Nevada State Board of Osteopathic Medicine
Application for Anesthesiologist Assistant License

Dear Applicant:

As you may be aware, the Governor of the State of Nevada signed AB 270 into law after the 2023 Nevada Legislative session. AB 270 created the licensing authority and framework for the Nevada State Board of Osteopathic Medicine ("the Board") to issue licenses to Anesthesiologist Assistants. However, AB 270 also required the Board to adopt regulations pertaining to Anesthesiologist Assistants. The Board has drafted those proposed regulations and submitted them to the Legislative Counsel Bureau in accordance with NRS 233B.063. The Board will begin issuing Anesthesiologist Assistant licenses once those regulations are officially adopted and set forth in the Nevada Administrative Code (NAC). Until such time, the Board will accept paper applications from Applicants subject to the following:

1) Each Applicant must submit a properly completed paper application for Anesthesiologist Assistant Application which is available on the Board's website, https://bom.nv.gov
2) Each Applicant must submit payment in the amount of $250.00 made payable to the "Nevada State Board of Osteopathic Medicine" as more particularly set forth in paragraph 7 on page 3 of the NV Application for AA Licensure 2023 ("the Application").
3) No Anesthesiologist Assistant license will be issued by the Board until the regulations are officially adopted and set forth in the NAC, the Board receives a properly completed application, the Board receives payment as set forth above, and is approved by the Board.
4) The Applicant has signed and returned the below Acknowledgement to the Board.

Should you have any questions, please do not hesitate to contact the Board office to speak with the licensing specialist. Contact information is listed on page 2 of the Application.

ACKNOWLEDGMENT

The undersigned Applicant has read and understood the information set forth above. The Applicant acknowledges and agrees to be bound by the information set forth above.

_____ _____

Applicant's signature Date

Return to:
Nevada State Board of Osteopathic Medicine
2275 Corporate Circle, Suite 210
Henderson, NV 89074

Nevada State Board of Osteopathic Medicine
Application for Anesthesiologist Assistant License

Dear Applicant:

Thank you for considering obtaining an Anesthesiologist Assistant Osteopathic License in the State of Nevada. Nevada remains among the fastest growing states in the country. With such population growth, the need for anesthesiologist assistants is increasing.

The Board of Osteopathic Medicine's primary mission is to protect the public by licensing osteopathic physicians, physician assistants, and anesthesiologist assistants who demonstrate clinical competence to practice or assist in the practice of medicine as well as the professional and ethical demeanor necessary to lead the modern health care team. With this in mind, we have developed application procedures, which are very thorough so that the board can maintain confidence that the licensees will benefit the community in which they practice.

Balancing the state's dramatic need for anesthesiology assistants with the public mandate of quality and professional excellence; the increased desire from the profession for license portability; the Board has worked tirelessly to modernize the application process. The application you will be completing, although somewhat lengthy in appearance, is as concise as legally permissible.

Nevada upholds some of the highest medical licensing standards in the United States to help maintain the public's trust in the osteopathic medical profession. Additionally, the Board has updated the requirements to obtain information considered important in the licensing process, please see below:

Fingerprinting for NCIC – National Criminal Information Center (FBI)**.** Pursuant to NRS 633.309, all applicants of licensure (except a special license) must submit to the board a complete set of fingerprints for a criminal background check. Although a criminal record or history may not be absolute grounds for denial of licensure, these and all issues will be seriously considered and MUST be disclosed on your application before this report is received in our office.

Per AB275: An Applicant for a license who does not have a social security number must provide an alternative personally identifying number, including, without limitation, his or her individual taxpayer identification number, when completing an application for a license.

After we have received your completed application with the fee, the required education verification, the criminal background check report, and all other required forms, the application packet for licensure will be reviewed by our Executive Director and pre-approved to be sent to our Board Members for their review. If the application packet is accepted, you will receive an email letting you know that you have been scheduled for consideration at the next board meeting.

If you do not meet the requirements, there are no other accommodations for special request and you must wait for the next board meeting for final Board decision regarding your license application! No exceptions!

An interview may be required if the Executive Director and President of the Board deem it necessary to explore your application packet more thoroughly if certain information was learned during the application process. All applicants required to attend an interview with the Board are notified at least 21 working days prior to the meeting date.

Again, thank you for considering licensure! If you have any questions, regarding the application process, please do not hesitate to contact the Board office and speak with the licensing specialist.

