

## **PLEASE DO NOT PROCEED UNTIL YOU HAVE READ THESE INSTRUCTIONS.**

The North Carolina Medical Board annually processes over two thousand applications for licensure. Our process involves the collection of credentials from you the applicant, and from other sources as well. Once all application materials have been collected, our staff must review them. After reviews have been done, it may be necessary for the staff to request additional information, and/or to return items that need corrections or clarifications. It is our goal to review materials as quickly as possible, but we must be thorough. You should not expect the entire process to take less than ***four months***. You must have successfully completed the National Commission for the Certification of Anesthesiologist Assistants (NCCAA) examination to qualify for licensure. Please adhere to the following guidelines:

1. Credentials received prior to receiving your application will be held in our office for one year. Items received more than a year ago are considered expired and will need to be resubmitted.
2. Processing time may take longer during the months of March through August, due to the increased number of applications received at the North Carolina Medical Board.
3. Without an anesthesiologist assistant license and a primary supervising anesthesiologist, you cannot practice as an anesthesiologist assistant in North Carolina. Do not make practice commitments prematurely.
4. If you have been named in any malpractice suits, or have answered "yes" to any of the questions on our application, please include detailed information and anticipate the possibility that additional information will be requested and a personal interview with the Board may be required.
5. State law will only allow us to speak to the applicant about the application. Relatives, staff members, future employers, placement services and insurance companies cannot be informed about the status of your application.
6. After your application has been received, you will be notified. Once your file has been reviewed, you will be provided with a status update regarding deficiencies.
7. The NC Medical Board does not grant temporary licenses. You must hold a full NC AA license to practice as an anesthesiologist assistant.

\*\*Questions regarding your application can be e-mailed to [license@ncmedboard.org](mailto:license@ncmedboard.org) \*\*

**NORTH CAROLINA MEDICAL BOARD**  
**Anesthesiologist Assistant License Application Instructions**

Submit all Material To: NC Medical Board  
1203 Front Street  
Raleigh, NC 27609  
(919) 326-1100

or

NC Medical Board  
PO Box 20007  
Raleigh, NC 27619

**DO NOT SUBMIT PHOTOCOPIES OR FACSIMILIES UNLESS SPECIFICALLY PERMITTED**

An application for license in North Carolina is a confidential matter therefore we are unable to respond to any questions regarding your application from anyone other than you, the applicant. You may leave voice mail messages, which will be returned but may not be returned within 24 hours. We may also be contacted by e-mail at [license@ncmedboard.org](mailto:license@ncmedboard.org). The Board reserves the right to request a personal interview.

Below is a summary of the rules of Chapter 32 of the North Carolina Administrative Code. These are the conditions that might allow licensure, but the Board reserves the right to make whatever additional demands on the applicant for licensure the Board deems appropriate at the time.

- 1. Completed application form.
  - CIRCLE the correct answer for all questions.
  - Provide DETAILED explanations for affirmative answers.
  - A claim form must be completed for EACH malpractice suit or settlement (form enclosed-photocopy as needed). ATTACH A PHOTOCOPY OF PLAINTIFF'S COMPLAINTS AND SETTLEMENT ORDERS FOR EACH INCIDENT.
  - Sign applicant's oath and have signature NOTARIZED. Make sure the original application form is submitted to the Board. Applications will be sent back to the applicant if the dates do not match.
  - Include name change documentation, if applicable.
- 2. One Certified Photograph: no smaller than 2 ½" x 3 ¼", head and shoulders shot, taken within the past sixty (60) days, of durable quality, (not a snapshot or home Polaroid) to be certified by your anesthesiologist assistant program on the Anesthesiologist Assistant Program Certification form. This certification must bear the original signature of the Dean or other Official of your program, their official title and the seal of the school must be placed over the photo and mailed to the Board's address. **THIS REQUIREMENT CANNOT BE WAIVED.**
- 3. Verification of certification from the National Commission for the Certification of Anesthesiologist Assistants (NCCAA). Verifications may be obtained by going to the NCCAA website (<http://www.aanccaa.org/cgi-bin/cert.pl>).
- 4. Applicant must secure a report from each state regarding status of AA licenses now active AND all AA licenses held previously (see enclosed form titled "License Biography from Other States"). Most states charge a fee for this service. Verifications must be sent directly to the North Carolina Medical Board.
- 5. Three current, original reference forms of recommendation. Reference forms must include the original signature, date and contact information for the author writing the letter. Reference forms must be dated within one year of the received date of the application at NCMB. **These forms must be sent from the reference sources directly to the North Carolina Medical Board.**
  - A.) The forms must be an original with an original signature of the author, addressed to the NC Medical Board (not "TO WHOM IT MAY CONCERN").
  - B.) At least one form must be from an anesthesiologist with whom you have worked or trained regarding your competence to practice as an AA.
  - C.) Recommendations must not be from a relative.

