

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

Submit all materials to:       NC Medical Board  
  PO Box 20007  
  Raleigh, NC 27619  
  800-253-9653

**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. We may be contacted by emailing [license@ncmedboard.org](mailto:license@ncmedboard.org).

Below is a summary of the rule 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. Attach a copy of the plaintiff's complaint and settlement orders for each case.
- Include name change documentation, if applicable.

2. Applicant's Oath

Attach a photograph on photo quality paper taken within the past year to the applicant's oath. Sign applicant's oath and have signature notarized.

3. Verification of Immigration Status. Documentation can be emailed to [license@ncmedboard.org](mailto:license@ncmedboard.org).

US Citizens must submit a photocopy of one of the following:

- Birth certificate
- Valid, unexpired US passport

Not a US citizen? Provide a photocopy of one of the following:

- Alien Registration Card or Green Card (form I-555)
- Employment Authorization Document (form I-688 or I-766)
- Certification of Report of Birth (form DS -1350)
- Arrival/Departure Record (form I-94)
- Other documentation providing lawful US status

4. Verification of Education form

This form should be sent to your school for completion. Your school should email the form directly to the NC Medical Board at [license@ncmedboard.org](mailto:license@ncmedboard.org).

5. Verification of certification from the National Commission for the Certification of Anesthesiologist Assistants (NCCAA). Verifications may be obtained by going to the NCCAA website ([www.aa-nccaa.org](http://www.aa-nccaa.org)). Verification can be emailed to [license@ncmedboard.org](mailto:license@ncmedboard.org).

6. Three current reference forms. These forms must be sent from the reference sources directly to the NC Medical Board.

- The forms must be an original with an original signature of the author.
- One form must be from an anesthesiologist with whom you have worked or trained regarding your competence to practice as an Anesthesiologist Assistant.
- Recommendations cannot be from a relative.

7. Fee of \$191.00 US dollars is to be paid at the time of the application is submitted. (\$150.00 for the license application fee; \$38.00 for the criminal background check fee; \$3.00 for the NPDB report). Applications will not be processed until the application fees have been received. Fees received are non-refundable.

8. Criminal Background Check

- Applicants being fingerprinted in North Carolina – Live scan is available to those applicants who will be fingerprinted in NC. You will need to go to your local law enforcement office to have this completed. You will need to take the Applicant Information form with you to the law enforcement office. The Electronic Authority to Release form will need to be sent to the NCMB.
- Applicants being fingerprinted outside of North Carolina – You will need to request a set of fingerprint cards to be mailed to you at [fpc@ncmedboard.org](mailto:fpc@ncmedboard.org). Fingerprint cards are mailed on a daily basis. You will need to send the Authority to Release form and fingerprint cards to the NCMB.

The Authority to Release forms can be emailed to: [license@ncmedboard.org](mailto:license@ncmedboard.org).

RENEWAL – NC law required license anesthesiologist assistants to renew with the Board within 30 days of their birthdate, every year, no matter when the license is issued. A renewal 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.**

**Complaint** includes, but is not limited to, any instance where any person or organization has raised a concern regarding you or your practice regardless of the outcome.

**Investigation** includes, but is not limited to, an inquiry (in person or otherwise), examination or inspection of, or gathering of evidence or information regarding you or your practice regardless of the outcome.

1. Are you aware of any **complaint or investigation or inquiry**, ever, regarding you that has been received or conducted by any of the following: YES NO

- professional licensing board or agency (including, but not limited to, the North Carolina Medical Board)
- military service
- medical or professional organization/association
- local, state, federal, or other governmental agency
- private or governmental insurance company or payor
- hospital or other healthcare organization
- professional certifying board

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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

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3. Have you ever: YES NO

- withdrawn a license application
- been denied a license
- surrendered a license
- had a license restricted or limited in any way
- placed a license on inactive status while under investigation

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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

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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

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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 or 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

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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

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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: YES NO

- 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?

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11. Have you ever: YES NO

1 – been named in a malpractice lawsuit;

2 - had a malpractice lawsuit filed against you that was resolved with a judgment (regardless of appeal), award, payment, or settlement regardless of whether the payment or settlement was in your name; or

3 – a malpractice settlement or payment was made involving your care of a patient.

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, a copy of the judgement, award, payment or settlement documents.

Malpractice payment information is requested for two reasons: (1) internal investigation, and (2) public reporting.

