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

# LOCUM TENENS NURSE ANESTHETIST 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 ________

Emergency Contacts:

1) Name ____________________

Phone ____________________

Relation to you ____________________

2) Name ____________________

Phone ____________________

Relation to you ____________________

If Incorporated: Business Name ____________________ Tax ID No. ____________

Height ________ Weight ________ Smoker: Yes ❑ No ❑ Group NPI No. ____________

Referral Source ______________________________________________

## II. EDUCATION AND LICENSURE:

Nursing School ____________________ Year Completion ________ Degree ____________

Anesthesia School ____________________ Year Completion ________ Degree ____________

Other Education ____________________ Year Completion ________ Degree ____________

High School ____________________ Year Completion ________ Degree ____________

Date of Certification? ____________________ Certification No. ____________ Exp. Date ________

States Licensed ______________________________________________

State of Original Licensure ____________________ Licenses Pending ____________________

Malpractice Carrier ____________________ Policy Limits ____________________

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



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## 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

Have you ever been the subject of disciplinary proceedings at any healthcare facility? ❑ Yes ❑ No

Has your license or certification in any state ever been voluntarily or involuntarily relinquished, suspended, terminated, restricted, or is currently being challenged? ❑ Yes ❑ No



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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

❑ Malpractice Insurance of $1mill/$3mill *(preferred but not required – agency can provide)*

❑ AANA Certification/Recertification Card

❑ Proof of Certification for BLS, ACLS, PALS and/or NALS, if applicable

❑ Four (4) letters of reference or completed CRNA 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)*

❑ Nursing and Anesthesia School Diplomas/Certificates

❑ Social Security Card

❑ Drivers License

❑ NPI Confirmation – Individual *(Group NPI if applicable)*

❑ Medicare / Medicaid / Blue Cross Numbers

## 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.: ______________________________


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## CLINICAL SKILLS CHECKLIST – NURSE ANESTHESIA

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
- ❑ PALS
- ❑ ACLS
- ❑ NALS
- ❑ Other (Describe):__________________________________

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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# 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: ________________________________________

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

______ Personal Appearance

______ Attitude

______ Technical Skills

______ Ability To Get Along With Physicians, Coworkers & Patients

______ Knowledge And Ability To Practice "Safe Anesthesia"

______ Physical Assessment And Management Of "High Risk Patients"

______ Emotional Stability

______ Attendance And Punctuality

______ Seeks Consultation When Necessary

______ Overall Professional Competence

______ Cooperation

Comments: ________________________________________________________________________________

________________________________________________________________________________

**Reference Signature**: ________________________________________ **Date**: ______________________



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