepatitis, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Currently" - This term means recently enough to have a real or perceived impact on one's functioning as a licensee.

"Chemical substances" - This term is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Controlled substances" - This term means those drugs listed on Schedules I through V of Section 202 of the Controlled Substances Act (21 USC § 812).

"Illegal use of controlled substances" - This term means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act, as periodically updated by the Food and Drug Administration. This term does not include the use of a drug taken under the supervision of a licensed health care professional or other uses authorized by the Controlled Substances Act or other provisions of federal law.

33. Do you have a medical condition that in any way impairs or limits your ability to practice medicine in your field of practice with reasonable skill and safety?

□ yes □ no

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your medical condition is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

34. Are you currently engaged in the use of alcohol or other chemical substances that in any way impairs your ability to practice medicine in your field of practice with reasonable skill and safety?

□ yes □ no

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your use is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

35. Are you currently engaged in the illegal use of controlled substances?

□ yes □ no

In explaining a "Yes" answer on Form A, please provide reasonable assurances that such use is not a real and ongoing problem in your practice of medicine.

IMPORTANT

Since 1999, Board fees have been used to create and maintain the Vermont Practitioners Health Program, a confidential program for the identification, treatment and rehabilitation of practitioners, including anesthesiologist assistants, affected by the disease of substance abuse. If you wish further information about this program, a service of the Vermont Medical Society, call 802-223-0400 (a confidential line).

Part IV - Statutory Profile Questions

The following questions are required by Vermont law, 26 VSA § 1368, to update and maintain a data repository within the Department of Health and to make individual profiles on all health care professionals licensed, certified, or registered by the Department available to the public. Your practitioner profile is located at the following website http://healthyvermonters.com/bmp/mbsearchform.shtml.

Please include photocopies of court papers, licensing authority decisions, and any other relevant documents if your answers to questions 36 through 41 have changed since your last application. We cannot process your application without them.

36. Criminal Convictions [See 26 VSA § 1368(a)(1)] □ Check here if none

    Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted within the past 10 years **Please provide complete copies of documentation for each matter.**

    _____
    (Conviction Date) (Court) (City/State) (Crime)

37. Nolo Contendere/Matters Continued [See 26 VSA § 1368(a)(2)] □ Check here if none

    Please provide a description of all charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continued without a finding by a court of competent jurisdiction. **Please provide complete copies of documentation for each matter.**

    _____
    (Conviction Date) (Court) (City/State) (Charge)

    _____
    (Conviction Date) (Court) (City/State) (Charge)

38. Vermont Board of Medical Practice Matters [See 26 VSA § 1368(a)(3)] □ Check here if none

    Please provide a description of all formal charges served, findings, conclusions, and orders of the Board of Medical Practice (including stipulations), and final disposition of such matters by the courts, if appealed.

    _____
    (Date) (Final Disposition - Summary)

    _____
    (Date) (Final Disposition - Summary)

39. Licensing or Certification Authority Matters in Other States [See 26 VSA § 1368(a)(4)]
    □ Check here if none

    Please provide a description of all formal charges served by licensing or certification authorities of other states, the findings, conclusions, and orders of such authorities, and final disposition of such matters by the courts, if appealed, in those states. **Please provide complete copies of documentation for each matter.**

_____
(Date of Final Disposition) (Licensing or Certification Authority) (Court) (City/State) (Nature of Charge)

(Date of Final Disposition) (Licensing or Certification Authority) (Court) (City/State) (Nature of Charge)

40. Restriction of Hospital Privileges [See 26 VSA § 1368(a)(5)]

Revocation/Involuntary Restrictions ☐ Check here if none

Please provide a description of any revocation or involuntary restriction of your hospital privileges that were related to competence or character and were issued by the hospital's governing body or any other official of the hospital after procedural due process (opportunity for hearing) was afforded to you. **Please provide complete copies of documentation for each matter.**

(Date) (Hospital) (State) (Nature of Restriction) (Reason for Restriction)

B. Other Restrictions ☐ Check here if none

Please provide a description of all resignations from, or non-renewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital. **Please provide complete copies of documentation for each matter.**

