

**NEVADA STATE BOARD OF MEDICAL EXAMINERS  
ANESTHESIOLOGIST ASSISTANT LICENSURE FOR APPLICANTS THAT WISH TO HOLD A  
SIMULTANEOUS LICENSE TO PRACTICE AS AN ANESTHESIOLOGIST ASSISTANT**

**Specific eligibility requirements are as follows:**

A person applying for a license to practice as an Anesthesiologist Assistant pursuant to the provisions of this chapter who wishes to hold a simultaneous license to practice as an Anesthesiologist Assistant pursuant to the provisions of chapter 630 of NRS must:

1. Indicate in the application that he or she wishes to hold a simultaneous license to practice as an Anesthesiologist Assistant pursuant to the provisions of chapter 630 of NRS;
  2. Apply for a license to practice as an Anesthesiologist Assistant to:
    - (a) The Board pursuant to this chapter; and
    - (b) The Board of Medical Examiners pursuant to chapter 630 of NRS; and
  3. Pay all applicable fees, including, without limitation:
    - (a) The application and initial simultaneous license fee for an Anesthesiologist Assistant; and
    - (b) The fee for application for and issuance of a simultaneous license as an Anesthesiologist Assistant.
1. Apply for a license to practice as an Anesthesiologist Assistant to the Board of Medical Examiners pursuant to chapter 630 of NRS; and
  2. Pay all applicable fees, including, without limitation:
    - (a) The annual simultaneous registration fee for an Anesthesiologist Assistant; and
    - (b) The fee for application for and issuance of a simultaneous license as an Anesthesiologist Assistant.

Applications which appear to have been altered in any form will not be accepted. Applications must be typed or legibly handwritten in ink (illegible or incomplete applications will be returned). Applications must be received on **single-sided**, white bond paper, 8 ½” x 11” in size. Your application is a public document.

Applications not completed within six (6) months from date of receipt will be rejected per NAC 630.180(2).

**Fees applicable if licensed between July 1, 2023 – June 30, 2024:**

<b>Application Fee</b>	<b>Registration Fee</b>	<b>Criminal Background Investigation Fee</b>	=	
\$200	\$400	\$75		\$675

**Fees applicable if licensed between July 1, 2024 – June 30, 2025:**

<b>Application Fee</b>	<b>Registration Fee</b>	<b>Criminal Background Investigation Fee</b>	=	
\$200	\$200	\$75		\$475

**The Application fee and Criminal Background Investigation fee will not be refunded.** You may pay by cashier's check or money order, payable to "NEVADA STATE BOARD OF MEDICAL EXAMINERS," or by credit card. If paying by credit card, please complete the Credit Card Authorization form on the last page of this application. A two-point five percent (2.5%) service fee will be assessed for payment by credit card.

The Board's staff conducts an investigation into your background during the application process. If staff becomes aware of circumstances\*\* warranting a personal appearance at a Board meeting prior to acceptance of your application for licensure, your application must be completed 45 days prior to any regularly scheduled Board meeting in order for your appearance to be scheduled for that meeting for consideration of acceptance of your application. Under Nevada law, a public body cannot hold a meeting to consider the character, alleged misconduct, professional competence, or physical or mental health of any person unless it has given written notice to that person of the time and place of the meeting. The written notice must be sent by certified mail to the last known address of that person at least 21 working days before the meeting. A public body must receive proof of service of the notice before such a meeting may be held.

- \*\* You may be required to personally appear before the Board for acceptance of your application for licensure if you have in any way ever been involved in any malpractice awards, judgments, or settlements in any amount.
- \*\* You may be required to personally appear before the Board for acceptance of your application for licensure if you have answered in the affirmative ("Yes") to questions 8, 9, 10, 11, 12, 12a, 13, 20, 21, 22, 23, 24, 25 and/or 26.

If, at the time you meet with the Board, the Board votes to deny or not accept your application for licensure, this denial or non-acceptance of your application may become a reportable action to the National Practitioner Data Bank and Federation of State Medical Boards of the United States, Inc., and the National Commission for Certification of Anesthesiologist Assistants, among other entities.

**THE FOLLOWING CONSTITUTE GROUNDS FOR DENIAL OF LICENSURE, AS SET OUT IN NRS 630.301 THROUGH NRS 630.3065:**

**NRS 630.301 Criminal offenses; disciplinary action taken by other jurisdiction; surrender of previous license while under investigation; malpractice; engaging in sexual activity with patient; disruptive behavior; violating or exploiting trust of patient for financial or personal gain; failure to offer appropriate care with intent to positively influence financial well-being; engaging in disreputable conduct; engaging in sexual contact with surrogate of patient or relatives of patient.** The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Conviction of a felony relating to the practice of medicine or the ability to practice medicine. A plea of nolo contendere is a conviction for the purposes of this subsection.
2. Conviction of violating any of the provisions of NRS 616D.200, 616D.220, 616D.240, 616D.300, 616D.310, or 616D.350 to 616D.440, inclusive.
3. Any disciplinary action, including, without limitation, the revocation, suspension, modification or limitation of a license to practice any type of medicine, taken by another state, the Federal Government, a foreign country or any other jurisdiction or the surrender of the license or discontinuing the practice of medicine while under investigation by any licensing authority, a medical facility, a branch of the Armed Services of the United States, an insurance company, an agency of the Federal Government or an employer.
4. Malpractice, which may be evidenced by claims settled against a practitioner, but only if the malpractice is established by a preponderance of the evidence.
5. The engaging by a practitioner in any sexual activity with a patient who is currently being treated by the practitioner.
6. Disruptive behavior with physicians, hospital personnel, patients, members of the families of patients or any other persons if the behavior interferes with patient care or has an adverse impact on the quality of care rendered to a patient.
7. The engaging in conduct that violates the trust of a patient and exploits the relationship between the physician and the patient for financial or other personal gain.
8. The failure to offer appropriate procedures or studies, to protest inappropriate denials by organizations for managed care, to provide necessary services or to refer a patient to an appropriate provider, when the failure occurs with the intent of positively influencing the financial well-being of the practitioner or an insurer.
9. The engaging in conduct that brings the medical profession into disrepute, including, without limitation, conduct that violates any provision of a code of ethics adopted by the Board by regulation based on a national code of ethics.
10. The engaging in sexual contact with the surrogate of a patient or other key persons related to a patient, including, without limitation, a spouse, parent or legal guardian, which exploits the relationship between the physician and the patient in a sexual manner.
11. Conviction of:
  - (a) Murder, voluntary manslaughter or mayhem;
  - (b) Any felony involving the use of a firearm or other deadly weapon;
  - (c) Assault with intent to kill or to commit sexual assault or mayhem;
  - (d) Sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime;
  - (e) Abuse or neglect of a child or contributory delinquency;
  - (f) A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS; or
  - (g) Any offense involving moral turpitude.(Added to NRS by 1977, 824; A 1981, 590; 1983, 305; 1985, 2236; 1987, 197; 1991, 1070; 1993, 782; 1997, 684; 2001, 766; 2003, 2707, 3433; 2003, 20th Special Session, 264, 265; 2005, 2522; 2007, 3045; 2011, 847)