Internal Investigation: The NCMB investigates all malpractice payment reports to determine if disciplinary or remedial action is necessary.

Public Reporting: 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.



## MISDEMEANOR/DUI/DWI

**Circle your answer to the following question. If you answer “yes” to the question, you will need to provide a detailed explanation below. You must supply all supporting court documents.**

Question:

Have you ever been charged with, arrested for or convicted of a misdemeanor including, but not limited to, Driving Under the Influence (“DUI”) or Driving While Impaired (“DWI”) and any other violation of law involving the operation of some means of transportation while under the influence of drugs or alcohol? If so, you must list every misdemeanor charge, arrest and conviction below.

YES      NO

Definitions:

You have been charged if you have been arrested, indicted or arraigned for a criminal act, even if the charge was later dismissed.

You have been convicted if you pleaded guilty, were found guilty by a court, 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.

Instructions:

Failure to report may result in denial of licensure, fines or other public disciplinary action. **You must report all charges, arrests and convictions for driving while intoxicated, driving under the influence, careless and reckless driving and any offenses involving serious injury or death.** Minor traffic offenses are not required to be reported.

Expungements:

**Do not report** expunged charges or convictions for which you possess written documentary proof of expungement. **Do not assume** any previous charge, arrest or conviction has been expunged unless you have in your possession an official written court order or document, signed by a judge, which explicitly orders the charge, arrest or conviction sealed and/or expunged.

Some misdemeanor convictions that involve offenses against a person, offenses of moral turpitude, offenses involving the use of drugs or alcohol, violations of public health and safety codes, and failure to file state or federal taxes will be publicly visible on the Board’s website for 10 years (from the date of conviction). The Board will notify you prior to publishing your misdemeanor conviction on the website. All felony convictions will be visible to the public on the Board’s website.

**Examples:**

2/12/2005	Driving Intoxicated While	NC	7/29/2005	Reckless Driving	Fine; Community Service	Crossed center line. Arrested for DWI. Pled guilty to reckless driving.
3/25/2006	Assault	NY	N/A	N/A	Charges Dismissed	Punched a guy at a bar. Charges dismissed after community service.
4/2/2007	Public Intoxification	SC	9/15/2007	Public Intoxification	Fine; probation	Drank too much at a football game. Found guilty by a judge.

Date of Charge or Arrest	What were you charged with or arrested for?	Jurisdiction in which Charge or Arrest Occurred	Date of Conviction (if you were not convicted, answer n/a)	What were you convicted of? (if you were not convicted answer n/a)	Sentence Imposed (If no sentence imposed, answer n/a)	Detailed Explanation
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## FELONY

Circle your answer to the following question. If you answer “yes” to the question, you will need to provide a detailed explanation below. You must supply all supporting court documents.

Have you **ever** been charged with, arrested for or convicted of a felony including, but not limited to, Driving Under the Influence (“DUI”) or Driving While Impaired (“DWI”) and any other violation of the law involving the operation of some means of transportation while under the influence of drugs or alcohol? YES      NO  
 If so, you must list every felony charge, arrest and conviction below.

*You have been charged if you have been arrested, indicted or arraigned for a criminal act, even if the charge was later dismissed.*

*You have been convicted if you pleaded guilty, were found guilty by a court, 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.*

**Instructions:**

Failure to report may result in denial of licensure, fines or other public disciplinary action. **You must report all charges, arrests and convictions** for driving while intoxicated, driving under the influence, careless and reckless driving and any offenses involving serious injury or death. Minor traffic offenses are not required to be reported.

**Expungements:**

**Do not report** expunged charges or convictions for which you possess written documentary proof of expungement. **Do not assume** any previous charge, arrest or conviction has been expunged unless you have in your possession an official written court order or document, signed by a judge, which explicitly orders the charge, arrest or conviction sealed and/or expunged.

Some misdemeanor convictions that involve offenses against a person, offenses of moral turpitude, offenses involving the use of drugs or alcohol, violations of public health and safety codes, and failure to file state or federal taxes will be publicly visible on the Board’s website for 10 years (from the date of conviction). The Board will notify you prior to publishing your misdemeanor conviction on the website. All felony convictions will be visible to the public on the Board’s website.

