



(800) 235-8986  
FAX: (800) 210-5545

**LOCUM TENENS ANESTHESIOLOGIST APPLICATION**

Date of Application \_\_\_\_\_

**I. PERSONAL INFORMATION:**

Full Name \_\_\_\_\_ Nickname \_\_\_\_\_

Address \_\_\_\_\_

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

Home Phone \_\_\_\_\_ Pager \_\_\_\_\_

Cell Phone \_\_\_\_\_

E-mail \_\_\_\_\_

Sex: M  F  Marital Status \_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security No. \_\_\_\_\_

Maiden / Former Name \_\_\_\_\_

U.S. Citizen: Yes  No

Place of Birth: City \_\_\_\_\_

State \_\_\_\_\_ Country \_\_\_\_\_

If Incorporated: Business Name \_\_\_\_\_ Tax ID No. \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Smoker: Yes  No  Group NPI No. \_\_\_\_\_

Referral Source \_\_\_\_\_

**Emergency Contacts:**

1) Name \_\_\_\_\_

Phone \_\_\_\_\_

Relation to you \_\_\_\_\_

2) Name \_\_\_\_\_

Phone \_\_\_\_\_

Relation to you \_\_\_\_\_

**II. EDUCATION AND LICENSURE:**

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: \_\_\_\_\_

States Licensed \_\_\_\_\_

State of Original Licensure \_\_\_\_\_ Licenses Pending \_\_\_\_\_



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Malpractice Carrier \_\_\_\_\_ Policy Limits \_\_\_\_\_

Are You Certified in BLS?  Yes  No ACLS?  Yes  No PALS?  Yes  No NALS?  Yes  No

**III. TYPES OF CASES COMFORTABLE WITH:**

- Ortho       Neuro       Hearts       Major Vascular       Thoracic       Uro       OB       GYN  
 Transplants       Eyes       Burns       Geriatrics       Trauma       ENT       Abortions       Peds

Comments: \_\_\_\_\_

**IV. SKILLS PROFICIENT WITH:**

- Epidurals       Spinals       Bier       Axillary       A-Lines       C-Lines       Swan Ganz

Other Skills or Comments: \_\_\_\_\_

**V. DESIRED WORK SITUATION:**

- Small Hosp.       Medium Hosp.       University Hosp.       Trauma       Surgery Center       Office  
 Supervised       Solo       Either

Are you interested in doing locums full-time or part-time? \_\_\_\_\_

When is your next availability? \_\_\_\_\_

Preferred length of assignment? \_\_\_\_\_

Are you willing to take call? \_\_\_\_\_ Are you willing to work overtime? \_\_\_\_\_

Maximum distance you are willing to drive to an assignment? \_\_\_\_\_

Do you travel with pets? \_\_\_\_\_ If so, what kind and size? \_\_\_\_\_

**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?       Yes       No

Do you have any communicable diseases?       Yes       No

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?       Yes       No

Have your privileges at any healthcare facility ever been voluntarily or involuntarily relinquished, denied, suspended, diminished, revoked, or not renewed for any reason?       Yes       No



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- Have you ever been the subject of disciplinary proceedings at any healthcare facility?  Yes  No
- Has your medical license in any state ever been voluntarily or involuntarily relinquished, suspended, terminated, restricted, or is currently being challenged?  Yes  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

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

- 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, Internship, Residency and Board Certification
- Proof of Certification for BLS, ACLS, PALS and/or NALS, if applicable
- Four (4) letters of reference or completed MDA Reference Inquiry Forms (enclosed in application)
- Signed Applicant's Statement of Consent and Release Form
- List of last three (3) places of employment, with complete addresses, phone numbers and contact names
- Recent photo (Passport size preferred)
- Immunization Records: PPD or Chest X-Ray, Rubella, Rubeola, Measles, Mumps, Hepatitis B (*preferred but not required – most hospitals require immunization records for credentialing*)
- Social Security Card
- Driver's License
- NPI Confirmation – Individual (*Group NPI if applicable*)
- Medicare / Medicaid / Blue Cross Numbers

