



ALABAMA STATE BOARD OF MEDICAL EXAMINERS

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OFFICE-BASED SURGERY
ADVERSE EVENT REPORT FORM

Physician Name: _____ AL License # _____

Address: _____
Street City State Zip

Physician Specialty: _____

Date of Surgery: _____ Type of Surgery: _____

Type of Anesthesia: Moderate Deep General

Name/Title of Person Administering Anesthesia: _____

Date of Adverse Event: _____ Patient Age: _____ Patient Gender: _____

Description of Adverse Event (i.e., Surgical Complication, Post-Op Infection, etc.)

Patient Hospitalized: Yes No

Patient Outcome: Full Recovery Disability Death **Pending

** If patient outcome is pending, please provide a follow-up report within 14 days of patient's discharge and/or recovery.

Provide a brief description of the adverse event and any protocol changes implemented as a result. Include any underlying disease processes and the rationale for performing this procedure in an office-based setting.

Please type or print legibly (no handwritten script). Attach additional pages if necessary.

I hereby certify that the foregoing information to be correct to the best of my knowledge, information, and belief. I also understand that the Alabama Board of Medical Examiners may conduct an on-site inspection at any time. Knowingly providing false information to the Alabama Board of Medical Examiners or Medical Licensure Commission of Alabama could result in disciplinary action.

Physician Signature*: _____ Date _____

* I understand and agree that by typing my name, I am providing an electronic signature that has the same effect as a written signature pursuant to Ala. Code §§ 8-1A-2 and 8-1A-7 (if applicable).

Complete form and submit via email to obs@albme.gov or mail to an above-listed address.