- 6. A fee of \$188.00 U.S. dollars is to be paid at the time the application is submitted. (\$150.00 for the license application fee and \$38.00 for the criminal background check fee). Personal checks made payable to the NC Medical Board are acceptable. Checks returned for insufficient funds will require an additional \$20.00 fee. Returned checks must be replaced by a certified check or money order. FEES RECEIVED ARE NOT REFUNDABLE. Applications will not be processed until an application fee has been received.
- 7. Applicants must submit **two completed fingerprint cards along with their application form, application fee and authority for release of information form** for the purpose of conducting a criminal background check. Expect a minimum of 8 weeks for the report to be received. Since rejections are common, the SBI has suggested that applicants use lotion or witch hazel on their hands before being fingerprinted. Fingerprint cards are submitted for processing twice a week. The SBI has suggested that using live scan when available may be a more reliable choice. When possible have different officials complete each card.
- 8. Continuing Medical Education. Documentation must be provided to show that the Anesthesiologist Assistant is in compliance with all continuing education requirements and recertification requirements of the National Commission for the Certification of Anesthesiologist Assistants or its successor organization.

The North Carolina Medical Board meets every month to vote on applications. Applicants will be notified in writing when they have been placed on the agenda for a Board Meeting

**REGISTRATION - NORTH CAROLINA LAW REQUIRES LICENSED ANESTHESIOLOGIST ASSISTANTS TO REGISTER WITH THE BOARD WITHIN 30 DAYS OF THEIR BIRTH DATE, EVERY YEAR, NO MATTER WHEN THE LICENSE IS ISSUED. A REGISTRATION FEE IS REQUIRED.**





Name: \_\_\_\_\_  
(Printed)

**CIRCLE** your answer to the following questions. Provide a detailed description of any YES answers. Any changes in your answers to these questions between the time your application is notarized and the time your application is complete must be reported to the Board. The following questions refer to events in any jurisdiction – U.S. or Foreign.

- |                   |   |     |    |
|-------------------|---|-----|----|
| 1.                | Are you aware of any <b>complaint or investigation</b> , ever, regarding you that has been received or conducted by any of the following: <ul style="list-style-type: none"><li>• professional licensing board or agency</li><li>• military service</li><li>• medical or professional organization/association</li><li>• local, state, federal, or other governmental agency</li><li>• private or governmental insurance company or payor</li><li>• hospital or other healthcare organization</li><li>• professional certifying board</li></ul> | YES | NO |
| <hr/> <hr/> <hr/> |   |     |    |
| 2.                | Have you ever been denied the privilege of taking an examination by any professional licensing board, agency, or any other organization which provides professional certification or credentialing?   | YES | NO |
| <hr/> <hr/> <hr/> |   |     |    |
| 3.                | Have you ever: <ul style="list-style-type: none"><li>• withdrawn a license application</li><li>• been denied a license</li><li>• surrendered a license</li><li>• had a license restricted or limited in any way</li><li>• placed a license on inactive status while under investigation</li></ul>   | YES | NO |
| <hr/> <hr/> <hr/> |   |     |    |
| 4.                | In the past five (5) years, have you used or consumed any controlled substance or other prescription drug that you obtained through illegal or improper means?  | YES | NO |
| <hr/> <hr/> <hr/> |   |     |    |
| 5.                | In the past five (5) years, have you used or consumed any illicit or illegal drugs including, but not limited to cocaine, heroin, ecstasy, LSD, mescaline, psilocybin, PCP and/or marijuana?  | YES | NO |
| <hr/> <hr/> <hr/> |   |     |    |
| 6.                | In the past five (5) years, have you used alcohol or other substances in a manner that could in any way impair or limit your ability to practice medicine with reasonable skill and safety of have you been told you were impaired by your use of alcohol or other substances in a manner that could impair or limit your ability to practice medicine with reasonable skill and safety?  | YES | NO |
| <hr/> <hr/> <hr/> |   |     |    |
| 7.                | In the past five (5) years, have you had, or have you been told you have, a mental health or physical condition (not referenced above) which in any way limits or impairs or, if untreated, could limit or impair your ability to practice medicine in a competent or professional manner?  | YES | NO |
| <hr/> <hr/> <hr/> |   |     |    |

