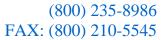




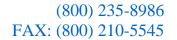
LOCUM TENENS ANESTHESIOLOGIST APPLICATION

I. PERSONAL INFORMATION:		
Full Name	Nickname	
Address		
City	State Zip County	
Home Phone	Pager	
Cell Phone	Emergency Contacts:	
E-mail		
Sex: M □ F □ Marital Status		
Date of Birth	Phone	
Social Security No	Relation to you	
Maiden / Former Name	2) Name	
U.S. Citizen: Yes □ No □	Phone	
Place of Birth: City	Relation to you	
State Country		
If Incorporated: Business Name	Tax ID No	
HeightSn	moker: Yes 🗖 No 🗖 Group NPI No	
Referral Source		
II. EDUCATION AND LICENSURI	E:	
Medical School	Year Completion Degree	
Residency	Year Completion Degree	
Other Education	Year Completion Degree	
High School	Year Completion Degree	
Board Eligible: Yes 🗖 No 🗖		
Written Exam completed? Yes □ No □ Date:	Oral Exam completed? Yes 🗖 No 🗖 Date:	
Board Certification: Yes 🗖 No 🗖 Date Completed:	Certification No Exp. Date _	
Other board certifications held:		
State of Original Licensure	Licenses Pending	



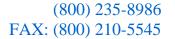


Malpractice Carri	er			Polic	y Limits					
Are You Certified	lin BLS? □	lYes □ No	ACLS?	□ Yes □	No PALS?	□ Yes	□ No	NALS?	☐ Yes	□ No
III. TYPES	OF CASE	ES COMF	ORTAE	BLE WITH	l:					
☐ Ortho	■ Neuro	□ Hearts	□ Ma	njor Vascular	■ Thorac	ic 🗖	Uro	□ ОВ		☐ GYN
□ Transplants	■ Eyes	■ Burns	☐ Ge	riatrics	☐ Trauma	a 🗖 1	ENT	☐ Ab	ortions	☐ Peds
Comments:										
IV. SKILLS										
□ Epidurals	☐ Spinals	s 🖵 Bi	er	□ Axillary	□ A-Li	ines	□ C-I	_ines	□ Swa	an Ganz
Other Skills or Co	omments: _			_						
V. DESIRED	WORK	SITUATI	ON:							
☐ Small Hosp.	☐ Mediu	m Hosp.	☐ Univ	ersity Hosp.	☐ Traui	ma	☐ Sur	gery Cen	ter	☐ Office
□ Supervised	☐ Solo	·	☐ Eithe	,				5		
Are you intereste	ed in doing	locums full-1	ime or pa	art-time?						
When is your nex	kt availabilit	ty?								
Preferred length	of assignme	ent?								
Are you willing to	o take call?			_ Are you wi	lling to work	overtir	ne?			
Maximum distand	ce you are v	villing to dri	ve to an a	assignment?						
Do you travel wit	th pets?		_ If so, wl	nat kind and	size?					
VI. IF YOU PROVIDE C							QUES	STION	S, PLE	ASE
Do you have any hinder your perfo						er physi 1 Yes	cal cond		which ma	ıy limit or
Do you have any	communica	able disease:	s? 🗖 '	Yes 🗖 No)					
Have you ever renerves? ☐ Ye			you curi	rently receivi	ng treatmen	t for su	bstance	abuse, a	lcohol at	ouse, or
Have you ever be	een convicte	ed of a felor	y or crim	e other than	a traffic vio	lation?	□ Y	'es	□ No	
Have your privile						oluntari I No	ily relind	quished,	denied, s	uspended





Have you ever been the subject of disciplinary proceeding	s at any healthcare facility? \square Yes \square No				
Has your medical license in any state ever been voluntarily restricted, or is currently being challenged? $\ \square$ Yes	y or involuntarily relinquished, suspended, terminated, □ No				
Have you ever been the subject of disciplinary proceeding	s by any state licensure board? \square Yes \square No				
Have you ever been suspended, terminated, sanctioned or otherwise restricted from participating in any private, public, federal, or state health insurance program (e.g., Medicare, Medicaid, Blue Shield)? Yes No					
Have judgments or settlements been made against you in professional liability cases, or are claims pending? ☐ Yes ☐ No					
VII. PLEASE INCLUDE CLEAR COPIES O APPLICATION:	F THE FOLLOWING WITH COMPLETED				
☐ Typed Resume or Curriculum Vitae					
☐ All State Licenses, DEA Certificate					
☐ Malpractice Insurance of \$1mill/\$3mill (preferred but	not required – agency can provide)				
☐ Copy of all Certificates from Medical School, Internshi	ip, Residency and Board Certification				
☐ Proof of Certification for BLS, ACLS, PALS and/or NAL	S, if applicable				
☐ Four (4) letters of reference or completed MDA Reference	ence Inquiry Forms (enclosed in application)				
☐ Signed Applicant's Statement of Consent and Release	Form				
☐ List of last three (3) places of employment, with comp	plete addresses, phone numbers and contact names				
☐ Recent photo (Passport size preferred)					
☐ Immunization Records: PPD or Chest X-Ray, Rubella, required – most hospitals require immunization records for	Rubeola, Measles, Mumps, Hepatitis B (preferred but not or credentialing)				
☐ Social Security Card					
☐ Driver's License					
☐ NPI Confirmation – Individual (Group NPI if applicable	e)				
☐ Medicare / Medicaid / Blue Cross Numbers					
VIII. APPLICANT'S STATEMENT OF CON	SENT AND RELEASE:				
The facts set forth in this application for job placement with National statements on this application shall be considered sufficient cause representatives are hereby authorized to make any investigations bureau necessary, including but not limited to, criminal background also authorized to investigate my ability, employment records or comentioned in this application. I understand that Nationwide Ascreen prior to and during any assignment.	e for dismissal. Nationwide Anesthesia Services, Inc. and its of my personal and professional history through any agency or nd and criminal reports. Nationwide Anesthesia Services, Inc. is character through inquiries to the individuals and/or employers				
Signature:	Date:				
Printed Name:	Social Security No.:				