Sincerely,

The Executive Director and Licensing Staff of
Nevada State Board of Osteopathic Medicine
2275 Corporate Circle, Suite 210
Henderson, NV 89074
Phone: 702-732-2147 ext. 222
Fax: 702-732-2079
Toll Free: 877-725-7828
Email: nmontano@bom.nv.gov
Website: www.bom.nv.gov

Nevada State Board of Osteopathic Medicine
Application for Anesthesiologist Assistant Licensure
Requirements and Instructions

Minimum Requirements for Anesthesiologist Assistant ("AA") Licensure refer to AB 270, section 47.

1. GRADUATION FROM AN ANESTHESIOLOGIST ASSISTANT PROGRAM ACCREDITED BY THE COMMISSION ON ACCREDITATION OF ALLIED HEALTH EDUCATION PROGRAMS OR ITS PREDECESSOR OR SUCCESSOR ORGANIZATION,
2. PASSES ALL PARTS OF THE CERTIFICATION EXAMINATION ADMINISTERED BY THE NATIONAL COMMISSION for CERTIFICATION of ANESTHESIOLOGIST ASSISTANTS (NCCAA), OR ITS SUCCESSOR ORGANIZATON,
3. CERTIFICATION BY NCCAA OR ITS SUCCESSOR ORGANIZATION,
4. COMPLETION OF THE APPLICATION AND ALL REQUESTED DOCUMENTATION; and.
5. SUBMISSION OF 1 (ONE) FINGERPRINT CARD.
6. COMPLETION OF FORM #5 - SUPERVISION AGREEMENT
7. PAYMENT OF FEES: Non-refundable application and initial licensure fee $450.00 for AA's (Includes $50 Fingerprinting Fee). Please remit payment of **$250.00 with this application**. If additional payment is needed, you will be contacted. **PAYMENT MUST BE RECEIVED BEFORE YOUR LICENSE IS APPROVED.**
    - ***a.*** The Board will reduce by one-half the application and initial license fee of $400.00 for an applicant who applies for an initial license as an anesthesiologist assistant that will expire less than 12 months after the date of issuance of the license **OR** for an applicant applying simultaneously for an AA license with the Nevada State Board of Medical Examiners.
    - ***b.*** An initial license issued during an odd-numbered year will expire at the end of that year and may then be renewed prior to the end of that year for a two-year period.
    - ***c.*** An initial license issued during an even-numbered year will expire at the end of the next odd-numbered year.
    - ***d.*** **Please include a payment of $250.00 with this application; if additional payment is required, you will be contacted.**

PAYMENT MUST BE RECEIVED BEFORE YOUR LICENSE IS APPROVED

INSTRUCTIONS

Application (pages 1-9): Completed by the applicant, notarized as indicated, and returned to the Nevada State Board of Osteopathic Medicine with the application fee. If additional space is required for answers, separate sheets may be attached to the application. All additional sheets must be 8 and ½ x 11 inches in size. Any "Yes" question, other than #12 and #13, on the survey section **MUST** be explained on a separate sheet of paper. **No Application will be processed prior to receipt of all required fees.**

FEES ARE NON-REFUNDABLE. THIS LICENSE HAS BI-ANNUAL RENEWALS.

FCVS is not required for anesthesiologist assistant applicants. We will require original college transcripts, NCCAA certification letter, notarized copy of your passport, or a certified copy of your birth certificate.

FBI Fingerprint Card and instructions will be sent to you upon receipt of this APPLICATION, the online application, **or** you can call to get them mailed to you.

Form #1, **VERIFICATION OF LICENS**E: Applicant is to fill out top portion and then forward to each State Board in which a license is/was held. Each state board will complete the bottom portion and return to the *Nevada State Board of Osteopathic Medicine*. Many States charge a fee for verification, which is the responsibility of the applicant. This form will only be accepted if received ***FROM*** that states professional licensing authority or board. We **do** accept verification through www.VeriDoc.org.

Form #2, **MEDICAL MALPRACTICE:** Applicant is to complete this form if there is an open, closed, or dismissed medical malpractice claim. Please also provide copies of the court documents for each case.

Form #4, **AFFIDAVIT OF MORAL AND PROFESSIONAL CHARACTER**: Applicant provides to three references and returns directly to the Board after being completed and notarized. **At least one Affidavit must be completed by a medical professional the applicant has known for at least three (3) years or more.** Additional copies may be obtained by photocopying Form 4.

ANESTHESIOLOGIST ASSISTANT SUPERVISION AGREEMENT: Must be completed by the anesthesiologist assistant and the supervising osteopathic anesthesiologist. All signatures on the agreement must be originals and use of an in-person notary is required. Return all pages of the original, completed, and notarized agreement to the Board.