Name: \_\_\_\_\_  
(Printed)

8. Have you ever had a professional liability policy cancelled or not renewed relating to an accusation of your poor medical care or misconduct? YES NO

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9. Have you ever been separated or discharged other than honorably from the US military, foreign military, Veteran's Administration or public health service? YES NO

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10. While at any professional school or training program, have you ever:  
• been suspended, placed on scholastic or disciplinary probation, expelled or requested to resign, or  
• withdrawn or gone on leave of absence while under investigation or threat of investigation or disciplinary action? YES NO

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11. Have you ever had an action taken against your privileges by a health care institution? If so, list each occurrence and provide documentation. YES NO

Actions include terminations, warnings, censures, discipline, admissions monitored, privileges limited, privileges suspended/revoked, remediation, probation, withdrawals/resignations of privileges, or denial of staff membership.

Health care institutions include hospitals, health maintenance organizations, preferred provider organizations, any facility in which you trained or any other provide organizations that issue credentials to physicians.

\*\* All final suspensions and revocations will be visible to the public on the Board's website for a period of seven years (from the date of the action).\*\*

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**FOR THE PURPOSE OF QUESTIONS 12 AND 13, IF "YES", SUBMIT COPIES OF ALL RELEVANT DOCUMENTATION, SUCH A POLICE REPORTS, CERTIFIED COURT RECORDS AND DISPOSITIONS**

12. Have you ever been charged with or convicted of a misdemeanor? If so, list each occurrence. YES NO

Note: You are not required to report minor traffic offenses. "Minor traffic offenses" do not include driving while intoxicated, driving under the influence, careless and reckless driving, or any offence involving serious injury or death.

Charged includes being arrested, indicted or arraigned.

Convicted includes if you pled guilty, were found guilty by a court of competent jurisdiction, or entered a plea of nolo contendere (no contest) or received a prayer for judgment continued (PJC) for a violation of federal, state, or local law.

\*\* Misdemeanor convictions that involve offenses against a person, offenses of moral turpitude, offenses involving the use of drugs or alcohol and violations of public health and safety codes will be visible to the public on the Board's website for a period of 10 years (from the date of the conviction). If one of the actions reported is determined to be public information, the Board will notify the licensee in writing). \*\*

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Name: \_\_\_\_\_  
(Printed)

13. Have you ever been charged with or convicted of a felony? Is so, list each occurrence. YES NO

Charged includes being arrested, indicted or arraigned.

Convicted includes if you pled guilty, were found guilty by a court of competent jurisdiction, or entered a plea of nolo contendere (no contest) or received a prayer for judgment continued (PJC) for a violation of federal, state or local law.

\*\* All felony convictions will be visible to the public on the Board's website. \*\*

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14. Have you ever had an action taken against you by a regulatory board or agency? If so, list each occurrence. YES NO

Action includes revocations, suspensions, probations, limitations/restrictions, disciplinary/non-disciplinary actions and fines, including private actions and letters, or the issuance of a license through an order.

Regulatory Board or Agency includes any professional licensing board or agency, the US Food or Drug Administration, the US Drug Enforcement Administration, Medicare, or Medicaid.

\*\* All public actions taken by state medica/regulatory boards will be visible to the public on the Board's website indefinitely. All actions taken by federal/state agencies such as the US Food and Drug Administration, the US Drug Enforcement Administration, Medicare, and Medicaid will be visible to the public on the Boards website for a period of seven years (from the date of the action). \*\*

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15. Have you ever been named in a malpractice lawsuit or a malpractice lawsuit filed against you was resolved – regardless of whether the judgment, award, payment or settlement was made in your name or a malpractice settlement or payment was made, affecting or involving you, where no lawsuit was filed? If so, you will need to complete the "Claims Information Form". In addition, you are required to provide a copy of the plaintiff's complaint and if applicable the judgement, award, payment or settlement documents. YES NO

\*\* Not all malpractice payment reports will be published. The NCMB will only publish:

- judgments or awards that occurred within the past seven years, and
- settlements that occurred on or after May 1, 2008 and are \$75,000 or greater.

