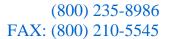




PERMANENT POSITION NURSE ANESTHETIST QUESTIONNAIRE

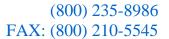
Date of Application	Expected Graduation Date					
I. PERSONAL INFORMATION: CRNA						
	Nickname					
Address						
	State Zip County					
	Pager					
Cell Phone	Fax					
E-mail	Emergency Contact:					
Sex: M F Marital Status	- Name					
Maiden / Former Name Phone						
U.S. Citizen: Yes No Smoker: Yes No Relation to you						
Date of Birth	-					
Social Security No	_ Height Weight					
Place of Birth: City	State Country					
If incorporated: Business Name	Tax ID No					
Spouse's Name	_ Spouse's Occupation					
Comments						
Number and Age of Children						
Children's Educational Preference: Public ☐ Private ☐ Home School ☐						
Comments						
Geographical Preference: Open \square NE \square SE	□ MW □ SW □ NW □					
Comments						
State Preference: 1) 2) 3)	4)					
Population Preference: Large City Medium City	✓ □ Small City □ Rural □					
Comments						
Do you currently rent or own your residence?	Housing Preference					
What are your hobbies and recreational interests?						
How soon would you be able to relocate?						





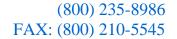
II. EDUCATION AND LICENSURE:

Nursing School		Yea	Year Completion			_ Degree						
Anesthesia School			Yea	Year Completion			_ Degre	ee				
Other Education			Yea	ar Comp	letion		_ Degr	ee				
High School					Yea	ar Comp	oletion		Degr	ee		
Date of Certificat	ion?				Cer	tificatio	n No			Exp. Dat	te	
States Licensed _												
Malpractice Carrier						Polic	y Limits _					
Are You Certified	in BLS?	□ Yes	□ No	ACLS?	☐ Yes	□ No	PALS?	☐ Yes	□ No	NALS?	☐ Yes	□ No
III. TYPES	OF CAS	SES CO	OMFO	RTABI	LE WIT	`H:						
☐ Ortho	■ Neuro	□ Не	earts	☐ Majo	or Vascula	ar 🗖	Thoracic	☐ Uro		□ ОВ		□ GYN
□ Transplants	□ Eyes	□ Bu	ırns	☐ Geri	atrics		Trauma	□ ENT		☐ Aborti	ions	□ Peds
Comments:												
IV. SKILLS Depidurals	☐ Spina	als	☐ Bier		□ Axillary				□ C-Lin		□ Swan	
Other Skills or Co												
V. DESIRED												
☐ Small Hosp.	☐ Med	ium Hos	p.	☐ Univ	ersity Ho	sp.	☐ Tra	auma	□ Sur	rgery Cer	iter	☐ Office
■ Supervised	☐ Solo	1		☐ Eith	er							
Are you willing to take call? Are you willing to work overtime?												
Please describe you	ır ideal pra	ctice situa	ation: (i.e	e. call sch	nedule, wo	rk sched	ule, overt	ime availal	oility, an	d clinical p	oreferenc	es)
Salary/Benefits Pref	ferences _											





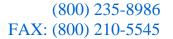
Vacation Preferences
Current Practice Situation
Likes and Dislikes About Current Situation
Reason for Leaving
VI. IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS, PLEASE PROVIDE COMPLETE DETAILS ON A SEPARATE SHEET:
Do you have any illness, disease, mental or physical disability, or any other physical condition(s) which may limit or hinder your performance in the position for which you are applying?
Do you have any communicable diseases?
Have you ever received treatment or are you currently receiving treatment for substance abuse, alcohol abuse, or nerves? ☐ Yes ☐ No
Have you ever been convicted of a felony or crime other than a traffic violation?
Have your privileges at any healthcare facility ever been voluntarily or involuntarily relinquished, denied, suspended, diminished, revoked, or not renewed for any reason? \square Yes \square No
Have you ever been the subject of disciplinary proceedings at any healthcare facility?
Has your license or certification in any state ever been voluntarily or involuntarily relinquished, suspended, terminated, restricted, or is currently being challenged? $\ \square$ Yes $\ \square$ No
Have you ever been the subject of disciplinary proceedings by any state licensure board? ☐ Yes ☐ 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
Is your CRNA certification/recertification by the Council on Recertification of Nurse Anesthetists current as of the date of this application? □ Yes □ No