**Examples:**

2/12/2005	Felony Prescription Fraud	NC	3/24/2006	Misdemeanor Larceny	12 months probation	Wrote prescriptions with intent to sell. Pleaded guilty to a lesser offense.
3/25/2006	Felony Embezzlement	NY	N/A	N/A	Charges Dismissed	Stole money from my practice. Charges dismissed after deferred prosecution completed.
4/2/2007	Felony Medicare Fraud	SC	6/14/2008	Felony Medicare Fraud	Fine and exclusion from participation	Medicare audit revealed I submitted false claims and up-coded charges

Date of Charge or Arrest	What were you charged with or arrested for?	Jurisdiction in which Charge or Arrest Occurred	Date of Conviction (if you were not convicted, answer n/a)	What were you convicted of? (if you were not convicted answer n/a)	Sentence Imposed (If no sentence imposed, answer n/a)	Detailed Explanation
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## REGULATORY BOARD/AGENCY ACTIONS

Circle your answer to the following question. If you answer “yes” to the question, you will need to provide a detailed explanation below. You must supply all supporting court documents.

Have you **ever** had an action taken against you by a regulatory board or agency?

YES      NO

**Definitions:**

Actions include, but are not limited to:

- Revocations
- Suspensions
- Probations
- Limitations/restrictions
- Disciplinary/non-disciplinary actions and fines
- Private actions and letters
- Issuance of a license through an order
- License denials

Regulatory board or agency includes:

- Any professional licensing board or agency
- The U.S. Food and Drug Administration
- The U.S. Drug Enforcement Administration
- Medicare or Medicaid

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

**Examples:**

2/12/2005	Florida Medical Board	Reprimand	Public	Disruptive Behavior
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Date of Action	Name of Regulatory Board or Agency that took action	Action Taken	Was the Action Public or Private	Reason for Action Taken
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**North Carolina Medical Board  
PO Box 20007  
Raleigh, NC 27619**

**This form cannot be faxed or emailed to the NCMB**

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

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

**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.*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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.

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

\_\_\_\_\_  
Applicant's Soc. Sec. Number

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

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

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

**Applicant's 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.

**NOTARY PUBLIC**

**I certify that on the date set forth above the individual named above did appear personally before me and that I did witness this applicant complete this form including the handwritten statement above.**

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

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

(Official Notary Seal)

\_\_\_\_\_  
**Official Signature of Notary**

\_\_\_\_\_  
**Notary's Printed Name**

**My Commission Expires:** \_\_\_\_\_



**NC MEDICAL BOARD  
IMMIGRATION STATUS FORM**

PO Box 20007  
Raleigh, NC 27619

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. A copy of your application for an H-1 B Visa.
  6. Other documentation providing lawful status in the United States of America.

# NORTH CAROLINA MEDICAL BOARD

## VERIFICATION OF EDUCATION

- 1) Complete the form.
- 2) Scan the completed form and email to [license@ncmedboard.org](mailto:license@ncmedboard.org).
- 3) This form must be emailed directly from the Medical School.

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

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

### Enrollment and Participation:

Our records indicate that the anesthesiologist assistant named above attended our medical school for a total of \_\_\_\_\_ weeks of medical education on the following dates:

From \_\_\_\_\_ to \_\_\_\_\_  
Month/Year Month/Year

This anesthesiologist assistant was awarded their degree on \_\_\_\_\_.  
Month/Year

This anesthesiologist assistant did not receive a degree and left the institution on \_\_\_\_\_.  
Month/Year

### 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 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):

\_\_\_\_\_

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

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

\_\_\_\_\_

3. Does this individual's official records reflect that there were any limitations or special requirements imposed on the physician 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):

\_\_\_\_\_

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

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

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

<u>Reason</u>	<u>From Month/Year</u>	<u>To Month/Year</u>	<u>Approved</u>	<u>Unapproved</u>
Personal/Family	_____	_____	( )	( )
Academic remediation	_____	_____	( )	( )
Health	_____	_____	( )	( )
Financial	_____	_____	( )	( )
Participation in joint degree program	_____	_____	( )	( )
Participation in non-research special study	_____	_____	( )	( )
Participation in non-degree research	_____	_____	( )	( )
Other	_____	_____	( )	( )

If other, specify reason \_\_\_\_\_

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

	<u>From Month/Year</u>	<u>To Month/Year</u>
Academic Probation	_____	_____
Probation for unprofessional conduct/behavior	_____	_____
Probation for other reason	_____	_____

