LCA
LOW COUNTRY ANESTHESIA, P.A.

Certified Registered Nurse Anesthetist (CRNA) Application

Date of Application: _____

I. Personal Information:

Full Name _____ Nickname _____

Address _____

City _____ State _____ Zip _____ County _____

Home Phone _____ Cell Phone _____

Email _____ Pager/Alt. Email_____

Sex: M___ F___ Date of Birth _____ Social Security No. _____

U.S. Citizen: Yes___ No___ City/State/Country of Birth _____

If Incorporated: Business Name _____ Tax ID No. _____

Maiden/Former Name _____

Emergency Contact:

Name _____

Phone _____ ____

Relation to You _____

Alternative Emergency Contact:

Name _____

Phone _____

Relation to You _____

II. Education and Licensure:

School/Program	Name	Yr. Completed	Degree
High School			
Nursing			
Anesthesia			
Other			

Low Country Anesthesia, P.A.
Post Office Box 2118
Beaufort, South Carolina 29901-2118

State of Original Licensure, License #, Expiration Date _____

State(s) of Current Licensure, License #(s), Expiration Date(s) _____

_____

Pending License(s) with Date(s) of Projected Issuance _____

III. Certifications:

BLS? Yes___ No___ ACLS? Yes___ No___ PALS? Yes___ No___ NALS? Yes___ No___

NBCRNA: ID # _____ Initial Certification Date _____ Expiration Date _____

IV. Work History - Please List All Previous Employers (add pages if necessary).

Employer	Address	Position	Start Date	End Date

V. Types of Cases Comfortable With:

Ortho___ Neuro___ Hearts___ Major Vascular___ Thoracic___ URO___ OB___ GYN___

Eyes___ Burns___ Trauma___ Transplants___ Abortions___ GER___ ENT___ PEDS___

Other Cases: _____

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VI. Background (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 as a CRNA? Yes___ No___

Do you require an accommodation for a communicable disease? 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 a disciplinary proceeding(s), regardless of outcome, 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___

Have you ever been the subject of a disciplinary proceeding(s), regardless of outcome, 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, etc.)? Yes___ No___

Have judgments or settlements been made against you in a professional liability case(s), or is(are) claim(s) pending? Yes___ No___

VII. Please Include Clear Copies or Photos of the Following Material with Your Completed Application:

___ Four (4) Letters of Reference or CRNA Reference Inquiry Forms (part of this application)

___ Signed Applicant's Statement of Consent and Release Form (part of this application)

___ Social Security Card

___ Current Driver's License or State Issued Photo Identification

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VIII. Applicant's Statement of Consent and Release:

I hereby acknowledge that my signature below is my affirmation that the facts set forth in this application for employment are true and complete. I further acknowledge that any false statement on this application shall be considered sufficient cause for dismissal. Low Country Anesthesia, P.A. and its representatives (hereinafter individually and collectively referred to as "Employer") are hereby authorized to make any investigations of my personal and professional history through any agency, bureau or other organization necessary, including but not limited to, criminal background and criminal reports. Employer 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 Low Country Anesthesia, P.A. has the right to request a drug screen prior to and during any employment.**

Signature: _____ Date: _____

Printed Name: _____ Social Security No.: _____

Low Country Anesthesia, P.A. is an Equal Opportunity Employer. It does not discriminate on the basis of race, gender, religion, age, sexual orientation, gender identity, nationality or ethnicity, disability, marital or veteran status, or any other classification protected by applicable law. It also complies with laws regarding reasonable accommodations for individuals with disabilities. **Nothing in the application should be construed as an offer or guarantee of employment.**

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APPLICANT'S STATEMENT OF CONSENT AND RELEASE

I hereby authorize Low Country Anesthesia, P.A. and its representatives (hereinafter individually and collectively referred to as "Employer") 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 Employer to request such criminal background histories, drug screen tests and credit reports as Employer deems appropriate. I hereby appoint Employer 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 Employer at the address set forth in the footer of this document. I hereby release Employer from any and all liability arising from all acts performed in connection with evaluating my application for employment. **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 the attached CRNA Reference Inquiry Form or preparing a letter of reference on your behalf. A signed copy of this Statement should also be provided to Low Country Anesthesia, P.A. with your other application materials.

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CRNA Reference Inquiry Form

Low Country Anesthesia, P.A., ("LCA") is a private anesthesiology group who practices in South Carolina. It strives to deliver the highest quality medical care to our patients. In order to fulfill its mission, LCA and its representatives thoroughly screen every candidate for employment. We recently spoke to the below named candidate who directed us to you for your professional and personal opinions. Please take a moment to complete this evaluation form and return it to the address listed below. Thank you in advance for your assistance.

Candidate's Name: _____

Reference's Name: _____ Phone: _____

Title: _____ Email: _____

Hospital/Group: _____ Fax: _____

Address: _____

Dates of Candidate's Employment: _____

Was Candidate Terminate? Yes___ No___ Would You Rehire? Yes___ No___

Were There Any Suspected Problems with Drugs, Alcohol, Nerves, etc? Yes___ No___

If Yes to any of the Above, 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

_____ Rapport with Physicians, Coworkers and Patients

_____ Assessment and Management of "High Risk Patients"

_____ Seeks Consultation When Necessary

_____ Overall Professional Competence

_____ Emotional Stability

_____ Attitude

_____ Technical Skill

_____ Personal Appearance

____ Attendance/Punctuality

Comments: _____

_____

Signature: _____ Date: _____

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CRNA Clinical Skills Checklist

My signature below certifies that I am proficient in the techniques and procedures indicated below:

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
___ Ultrasound Guided Regional Blocks
Other (Describe): _____
_____

DIAGNOSTIC & THERAPEUTIC BLOCKS:

___ Sympathetic Blocks
___ Epidural
___ Bier
___ Spinal – Differential
___ Steroid, Alcohol & Drug Phenol Blocks
Other (Describe): _____
_____

INTRAVENOUS ADMINISTRATION OF:

___ Fluids
___ Blood
___ Plasma
___ Plasma Expanders
___ Muscle Relaxants
___ Vasoactive Drugs
___ Cardiac Drugs
Other (Describe): _____
_____

PROCEDURES:

___ Intravenous Catheter Placement
___ Swan Ganz
___ Placement of CVL Lines
___ Placement of Arterial Lines
___ Placement Right Heart
___ Placement of Pulmonary Lines
___ Placement of Axillary Lines
___ Mechanical Ventilation
___ Resuscitation Techniques & Therapy
___ Cardiopulmonary Bypass Techniques
___ Autotransfusion Techniques
___ Hypotensive Techniques
___ Hypertensive Techniques
___ Hypothermia
Other (Describe): _____
_____

Signature: _____ Date: _____

Printed Name: _____

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