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**VIII. APPLICANT'S STATEMENT OF CONSENT AND RELEASE:**

The facts set forth in this application for job placement with Nationwide Anesthesia Services, Inc. are true and complete. False statements on this application shall be considered sufficient cause for dismissal. Nationwide Anesthesia Services, Inc. and its representatives are hereby authorized to make any investigations of my personal and professional history through any agency or bureau necessary, including but not limited to, criminal background and criminal reports. Nationwide Anesthesia Services, Inc. is also authorized to investigate my ability, employment records or character through inquiries to the individuals and/or employers mentioned in this application. **I understand that Nationwide Anesthesia Services, Inc. has the right to request a drug screen prior to and during any assignment.**

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



## CLINICAL SKILLS CHECKLIST – ANESTHESIOLOGIST

I am proficient in the techniques and procedures indicated:

### GENERAL ANESTHESIA AND ANALGESIA:

- Preoperative Evaluation and Meds
- Intravenous Agents
- Inhalation Agents
- Intramuscular Agents
- Other (Describe): \_\_\_\_\_

### REGIONAL ANESTHESIA:

- Topical
- Infiltration
- Spinal
- Epidural & Caudal
- Intravenous
- Upper Extremity Blocks
- Lower Extremity Blocks
- Field Blocks
- Other Peripheral Blocks
- Other (Describe): \_\_\_\_\_

### DIAGNOSTIC & THERAPEUTIC BLOCKS:

- Sympathetic Blocks
- Epidural
- Spinal – Differential
- Steroid, Alcohol & Drug Phenol Blocks
- Other (Describe): \_\_\_\_\_

### SPECIALTIES OR SPECIFIC SKILLS:

- Open Heart
- Peds
- OB
- Pain Management

### PROCEDURES:

- Intravenous Catheter Placement

#### Intravenous Administration of:

- Fluids
- Blood
- Plasma
- Plasma Expanders
- Muscle Relaxants
- Vasoactive Drugs
- Cardiac Drugs
- Other (Describe): \_\_\_\_\_

- Placement of CVP Lines
- Placement of Arterial Lines
- Placement of Right Heart & Pulmonary Lines
- Mechanical Ventilation
- Resuscitation Techniques & Therapy
- Cardiopulmonary Bypass Techniques
- Autotransfusion Techniques
- Hypotensive & Hypertensive Techniques
- Hypothermia
- Other (Describe): \_\_\_\_\_

### CERTIFICATIONS:

- BLS
- ACLS
- Other (Describe): \_\_\_\_\_
- PALS
- NALS

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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



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### 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.*



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### 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  Would You Rehire? YES  NO

Were There Any Suspected Problems With Drugs, Alcohol, Nerves, Etc.? YES  NO

If Yes, Please Explain: \_\_\_\_\_

Please Evaluate The Candidate Below According To The Following Scale:

**A = ABOVE AVERAGE**

**B = AVERAGE**

**C = BELOW AVERAGE**

**D = UNACCEPTABLE**

\_\_\_\_\_ Adaptability To Work Situations

\_\_\_\_\_ Emotional Stability

\_\_\_\_\_ Personal Appearance

\_\_\_\_\_ Attendance And Punctuality

\_\_\_\_\_ Attitude

\_\_\_\_\_ Seeks Consultation When Necessary

\_\_\_\_\_ Technical Skills

\_\_\_\_\_ Overall Professional Competence

\_\_\_\_\_ Ability To Get Along With Physicians, Coworkers & Patients

\_\_\_\_\_ Cooperation

\_\_\_\_\_ Knowledge And Ability To Practice "Safe Anesthesia"

\_\_\_\_\_ Physical Assessment And Management Of "High Risk Patients"

Comments: \_\_\_\_\_

Reference Signature: \_\_\_\_\_ Date: \_\_\_\_\_