Checklist

After completing the enclosed application, you are responsible for submitting the application along with certain documents. This checklist is intended to help you ensure that all proper documents accompany your application.

Completed Application	☐
State Licensure Verification form sent to the Board from **all** states in which you have ever held **any** AA license(s)	☐
Completed and notarized "Affidavit and Authorization for Release of Information" form with color photo attached	☐
Official transcripts for AA program, NCCAA certification letter, and passport or birth certificate. **Note:** This Board requires current NCCAA certification.	☐
Payment of initial licensing fee. (Please see #7 - PAYMENT OF FEES - on previous page for amount.)	☐
Child Support Information Form (per NRS 633.307)	☐
Completed Medical Malpractice and or Professional Liability Reporting form for **any and all** malpractice claims, settlements, and or judgments.	☐
A certified birth certificate or notarized passport copy	☐
1 (one) Completed FBI Applicant Fingerprint Card (A fingerprint packet will be mailed to you upon receipt of application.)	☐
3 (three) Affidavits of Moral and Professional Character from licensed DO, MD, PA, AA, or APRN.	☐ ☐ ☐

IMPORTANT! It is your responsibility to immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license being granted to you by the board.

All forms should be sent directly to the board unless otherwise indicated:

Nevada State Board of Osteopathic Medicine
2275 Corporate Circle, Suite 210
Henderson, NV 89074
Phone: 702-732-2147
Fax: 702-732-2079
Toll Free: 877-325-7828
Email: nmontano@bom.nv.gov

State of Nevada - Board of Osteopathic Medicine
Application for Anesthesiologist Assistant Licensure

Dual License: Are you applying simultaneously (at the same time) for an AA license with the Nevada Board of Medical Examiners? NOTE: If not, or if you are currently licensed with the Nevada Board of Medical Examiners, you do not qualify for a dual AA license. ☐ YES ☐ NO

Note: If **YES**, AA applicants who simultaneously apply for a license with both the Nevada State Board of Osteopathic Medicine and the Nevada Board of Medical Examiners shall pay the required fees as set forth in each Board's regulations. For the fees due the Nevada State Board of Osteopathic Medicine, see PAYMENT OF FEES section 7a on page three of these materials.

1. Name: Indicate your full legal name. If your name has changed at any time during your life, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Full Name (use no initials)

Last Name	First Name	Middle Name	Suffix	Maiden Name

All other names used

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the osteopathic medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website; therefore you should consider what your preferred address is for these purposes.

2. Address/Phone

Practice Address
☐ Public Access
☐ Mailing

Street

City State Zip Code

Telephone Fax E-mail address Alternate Phone

Home Address
☐ Public Access
☐ Mailing

Street

City State Zip Code

Telephone Fax E-mail address Alternate Phone

Are you NCCAA Certified? ☐ Yes ☐ No
If yes, please complete the following:

NCCAA	Certification Number	Date of Certification	Date of Expiration

Active Military: ☐ **Yes** ☐ **No** **Spouse Active Military:** ☐ **Yes** ☐ **No**

Have you ever served in the Armed Forces of the United States? ☐ **Yes** ☐ **No**
If yes, in which branch and when? _____

Are you the surviving spouse of a veteran? ☐ **Yes** ☐ **No**

Have you ever been assigned to duty for minimum of <u>6 continuous years</u> in the National Guard or a reserve component of the Armed Forces of the United States and separated from such service under conditions other than dishonorable? ☐ **Yes** ☐ **No**

Have you ever served the Commissioned Corps of the United States Public Health Service of the Commissioned Corps of the National Oceanic and Atmospheric Administration of the United States in the <u>capacity of a commissioned officer while on active duty</u> in defense of the United States and separated from such service under conditions other than dishonorable? ☐ **Yes** ☐ **No**

3. Identification

__/__/__

Date of Birth (mm/dd/yyyy) | Birth City | Birth State | Birth Country

_____ _____

Gender | Social Security Number, or

_____

Alternative Personal Identification Number (such as Taxpayer ID)

_____ _____ _____ _____

Height | Weight | Color of Hair | Color of Eyes

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law (NRS 633.326).

4. List name and address for any and all colleges or universities attended other than schools where professional medical education was received.

4. Colleges or Universities (attach additional pages if necessary)

1. _____

School Name | Address

_____

City | State | Zip Code | Country | Attendance Dates From – To | Graduation Date | Degree

2. _____

School Name | Address

_____

City | State | Zip Code | Country | Attendance Dates From – To | Graduation Date | Degree

5. Anesthesiologist Assistant Programs: List **all** anesthesiologist assistant programs you have attended, even those from which you did not graduate in chronological order. Attach an additional sheet if necessary.