(Date) (Hospital) (State)

(Nature of Action) (Action) (Reason for Action)

☐ In lieu ☐ In settlement

41. Medical Malpractice Court Judgments/Settlements [See 26 VSA § 1368(a)(6A)]

A. Judgments ☐ Check here if none

Please complete the attached Form A and provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you within the past 10 years (10 years from payment date) in which a payment was awarded to a complaining party if not listed below. **Please provide complete copies of documentation, to include final disposition and, if possible, a copy of the complaint for each matter.**

☐ Judgment ☐ Arbitration

(Date) (Court) (State) (Nature of Case) (Amount Assessed Against You)

☐ Judgment ☐ Arbitration

(Date) (Court) (State) (Nature of Case) (Amount Assessed Against You)

B. Settlements ☐ Check here if none

Please provide a description of all settlements of medical malpractice claims against you within the past 10 years (10 years from payment date) in which a payment was awarded to a complaining party if not listed below. **Please provide complete copies of documentation, to include final disposition and, if possible, a copy of the complaint for each matter.**

(Date) (Court) (State) (Amount of Settlement Against You)

(Date) (Court) (State) (Amount of Settlement Against You)

42. Years of Practice [See 26 VSA § 1368(a)(10)]

What month and year did you start practicing as an Anesthesiologist Assistant? _____

43. Appointments/Teaching [See 26 VSA § 1368(a)(12)] Note: Answering #43 is optional. By answering, you are granting permission to have this information posted on the web. (This form follows the statutory wording. Since most appointments are teaching appointments, these questions may overlap.)

A. Appointments

Please provide information about your appointments to medical school or professional school faculties.

(School) (City) (State) (Nature of Appointment) From (year) To (year)

(School) (City) (State) (Nature of Appointment) From (year) To (year)

B. Teaching

Please provide information regarding your responsibility for teaching graduate medical education within the past 10 years.

(School/Institution) (City) (State) (Nature of Teaching) From (year) To (year)

44. Publications [See 26 VSA § 1368(a)(13)]

Note: Answering #44 is optional. By answering, you are granting permission to have this information posted on the web. Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years.

(Title) (Publication) (Year)

(Title) (Publication) (Year)

45. Activities [See 26 VSA § 1368(a)(14)]

Note: Answering #45 is optional. By answering, you are granting permission to have this information posted on the web. Please provide information regarding your professional or community service activities and awards.

_____

(Activities or Awards)

_____

46. Practice Setting [See 26 VSA § 1368(a)(15)]

What is the location of your primary practice setting?

_____

Town/City, State

47. Translating Services [See 26 VSA § 1368(a)(16)]

Please identify any translating services available at your primary practice location.
Are any translating services available at your primary practice location? ☐ Yes ☐ No

If yes, please describe the translating services available:

_____

_____

_____

48. Medicaid/New Patients [See 26 VSA § 1368(a)(17)]

A. Medicaid participation
Do you participate in the Medicaid program? ☐ Yes ☐ No

B. New Medicaid Patients
Are you currently accepting new Medicaid patients? ☐ Yes ☐ No

Part V

I hereby affirm that the information provided above is true and accurate, and that I have answered the questions to the best of my knowledge and ability.

Date:_____ _____

Applicant's Signature

Reminder - You must also complete the enclosed Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions regardless of whether or not you have children

Vermont Department of Health - Board of Medical Practice
Form A

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

(Questions 21 and 22)Withdrawal or denial of License - Attach documents

State_____ Year_____
Circumstances under which license was withdrawn, denied, revoked, not renewed, or otherwise terminated_____

_____

(Question 23) Voluntarily surrendered or resigned a license to practice medicine or any healing art - Attach documents

State_____ Year_____

Circumstances_____

_____

(Question 24) Disciplinary charges or action - Attach documents

Name of organization involved_____ Date_____

Duration_____

Action taken (circle all that apply)

