

## REQUIREMENTS FOR APPLICATION FOR ANESTHESIOLOGIST ASSISTANT LICENSE

North Carolina Medical Board  
PO Box 20007  
Raleigh, NC 27619  
1203 Front Street, Raleigh, NC 27609 (use this address for express/overnight deliveries)  
(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. The form will need to be signed and 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 I555)
    - Employment Authorization Document (form I-688 or I-766)
    - Certificate 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. Three current reference forms. These forms must be sent from the reference sources directly to the North Carolina Medical Board.

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").

At least one form must be from an anesthesiologist with whom you have worked or trained regarding your competence to practice as an AA.

Recommendations must not be from a relative.

6. You must secure a report from each state, Canadian province or US territory regarding status of licensure. **All licenses, active and/or inactive, must be verified.** Most licensing agencies charge a fee for this service. The verifications should be sent directly to the NC Medical Board. The NCMB accept license verification through the veridoc service.

- If you have ever been licensed in Connecticut, you must send the consent for release of confidential disciplinary records form, along with the NC licensure verification form to the Connecticut Department of Public Health. If you have never been licensed in Connecticut, disregard the form.

7. 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)). Verifications can be emailed to [license@ncmedboard.org](mailto:license@ncmedboard.org).

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 can be emailed to [license@ncmedboard.org](mailto:license@ncmedboard.org)
- Applicants 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. The Authority to Release form can be emailed to [license@ncmedboard.org](mailto:license@ncmedboard.org). Fingerprint cards cannot be accepted via email.

9. Fee of \$190.00 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; \$2.00 for the NPDB report). Applications will not be processed until the fees have been received. Fees received are non-refundable.

RENEWAL – NC law requires 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. This also includes requests to meet with or appear before a professional licensing board or agency, formally or informally.

**Registration** includes, but is not limited to, a number, alphanumeric, or other unique identifier assigned to a health care provider allowing them to perform specific medical acts (such as the DEA registration number issued by the U.S. Drug Enforcement Administration allowing health care providers to issue prescriptions for controlled substances).

**Inquiry** includes, but is not limited to, a request for information related to a concern 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 (NCMB actions do not need to be included)
  - 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**: YES NO
- Withdrawn a license or registration application
  - Been denied a license or registration
  - Surrendered a license or registration
  - Had a license or registration restricted or limited in any way
  - Placed a license or registration on inactive status while under investigation

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3. 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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4. 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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5. 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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6. Important: The Board recognizes that licensees encounter health conditions, including those involving mental health and substance use disorders, just as their patients and other health care providers do. The Board expects its licensees to address their health concerns and ensure patients safety. Options include seeking medical care, self-limiting the licensee's medical practice, and anonymously self-referring to the North Carolina Physicians Health Program ([www.ncphp.org](http://www.ncphp.org)), a physician advocacy organization dedicated to improving the health and wellness of medical professionals in a confidential manner. YES NO

**The Failure to adequately address a health condition, where the licensee is unable to practice medicine with reasonable skill and safety to patients, can result in the board taking action against the license to practice medicine.**

I have read and understood the above advisory and acknowledge same by answering "Yes."

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7. Have you ever had a professional liability insurance policy cancelled, denied, or not renewed? YES NO

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

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9. Check the box to the right indicating you have read and understand the public notice statement below.

10. In the past five (5) years, have you been investigated for employee misclassifications as defined in the public notice statement below? If yes, please list the result of each occurrence.

YES NO

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**PUBLIC NOTICE STATEMENT**

*Required by N.C. Gen. Stat. § 143-764(a)(5), effective December 31, 2017*

Any worker who is defined as an employee by N.C. Gen. Stat. §§ 95-25.2(4)(NC Department Of Labor), 143-762(a)(3)(Employee Fair Classification Act), 96-1(b)(10)(Employment Security Act), 97-2(2)(Workers' Compensation Act), or 105-163.1(4)(Withholding; Estimated Income Tax for Individuals) shall be treated as an employee unless the individual is an independent contractor. Any employee who believes that the employee has been misclassified as an independent contractor by the employee's employer may report the suspected misclassification to the Employee Classification Section within the North Carolina Industrial Commission.