5. Anesthesiologist Assistant Programs (attach additional pages if necessary)

1. _____
School Name Address

_____
City State Zip Code Country Attendance Dates From – To Graduation Date Degree

2. _____
School Name Address

_____
City State Zip Code Country Attendance Dates From – To Graduation Date Degree

6. Child Support Information (per NRS 633.326)

Please mark the appropriate response:

_____ I am NOT subject to a court order for the support of a child.

_____ I AM subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the District Attorney or other controlling public agency enforcing the order for the repayment of the amount owed pursuant to the order; or

_____ I AM subject to a court order for the support of one or more children and am not in compliance with the order or a plan approved by the District Attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

_____
Signature of Applicant

7. Examination History

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, Etc.). If additional space is necessary, please enclose a separate sheet with your application and include all the information below.

Examination	Most Recent Date taken (Month/Year)	Passed (P) or Failed (F)	Number of attempts
☐ NCCAA	_____	☐ P ☐ F	_____

8. State or Professional Licensure: You must complete the attached "Licensure Verification" form and forward it to **all** states in which you have held **any** healthcare license or certification. The verifying entity must forward all documentation directly to this board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

8. State Licensure

1. State_____Type _____License Number_____Status_____Issue Date_____
   (Special, Training, or Full License)
2. State_____Type_____License Number_____Status_____Issue Date_____
   (Special, Training, or Full License)
3. State_____Type_____License Number_____Status_____Issue Date_____
   (Special, Training, or Full License)
4. State_____Type_____License Number_____Status_____Issue Date_____
   (Special, Training, or Full License)
5. State_____Type_____License Number_____Status_____Issue Date_____
   (Special, Training, or Full License)
6. State_____Type_____License Number_____Status_____Issue Date_____
   (Special, Training, or Full License)

9. Chronology of Activities (copy and attach additional pages if necessary)

Dates: From/To	Practice/Employment
1. From: To:	_____ Practice/Employment Name _____ Practice/Employment Address City State Zip Code Country Position & Department: _____% Clinical ____ % Administrative ____ ☐Employment ☐Staff Privileges ☐Affiliation ☐Other _____
2. From: To:	_____ Practice/Employment Name _____ Practice/Employment Address City State Zip Code Country Position & Department: _____% Clinical ____ % Administrative ____ ☐Employment ☐Staff Privileges ☐Affiliation ☐Other _____
3. From: To:	_____ Practice/Employment Name _____ Practice/Employment Address City State Zip Code Country Position & Department: _____% Clinical ____ % Administrative ____ ☐Employment ☐Staff Privileges ☐Affiliation ☐Other _____

10. Questions: Please answer yes or no to the following questions. All, **'yes'**, answers in questions **1 through 11 must be explained** on a **separate sheet of 8 1/2 x 11 piece of paper**. Each numbered question corresponds to a numbered, 'yes', or, 'no', check box on the right side of this page.

1. Have any disciplinary or administrative actions ever been taken against any healing art license which you now hold or have held by the U.S. Military, U.S. Public Health Service, or other U.S. federal government entity?
1. ☐Yes ☐No

2. Have you ever been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country, or U.S. territory?
2. ☐Yes ☐No

3. Have you ever had a medical license revoked, suspended, or limited in any state, or U.S. territory?
3. ☐Yes ☐No

4. Have you ever voluntarily surrendered a license to practice in the healing arts in any state, country or U.S. territory?
4. ☐Yes ☐No

5. Have you ever failed a state licensure examination, any part of NCCAA, FLEX, COMLEX, USMLE, or NBOME even if subsequently passed?
5. ☐Yes ☐No

6. Have you ever had staff privileges in a hospital denied, suspended, limited, revoked or non-renewed, or have you ever resigned from a medical staff in lieu of disciplinary or administrative action? (This does not include suspensions or restrictions for failure to complete medical records.)
6. ☐Yes ☐No

7. Have you ever been investigated for, charged with, or convicted of unprofessional conduct, professional incompetence, gross malpractice or malpractice, or any other violation or statute, rule or regulation governing the practice of medicine by any medical licensing board or other agency (including Federal), hospital or medical society or **sued in a court of law for alleged malpractice**?
7. ☐Yes ☐No

8. Have you ever been denied membership or expelled from a medical society or professional medical organization including the AAAA, AOA, any member specialty board of the AOA or ABMS?
8. ☐Yes ☐No