01 Revocation of right or privilege
02 Suspension of right or privilege
03 Censure
04 Written reprimand or admonition
05 Restriction of right or privilege
06 Non-renewal of right or privilege
07 Fine
08 Required performance of public service
09 Education/Training/Counseling/Monitoring
10 Denial of rights or privilege
11 Resignation
12 Leave of absence
13 Withdrawal of an application
14 Termination or non-renewal of contract
15 Medical Records Suspension
16 Probation
17 Assurance of Discontinuance
18 Consent Agreement
19 Letter of Agreement
20 Expulsion from Membership
21 Reprimand
22 Other (specify)_____

Circumstances_____

_____

_____

(Question 25) Denial of examination privileges - Attach documents

State_____ Year_____

Circumstances under which examination privileges denied _____

_____

_____

(Questions 26 and 27) Residency Training Program(s) not completed - discontinued education, training, practice - Attach documents

Residency Training Program(s) _____

Location of Programs _____ Year _____

Circumstances_____

_____

(Question 28) Affecting Health Care Institution Staff Privileges, Employment or Appointment - Attach documents

Institution involved _____

Location _____ Year _____

Circumstances_____

_____

(Question 29) Privilege to prescribe controlled substances - Attach documents

Name of organization involved _____

Type of restriction _____ Date _____

Circumstances of restriction

_____

_____

_____

_____

(Questions 30 and 32) Criminal Investigation - Proceeding - Attach documents

Court _____

City and State _____

Charge _____

Description _____

_____

_____

Status_____

_____

Conviction? _____ Yes _____ No Date _____

Plea? _____ Yes _____ No Date _____

(Question 31) Investigation by any other licensing board - Attach documents

Name of Licensing Board_____ Date _____

Location of Licensing Board_____

Circumstances_____

(Questions 33-35) Medical condition, treatment, use of chemical or illegal substances

Treating organization _____

Address _____Telephone _____

Type of diagnosis, condition or treatment - field of practice - use of chemical substances

_____

_____

Dates of illness or dependency _____ to _____

Dates of treatment _____ to _____

Name of Rehabilitation/Professional Assistance or Monitoring Program _____

Address _____Telephone _____

Contact person at Program _____

(Question 41) Medical Malpractice Claim

Please provide the following information regarding each instance of alleged malpractice. This section should be photo copied and filled out separately for each claim. Additional sheets may be obtained/used if necessary.

Insurer_____

Claimant name _____

Description of alleged claim (allegations only): This does not constitute an admission of fault or liability.

Please indicate:
1. Patient's condition at point of your involvement;
2. Patient's condition at end of treatment;
3. The nature and extent of your involvement with the patient;
4. Your degree of responsibility for the course of treatment in leading to the claim; and
5. Narrative of event.

_____

_____

_____

_____

If the incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:

_____

Your role (circle one):

01 Anesthesiologist
02 Primary Care Physician
03 Referring Physician
04 Attending Physician
05 Consultant Specialist
06 Surgeon
07 Fellow
08 PGY 1
09 PGY 2
10 PGY 3
11 PGY 4
12 PGY 5
13 PGY 6
14 PGY 7
15 Workmen's Compensation Evaluator
16 Court Psychiatrist
17 On-Call Physician
18 Group Practitioner/Partner
19 Other: Specify _____
20 Unknown

Your Legal Representative in this matter (include name, address and telephone number)

Name _____

Firm _____

Address _____

City, State, Zip _____

Phone _____

Indicate Decision, Appeal, Settlement, Dismissal:
If a Court or Arbitration Panel heard your case, indicate the following:

Court_____

Court's location_____

Docket number_____

Date the action was filed_____

Decision determined by (check one): _____ Judge _____ Jury _____ Arbitration Panel

Decision: _____ Award: _____

If your case was appealed, indicate the following: Date appeal filed (month, day, year) _____/_____/_____
Date appeal decided: (month, day, year) _____/_____/_____

If your case was settled, indicate the following:

Settlement amount paid on your behalf: _____

Total settlement amount: _____

Date of settlement: (month, day, year) _____/_____/_____

_____ Case dismissed against you _____ Against all defendants

Important: In addition to the above information, please attach a copy of the complaint and final judgment, settlement and release, or other final disposition of the claim. This information can be obtained from your legal representative.

Additional information, if any:

_____

_____

_____