Specify probation for other reason: \_\_\_\_\_

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

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

Signature of certifying official: \_\_\_\_\_  
**(Signature is required)**

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

Email address: \_\_\_\_\_

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



**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 physician 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 physician and other health care workers?   | Yes | No | N/A |
| 5. Do you know of any derogatory information about this physician with respect to his/her ability to practice medicine?   | Yes | No | N/A |
| 6. Do you know if this physician has had any mental, emotional, or physical illnesses that have interfered with his/her medical practice within the past five (5) years?              | Yes | No | N/A |
| 7. Do you know if this physician 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 physician?  | Yes | No | N/A |
| 9. Do you know of any restrictions, limitations or other disciplinary actions of any nature taken against this physician by a hospital or other health care organization?             | Yes | No | N/A |

**If you answer “NO” to questions 10 - 13, 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 medical licensure in North Carolina?  | Yes | No | N/A |
| 13. Have you interacted with this physician within the past three years and are you knowledgeable about their competence as an anesthesiologist assistant?            | 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**



**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 physician 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 physician and other health care workers?   | Yes | No | N/A |
| 5. Do you know of any derogatory information about this physician with respect to his/her ability to practice medicine?   | Yes | No | N/A |
| 6. Do you know if this physician has had any mental, emotional, or physical illnesses that have interfered with his/her medical practice within the past five (5) years?              | Yes | No | N/A |
| 7. Do you know if this physician 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 physician?  | Yes | No | N/A |
| 9. Do you know of any restrictions, limitations or other disciplinary actions of any nature taken against this physician by a hospital or other health care organization?             | Yes | No | N/A |

**If you answer “NO” to questions 10 - 13, 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 medical licensure in North Carolina?  | Yes | No | N/A |
| 13. Have you interacted with this physician within the past three years and are you knowledgeable about their competence as an anesthesiologist assistant?            | 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**



**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 physician 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 physician and other health care workers?   | Yes | No | N/A |
| 5. Do you know of any derogatory information about this physician with respect to his/her ability to practice medicine?   | Yes | No | N/A |
| 6. Do you know if this physician has had any mental, emotional, or physical illnesses that have interfered with his/her medical practice within the past five (5) years?              | Yes | No | N/A |
| 7. Do you know if this physician 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 physician?  | Yes | No | N/A |
| 9. Do you know of any restrictions, limitations or other disciplinary actions of any nature taken against this physician by a hospital or other health care organization?             | Yes | No | N/A |

**If you answer “NO” to questions 10 - 13, 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 medical licensure in North Carolina?  | Yes | No | N/A |
| 13. Have you interacted with this physician within the past three years and are you knowledgeable about their competence as an anesthesiologist assistant?            | 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**

PO 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 medical license with the North Carolina Medical Board pursuant to N.C.G.S. 90-11(HB 1638).

Please print or type the following information:

Name: \_\_\_\_\_  
Last First Middle Maiden

Soc Sec #: \_\_\_\_\_ 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**

**APPLICANT INFORMATION**

**Last Name:** \_\_\_\_\_

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

**First Name:** \_\_\_\_\_

**Place of Birth** \_\_\_\_\_

**Middle Name:** \_\_\_\_\_

**Residence:** \_\_\_\_\_

**Maiden Name:** \_\_\_\_\_

**Aliases:** \_\_\_\_\_

**Employer and Address:**

**NC Medical Board  
PO Box 20007 Raleigh, NC 27619**

**Sex: Male** \_\_\_\_\_ **Female** \_\_\_\_\_

**Reason Fingerprinted:**

**NCGS 90-11- State and Federal**

**Race:** \_\_\_\_\_

(write the appropriate letter in the space provided)

W – White, B – Black, I – American Indian,  
A – Asian or Pacific Islander, U - Unknown

**Social Security Number:** \_\_\_\_\_  
(\*Optional)

Your Case No. (OCA): **BOME00000**

**Height:** \_\_\_\_\_

Type of Transaction: **NFUF**  
**Non fed-User Fee**

**Weight:** \_\_\_\_\_

NC FP Card Type: **BOME**

**Eye Color:** \_\_\_\_\_

(write the appropriate letters in the space provided)

BLK – Black    GRY – Gray    MAR – Maroon  
BLU – Blue    BRO – Brown    GRN – Green  
HAZ – Hazel    PNK – Pink    XXX – Unknown

**Hair Color:** \_\_\_\_\_

(write the appropriate letters in the space provided)

BAL – Bald    BLK – Black    BLN – Blonde or Strawberry  
BRO – Brown    GRY – Gray or partially  
RED – Red or Auburn    SDY - Sandy

\*Disclosure of social security number is entirely voluntary and not required. If disclosed, the social security number will be utilized to assist with accurate identification/exclusion of possible criminal history records.