9. Have you ever surrendered your state or federal controlled substance registration or had it restricted in any way?
9. ☐Yes ☐No

10. Are you now or have been within the past year investigated for, charged with or convicted of, or pled nolo contendere to a violation of any federal, state or local law relating to the manufacture, distribution, or dispensing of controlled substances, or to drug addiction?
10.. ☐Yes ☐No

11. Have you ever been arrested, investigated for, charged with or convicted of, or pled nolo contendere to any offense, misdemeanor or felony in any state, the United States, or a foreign country? (Except minor traffic violations).
11. ☐Yes ☐No

12. Do you attest to knowledge of safe injection practices and CDC Guidelines?
12. ☐Yes ☐No

13. If granted a license, do you intend to practice in Nevada?
13. ☐Yes ☐No
If yes, LOCATION _____
When: _____

IMPORTANT: The Board recognizes that licensees encounter health conditions, including those involving physical health, mental health and substance use disorders, just as their patients and other healthcare providers do. The Board expects its licensees to properly address their health concerns to ensure patient safety. Options include seeking medical care, self-limiting the licensee's medical practice, and self-referring to a Health Professionals Assistance Program. See our website for a listing of some Health Professional Assistance Programs in Nevada. **The failure to adequately address a health condition, where the licensee is unable to assist in the practice medicine within a reasonable degree of skill and safety to patients, can, and will likely, result in the Board taking action against the licensee.**

I attest that I have read and understood the statements in the above paragraph.

Applicant Signature: _____

Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to the Nevada State Board of Osteopathic Medicine ("the Board").

Affidavit
And
Authorization For Release of Information

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Application for Anesthesiologist Assistant Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the Board, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my licensure or permit to assist in the practice medicine.

Applicant's Signature (must be signed in the presence of a notary)

_____

Applicant's **Printed** Last Name

_____

Applicant's **Printed** First Name, Middle Initial, and Suffix (e.g., Jr.)

_____

Date of Signature

Applicant Photograph

Securely tape or glue in this square a current, front-view, 2-inch by 2-inch passport-type color photograph of yourself

NOTARY

Dated _____ Signed _____

State of _____ County of _____

SUBSCRIBED AND SWORN TO before me this _____ day of _____, 20___.

My commission expires: _____ (NOTARY PUBLIC SIGNATURE & SEAL)

Form #1

Licensure Verification Form

(Copy this form for multiple licenses)

I am applying for a license to practice as an anesthesiologist assistant with the **Nevada State Board of Osteopathic Medicine**. The Board requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. Please complete the form and return it directly to the following Board:

To be completed by applicant

Applicant Name: _____
Last First Middle Suffix

Date of Birth: _____ Social Security Number: _____ License Number: _____
(From State/Province you are sending this form to)

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

I hereby authorize the licensing agency of the State/Province of _____ to furnish the information to the Board indicated below.

Signature of Applicant _____ Date _____

Board Name: NEVADA STATE BOARD OF OSTEOPATHIC MEDICINE

Address: 2275 Corporate Circle, Suite 210 Henderson NV 89074
Street City State Zip Code

TO BE COMPLETED BY STATE LICENSING BOARD OR CANADIAN PROVINCE

Name of Licensee: _____
Last First Middle Suffix

License Type: _____ License Number: _____ Issue Date: _____

Is this license current? ☐Yes ☐No Expiration Date: _____

1) Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state?
☐Yes ☐No ☐Cannot answer under state law
If Yes, please explain: _____

2) Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand or in any other manner disciplined or has applicant's license been revoked, suspended, or in any other manner limited by a licensing or disciplinary authority in your state?
☐Yes ☐No ☐Cannot answer under state law
If Yes, please explain: _____

Affix Board Seal Here

Board Authorized Signature: _____

Title: _____

Date: _____

Return to:
Nevada State Board of Osteopathic Medicine
2275 Corporate Circle, Suite 210
Henderson, NV 89074

Form #2

Medical Malpractice/Professional Liability Claims Information

(Copy this form to report multiple claims)

Date of Claim/Suit:_____ Date You Received Notice:_____

State/County of Event:_____ Date of Event:_____

Court Case Number:_____ Court Filing Date:_____

Court Where Filed In:_____

Insurance Company (or specify if self-insured):_____

Insurance Claim No. (or if self-insured write n/a):_____

Claimant:_____

Respondent:_____

Brief Description of Allegations:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

***** Please attach/mail a copy of the Summons/Complaint/Claim notice with form*****

Claim status & Effective Date of That Status:

☐Open (pending) ☐Arbitration/Mediation ☐Closed (settled) ☐Dismissed ☐Other

Date of Closure:_____

Amount of judgment or settlement $_____ Amount paid on your behalf $_____

*****Refer to NRS 633.527 for all requirements of reporting Malpractice Claims/Board Actions*****

Form #3

NEVADA STATE BOARD OF OSTEOPATHIC MEDICINE
Affidavit of Moral and Professional Character

(This form may be duplicated for a total of THREE from different references is required) **At least one Affidavit must be completed by a medical professional the applicant has known for at least three (3) years or more.**

This letter of recommendation must be signed by a licensed D.O., M.D., P.A., A.A., or APRN

_____, 20_____

City State Date

To the Nevada State Board of Osteopathic Medicine:

I certify that I am licensed under the laws of _____ to practice either allopathic or osteopathic medicine and that I have known the applicant,

_____**,** D.O or P.A. or A.A., for _____ years, that I personally knew the applicant while actively engaged as an anesthesiologist assistant assisting in the practice of osteopathic medicine; that he/she is of good moral character and worthy of professional recognition, that he/she is free from habits liable to interfere with the provision of professional services, has good standing in the community in which he/she resides and is worthy of receiving an anesthesiologist assistant license to assist in the practice osteopathic medicine in the State of Nevada.

_____ _____
Signature Address

_____ _____
Print Name

_____

State of _____

County of _____

Subscribed and sworn to before me on the _____ day of _____, 20 _____

_____
Signature of Notary

My Commission expires on _____

Please return completed form to the:

Nevada State Board of Osteopathic Medicine
2275 Corporate Circle, Suite 210
Henderson, NV 89074 **Phone: 702-732-2147**

NOTIFICATION TO NEVADA STATE BOARD OF OSTEOPATHIC MEDICINE
OF SUPERVISION OF ANESTHESIOLOGIST ASSISTANT ("AA")

COMES NOW _____, D.O., being first duly sworn who deposes and says that: I, the undersigned physician, am duly licensed to practice medicine in the state of Nevada by the Nevada State Board of Osteopathic Medicine, possess an active license to practice medicine in the state of Nevada, license number _____, am in good standing with the Nevada State Board of Osteopathic Medicine, and am certified or eligible to be certified as an anesthesiologist by the American Osteopathic Board of Anesthesiology. I am engaged in the active practice of medicine in the state of Nevada, am current on all my required CME and am not aware of any disciplinary action, formal or informal, pending against me by the Nevada State Board of Osteopathic Medicine or any other jurisdiction's medical licensing entity. I have checked with the Nevada State Board of Osteopathic Medicine and determined that the anesthesiologist assistant I am going to supervise has not __ or has __ (mark one) been formally disciplined by the Nevada State Board of Osteopathic Medicine and is licensed by the Nevada State Board of Osteopathic Medicine.

I have read and am aware of the provisions of AB 270, Chapter 633 of the Nevada Revised Statutes concerning the duties of a supervising osteopathic anesthesiologist, as well as Chapter 633 of the Nevada Administrative Code which are the regulations adopted (or to be adopted) by the Nevada State Board of Osteopathic Medicine as they apply to a supervising osteopathic anesthesiologist and an anesthesiologist assistant. I have read and am aware of the proposed regulation of the Nevada State Board of Osteopathic Medicine under Chapter 633 of the Nevada Administrative Code that precludes a physician from simultaneously supervising more than four anesthesiologist assistants.

I hereby certify that this relationship does not violate the limitation cited above concerning the total number of anesthesiologist assistants with whom I may simultaneously supervise or collaborate. Upon receipt of same, I will be supervising the following named anesthesiologist assistant at the following practice location(s):

_____		_____	
Practice Location	Telephone #	Practice Location	Telephone #
_____		_____	
Practice Location	Telephone #	Practice Location	Telephone #

I am aware that a copy of this Notification will be placed in my licensing file at the offices of the Nevada State Board of Osteopathic Medicine.

WHEREFORE, I set my hand this _____ day of _____, 20_____.

_____	_____
Supervising Osteopathic Anesthesiologist Name (Print or Type)	Supervising Osteopathic Anesthesiologist (Signature)

State of _____ County of _____

The above - named supervising osteopathic anesthesiologist, being first duly sworn, deposes and states that he/she appeared before me, a notary public, on the ____ day of _____, 20__, and in my presence, executed this one-page document.

