



New Jersey Office of the Attorney General

Division of Consumer Affairs
State Board of Medical Examiners
140 East Front Street, Trenton, NJ 08608
(973) 273-8080



APPLICATION FOR AN EXTENSION FOR NOT MORE THAN 60 DAYS

1. Name of applicant practitioner: _____
First name Middle initial Last name

License number: _____

Address of record: _____
Street address or P.O. Box City State ZIP code County

Telephone number: _____ (include area code) Fax number: _____ (include area code)

E-mail address: _____

2. Practice / Facility name (if different), location of practice:

_____ Street address City State ZIP code County

3. Provide the name of the anesthesia provider(s) to be supervised during the temporary extension of time before the enforcement of the rule prohibiting concurrent performance of surgery and supervision of general or regional anesthesia in the office setting, AND requiring alternative privileges in anesthesia services and special procedures. (Use additional sheets of paper, if necessary.)

Name: _____
First name Middle initial Last name

License number: _____

Address: _____
Street address City State ZIP code County

Name: _____
First name Middle initial Last name

License number: _____

Address: _____
Street address City State ZIP code County

4. Procedures performed in the office setting requiring regional or general anesthesia.

Regional Anesthesia _____

General Anesthesia _____

5. Hospital(s) where you have full privileges to perform listed procedures requiring general or regional anesthesia:

Name: _____

Address: _____
Street address City State ZIP code

Telephone: _____ **Contact name:** _____
(include area code)

Procedure: _____

Name: _____

Address: _____
Street address City State ZIP code

Telephone: _____ **Contact name:** _____
(include area code)

Procedure: _____

6. Alternative Privileges application initiated: Yes No

Date privileges requested: _____

Privileges requested:

- Conscious Sedation _____
- Surgical/Special Procedure (specify): _____
- Other (please specify): _____

7. Please identify the changes to be made in your practice, if known, for the provision of regional and general anesthesia when the extension expires. _____

Signature

Print name

Date: _____