**NRS 630.304 Misrepresentation in obtaining or renewing license; false advertising; practicing under another name; signing blank prescription forms; influencing patient to engage in sexual activity; discouraging second opinion; terminating care without adequate notice.** The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Obtaining, maintaining or renewing or attempting to obtain, maintain or renew a license to practice medicine by bribery, fraud or misrepresentation or by any false, misleading, inaccurate or incomplete statement.
  2. Advertising the practice of medicine in a false, deceptive or misleading manner.
  3. Practicing or attempting to practice medicine under another name.
  4. Signing a blank prescription form.
  5. Influencing a patient in order to engage in sexual activity with the patient or with others.
  6. Attempting directly or indirectly, by way of intimidation, coercion or deception, to obtain or retain a patient or to discourage the use of a second opinion.
  7. Terminating the medical care of a patient without adequate notice or without making other arrangements for the continued care of the patient.
- (Added to NRS by 1983, 301; A 1985, 2236; 1987, 198)

**NRS 630.305 Accepting compensation to influence evaluation or treatment; inappropriate division of fees; inappropriate referral to health facility, laboratory or commercial establishment; charging for services not rendered; aiding practice by unlicensed person; delegating responsibility to unqualified person; failing to disclose conflict of interest; failing to initiate performance of community service; exception.**

1. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:
    - (a) Directly or indirectly receiving from any person, corporation or other business organization any fee, commission, rebate or other form of compensation which is intended or tends to influence the physician's objective evaluation or treatment of a patient.
    - (b) Dividing a fee between licensees except where the patient is informed of the division of fees and the division of fees is made in proportion to the services personally performed and the responsibility assumed by each licensee.
    - (c) Referring, in violation of NRS 439B.425, a patient to a health facility, medical laboratory or commercial establishment in which the licensee has a financial interest.
    - (d) Charging for visits to the physician's office which did not occur or for services which were not rendered or documented in the records of the patient.
    - (e) Aiding, assisting, employing or advising, directly or indirectly, any unlicensed person to engage in the practice of medicine contrary to the provisions of this chapter or the regulations of the Board.
    - (f) Delegating responsibility for the care of a patient to a person if the licensee knows, or has reason to know, that the person is not qualified to undertake that responsibility.
    - (g) Failing to disclose to a patient any financial or other conflict of interest.
    - (h) Failing to initiate the performance of community service within 1 year after the date the community service is required to begin, if the community service was imposed as a requirement of the licensee's receiving loans or scholarships from the Federal Government or a state or local government for the licensee's medical education.
  2. Nothing in this section prohibits a physician from forming an association or other business relationship with an optometrist pursuant to the provisions of NRS 636.373.
- (Added to NRS by 1983, 301; A 1985, 2237; 1987, 198; 1989, 1114; 1991, 2437; 1993, 2302, 2596; 1995, 714, 2562)

**THE FOLLOWING CONSTITUTE GROUNDS FOR DENIAL OF LICENSURE, AS SET OUT IN NRS 630.301 THROUGH NRS 630.3065 (cont.):**

**NRS 630.306 Inability to practice medicine; deceptive conduct; violation of regulation governing practice of medicine or adopted by State Board of Pharmacy; unlawful distribution of controlled substance; injection of silicone; practice beyond scope of license; practicing experimental medicine without consent of patient or patient's family; lack of skill or diligence; habitual intoxication or dependency on controlled substances; filing of false report; failure to report certain changes of information or disciplinary or criminal action in another jurisdiction; failure to be found competent after examination; certain operation of a medical facility; prohibited administration of anesthesia or sedation; engaging in unsafe or unprofessional conduct; knowingly or willfully procuring or administering certain controlled substances or dangerous drugs; failure to supervise medical assistant adequately; allowing person not enrolled in accredited medical school to perform certain activities; failure to obtain required training regarding controlled substances.**

1. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:
  - (a) Inability to practice medicine with reasonable skill and safety because of illness, a mental or physical condition or the use of alcohol, drugs, narcotics or any other substance.
  - (b) Engaging in any conduct:
    - (1) Which is intended to deceive;
    - (2) Which the Board has determined is a violation of the standards of practice established by regulation of the Board; or
    - (3) Which is in violation of a regulation adopted by the State Board of Pharmacy.
  - (c) Administering, dispensing or prescribing any controlled substance, or any dangerous drug as defined in chapter 454 of NRS, to or for himself or herself or to others except as authorized by law.
  - (d) Performing, assisting or advising the injection of any substance containing liquid silicone into the human body, except for the use of silicone oil to repair a retinal detachment.
  - (e) Practicing or offering to practice beyond the scope permitted by law or performing services which the licensee knows or has reason to know that he or she is not competent to perform or which are beyond the scope of his or her training.
  - (f) Performing, without first obtaining the informed consent of the patient or the patient's family, any procedure or prescribing any therapy which by the current standards of the practice of medicine is experimental.
  - (g) Continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field.
  - (h) Habitual intoxication from alcohol or dependency on controlled substances.
  - (i) Making or filing a report which the licensee or applicant knows to be false or failing to file a record or report as required by law or regulation.
  - (j) Failing to comply with the requirements of NRS 630.254.
  - (k) Failure by a licensee or applicant to report in writing, within 30 days, any disciplinary action taken against the licensee or applicant by another state, the Federal Government or a foreign country, including, without limitation, the revocation, suspension or surrender of a license to practice medicine in another jurisdiction.
  - (l) Failure by a licensee or applicant to report in writing, within 30 days, any criminal action taken or conviction obtained against the licensee or applicant, other than a minor traffic violation, in this State or any other state or by the Federal Government, a branch of the Armed Forces of the United States or any local or federal jurisdiction of a foreign country.
  - (m) Failure to be found competent to practice medicine as a result of an examination to determine medical competency pursuant to NRS 630.318.
  - (n) Operation of a medical facility at any time during which:
    - (1) The license of the facility is suspended or revoked; or
    - (2) An act or omission occurs which results in the suspension or revocation of the license pursuant to NRS 449.160.
- ➔ This paragraph applies to an owner or other principal responsible for the operation of the facility.
  - (o) Failure to comply with the requirements of NRS 630.373.
  - (p) Engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board.
  - (q) Knowingly or willfully procuring or administering a controlled substance or a dangerous drug as defined in chapter 454 of NRS that is not approved by the United States Food and Drug Administration, unless the unapproved controlled substance or dangerous drug:
    - (1) Was procured through a retail pharmacy licensed pursuant to chapter 639 of NRS;
    - (2) Was procured through a Canadian pharmacy which is licensed pursuant to chapter 639 of NRS and which has been recommended by the State Board of Pharmacy pursuant to subsection 4 of NRS 639.2328;
    - (3) Is marijuana being used for medical purposes in accordance with chapter 453A of NRS; or
    - (4) Is an investigational drug or biological product prescribed to a patient pursuant to NRS 630.3735 or 633.6945.
  - (r) Failure to supervise adequately a medical assistant pursuant to the regulations of the Board.
  - (s) Failure to comply with the provisions of NRS 630.3745.
  - (t) Failure to obtain any training required by the Board pursuant to NRS 630.2535.
2. As used in this section, "investigational drug or biological product" has the meaning ascribed to it in NRS 454.351.  
(Added to NRS by 1983, 302; A 1985, 2238; 1987, 199, 800, 1554, 1575; 2007, 3046; 2009, 533, 879, 2961, 2962; 2011, 257, 2612; 2015, 116, 492, 985, 1536)

**NRS 630.3062 Failure to maintain proper medical records; altering medical records; making false report; failure to file or obstructing required report; failure to allow inspection and copying of medical records; failure to report other person in violation of chapter or regulations; failure to comply with certain requirements relating to controlled substances.** The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient.
2. Altering medical records of a patient.
3. Making or filing a report which the licensee knows to be false, failing to file a record or report as required by law or knowingly or willfully obstructing or inducing another to obstruct such filing.
4. Failure to make the medical records of a patient available for inspection and copying as provided in NRS 629.061.
5. Failure to comply with the requirements of NRS 630.3068.
6. Failure to report any person the licensee knows, or has reason to know, is in violation of the provisions of this chapter or the regulations of the Board within 30 days after the date the licensee knows or has reason to know of the violation.
7. Failure to comply with the requirements of NRS 453.163 or 453.164.  
(Added to NRS by 1985, 2223; A 1987, 199; 2001, 767; 2002 Special Session, 19; 2003, 3433; 2009, 2963; 2015, 493, 1170)

**NRS 630.3065 Knowing or willful disclosure of privileged communication; knowing or willful failure to comply with law, subpoena or order; knowing or willful failure to perform legal obligation.** The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Knowingly or willfully disclosing a communication privileged pursuant to a statute or court order.
2. Knowingly or willfully failing to comply with:
  - (a) A regulation, subpoena or order of the Board or a committee designated by the Board to investigate a complaint against a physician;
  - (b) A court order relating to this chapter; or
  - (c) A provision of this chapter.
3. Knowingly or willfully failing to perform a statutory or other legal obligation imposed upon a licensed physician, including a violation of the provisions of NRS 439B.410.  
(Added to NRS by 1983, 302; A 1985, 2238; 1987, 200; 1989, 1663; 1993, 2302; 2015, 494)