_____
Notary Public

COMES NOW _____, A.A., **being first duly sworn who deposes and says that**: I, the undersigned anesthesiologist assistant, am duly licensed as an anesthesiologist assistant in the state of Nevada by the Nevada State Board of Osteopathic Medicine, and am in good standing with the Nevada State Board of Osteopathic Medicine, and **has not __or has __ (mark one)** been formally disciplined by the Board for a violation of the Medical Practice Act of the state of Nevada. I have read and am aware of the provisions of Chapter 633 of the Nevada Revised Statues and the Nevada Administrative Code as those laws apply to anesthesiologist assistants. I am aware a copy of this Notification will be placed in my licensing file at the offices of the Board, and, that if this relationship is terminated, my failure to notify the Board of the termination of this agreement within 10 days of termination or my continuing to practice as an AA without a new approved supervision agreement, may be grounds for disciplinary action against me.

WHEREFORE, I set my hand this _____ day of _____, 20_____.

_____	_____
Anesthesiologist Assistant Name (Print or Type)	Anesthesiologist Assistant (Signature)

State of _____ County of _____

The above - named anesthesiologist assistant, being first duly sworn, deposes and states that he/she appeared before me, a notary public, on the ____ day of _____, 20__, and in my presence, executed this one-page document.

_____
Notary Public

Written Supervision Agreement
Supervising Osteopathic Anesthesiologist and Anesthesiologist Assistant

This is a Written Supervision agreement, in compliance with AB 270, between _____, A.A. (hereinafter "the Anesthesiologist Assistant") and _____D.O. (hereinafter "the Doctor"). Through this agreement, the Doctor and the Anesthesiologist Assistant affirm they each have read and are aware of the Nevada Revised Statutes (NRS 633), the Nevada Administrative Code (NAC 633), and AB 270 that govern the supervision of a Anesthesiologist Assistant by a Nevada licensed osteopathic anesthesiologist physician, and each affirm they will comply with all the statutes and regulations governing such supervision.

We agree that the Anesthesiologist Assistant's practice shall be within the scope of practice of the Doctor, and that that scope of practice shall be: _____. We agree that the Anesthesiologist Assistant will provide services at the following location and at the following times:

Location: _____
Times: _____

We agree that in furtherance of the Anesthesiologist Assistant's practice under the supervision of the Doctor, the Anesthesiologist Assistant shall perform delegated medical tasks only under the medical direction of the Doctor and may perform the following tasks which tasks must be commensurate with the education, training, experience, and level of competence of the Anesthesiologist Assistant [check all that apply and add any that are not on the following list]:

___ (a) Developing and implementing an anesthesia care plan for a patient;
___ (b) Obtaining the comprehensive health history of a patient;
___ (c) Performing relevant elements of a physical examination of a patient and recording relevant data;
___ (d) Ordering and performing preoperative and postoperative anesthetic patient evaluations and consultations and maintaining progress notes;
___ (e) Subject to the limitations of NRS 453.375, possessing and administering preoperative and perioperative medications for the purposes of:
  (1) Maintaining and altering the levels of anesthesia and providing continuity of anesthetic care into and during the postoperative recovery period;
  (2) The continuation of perioperative medications;
  (3) Performing general anesthesia and other procedures associated with general anesthesia;
  (4) Administering vasoactive drugs and starting and titrating vasoactive infusions to treat a response of a patient to anesthesia; and,
  (5) Administering postoperative sedation, anxiolysis or analgesia medication to treat patient responses to anesthesia;
___ (f) Changing or discontinuing an anesthesia care plan after consulting with the supervising osteopathic anesthesiologist;
___ (g) Obtaining informed consent from a patient or the parent or guardian of the patient, as applicable, for the administration of anesthesia or related procedures;
___ (h) Entering in the medical record of a patient verbal or written medication chart orders prescribed by the supervising osteopathic anesthesiologist;
___ (i) Pretesting and calibrating anesthesia delivery systems and obtaining information therefrom;
___ (j) Implementing medically accepted monitoring techniques;
___ (k) Establishing airway interventions and performing ventilatory support;
___ (l) Establishing peripheral intravenous lines and performing invasive procedures;
___ (m) Performing, maintaining, evaluating and managing epidural, spinal and regional anesthesia;__
___ (n) Performing monitored anesthesia care;
___ (o) Conducting laboratory and other related studies;

___ (p) Performing, ordering, and interpreting preoperative, point-of-care, intraoperative or postoperative diagnostic testing or procedures;

___ (q) Monitoring the patient while in the preoperative suite, recovery area or labor suites and making postanesthesia rounds;

