ANESTHESIA PROVIDERS, INC.

JOB APPLICATION

GENERAL INFORMATION

NAME: _____ SS#: _____ DATE: _____

HOME ADDDRESS: _____

HOME PHONE: _____ CELL PHONE: _____ FAX: _____

EMAIL: _____ PAGER: _____ MARITAL STATUS: _____

PLACE OF BIRTH: _____ US CITIZEN?:_____

DOB: _____ MEDICARE #: _____ MEDICAID #: _____

EMERGENCY CONTACT NAME: _____ PHONE: _____

EDUCATIONAL TRAINING

GRADUATE SCHOOL NAME: _____

ADDRESS: _____

DATES ATTENDED: _____ DEGREE:_____

UNDERGRADUATE SCHOOL NAME: _____

ADDRESS: _____

DATES ATTENDED: _____ DEGREE: _____

HIGH SCHOOL NAME: _____

ADDRESS: _____

DATES ATTENDED: _____ DEGREE: _____

LICENSURE/CERTIFICATION

STATE: _____ CERTIFICATION #: _____ TYPE: _____ EFFECTIVE: _____ to ____

STATE: _____ CERTIFICATION #: _____ TYPE: _____ EFFECTIVE: _____ to ____

STATE: _____ CERTIFICATION #: _____ TYPE: _____ EFFECTIVE: _____ to ____

Anesthesia Providers Inc
2626 Lake Drive
Singer Island, Florida 33404
Telephone: (561) 842-3833
FAX: (561) 842-6360
Email: info@anesthesiaproviders.com

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HEALTHCARE AFFILIATIONS
Please also attach Curriculum Vitae along with this information. Please do not put refer to CV on the section as this is one of the more important sections and we like this for accuracy. Please only list the past 10 years of work history and any Agency you have been associated with.

HOSPITAL or FACILITY _____

ADDRESS _____

SUPERVISOR NAME & TITLE _____

PHONE_____ EXT. _____

EMPLOYMENT FROM _____ TO _____ POSITION HELD _____

SALARY UPON LEAVING_____

_____

HOSPITAL or FACILITY _____

ADDRESS _____

SUPERVISOR NAME & TITLE _____

PHONE_____ EXT. _____

EMPLOYMENT FROM _____ TO _____ POSITION HELD _____

SALARY UPON LEAVING_____

_____

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PROCEDURE/CLASSIFICATION
Types of Anesthesia:

General

☐ Yes ☐ No Inhalational — Would Perform? ☐ Yes ☐No
☐ Yes ☐ No Intravenous — Would Perform? ☐ Yes ☐No

Regional

☐ Yes ☐ No Spinal — Would Perform? ☐ Yes ☐No
☐ Yes ☐ No Epidural — Would Perform? ☐ Yes ☐No
☐ Yes ☐ No Caudal — Would Perform? ☐ Yes ☐No
☐ Yes ☐ No Blocks — Would Perform? ☐ Yes ☐No
☐ Yes ☐ No PEDS — Would Perform? ☐ Yes ☐No
☐ Yes ☐ No Monitored Anesthesia Care (MAC) — Would Perform? ☐ Yes ☐No

Resuscitation

☐ Yes ☐ No Emergency Laryngoscopy/Intubation — Would Perform? ☐ Yes ☐No
☐ Yes ☐ No Emergency Treatment — Would Perform? ☐ Yes ☐No

Other

☐ Yes ☐ No Pre-and Post-operative consultation and evaluation — Would Perform? ☐ Yes ☐No
☐ Yes ☐ No Anesthesia for all surgical specialties — Would Perform? ☐ Yes ☐No
☐ Yes ☐ No Participation in the perculaneous insertion of monitoring devices under direct — Would Perform? ☐ Yes ☐No
☐ Yes ☐ No Supervision of an MD Anesthesiologist — Would Perform? ☐ Yes ☐No

Note: All under the supervision of a board certified or board eligible M.D. Anesthesiologist.

SKILLS
Please note all the skills you are either **P**roficient or **T**rained in you may use a **P** or **T**.

Epidural Blocks	____	Retrobulb Blocks	____	Spinal Blocks	____
Bier Blocks	____	CVP Lines	____	MAC	____
A-Lines	____	Other	____	Hearts	____
Neuro	____	PEDS	____		

SPECIAL SKILLS
Please list any special skills you would feel that a Hospital, Surgery Center, or Doctor's Office looking at you as a candidate would find interesting.

_____

_____

_____

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CITY AND STATE POSITION IS SOUGHT
Please list the CIty and States you are seeking a position

CITY	STATE	POSITION
_____	_____	_____
_____	_____	_____

PROFESSIONAL LIABILITY INSURANCE
PRESENT INSURANCE CARRIER NAME: _____

ADDRESS: _____

POLICY #: _____ COVERAGE LIMITS: _____ EXP. DATE: _____

PRIOR INSURANCE CARRIER NAME: _____

ADDRESS: _____

POLICY #: _____ COVERAGE LIMITS: _____ EXP. DATE: _____

Have you ever been involved in, or are there currently pending, any medical liability claims, suits, settlements, udgments, or arbitration proceedings against you? YES or NO (If yes, please explain)

Have you ever been denied professional liability insurance or has coverage ever been canceled or have you ever been levied a surcharge based on your own claims history? YES or NO (If yes, please explain)

