



# ALASKA STATE MEDICAL BOARD

Department of Commerce, Community, and Economic Development  
Division of Corporations, Business, and Professional Licensing  
(333 Willoughby Avenue - Ninth Floor)  
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## MED

For Office Use Only

## CHANGE or ADDITION OF PARAMEDIC PHYSICIAN SPONSOR

- Change of Sponsor Physician
- Addition of Sponsor Physician

**12 AAC 40.315. SPONSORSHIP.** (a) A person licensed as a mobile intensive care paramedic shall immediately report to the board, in writing, any change of sponsorship.  
 (b) When a sponsor withdraws sponsorship of a mobile intensive care paramedic, the paramedic is not authorized to practice until a new physician sponsor is approved by the board.

**Paramedic:** Please type or print legibly. Please complete the upper portion of this form and forward to the new physician sponsor who is assuming the role of sponsorship for you.

Paramedic Name \_\_\_\_\_

Employer Name \_\_\_\_\_

Address \_\_\_\_\_

Work Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Daytime Phone \_\_\_\_\_ License No. \_\_\_\_\_

Employer's Telephone \_\_\_\_\_

Scope of Duties: \_\_\_\_\_

✓ Paramedic Signature \_\_\_\_\_

Date \_\_\_\_\_

**PHYSICIAN SPONSOR:** As indicated by my signature below, I acknowledge and confirm that I am assuming responsibility as physician sponsor for the paramedic identified above in accordance with 12 AAC 40.315.

✓ \_\_\_\_\_  
Signature, Supervising Physician

NOTARY:

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

SUBSCRIBED AND SWORN before me, a Notary

License Number \_\_\_\_\_

Public, in and for the state of \_\_\_\_\_

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

this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Street/PO Box \_\_\_\_\_

\_\_\_\_\_  
Notary Public

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

My commission expires: \_\_\_\_\_

Daytime Telephone \_\_\_\_\_

(Notary Seal)