___ (r) Participating in administrative, research and clinical teaching activities;

___ (s) Initiating and managing cardiopulmonary resuscitation in response to a life-threatening situation.

We agree that the Doctor shall ensure that:

(a) The anesthesiologist assistant is clearly identified to the patients as an anesthesiologist assistant;

(b) The anesthesiologist assistant performs only those medical services which are specified in the written supervision agreement between the supervising osteopathic anesthesiologist physician and the anesthesiologist assistant; and

(c) The anesthesiologist assistant strictly complies with:

(1) The provisions of the registration certificate issued to the anesthesiologist assistant by the State Board of Pharmacy pursuant to NRS 639.1373; and

(2) The regulations of the State Board of Pharmacy regarding controlled substances, poisons, dangerous drugs or devices.

We agree that the Doctor shall:

(a) Include language in the patient consent form that informs the patient that the osteopathic anesthesiologist uses an anesthesiologist assistant.

(b) Adopt a written protocol regarding the supervision of the anesthesiologist assistant. This written protocol shall be provided to the anesthesiologist assistant and to the Nevada State Board of Osteopathic Medicine.

(c) Detail in the written protocol the tasks that the anesthesiologist assistant is authorized to perform and the manner in which the Doctor will supervise the anesthesiologist assistant.

(d) Conduct regular reviews of the medical records of the patients delegated to the anesthesiologist assistant.

(e) Complete a performance assessment of the anesthesiologist assistant every two years, a record of which must be maintained by both the Doctor and the anesthesiologist assistant.

(d) Shall include, at a minimum, in the performance assessment:

(1) An assessment of the medical competency of the anesthesiologist assistant;

(2) A review and initialing of selected charts; and,

(3) An assessment of the ability of the anesthesiologist assistant to take a medical history from, and perform an examination of, patients representative of those cared for by the anesthesiologist assistant. e referrals or consultations made by the physician assistant with other health professionals as required by the condition of the patient.

We agree that any additional terms and conditions that shall apply to or govern our relationship – such as, for example, the terms of the written protocol, the terms of the quality assurance program – are attached to this document and that those terms and conditions will be deemed incorporated into this document as if they were fully set out herein.

_____ A.A.	**_____D.O.**
(printed name)	(printed name)
_____	_____
(signature)	(signature)

Completed original agreement is to be mailed directly to:
Nevada State Board of Osteopathic Medicine
2275 Corporate Circle, Suite 210, Henderson, NV 89074

Addendum to Notification to Nevada State Board of Osteopathic Medicine of Supervision of Anesthesiologist Assistant ("AA")

COME NOW _____,D.O., and _____, A.A., first being duly sworn, who depose and state that: We, the undersigned physician and the undersigned A.A., are aware that, at the time the original Notification to Nevada State Board of Osteopathic Medicine of Supervision of Anesthesiologist Assistant ("AA") was signed by us, the regulations set forth in the Nevada Administrative Code ("NAC") pertaining to A.A.s and supervising osteopathic anesthesiologists were not yet available for us to read. We are now aware that regulations pertaining to A.A.s and supervising osteopathic anesthesiologists are set forth in NAC Chapter 633. We have read and are aware of the provisions of the regulations pertaining to A.A.s and supervising osteopathic anesthesiologists as set forth in NAC Chapter 633. We are further aware that a copy of this Addendum will be placed in the licensing files of the undersigned A.A. and physician at the offices of the Nevada State Board of Osteopathic Medicine ("the Board"). We further understand that this Addendum shall **NOT** be submitted to the Board until after the regulations have been published in the Nevada Administrative Code and we have read them.

WHEREFORE, I set my hand this _____ day of _____, 20_____.

_____ _____

Supervising Osteopathic Anesthesiologist Name (Print or Type) Supervising Osteopathic Anesthesiologist (Signature)

State of _____ County of _____

The above - named supervising osteopathic anesthesiologist, being first duly sworn, deposes and states that he/she appeared before me, a notary public, on the ____ day of _____, 20__, and in my presence, executed this one-page document.

_____

Notary Public

WHEREFORE, I set my hand this ____ day of _____, 20_____.

_____ _____

Anesthesiologist Assistant Name (Print or Type) Anesthesiologist Assistant (Signature)

State of _____ County of _____

The above – named anesthesiologist assistant, being first duly sworn, deposes and states that he/she appeared before me, a notary public, on the ____ day of _____, 20__, and in my presence, executed this one-page document.

_____

Notary Public

Return to:
Nevada State Board of Osteopathic Medicine
2275 Corporate Circle, Suite 210
Henderson, NV 89074