REFERENCES
NAME: _____ PHONE: _____ FAX: _____

ADDRESS: _____SPECIALTY: _____

CELL PHONE: _____ YEARS AQUAINTED: _____TITLE: _____

NAME: _____ PHONE: _____ FAX: _____

ADDRESS: _____ SPECIALTY: _____

CELL PHONE: _____ YEARS AQUAINTED: _____TITLE: _____

NAME: _____ PHONE: _____ FAX: _____

ADDRESS: _____ SPECIALTY: _____

CELL PHONE: _____ YEARS AQUAINTED: _____TITLE: _____

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DISCIPLINARY ACTIONS
Have any of the following ever been, or are any currently in the process of being involuntarily or voluntarily denied, revoked, suspended, reduced, limited, placed on probation, not renewed, relinquished or have you ever withdrawn or failed to proceed with an application for any of the following? If "yes" please provide full explanation.

☐ Yes ☐ No Are you license in any state or other health related professional registration/license.

☐ Yes ☐ No DEA / Controlled Substance Registration?

☐ Yes ☐ No Membership, clinical privileges or prerogatives / rights on any hospital medical staff.

☐ Yes ☐ No Other institutional affiliation or status or privileges.

☐ Yes ☐ No Health-related professional society membership or fellowship or Board Certification

☐ Yes ☐ No Any other type of professional sanction?

☐ Yes ☐ No Have you ever been convicted of or pleaded no contest to any criminal charges?

☐ Yes ☐ No Have you ever been convicted of or pleaded no contest to a drug or alcohol related offense?

HEALTH STATUS
If "yes" to any of the following, please provide full explanation.

☐ Yes ☐ No Do you have any physical handicap or condition that could limit your ability to perform the Privileges you are requesting? (If yes, please explain)

☐ Yes ☐ No Are you currently taking any medication or under other therapy for a condition which could affect your ability to perform your duties (as related to the clinical privileges which you are requesting) if it were discontinued today?

☐ Yes ☐ No Have you ever been or are you currently under treatment for a mental health condition or chemical dependency?

When was your most recent physical examination? _____ Performed by: _____

Please include the following documents:

Current Resume, Malpractice Insurance, ACLS, BCLS, PALS. , Recertification Card, AANA Member Card, FLA RN LIC.

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HOSPITAL STATISTICS AND BENEFIT/SALARY REQUIREMENTS
Please answer the following questions below regarding what you would like for Salary and Benefits. If there is something that is not listed that you would like negotiated for you please list.

Date you could start an assignment _____

Size Hospital _____ # OR Rooms _____

CRNA _____ # MDA _____ # Surgeons _____

Position Sought: Chief/Solo/Staff (Choose One) Hours per week: _____

Willing to pull Call (Y/N): _____ Day off after call (Y/N): _____

Willing to pull Weekend Call (Y/N): _____

Are you willing to work with Medically Directed Department (Y/N): _____

Do you want to be Unsupervised and function independently (Y/N): _____

Salary Desired: _____

Call Pay (Is this amount separate from salary Y/N): _____

Complete the questions below. If you have a dollar amount in mind please list the amount desired.

Moving Expenses Paid:	Y/N	Working Interview Allowed:	Y/N
Interviewing Expenses Paid:	Y/N	Tuition Reimbursement:	Y/N
Medical Insurance:	Y/N	HMO/PPO (Choose One)	_____
Malpractice:	Y/N	Life Insurance (Amount):	Y/N _____
Dental Insurance:	Y/N	Disability Insurance: Long/Short	Y/N
Vacation or PTO: # Weeks	_____	401K or Simple IRA:	Y/N
Employer Contribution	Y/N		
Continuing Education time-off (How much)	_____	CEU Reimbursement Amount	_____
Profit Sharing	Y/N	License Reimbursement	Y/N

If there is something else you would like to add to this application that we have overlooked please list below:

_____

_____

_____

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RELEASE OF INFORMATION

These facts set forth in this application for seeking a position are True and Complete. I understand that if utilized, false statements on this application shall be considered sufficient cause for non-utilization. Anesthesia Providers, Inc. is hereby authorized to make any investigations of my personal and professional history through any agency or bureau necessary. You are also authorized to investigate my ability, work record or character through inquires to the individual and employers mentioned in the application and hereby release you and the person to whom inquiry is made from any and all claims and liability growing out of such inquires.

_____ _____

Signature Date

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As a way to better serve all our clients we are requesting an evaluation of the CRNA that performed services for your facility. If you could please take a moment and complete the following evaluation form this would help Anesthesia Providers, Inc. be able to continue to provide quality CRNA staffing.

CRNA Name: _____

Facility Name: _____

Address: _____

Dates CRNA Provided Coverage: From_____To _____

Would this CRNA be considered for future coverage? Yes_____No_____
If No, please explain:

_____

_____

Were there any problems or concerns with this CRNA? Yes____No_____
If Yes, please explain:

_____

_____

Please evaluate using a scale of 1 to 5 with 1 being Poor and 5 being Excellent

_____ Overall Anesthesia Competency

_____ Rapport with OR staff

_____ Anesthesia Skills and Techniques

_____ Emotional Stability

_____ Appearance and Hygiene

_____ Overall Performance

_____ Patient Care and Evaluation

_____ Rapport with patients

_____ Decision Making

_____ Attitude

_____ Punctuality

Reference Signature: _____ Date: _____

Printed Name: _____ Contact #: _____

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