

Department of Health, Board of Medicine
ANESTHESIOLOGIST ASSISTANTS
FINANCIAL RESPONSIBILITY
(Please Print the Following Information)

NAME: _____ LICENSE NUMBER: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

Mailing address will not be published on the Internet.

PRACTICE LOCATION: _____

CITY: _____ STATE: _____ ZIP: _____

Practice locations will be published on the Internet.

Financial Responsibility options are divided into two categories, coverage and exemptions. Choose only one option of the five provided pursuant to s.458, Florida Statutes.

FINANCIAL RESPONSIBILITY COVERAGE:

- 1. I have established an irrevocable letter of credit or an escrow account in an amount of \$100,000/ \$300,000, in accordance with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.
- 2. I have obtained and maintain professional liability coverage in an amount not less than \$100,000 per claim, with a minimum annual aggregate of not less than \$300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F.S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F.S.

FINANCIAL RESPONSIBILITY EXEMPTIONS:

- 3. I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.
- 4. I do not practice medicine in the State of Florida.
- 5. I practice only in conjunction with my teaching duties at an accredited school or its main teaching hospitals.

Signature of Anesthesiologist Assistant _____

Date _____

The Dept. of Financial Services provides a web site listing only authorized insurers pursuant to s.624.09, F.S. Before choosing an insurer, review the web site to insure compliance with the Florida Statutes.
<http://www.fldfs.com/data/companysearch/indes.asp>

Mail to: Department of Health
Board of Medicine
4052 Bald Cypress Way, Bin #C03
Tallahassee, Florida 32399-3253
Tel: (850) 245-4131, Fax: (850) 488-0596