## Anesthesiologist Assistant – Application Checklist

_____	a.	<p><b>APPLICATION:</b></p> <ul style="list-style-type: none"> <li>• Properly completed, signed and notarized application, including Applicant Responsibility statement;</li> <li>• Recent passport quality photograph (at least 2”x 2”), attached to application;</li> <li>• Appropriate explanations and copies of all pertinent documentation must be attached for affirmative responses to questions numbered 8, 9, 10, 11, 12, 12a, 13, 20, 21, 22, 23, 24, and 25;</li> <li>• Release form - signed and notarized (Form A);</li> </ul>
_____	b.	<p><b>FEES:</b></p> <ul style="list-style-type: none"> <li>• Proper application, registration, AND criminal background investigation fees – cashier’s check or money order made payable to Nevada State Board of Medical Examiners (NSBME) or by credit card as instructed. Credit cards will only be accepted by receipt of the signed credit card authorization form or online via the Applicant Portal. Note: Application and criminal background investigation fees are <u>non</u>-refundable;</li> </ul>
_____	c.	<p><b>IDENTITY:</b></p> <ul style="list-style-type: none"> <li>• <b>U.S. born citizens</b> – Photocopy of U.S. Birth Certificate or current (unexpired) U.S. passport <u>with notarized</u> Certificate of Identification</li> <li>• Proof of affiliation with the Armed Forces of the United States (DD214, Orders, Military ID., etc.) <i>if applicable</i>;</li> <li>• <b>Foreign-born citizens</b> – Photocopy of current (unexpired) U.S. passport or Certificate of Naturalization <u>with notarized</u> Certificate of Identification</li> <li>• <b>Non U.S. citizens</b> – Copy of both sides of Alien Registration card, Employment Authorization card, or Visa <u>and</u> copy of foreign passport;</li> </ul>
_____	d.	<p><b>SELF-QUERY VERIFICATION:</b></p> <ul style="list-style-type: none"> <li>• Self-query response from the National Practitioner Data Bank (NPDB); The NPDB will send the report directly to you and you will forward <u>the final report</u> to the Board office;</li> </ul> <p>The request form for the National Practitioner Data Bank (NPDB) is available at <a href="http://www.npdb.hrsa.gov">http://www.npdb.hrsa.gov</a>. Click on ‘Self-Query’ for Healthcare Professionals on the right side of the page and follow the instructions provided. If you require additional information, please call the NPDB at (800) 767-6732. Once you have received the <u>final report</u> or self-query response from the NPDB, forward a copy of this report to the Board office.</p>
_____	e.	<p><b>SUPPLEMENTARY FORM:</b></p> <p>FORM B: ONLY if you have answered affirmatively to either of the two malpractice questions on the application. List all carriers held within the past 10 years. Also include;</p> <ul style="list-style-type: none"> <li>○ Copy of the legal Complaint</li> <li>○ Copy of the Settlement and/or filed Dismissal</li> </ul>
_____	f.	<p><b>EDUCATION:</b></p> <ul style="list-style-type: none"> <li>• Copy of transcripts or diplomas for degrees other than Anesthesiologist Assistant degree – an Associates, Bachelors or Masters Degree that you would like added to your educational profile on the Board’s website;</li> </ul>
_____	g.	<p><b>CONTINUING EDUCATION:</b></p> <ul style="list-style-type: none"> <li>• Proof of 4 hours bioterrorism <u>AMA Cat 1 or AAPA Cat 1</u> continuing medical education (CME) relating to the medical consequences of an act of terrorism that involves the use of a weapon of mass destruction. Search for an online course “AMA Category 1 bioterrorism continuing medical education” or take a classroom course;</li> <li>• Proof of 2 hours <u>AMA Cat 1 or AAPA Cat 1</u> continuing medical education (CME) in clinically based suicide prevention and awareness;</li> <li>• Proof of 2 hours <u>AMA Cat 1 or AAPA Cat 1</u> continuing medical education (CME) in Screening, Brief Intervention &amp; Referral to Treatment (SBIRT);</li> </ul>
_____	h.	<p><b>FINGERPRINTING:</b></p> <p>Once the application and criminal background investigation fee have been received, a sample fingerprint card and instructions will be emailed to you. The sample fingerprint card you receive from the Board contains the necessary account numbers required for processing. The completed card <u>must</u> be returned to the Board as well as the signed Civil Applicant Waiver prior to licensure. <b>Note:</b> Receipt of the Criminal history background results will not delay licensure</p>

# ANESTHESIOLOGIST ASSISTANT APPLICATION CHECKLIST

## **DIRECT SOURCE VERIFICATIONS** **TO BE SOLICITED BY APPLICANT FOR DIRECT RETURN** **BY THE VERIFYING INSTITUTION TO BOARD OFFICE**

*Verifying agencies may charge a fee. Do not provide pre-stamped or pre-addressed envelopes for direct source verifications.*

_____	a.	ANESTHESIOLOGIST ASSISTANT SCHOOL: <ul style="list-style-type: none"><li><input type="checkbox"/> Verification of completion of Anesthesiologist Assistant Education (Form 1) to be completed by your Anesthesiologist Assistant program;</li><li><input type="checkbox"/> Official transcripts from Anesthesiologist Assistant program;</li></ul>
_____	b.	EXAMINATION: <ul style="list-style-type: none"><li>• Current certification by the National Commission for Certification of Anesthesiologist Assistants (Form 2);</li></ul>
_____	d.	MALPRACTICE INSURANCE CARRIER VERIFICATIONS: <ul style="list-style-type: none"><li>• Malpractice insurance carrier verification (Form 4) to be completed by appropriate entity and returned directly by the verifying institution to the Board office and must include the loss history report for any and all malpractice cases that occurred within the past 10 years with a liability, settlement or claim paid on your behalf (see Disclaimer below).</li></ul>

**Disclaimer: Per Nevada Revised Statute 630.173(2), the Board has the right to consider information for any malpractice history or derogatory hospital privilege history that is more than 10 years old.**

# APPLICATION GUIDE

**Identity** - Licenses will be issued in the applicant's name as it is indicated on the submitted documented proof of such name i.e. U.S. Birth Certificate, Certificate of Naturalization, Alien Registration card, Employment Authorization card, and/or other legal documentation reflecting name change.

**Malpractice** - If you have ever been named in a legal action involving professional liability (malpractice), whether or not you have ever had a professional liability, settlement, claim paid on your behalf, or paid such a claim yourself, provide signed and dated explanations for all malpractice cases throughout your career. Provide copies of legal documentation for malpractice cases that occurred within the past 10 years unless otherwise instructed, which includes copies of Complaints, Settlements and/or Dismissals. If you have a pending case or cases, request a letter from your attorney to be sent directly to the Board describing the current status of the case(s). In summary:

- Provide descriptive explanations for any and all malpractice cases (who, what, where, when and why);
- Complete Form B listing all malpractice insurance carriers;
- Provide copies of legal documentation for cases that occurred within the past 10 years:
  - Complaint
  - Settlement
  - and/or Dismissal.
- Request malpractice carrier verifications (Form 4) from all malpractice insurance carriers within the past 10 years if you have been named in a malpractice case where there was a liability, settlement or claim paid on your behalf;
- For any pending case(s), request a status letter to be sent directly to the Board from your attorney.

**Investigation** - If you have ever been notified that you were under investigation by any medical licensing board, hospital, medical society, governmental entity or other agency, whether or not you were charged with or convicted of any violations of a statute, rule or regulation governing your practice as an anesthesiologist assistant, you should answer affirmatively to question #24 and submit the appropriate documentation. Provide signed and dated explanations and copies of any related documentation you received regarding any investigation unless otherwise instructed.

**Arrest** - If you have ever been arrested, read question #13 carefully. You will be expected to provide a signed and dated explanation addressed to the Nevada State Board of Medical Examiners for any arrest(s) no matter how long ago it may have occurred, whether it was expunged or not. You may be asked to provide a copy of the arrest report, proof of completion of probation and/or time served, community service, fines paid and any other documentation applicable to the incident(s).