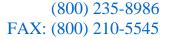




CLINICAL SKILLS CHECKLIST - ANESTHESIOLOGIST

I am proficient in the techniques and procedures indicated:

GENERAL ANESTHESIA AND ANALGESIA:	PROCEDURES:			
☐ Preoperative Evaluation and Meds	☐ Intravenous Catheter Placement			
☐ Intravenous Agents				
☐ Inhalation Agents	Intravenous Administration of:			
☐ Intramuscular Agents	☐ Fluids			
☐ Other (Describe):	Blood			
	☐ Plasma			
REGIONAL ANESTHESIA:	☐ Plasma Expar	ders		
☐ Topical	. ☐ Muscle Relaxants			
☐ Infiltration	☐ Vasoactive Dr	ugs		
□ Spinal	☐ Cardiac Drugs			
☐ Epidural & Caudal	☐ Other (Descri	be):		
☐ Intravenous				
☐ Upper Extremity Blocks	☐ Placement of CVP Lin	es		
☐ Lower Extremity Blocks	☐ Placement of Arterial Lines			
☐ Field Blocks	☐ Placement of Right Heart & Pulmonary Lines☐ Mechanical Ventilation			
☐ Other Peripheral Blocks				
☐ Other (Describe):	Resuscitation Techniques & Therapy			
	☐ Cardiopulmonary Bypass Techniques			
DIAGNOSTIC & THERAPEUTIC BLOCKS:	□ Autotransfusion Techniques			
☐ Sympathetic Blocks	☐ Hypotensive & Hypertensive Techniques			
☐ Epidural	☐ Hypothermia			
☐ Spinal – Differential	☐ Other (Describe):			
☐ Steroid, Alcohol & Drug Phenol Blocks				
☐ Other (Describe):				
SPECIALTIES OR SPECIFIC SKILLS:	CERTIFICATIONS:			
☐ Open Heart	□ BLS	□ PALS		
□ Peds	□ ACLS	□ NALS		
□ OB				
☐ Pain Management	_ = (2 = 3 =)			
a managomom				
Signature:	Date:			
Printed Name				





APPLICANT'S STATEMENT OF CONSENT AND RELEASE

I hereby authorize Nationwide Anesthesia Services, Inc. and its representatives to consult any person or organization and to inspect any materials having or containing information which may have any bearing on my professional, ethical, and moral qualifications, including my personal character and professional competence. I hereby authorize Nationwide Anesthesia Services, Inc. to request such criminal background histories, drug screen tests and credit reports as Nationwide Anesthesia Services, Inc. deems appropriate. I hereby appoint Nationwide Anesthesia Services, Inc. my attorney in fact to request any such criminal, credit, drug, professional, and personal reports, at any time, without the need to seek further authorization from me. I hereby agree that this authorization and appointment shall be valid until revoked by me in a written revocation delivered to Nationwide Anesthesia Services, Inc. I hereby release from liability Nationwide Anesthesia Services, Inc. and its representatives for all acts performed in connection with evaluating my application for temporary job placement. I hereby release from liability all persons and organizations who furnish information concerning my professional competence, ethics, character, and other qualifications, and consent to the release of such information.

Signature:	Date:
Printed Name:	Social Security No.:

NOTE TO APPLICANT: You should provide a signed copy of this Statement of Consent and Release to each reference who will be completing an inquiry/evaluation form or letter of reference on your behalf. A signed copy of this Statement should also be provided to Nationwide Anesthesia Services, Inc. with your other application materials.



ANESTHESIOLOGIST INQUIRY FORM

Nationwide Anesthesia Services, Inc. is a national placement service for Locum Tenens and Permanent Anesthesiologists. It is our policy that before an applicant can be considered for temporary assignments or permanent placement, they are screened thoroughly. We have spoken with a candidate who has directed us to you for your personal and professional opinions. Please take a moment to complete this evaluation form and return to Nationwide Anesthesia Services, Inc., P.O. Box 992, Sandersville, GA 31082, or fax toll-free to (800) 210-5545. Thank you in advance for your assistance.

Candidate Name:	Phone:	
Reference Name:	Fax:	
Title:	Email:	
Hospital/Group:		
Address:		
Dates of Candidate's Employment:		
Was Candidate Terminated? YES 🗖 NO 🗖 W	Would You Rehire? YES □ NO □	
Were There Any Suspected Problems With Drugs, Al	lcohol, Nerves, Etc.? YES □ NO □	
If Yes, Please Explain:		
Please Evaluate The Candidate Below According To A = ABOVE AVERAGE B = AVERAGE	The Following Scale:	:
Adaptability To Work Situations	Emotional Stability	
Personal Appearance	Attendance And Punctuality	
Attitude	Seeks Consultation When Necess	ary
Technical Skills	Overall Professional Competence	-
Ability To Get Along With Physicians, Cowork	kers & Patients Cooperation	
Knowledge And Ability To Practice "Safe Ane	esthesia"	
Physical Assessment And Management Of "Hi	ligh Risk Patients"	
Comments:		

Reference Signature: _____ Date: ___