Please note that the dollar amount of the payment will not be published; nor will any information that might identify a patient. Payments that meet the criteria for public reporting will be visible to the public on the Board's website for a period of 7 years from the date of payment.

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# North Carolina Medical Board Affidavit, Release, and Authorization

**\*THIS ENTIRE FORM MUST BE COMPLETED IN THE PRESENCE OF A NOTARY PUBLIC\***

THE FOLLOWING SENTENCE IS TO BE COPIED BY THE APPLICANT IN THE APPLICANT'S USUAL HANDWRITING.

*I hereby certify under oath that I am the person named in this application and that all statements I have made or may make are true and complete.*

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I further certify and acknowledge the following (initial each statement):

- \_\_\_\_\_ I am the person named in the various forms and credentials furnished with respect to my application and that all documents, forms or copies furnished with respect to my application are true in every aspect.
- \_\_\_\_\_ If I fail to answer questions truthfully and completely, the NC Medical Board (NCMB) may deny my application or take other disciplinary action and that all license denials are reported to the National Practitioners Data Bank and other state medical boards.
- \_\_\_\_\_ If I am in doubt about whether to report any information requested, I should fully disclose the information and provide an explanation of the circumstances.
- \_\_\_\_\_ If someone else completed the application for me, I am responsible to make sure the answers are truthful and complete.

I waive confidentiality, 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 NCMB any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, my examination grades, or any other pertinent data and to permit the NCMB or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application that can subsequently be provided to professional licensing boards, hospitals and other entities when I apply for licensure, staff membership, employment or other privileges.

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

I will immediately notify the NCMB in writing of any changes to the answers to any questions contained in this application if such a change occurs at any time prior to a decision by the NCMB regarding my application.

**NOTE: NOTARY SEAL MUST BE PARTIALLY OVER THE APPLICANT'S PHOTO**

**Applicant Photograph**

Securely tape or glue in this square a current, front-view, 2" X 2" passport-type color photograph of yourself on photo quality paper.

\_\_\_\_\_  
Applicant's Printed Name

\_\_\_\_\_  
Applicant's Social Security Number

\_\_\_\_\_  
Applicant's Date of Birth

\_\_\_\_\_  
**Applicant's Signature**

\_\_\_\_\_  
**Date of Signature**

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**NOTARY PUBLIC**

State of \_\_\_\_\_, County of \_\_\_\_\_

SUBSCRIBED AND SWORN TO before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

My commission expires: \_\_\_\_\_

\_\_\_\_\_  
**Notary Public**

I certify that on the date set forth above the individual named above did appear personally before me and that I: (a) did identify this applicant by comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) did witness this applicant complete this form including the handwritten statement above.

**NORTH CAROLINA MEDICAL BOARD  
CLAIMS INFORMATION FORM**

**PLEASE ATTACH A PHOTOCOPY OF THE PLAINTIFF'S COMPLAINT AND THE SETTLEMENT ORDER, IF THERE IS ONE**

The applicant must complete this form for each liability or malpractice claim of which they are aware. Please make as many photocopies of this form as you need. Please use one form for each claim or suit.

1. In addition to copies of the complaint and settlement order, if any, describe below the allegations against you. **A copy of the complaint will not replace a written description by you.** Include the patient's name, a brief history, comments regarding the examination and care surrounding the allegations. If suites are pending a very brief summary of the allegations or charges must be included regardless of the litigation stage. Simply stating that the charges were dismissed is inadequate. More details must be provided. Use additional pages if necessary.

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2. Date of the claim: \_\_\_\_\_

3. If an insurance carrier was involved, list the name, address and telephone: \_\_\_\_\_

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4. Plaintiff's Attorney & Telephone #: \_\_\_\_\_

5. Is the claim pending? YES NO

6. Was there a judgment or settlement? YES NO

7. What was the amount and date of the judgment or settlement? \_\_\_\_\_

8. Comments: \_\_\_\_\_

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I certify that the information, which I have provided, is correct to the best of my knowledge.

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Signature of AA Applicant

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Date

**NC MEDICAL BOARD  
IMMIGRATION STATUS FORM**

PO Box 20007  
Raleigh, NC 27619

Applicant's Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

1. If you are not physically present in the United States of America or a United States Territory and have no plans to enter the United States of America or a United States Territory, please check below and then continue to the next page.