**Release for Communication with a Person other than the Applicant:** If you wish to authorize the Board to communicate about the status of your application for licensure with someone other than yourself, provide a brief signed written release of authorization indicating the specific name of the person thus providing the Board with authority to tender information related to your application status.

**Disclaimer:** Per Nevada Revised Statute 630.173(2), the Board has the right to consider information that is more than 10 years old regarding malpractice, investigations by another licensing board, complaints or disciplinary actions from a hospital, clinic or medical facility if the Board receives the information from the applicant or any other source from which the Board is verifying the information provided by the applicant.

**ATTENTION APPLICANT!**  
**RESPONSIBILITY STATEMENT**

**Please sign and return this statement with your application for licensure to:  
The Nevada State Board of Medical Examiners  
9600 Gateway Drive  
Reno, NV 89521**

Because you are applying for the privilege of assisting in the practice of medicine in Nevada, you should know that our state has some of the most stringent licensing requirements and comprehensive investigation programs in the United States.

Via FBI fingerprinting and other investigative modalities, our licensing specialists are likely to discover if data you have submitted on your application is erroneous or incomplete; therefore, you must answer all questions truthfully and completely. Specifically, this includes any sanctions or disciplinary actions you may have experienced during your training, or any involvement you may have had with the legal system, either civil or criminal — criminal to include charges that may have ultimately been expunged, lessened, or dismissed, and no matter how long ago the event(s) occurred.

Explaining and documenting a problem to your licensing specialist will be much less painful than discussing your veracity before the entire Board of Medical Examiners due to inconsistencies between your application and incongruent input from outside sources.

**ONLY YOU — NOT A LAWYER, DOCTOR, SPOUSE, OR CREDENTIALING COMPANY — ARE RESPONSIBLE FOR READING AND ANSWERING EVERY QUESTION ACCURATELY AND COMPLETELY.**

If you have *any* questions about your application, **ASK YOUR LICENSING SPECIALIST**. Our licensing specialists are here to help you.

○ ○ ○ ○ ○

I have read this responsibility statement and understand that I alone am accountable for completing my application for anesthesiologist assistant licensure in Nevada.

*Print your name* \_\_\_\_\_

*Sign your name* \_\_\_\_\_

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

Note: It is your responsibility to keep the Board informed of any circumstance or event that would require a change to your initial responses provided to the Board in your application for licensure, and which occurs prior to you being granted licensure to assist in the practice of medicine in the State of Nevada.



# Nevada Department of **Public Safety**

As an applicant who is subject pursuant to NRS 630.167, and who is the subject of a national fingerprint-based criminal history record check for a noncriminal justice purpose (such as an application for employment or a license, an immigration or naturalization matter, security clearance, or adoption), you have certain rights which are discussed below. All notices must be provided to you in writing. These obligations are pursuant to the Privacy Act of 1974, Title 5, United States Code (U.S.C.) Section 552a, and Title 28 Code of Federal Regulations (CFR), 50.12, among other authorities.

1. You must be notified by Nevada State Board of Medical Examiners that your fingerprints will be used to check the criminal history records of the FBI and the State of Nevada.
2. Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.
3. Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.
4. Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.
5. If you have a criminal history record, you should be afforded a reasonable amount of time to correct or complete the record (or decline to do so) before the officials deny you the employment, license, or other benefit based on information in the FBI criminal history record. The procedures for obtaining a change, correction, or update of your FBI criminal history record as set forth at, 28 CFR 16.34 provides for the proper procedure to do so.
6. If agency policy permits, the officials may provide you with a copy of your FBI criminal history record for review and possible challenge. If agency policy does not permit it to provide you a copy of the record, you may obtain a copy of the record by submitting fingerprints and a fee to the FBI. Information regarding this process may be obtained at <https://www.fbi.gov/services/cjis/identity-history-summary-checks> and <https://www.edo.cjis.gov>.

Applicant's Initials: \_\_\_\_\_ Date: \_\_\_\_\_



**ANESTHESIOLOGIST ASSISTANT  
APPLICATION FOR SIMULTANEOUS LICENSURE  
NEVADA STATE BOARD OF  
MEDICAL EXAMINERS**

9600 Gateway Drive, Reno, NV 89521  
Phone (775) 688-2559

Date Received by Board

License No. \_\_\_\_\_

File No: \_\_\_\_\_

For Board Use Only

**Identity:**

1. Present Legal Name \_\_\_\_\_  
Last First Middle Maiden

List any other name ever used \_\_\_\_\_

1(a)  Please check if you wish to hold simultaneous licensure to assist in the practice of medicine as an Anesthesiologist Assistant pursuant to the provisions of chapter 630 of the Nevada Revised Statutes.

**Address:**

The **Public Access Address** will be available to the public on the Board's website, and will also be your contact address once licensed. It can be changed if the Licensee completes the Notification of Address Change form available on the Board's website: [www.medboard.nv.gov](http://www.medboard.nv.gov).

The **Mailing Address** that you choose will be used for communication during the application process. It can be one and the same.

2. Public Address \_\_\_\_\_  
Street City County State Zip

Please check if you choose to have your Mailing Address the same as the Public Address you have entered above.

3. Mailing Address \_\_\_\_\_  
Street City County State Zip

4. Telephone Numbers (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Office Fax Home Cellular (Optional)

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

5. Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_ Gender \_\_\_ F \_\_\_ M  
(Month / Day / Year) (City / State / Country)

6. Citizenship: U.S. Citizen \_\_\_\_\_ Alien Registration # \_\_\_\_\_ Employment Authorization # \_\_\_\_\_ Visa \_\_\_\_\_

7. Social Security Number \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Color of Eyes \_\_\_\_\_ Color of Hair \_\_\_\_\_

**Questions:**

**For the purposes of the following questions, these phrases or words have these meanings:**

**"Ability to practice as an Anesthesiologist Assistant"** is to be construed to include all of the following:

1. The cognitive capacity to assist with the practice of medicine and exercise reasoned medical judgments and to learn and keep abreast of medical developments;

2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

3. The physical capability to assist with the practice of medicine, with or without the use of aids or devices, such as corrective lenses or hearing aids.