VII. PLEASE INCLUDE CLEAR COPIES OF THE FOLLOWING WITH COMPLETED APPLICATION:

☐ Typed Resume or Curriculum Vitae	
☐ All State Nursing/ARNP Licenses	
☐ AANA Certification/Recertification Card	
☐ Proof of Certification for BLS, ACLS, PALS ar	nd/or NALS, if applicable
☐ Four (4) letters of reference or completed C	RNA Reference Inquiry Forms (enclosed in application)
☐ Letter of Reference from Clinical Supervisor-	SRNA only
☐ Signed Applicant's Statement of Consent and	d Release Form
☐ List of last three (3) places of employment,	with complete addresses, phone numbers and contact names-CRNA only
☐ Recent photo (Passport size preferred)	
☐ Immunization Records: PPD or Chest X-Ray, required – most hospitals require immunization in	Rubella, Rubeola, Measles, Mumps, Hepatitis B (preferred but not records for credentialing)
☐ Nursing and Anesthesia School Diplomas/Ce	tificates
☐ Social Security Card	
☐ Drivers License	
☐ NPI Confirmation – Individual (Group NPI if	applicable)-CRNA only
☐ Medicare / Medicaid / Blue Cross Numbers-0	RNA only
VIII. APPLICANT'S STATEMENT C	OF CONSENT AND RELEASE:
statements on this application shall be considered suffi representatives are hereby authorized to make any inve pureau necessary, including but not limited to, criminal also authorized to investigate my ability, employment r	with Nationwide Anesthesia Services, Inc. are true and complete. False cient cause for dismissal. Nationwide Anesthesia Services, Inc. and its estigations of my personal and professional history through any agency or background and criminal reports. Nationwide Anesthesia Services, Inc. is ecords or character through inquiries to the individuals and/or employers ionwide Anesthesia Services, Inc. has the right to request a drug
Signature:	Date:
Printed Name:	Social Security No.:

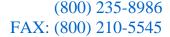




CLINICAL SKILLS CHECKLIST - NURSE ANESTHESIA

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 Expanders			
☐ Topical	☐ Muscle Relaxants			
☐ Infiltration	■ Vasoactive Drugs			
	☐ Cardiac Drugs			
☐ Epidural & Caudal	☐ Other (Describe):			
□ Intravenous				
☐ Upper Extremity Blocks	☐ Placement of CVP Lines			
☐ Lower Extremity Blocks	☐ Placement of Arterial Lines			
☐ Field Blocks	☐ Placement of Right Heart & Pulmonary Lines			
☐ Other Peripheral Blocks	☐ Mechanical Ventilation			
☐ 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	☐ Other (Describe):			
☐ Pain Management				
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.



CRNA INQUIRY FORM

Nationwide Anesthesia Services, Inc. is a national placement service for Locum Tenens and Permanent Certified Registered Nurse Anesthetists. 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:	Phone:			
Reference Name:		Fax:	Fax:			
Title:		Email:				
Hospital/Group:						
Address:						
Dates of Candidate's Employr	ment:					
Was Candidate Terminated?	YES NO W	ould You Rehire? YES □ NC) 🗖			
Were There Any Suspected P	roblems With Drugs, Ald	cohol, Nerves, Etc.? YES 🗆 🛚 1	NO 🗖			
If Yes, Please Explain:						
Please Evaluate The Candidat A = ABOVE AVERAGE	te Below According To 1 B = AVERAGE	The Following Scale: C = BELOW AVERAGE	D = UNACCEPTABLE			
Adaptability To Work	Situations	Emotic	onal Stability			
Personal Appearance		Attend	Attendance And Punctuality			
Attitude		Seeks	Seeks Consultation When Necessary			
Technical Skills		Overal	Overall Professional Competence			
Ability To Get Along V	Vith Physicians, Cowork	ers & Patients Coope	ration			
Knowledge And Ability	y To Practice "Safe Anes	sthesia"				
Physical Assessment A	And Management Of "Hi	gh Risk Patients"				
Comments:						
Reference Signature:		Date:				