I am not physically present and I have no plans to enter the United States of America or a United States Territory.

\*If you do enter the United States of America or a United States Territory and practice as a licensee of the North Carolina Medical Board, you must notify the Legal Department at the North Carolina Medical Board immediately.

2. Are you a citizen of the United States of America?

Yes

No

If you answered "Yes," you must provide a copy of **one** of the following documents:

- a. Birth certificate indicating birth in the United States of America or a United States Territory.
- b. Valid and unexpired United States of America passport.
- c. Other appropriate documentation of United States of America citizenship deemed acceptable by the North Carolina Medical Board, which may include:
  1. Report of Birth Abroad of a United States of America citizen (FS-240)
  2. Certification of Report of Birth (DS-1350 or FS-545)
  3. Certificate of United States of America Citizenship (N-561)
  4. United States of America Citizen Identification Card (I-197)

If you answered "No," you must provide:

- a. A statement defining and specifying your immigration and alien status:

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**AND**

- b. A copy of a document indicating your immigration and alien status deemed acceptable by the North Carolina Medical Board, which may include one of the following documents:
1. Alien Registration Card or Green Card (Form I-551)
  2. Employment Authorization Document (Form I-688B or Form I-766)
  3. Certification of Report of Birth (DS-1350)
  4. Arrival-Departure Record (Form I-94)
  5. Other documentation providing lawful status in the United States of America.

**VERIFICATION OF MEDICAL EDUCATION**

**Please return the form to:**            **NORTH CAROLINA MEDICAL BOARD**  
   **P.O. Box 20007**  
   **Raleigh, NC 27619**

Name of Anesthesiologist Assistant: \_\_\_\_\_

Name of Institution: \_\_\_\_\_

Institution Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Country: \_\_\_\_\_

If name of institution was different when this individual attended, please note the prior name below:

\_\_\_\_\_

**Enrollment and Participation:**

Our records indicate \_\_\_\_\_ attended our medical school for a total of  
(Anesthesiologist Assistant name)

\_\_\_\_\_ weeks of medical education on the following dates (mm/dd/yy):

From \_\_\_\_\_ to \_\_\_\_\_

This institution's minimum attendance requirement is \_\_\_\_\_ weeks.

This individual was awarded the certificate/degree on \_\_\_\_\_  
month/year

**The Dean or other medical school official must complete the certification and sign.**

Certification:     By my signature, I \_\_\_\_\_,  
certify that the above information is an accurate account of the above named individual's office  
records maintained in this and is true and correct to my knowledge.

**Affix Institutional Seal  
Here**

Signature of certifying official: \_\_\_\_\_  
(Original signature is required – stamps not accepted)

Title: \_\_\_\_\_

Date of signature: \_\_\_\_\_

**Verification of Medical Education**  
**Page 2 of 2**

**Unusual Circumstances:** The following questions apply to unusual circumstances that occurred during any part of the anesthesiologist assistant's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

1. Does this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education? Yes ( ) No ( )

If YES, select the reasons(s) for, indicate the dates of the interruption(s) or extensions(s) and check whether the interruption/extension was approved or unapproved.

	<u>From Mo/Yr</u>	<u>To Mo/Yr</u>	<u>Approved</u>	<u>Unapproved</u>
<u>Personal/Family</u>	( )	( )	( )	( )
<u>Academic remediation</u>	( )	( )	( )	( )
<u>Health</u>	( )	( )	( )	( )
<u>Financial</u>	( )	( )	( )	( )
<u>Participation in joint degree program</u>	( )	( )	( )	( )
<u>Participation in non-research special study (e.g., fellowship, international experience)</u>	( )	( )	( )	( )
<u>Participation in non-degree research</u>	( )	( )	( )	( )
<u>Other</u>	( )	( )	( )	( )

Please specify \_\_\_\_\_

2. Does this anesthesiologist assistant's official record reflect he/she was ever placed on academic or disciplinary probation during his/her medical education? Yes ( ) No ( )

	<u>From Mo/Yr</u>	<u>To Mo/Yr</u>
<u>Academic Probation</u>		
<u>Probation for unprofessional conduct/behavior</u>		
<u>Probation for other reason</u>		

Please specify reason: \_\_\_\_\_

3. Does this anesthesiologist assistant's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Yes ( ) No ( )

If YES, provide detailed documentation/information about the circumstances and outcomes(s):  
 \_\_\_\_\_  
 \_\_\_\_\_