**"Medical condition"** includes physiological, mental or psychological condition or disorder.

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

**FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR SIGNED WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED APPLICATION FOR LICENSURE FORM.**

8. Do you currently have a medical condition which in any way impairs or limits your ability to practice as an anesthesiologist assistant with reasonable skill and safety? (If "Yes," attach explanation on separate sheet.) \_\_\_\_\_ Yes \_\_\_\_\_ No

9. If you currently have a medical condition which in any way impairs or limits your ability to practice as an anesthesiologist assistant, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, the manner in which you have chosen to practice, or by any other reasonable accommodation? (If "Yes," attach explanation on separate sheet.) \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ N/A

10. If you currently use chemical substances, does your use in any way impair or limit your ability to practice as an anesthesiologist assistant with reasonable skill and safety? (If "Yes," attach explanation on separate sheet.) \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ N/A

11. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? (If "Yes," attach explanation on separate sheet.) \_\_\_\_\_ Yes \_\_\_\_\_ No

**Malpractice Questions:**

12. Have you EVER been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, or malpractice, including any military tort claims if applicable? \_\_\_\_\_ Yes \_\_\_\_\_ No

12a. Have you EVER had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Malpractice Explanation(s):**

List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If you have not answered "yes" to questions #12 and/or #12a and do not have any such claims or suits, this section will be left blank. If you have more than 1 claim, make a copy or copies of this page and submit all explanations with your application for licensure.

Name of patient involved:

In which state did the action take place?

Case number (if applicable):

Which court?  
(If settled before initiation of civil action, state here.)

Current status of claim:  
 Open       Closed (settled or judgment)       Dismissed (no money paid out)       Other

Date claim was closed/settled or dismissed: \_\_\_\_\_  
Month/Year

Amount of judgment or settlement \$

Month and year of event precipitating claim:

Month and year of lawsuit or court filing:

Insurance carrier at time:

What is/was your status?       Primary defendant       Co-defendant       Other

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

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**Arrest Question:**

13. Have you EVER been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? \*Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement. \_\_\_\_\_ Yes \_\_\_\_\_ No  
(If "Yes," attach explanation on separate sheet.)

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**Nevada License History:**

14. Have you previously applied for anesthesiologist assistant licensure in Nevada? \_\_\_\_\_ Yes \_\_\_\_\_ No  
(If "Yes," attach explanation on separate sheet.)

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**Anesthesiologist Assistant Education:**

**All information must begin on the application, if more space is needed, please attach a separate sheet.**

15. List all postsecondary schools attended, type of degree received and dates of attendance. **Also list your Anesthesiologist Assistant school information.**

Name	City/State	Type of Degree Received	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)

16. Anesthesiologist Assistant Certificate / Degree granted by:

Anesthesiologist Assistant School	City / State	Exact Date of Issuance (Month/Day/Year)

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**Activities:**

17. Account for, in chronological order, all activities for the five (5) years preceding your application submission date. Activities include working as an Anesthesiologist Assistant and also non-medical activities (seeking employment, moving, job search, applying for a license, vacation etc.) **ALL PERIODS OF TIME MUST BE ACCOUNTED FOR.**

Activities	City / State (and Country if other than U.S.)	From (Mo./Yr.) To (Mo./Yr.)	Percent Clinical (%)

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**State licenses:**

18. List any and all licenses (including training licenses and permits) YOU HOLD OR HAVE HELD to practice as an Anesthesiologist Assistant in any state, territory or country:

State/Territory	License #	Date of Issuance (Mo./Yr.)	Status
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Examination:**

19. Are you currently certified by the National Commission for Certification of Anesthesiologist Assistants (NCCAA)? \_\_\_\_\_ Yes \_\_\_\_\_ No

If "Yes:" certification number \_\_\_\_\_ certification expires \_\_\_\_\_

If "No:" date scheduled to sit for the examination \_\_\_\_\_ \*

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**Disciplinary Questions:**

20. Have you ever been denied a license or certificate to practice as an Anesthesiologist Assistant, or in any other healing art, or permission to take an examination to practice as an Anesthesiologist Assistant or in any other healing art(s) in any state, country or U.S. territory? \_\_\_\_\_ Yes \_\_\_\_\_ No  
(If "Yes," attach explanation on separate sheet.)

21. Have you ever had an Anesthesiologist Assistant license or certificate, or license or certificate to practice in any other healing art, revoked, suspended, limited, or restricted in any state, country or U.S. territory? (If "Yes," attach explanation on separate sheet.) \_\_\_\_\_ Yes \_\_\_\_\_ No

22. Have you ever voluntarily surrendered a license or certificate to practice as an Anesthesiologist Assistant, or in any other healing art, in any state, country or U.S. territory? (If "Yes," attach explanation on separate sheet.) \_\_\_\_\_ Yes \_\_\_\_\_ No

23. Have you ever failed the NCCAA examination, or any state or other jurisdiction examination for certification as an Anesthesiologist Assistant? (If "Yes," attach explanation on separate sheet.) \_\_\_\_\_ Yes \_\_\_\_\_ No

24. Have you ever been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as an Anesthesiologist Assistant by any medical licensing board, hospital, medical society, governmental entity or other agency other than the Nevada State Board of Medical Examiners? \_\_\_\_\_ Yes \_\_\_\_\_ No  
(If "Yes," attach explanation on separate sheet.)

25. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance).

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.) To (Mo./Yr.)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(If more space is needed, please attach separate sheet .)

Attestations/Affirmations:

**CHILD SUPPORT STATEMENT**

The law of the state of Nevada requires that all applicants for issuance of a license be required to provide the following information concerning the support of a child. You are advised that this question is part of your application, your response is given under oath, and any response hereto which is false, fraudulent, misleading, inaccurate or incomplete, may result in your application being denied. You must mark one of the following responses, and failure to mark one of the responses may result in denial of your application.