ROY COOPER  
ATTORNEY GENERAL

NORTH CAROLINA  
STATE BUREAU OF INVESTIGATION  
DEPARTMENT OF JUSTICE

3320 GARNER ROAD  
PO Box 29500  
RALEIGH, NC 27626-0500  
(919) 662-4500  
FAX: (919) 662-4523



GREGORY S. MCLEOD  
DIRECTOR

**ELECTRONIC FINGERPRINT  
SUBMISSION RELEASE OF INFORMATION**

I authorize the North Carolina Department of Justice through the State Bureau of Investigation, Criminal Information and Identification Section, to perform a national criminal history record check in connection with my application for licensure with NC Medical Board pursuant to NCGS 90-11.

I understand that the North Carolina State Bureau of Investigation, Criminal Information and Identification Section, the Federal Bureau of Investigation, and its officials and employees shall not be held legally accountable in any way for providing this information to the above named agency, 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 understand that the above named agency cannot provide a hard copy of the results of this criminal history record check to me.

\_\_\_\_\_  
Applicant/Licensee's Printed Name

\_\_\_\_\_  
Applicant/Licensee's Signature

\_\_\_\_\_  
Date

I authorize the above named subject to be fingerprinted and have the fingerprints submitted to the SBI electronically.

*Michelle Lee*  
\_\_\_\_\_  
Agency Authorized Official's Signature

April 25, 2016  
Date

**Agency Contact Information**  
Michelle Lee  
NC Medical Board  
PO Box 20007  
Raleigh, NC 27619  
919-326-1100/license@ncmedboard.org

I certify that I have taken the fingerprints of the above named subject and forwarded them electronically to the State Bureau of Investigation.

\_\_\_\_\_  
Signature of Official Taking Fingerprints

\_\_\_\_\_  
Date

Agency Seal/Certification \_\_\_\_\_



A Nationally Accredited State Agency

An ASCLD/LAB Accredited Laboratory Since 1988



# Instruction Sheet for Completing the Fingerprint Cards

**The NC Medical Board requires 2 fingerprint cards for processing. Failure to submit 2 fingerprint cards will delay your application if the first card is rejected.**

1. The complete name of the subject is to be listed as indicated: Last name, First name, and Middle name. Please ensure the name is legible if written.
2. Signature of the subject being fingerprinted is written here.
3. List any and all alias names or nicknames, maiden name or any other married names.
4. List the date of birth numerically – month, day, and year.  
  
Example: May 11, 1948, should be shown as 05111948; October 15, 1930, should be shown as 10151930
5. Current residence of subject fingerprinted is written here.
6. Sex is to be listed M for male, and F for female, or U for Unknown.
7. Race is to be listed by placing an individual into one (1) of the following categories by writing the appropriate letter in the space provided:  
  
W      White  
B      Black  
I      American Indian or Alaskan Native  
A      Asian or Pacific Islander  
U      Unknown if unsure or unable to determine
8. Indicate the subject's height in feet and inches using all numerics.  
  
Example: 6'01" = 601, 6'11" = 611, 6' = 600
9. Indicate the subject's weight in pounds using all numerics.  
  
Example: 186 or 098, etc.
10. List the subject's eye color by placing one (1) of the following eye color codes in the space provided:  
  
BLK – Black                      GRY – Gray                      MAR – Maroon  
BLU – Blue                        GRN – Green                      PNK – Pink  
BRO – Brown                      HAZ – Hazel                      XXX – Unknown
11. Color of hair should be indicated by writing one (1) of the following color codes in the space provided:  
  
BAL – Bald (When subject has lost most of his hair or is hairless)  
BLK – Black  
BLN – Blond or Strawberry  
BRO – Brown  
GRY – Gray or partially  
RED – Red or Auburn  
SDY – Sandy
12. Indicate, if possible, the city and state where the subject was born. The state should be indicated by the two-digit abbreviation.
13. Indicate the date of the fingerprinting.
14. Signature of Official taking fingerprints.
15. Write the Social Security number in this space. The Social Security number is a very important identifier.