**Employee Classification Section**  
**North Carolina Industrial Commission**  
**1233 Mail Service Center**  
**Raleigh, NC 27699-1233**  
**Telephone: (919) 807-2582/Fax: (919)715-0282**  
**Email: [emp.classification@ic.nc.gov](mailto:emp.classification@ic.nc.gov)**

Employee misclassification is **defined** as avoiding tax liabilities and other obligations imposed by Chapter 95, 96, 97, 105, or 143 of the North Carolina General Statutes by misclassifying an employee as an independent contractor. [N.C. Gen. Stat. § 143-762(5)]

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.

# PRIVILEGES

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 documents.

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)

Have you **ever** had an action taken against you by a health care institution, including employers or group practices? YES    NO  
 If so, list each occurrence.

**Definitions:**

Actions include:

- Warnings
- Censures
- Discipline
- Admissions monitored
- Privileges limited, suspended or revoked
- Remediation
- Probation
- Suspension or termination of employment
- Withdrawal or resignation under threat of investigation or disciplinary action
- Denial of staff membership or credential

Health care institutions include:

- Hospitals
- Health maintenance or preferred provider organizations
- Any facility in which you trained
- Any group practice
- Any other organization that issue credentials to physicians

**Example:**

|                |   |              |  |                         |
|----------------|---|--------------|--|-------------------------|
| 2/12/2005      | Wake Med, Cary, NC  | Suspension   | Yes  | Disruptive behavior     |
| Date of Action | Name of Health Care Institution That Took Action and Location | Action Taken | Was Action a Final Suspension or Revocation? | Reason for Action Taken |

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# REGULATORY 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? (NCMB actions do not need to be included)      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 entities include, but are not limited to:

- Any professional licensing board and agency
- 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
- 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     |
| 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  
Do not double side document**

**\*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.

I will not be asked any initial questions regarding my criminal background. Instead, a criminal background check will be conducted on me as part of my licensing application process. I agree that, in the event I am charged with, arrested for, or convicted of any crime during the pendency of my licensing application, I shall immediately notify the NCMB in writing of all such charges, arrests and convictions.

\_\_\_\_\_  
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**

**NORTH CAROLINA MEDICAL BOARD**

**CLAIMS INFORMATION FORM**

**Please attach a PHOTOCOPY of the PLAINTIFF'S COMPLAINT AND 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, a brief history, comments regarding the examination and care surrounding the allegations. If suits 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 detail must be provided. Use additional pages if necessary.

Patient's Name: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

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

\_\_\_\_\_

\_\_\_\_\_

4. Is the claim pending?                      Yes              No

5. Was there a judgment or settlement?      Yes              No

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

7. Comments: \_\_\_\_\_

\_\_\_\_\_

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

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

Date: \_\_\_\_\_

Printed Name: ----- Social Security Number: \_\_\_\_\_

**NC MEDICAL BOARD  
IMMIGRATION STATUSFORM**

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 (1-197)

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 1-551)
  2. Employment Authorization Document (Form I-688B or Form 1-766)
  3. Certification of Report of Birth (DS-1350)
  4. Arrival-Departure Record (Form 1-94)
  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):

\_\_\_\_\_

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.

Table with 5 columns: Reason, From Month/Year, To Month/Year, Approved, Unapproved. Rows include Personal/Family, Academic remediation, Health, Financial, Participation in joint degree program, Participation in non-research special study, Participation in non-degree research, and 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 ( )

Table with 3 columns: Reason, From Month/Year, To Month/Year. Rows include Academic Probation, Probation for unprofessional conduct/behavior, and 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 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 medicine?   | 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 medical practice 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 anesthesiology assistant?  | Yes | No | N/A |
| 9. Do you know of any restrictions, limitations or other disciplinary actions of any nature taken against this anesthesiology assistant 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 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 medicine?   | 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 medical practice 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 anesthesiology assistant?  | Yes | No | N/A |
| 9. Do you know of any restrictions, limitations or other disciplinary actions of any nature taken against this anesthesiology assistant 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 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 medicine?   | 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 medical practice 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 anesthesiology assistant?  | Yes | No | N/A |
| 9. Do you know of any restrictions, limitations or other disciplinary actions of any nature taken against this anesthesiology assistant 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

## 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: \_\_\_\_\_

\_\_\_\_\_

\*\*\*\*\*

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

Respond to the following questions:

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



**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 SOY - 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  
SOY-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                      important identifier.