**Please place a check mark next to one of the following statements:**

\_\_\_\_\_ (a) I am not subject to a court order for the support of a child;

\_\_\_\_\_ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

\_\_\_\_\_ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

**ATTESTATION REGARDING THE REPORTING OF THE ABUSE OR NEGLECT OF A CHILD**

I attest and affirm that I am aware of and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child. \_\_\_\_\_ Yes \_\_\_\_\_ No

[www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220](http://www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220)

**SAFE INJECTION PRACTICE ATTESTATION**

**ATTESTATION TO KNOWLEDGE OF AND COMPLIANCE WITH THE GUIDELINES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION FOR APPLICANT ANESTHESIOLOGIST ASSISTANTS**

I hereby attest to knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. I also attest that any person who is currently, or will be under my supervision in the future, and who is not licensed pursuant to Chapter 630 of the Nevada Revised Statutes and whose duties involve injection practices, has knowledge of and is in compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. \_\_\_\_\_ Yes \_\_\_\_\_ No

[http://www.cdc.gov/injectionsafety/IP07\\_standardPrecaution.html](http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html)

**COMMUNICATIONS AFFIRMATION**

**Consent to accept communications and service of process from the Nevada State Board of Medical Examiners (Board) by electronic mail, for Anesthesiologist Assistants who assist with the practice of medicine in the state of Nevada:**

I am willing to accept Board communications to me, to include service of process as defined under Nevada Revised Statute (NRS) 630.344, via electronic mail (more commonly known as e-mail). Further, should the electronic mail address provided below change for any reason, I agree to apprise the Board in writing of my new electronic mail address within 30 days after the change.

Printed Name of Applicant/Licensee: \_\_\_\_\_

Signature of Applicant/Licensee: \_\_\_\_\_

Electronic Mail Address: \_\_\_\_\_

# **MILITARY SERVICE ATTESTATION**

1-Have you ever served in the United States Military (to include National Guard or Reserves)? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If your answer is "No", you do not have to complete the remaining questions for the Military Service Attestation.

2-If yes, which branch of service did you serve?  Air Force  
 Army  
 Navy  
 Marine Corp  
 Coast Guard

3-Military occupation specialty or specialties?  Administration or Personnel  Logistics or Supply  
 Aviation  Maintenance  
 Civil Engineering  Medical Services  
 Communications  Security Forces or Military Police  
 Infantry or Armor  Other  
 Legal or Chaplin Corps

4&5-Dates of service in the Military: 4-From: \_\_\_\_/\_\_\_\_/\_\_\_\_ 5-To: \_\_\_\_/\_\_\_\_/\_\_\_\_  
DD MM YYYY DD MM YYYY

6-Are you still serving? \_\_\_\_\_ Yes \_\_\_\_\_ No

7-Have you ever served on active duty in the Armed Forces of the United States? \_\_\_\_\_ Yes \_\_\_\_\_ No

8-Have you ever been assigned to duty for a minimum of 6 continuous years in the National Guard or a reserve component of the Armed Forces of the United States? \_\_\_\_\_ Yes \_\_\_\_\_ No

9-Have you ever served the Commissioned Corps of the United States Public Health Service or the Commissioned Corps of the National Oceanic and Atmospheric Administration of the United States in the capacity of a commissioned officer while on active duty in defense of the United States? \_\_\_\_\_ Yes \_\_\_\_\_ No

10-If the answer to question(s) 7, 8 and/or 9 is "yes," did you separate from such service under conditions other than dishonorable? (Unless you were dishonorably discharged, your answer should be "Yes.") \_\_\_\_\_ Yes \_\_\_\_\_ No

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## **APPLICANT PHOTOGRAPH**

ATTACH A FINISHED PHOTOGRAPH OF PASSPORT QUALITY OF YOUR HEAD AND SHOULDERS ONLY.

PHOTOGRAPH MUST HAVE BEEN TAKEN WITHIN THE LAST SIX MONTHS AND BE AT LEAST 2" x 2" IN SIZE.

***CENTER AND ATTACH PHOTOGRAPH HERE.***

I hereby certify that the attached photograph is a true likeness of me taken within the last six months.

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





**RELEASE**

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Nevada State Board of Medical Examiners any information, files or records required by the Nevada State Board of Medical Examiners for its evaluation of my professional, ethical, physical, and mental qualifications for licensure in the state of Nevada.

DATED this \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_\_.

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

Typed or Printed Name: \_\_\_\_\_

(NOTARY SEAL)

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

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_\_.

Notary Public for the State of \_\_\_\_\_

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

Residing at: \_\_\_\_\_  
City State

\_\_\_\_\_  
Signature of Notary

A photocopy of this form will serve as an original (Board use only).

**Please return completed form to:**

Nevada State Board of Medical Examiners  
9600 Gateway Drive  
Reno, NV 89521

**LIST OF MALPRACTICE INSURANCE CARRIERS**

If you answered affirmatively to questions #12 and/or #12a on the Application for Licensure, list all malpractice carriers held **within the past 10 years.**

**Name of Insured:** \_\_\_\_\_

**Insurance Company:** \_\_\_\_\_  
**Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_  
**Fax Number:** \_\_\_\_\_  
**Policy Number:** \_\_\_\_\_  
**Dates:** \_\_\_\_\_

**Insurance Company:** \_\_\_\_\_  
**Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_  
**Fax Number:** \_\_\_\_\_  
**Policy Number:** \_\_\_\_\_  
**Dates:** \_\_\_\_\_

**Insurance Company:** \_\_\_\_\_  
**Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_  
**Fax Number:** \_\_\_\_\_  
**Policy Number:** \_\_\_\_\_  
**Dates:** \_\_\_\_\_

**Insurance Company:** \_\_\_\_\_  
**Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_  
**Fax Number:** \_\_\_\_\_  
**Policy Number:** \_\_\_\_\_  
**Dates:** \_\_\_\_\_

**Insurance Company:** \_\_\_\_\_  
**Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_  
**Fax Number:** \_\_\_\_\_  
**Policy Number:** \_\_\_\_\_  
**Dates:** \_\_\_\_\_

**Applicant:** Each school where anesthesiologist assistant education was received must complete this form. If more than one school, photocopies of this blank form may be made and used. Transcripts must also be submitted by the school(s).

# FORM 1

## NEVADA STATE BOARD OF MEDICAL EXAMINERS ANESTHESIOLOGIST ASSISTANT EDUCATION VERIFICATION

This certifies that \_\_\_\_\_  
Printed Name of Applicant Date of Birth

was enrolled in \_\_\_\_\_  
Name of Anesthesiologist Assistant School (Location – City / State / Country)

.....