4. Does this anesthesiologist assistant's official records reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medial school or parent university? Yes ( ) No ( )

If YES, provide detailed documentation/information about the circumstances and outcomes(s):  
 \_\_\_\_\_  
 \_\_\_\_\_

5. Does this anesthesiologist assistant's official records reflect that there were any limitations or special requirements imposed on the anesthesiologist assistant because of questions of academic incompetence, disciplinary problems, or any other reason? Yes ( ) No ( )

If YES, provide detailed documentation/information about the circumstances and outcomes(s):  
 \_\_\_\_\_  
 \_\_\_\_\_

**NORTH CAROLINA MEDICAL BOARD  
ANESTHESIOLOGIST ASSISTANT REFERENCE FORM**

P.O. Box 20007, Raleigh, NC 27619  
or  
1203 Front Street, Raleigh, NC 27609

**TO APPLICANT:** The North Carolina Medical Board requests completion of **THREE** reference forms. These forms must be sent from the reference sources **directly** to the NC Medical Board.

In addition, the forms must meet the following criteria:

- a) They must be completed and returned to the Board within six months of the date of your application.
- b) They must have an original signature. Signature stamps will not be accepted.
- c) One form must be completed by an anesthesiologist and two forms completed by peers with whom you have worked or trained. They must have interacted with you within the past three years and have knowledge of your competence as an anesthesiologist assistant.

Please be sure to indicate your name below for identification purposes.

**Name of Applicant:** \_\_\_\_\_  
(Please Print Clearly)

**\*\* On the application form, the applicant has agreed to release, discharge and exonerate any person furnishing information from any and all liability of every nature and kind arising out of this furnishing or inspection of such documents, records, other information or the investigation made by the North Carolina Board. \*\***

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**REFERENCE SOURCE:** Please complete this form and return to the NC Medical Board. Your response is confidential, pursuant to North Carolina law. **Please print or type all information.**

**Important:** The processing time for licensure directly depends on timely receipt of critical forms such as this.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Email Address

1. How long have you known the applicant? \_\_\_\_\_

2. In what capacity are you acquainted with him/her? \_\_\_\_\_

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**If you answer “YES” to questions 3 - 9, you will need to provide an explanation.**

- |    |   |     |    |     |
|----|---|-----|----|-----|
| 3. | Have you ever received reports of poor medical practice by this anesthesiologist assistant or have you discussed concerns you had about his/her practice with medical staff officers at a hospital?             | Yes | No | N/A |
| 4. | Have you ever received reports of poor relationships between this anesthesiologist assistant and other health care workers?   | Yes | No | N/A |
| 5. | Do you know of any derogatory information about this anesthesiologist assistant with respect to his/her ability to practice?  | Yes | No | N/A |
| 6. | Do you know if this anesthesiologist assistant has had any mental, emotional, or physical illnesses that have interfered with his/her practice as an anesthesiologist assistant within the past five (5) years? | Yes | No | N/A |
| 7. | Do you know if this anesthesiologist assistant has abused alcohol or drugs or shown signs of chemical dependency within the past five (5) years?  | Yes | No | N/A |
| 8. | Do you know of any judgments, awards, payments or settlements regarding this anesthesiologist assistant?  | Yes | No | N/A |
| 9. | Do you know of any restrictions, limitations or other disciplinary actions of any nature taken against this anesthesiologist assistant by a hospital or other health care organization?                         | Yes | No | N/A |

**If you answer “NO” to questions 10 - 12, you will need to provide an explanation.**

- |     |   |     |    |     |
|-----|---|-----|----|-----|
| 10. | Does this anesthesiologist assistant understand medical staff and hospital policies and abide by these policies?  | Yes | No | N/A |
| 11. | Does this anesthesiologist assistant enjoy professional respect among his or her colleagues and in the community where this anesthesiologist assistant practices? | Yes | No | N/A |
| 12. | Do you recommend this anesthesiologist assistant for unrestricted licensure in North Carolina?  | Yes | No | N/A |

**\*\* Additional comments are encouraged and assist the Board in evaluating the applicant. \*\***

**COMMENTS:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
**Name of Hospital (if applicable)**

\_\_\_\_\_  
**Date**

# NORTH CAROLINA MEDICAL BOARD

## LICENSE VERIFICATION FORM

**Applicant:** Complete the top portion of this form and forward one copy to each licensing board in all the states where you **have held OR currently hold** a medical license. Training licenses do not need to be verified. This form should be mailed directly to the North Carolina Medical Board from the state licensing board. Most states require a fee for processing. The fee is the applicant's responsibility. The NC Medical Board accepts license verifications through the VeriDoc service.