### The following information to be completed by program only!

The undersigned further certifies that the records of this institution show that the applicant attended this program:

from \_\_\_\_\_ to \_\_\_\_\_  
(month / year) (month / year)

- The applicant was granted:
- Anesthesiologist Assistant Certificate
  - Anesthesiologist Assistant Degree
  - Bachelor's Degree
  - Combined Anesthesiologist Assistant/Bachelor's Degree
  - Combined Anesthesiologist Assistant/Masters Degree
  - Other (Please attach explanation.)

The degree or certificate was granted: \_\_\_\_\_  
(month / day / year)

Signed and the institutional seal affixed this

\_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

By: \_\_\_\_\_  
Printed name of President, Registrar or Dean)

Title \_\_\_\_\_  
Title of President, Registrar or Dean

Signature \_\_\_\_\_  
*Signature of President, Registrar or Dean \*\**

Affix Seal Here

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

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

\*\* Signatures by personnel other than the President, Registrar or Dean must attach documentation granting authorization to sign in lieu of the President, Registrar or Dean.

**Completed form is to be mailed by the verifying institution directly to:**

**Nevada State Board of Medical Examiners  
9600 Gateway Drive  
Reno, NV 89521**

***This form may also be emailed to [nsbme@medboard.nv.gov](mailto:nsbme@medboard.nv.gov)***

**Anesthesiologist Assistant School:** If you have questions, you may contact the Board at (775) 688-2559. The Board requires that this verification form be received by mail or email and NOT by facsimile.

**Applicant:** This form is to be mailed to the NCCAA for completion. You may prefer to contact the NCCAA to request that an electronic verification to be sent to the Nevada State Board of Medical Examiners.

**FORM 2**

**NEVADA STATE BOARD OF MEDICAL EXAMINERS  
NCCAA CERTIFICATION**

National Commission for Certification  
Of Anesthesiologist Assistants  
8459 US 42 #160  
Florence, KY 41042  
(859) 903-0089  
www.nccaatest.org

**Part 1 – to be completed by applicant**

I, \_\_\_\_\_ am in the process  
(Name of Applicant)

of applying for Anesthesiologist Assistant licensure in the state of Nevada and hereby authorize release of the following information directly to the Nevada State Board of Medical Examiners.

\_\_\_\_\_  
(Signature of Applicant)

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**Part 2 – to be completed by NCCAA and returned directly to the Nevada State Board of Medical Examiners**

I, the undersigned, certify that \_\_\_\_\_  
(Name Of Applicant)

was granted initial certification by the National Commission for Certification of Anesthesiologist Assistants on:

Date Issued \_\_\_\_\_

Certificate Number \_\_\_\_\_.

The above certificate is: \_\_\_\_\_ current, in good standing \_\_\_\_\_ not current.

Expiration date of current certification: \_\_\_\_\_.

Signature of certifying individual: \_\_\_\_\_

Print name: \_\_\_\_\_

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

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

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

AFFIX BOARD SEAL HERE

**Completed form is to be returned by the verifying institution directly to:**

**Nevada State Board of Medical Examiners  
9600 Gateway Drive  
Reno, NV 89521  
(775) 688 – 2559  
nsbme@medboard.nv.gov**

**Applicant:** If you answered affirmatively to questions #12 and #12a on the Application for Licensure, complete both the top portion and release area of this form; have this form notarized, and submit this form to all malpractice carriers verifying coverage **within the past 10 years**. Copies of this form may be used if you have more than one malpractice carrier.

# FORM 4

## MALPRACTICE CLAIM VERIFICATION REQUEST

### Insurance Carrier Information:

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

Name of Insurance Company: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_



### To be completed by verifying agency only

Policy Number: \_\_\_\_\_

Policy Period From: \_\_\_\_\_ To: \_\_\_\_\_

\*\*Please provide a loss history report with this verification.

### Claims Experience:

Has this Anesthesiologist Assistant had a settlement paid on his/her behalf? \_\_\_\_\_ Yes \_\_\_\_\_ No

If "yes", please provide the following information:

<i>Occurrence Date</i>	<i>Status</i>	<i>Date Closed</i>	<i>Indemnity Amount</i>
_____	_____	_____	_____

Description of Claim: \_\_\_\_\_  
\_\_\_\_\_

### Insurance Carrier Agent:

\_\_\_\_\_  
Print Name and Title

\_\_\_\_\_  
Signature of Agent

\_\_\_\_\_  
Telephone

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

**Please mail completed form to:**  
Nevada State Board of Medical Examiners  
9600 Gateway Drive  
Reno, NV 89521

### RELEASE

I hereby authorize the above named institution to release any information, files, or records required by the Nevada State Board of Medical Examiners for licensure in the State of Nevada.

\_\_\_\_\_  
*Anesthesiologist Assistant (applicant) signature and date*

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_\_,

Notary Public for the State of \_\_\_\_\_

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

Residing at: \_\_\_\_\_ City \_\_\_\_\_ State

\_\_\_\_\_  
*Signature and Seal of Notary Public*

# CREDIT CARD AUTHORIZATION FORM

*If mailing or faxing this page separately from the application, please mail to:  
Nevada State Board of Medical Examiners  
9600 Gateway Drive  
Reno, NV 89521  
or fax to:  
775-688-2321*

**Please type or print legibly.**

Method of Payment: MasterCard / Visa / American Express / Discover

Name on Credit Card: \_\_\_\_\_

Business Name (if applicable): \_\_\_\_\_

Credit Card Billing Address:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

Name of Applicant (if applying for licensure): \_\_\_\_\_

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_ / \_\_\_\_  
(MM) (YYYY)

Credit Card Verification Code (CVC): \_\_\_\_  
(Three or four digit code found on the front or back of the card)

***For security of your financial information, please do not email this form to the Board; emailed forms will not be accepted.***

I authorize the Nevada State Board of Medical Examiners to charge the above credit card for a

One-time payment in the amount of \$\_\_\_\_\_.

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

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Email Address for receipt: \_\_\_\_\_

***Disclosure: By continuing, you will be charged a non-refundable card payment-processing fee of 2.5% for debit and credit cards by our payment processor. If you do not wish to pay the fee, you can select another payment option.***