**Licensing Board:** The North Carolina Board requires information regarding my license. This is my request for you to respond to the questions below and also gives you authority to release any information, favorable or otherwise, to the North Carolina Medical Board.

I am applying for a North Carolina medical license. I was granted license number \_\_\_\_\_ on \_\_\_\_\_ by the State of \_\_\_\_\_.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Soc. Sec. #: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

\_\_\_\_\_

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This is to certify that the records of the \_\_\_\_\_ State Licensing Board indicate that \_\_\_\_\_ anesthesiologist assistant was issued license number \_\_\_\_\_ on \_\_\_\_\_ to practice as an anesthesiologist assistant in the State of \_\_\_\_\_,

Respond to the following questions:

1. Is this license current and in good standing? \_\_\_\_\_ YES NO
2. Has any public or private action been taken against this practitioner? \_\_\_\_\_ YES NO
3. Are there any pending investigations against this practitioner? \_\_\_\_\_ YES NO

**If YES answered to questions 2 and 3, attach an explanation.**

(Board Seal)

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

**PLEASE COMPLETE AND RETURN THIS FORM DIRECTLY TO THE NORTH CAROLINA MEDICAL BOARD, P.O. Box 20007, RALEIGH, NC 27619.**

**AUTHORITY FOR RELEASE OF INFORMATION**  
**State and Federal Record Check**

I authorize the North Carolina Department of Justice through the State Bureau of Investigation, Division of Support Services to perform a fingerprint search of the State's criminal history record file and a fingerprint search of the Federal Bureau of Investigation's files for a national criminal history record check in connection with my application for a anesthesiologist assistant license with the North Carolina Medical Board pursuant to N.C.G.S. 90-11(HB 1638).

(Print or Type)

Last Name	First	Middle	Maiden
_____	_____	_____	_____

Social Security Number	Date of Birth	Sex	Race
_____	_____	_____	_____

I understand that the North Carolina State Bureau of Investigation, Division of Support Services, and its officials and employees shall not be held legally accountable in any way for providing this information to the North Carolina Medical Board, and I hereby release said agency and persons from any and all liability which may be incurred as a result of furnishing such information. I further understand that the North Carolina Medical Board cannot provide a **hard copy** of the results of this criminal history record check to me.

Applicant's Signature  
\_\_\_\_\_

Date  
\_\_\_\_\_

**ORI # BOME00000 – NORTH CAROLINA MEDICAL BOARD**

CRIMINAL BACKGROUND CHECK INSTRUCTIONS  
ANESTHESIOLOGIST ASSISTANT LICENSE

Effective February 1, 2003, pursuant to N.C. G.S. 90-11 (b) and 21 N.C.A.C. 32B.0104, applicants for licensure by this Board must provide fingerprints as set forth in the above-referenced rule in order for the Board to conduct a state and federal criminal history record check.

Please go to your nearest law enforcement center and ask to be fingerprinted on a card like the sample. To ensure that a proper finger print card is used you should email the North Carolina Medical Board's License Department at [license@ncmedboard.org](mailto:license@ncmedboard.org) and request a set of cards be sent to you. On the card containing your fingerprints, you must fill in the information in each block that is checked on the example. Be aware that photo identification and a fee may be required by the law enforcement agency performing this service. Fingerprints of poor quality will be rejected and new prints will be required. If this occurs there will be a delay in processing your application. Enclosed is a sample fingerprint card with instructions. We have been advised by the State Bureau of Investigation that there will be a **minimum** of 4 weeks processing time.

When you have completed your application, please return, along with your application, the properly completed fingerprint card, the form entitled "Authority For Release of Information" completed by you, and a check in the amount of \$188.00 payable to the North Carolina Medical Board, to the North Carolina Medical Board, PO Box 20007, Raleigh, NC 27619. Checks made payable to the State Bureau of Investigation will not be accepted. This check includes a fee of \$38.00, which will be paid by the North Carolina Medical Board to the North Carolina State Bureau of Investigation in accordance with the statute for the record check.

Any questions regarding this procedure can be submitted by email to the License Department at [license@ncmedboard.org](mailto:license@ncmedboard.org).