PROFESSIONAL ANESTHESIA SERVICES
OF NORTH AMERICA

CRNA Application for Employment

Name _____
(Last) (First) (Middle)

Social Security Number _____ Telephone _____

Home Address _____

City _____ State _____ Zip code _____

Birth Date _____ Birth Place _____

Email address _____ Cell Phone _____

Education:

College _____

Graduation Date _____ Degree _____

Address _____

City _____ State _____ Zip code _____

Nursing School

Name:_____

Graduation Date _____ Degree _____

Address _____

City _____ State _____ Zip code _____

Anesthesia Training

Name:_____

Graduation Date _____ Certificate:_____

Address _____

City _____ State _____ Zip code _____

Other Education:

College / Location _____

Address _____

City _____ State _____ Zip code _____

Major /Specialty _____ Years Completed _____ Degree _____
(if applicable)

Professional Organization Memberships:

_____

_____

_____

Licenses: (Submit copies of documents)

State ____PA_____ RN License Number _____ Expiration Date_____

State _____ RN License Number _____ Expiration Date_____
(if other)

CRNA Certifications: (Submit copies of documents)

AANA number: _____ Original Date of Certification _____

Recertification Expiration Date _____

Other Certification Expiration
or Licensure Type _____License Number _____ Date_____

Other Certifications / Training: (submit copies of these documents)

BLS Expiration Date: _____ ACLS Expiration Date: _____

PALS Expiration Date: _____

Other Certifications: _____Expiration Date: _____

Professional Liability Insurance: (submit copy of documents)

Name of Carrier: _____

Address: _____

City:_____ State:_____ Zipcode:_____

Policy Number: _____ Limits of Liability: _____

Dates of policy: _____until _____

A. Are you responsible for your Professional Liability Insurance Coverage or is it provided by your present employer/hospital? Self-insured _____ Employer insured _____

B. Has your professional liability insurance carrier and/or the amount of professional liability insurance changed since your last appointment? Yes _____ No _____

If the answer to any of the questions below is YES, please provide a full explanation of the details on a separate sheet and attach to this application. If the answer to #3 is YES, your explanation should include the following information: (a) date suit or claim was initiated; (b) brief description of the nature of the claim; and (c) current status, including the substance of the findings in each action that has been concluded and the amount of any final judgments or settlements made.

1. Have you been denied professional liability insurance or has your coverage been canceled or has a surcharge been imposed based on your claims experience? Yes _____ No _____

2. Has your present professional liability insurance carrier excluded any specific procedures from your insurance coverage? Yes _____ No _____

3. Have there been, or are there currently pending, any malpractice claims, suits, settlements, or arbitration proceedings involving your professional position? Yes _____ No _____

Peer Recommendations: Please furnish two letters of recommendation, one from your current department head.

Continuing Education: Please furnish copies of CEU's for past two years

General Information:

Have any of the following been, or are any currently in the process of being denied, revoked, suspended, reduced, limited, placed on probation, or not renewed? Or have you voluntarily relinquished, withdrawn or failed to proceed with an application for any of the following in order to avoid an adverse action, for non-adverse reasons, or to preclude an investigation or while under investigation relating to professional conduct? If the answer to any of the following questions is YES, please provide full explanation, including resolutions of occurrence on a separate sheet and attach.

A. License(s) for practice in any state Yes _____ No _____
B. Other health related professional registration/license Yes _____ No _____
C. Any other type of professional sanction Yes _____ No _____
D. Have you been convicted of or pleaded no contest to any criminal charges (other than motor vehicle speeding violations) brought against you? Yes _____ No _____
E. Have you been convicted of or pleaded no contest to a drug or alcohol related offence? Yes _____ No _____
F. Have any disciplinary actions or investigations by any state licensing board been initiated against you? Yes _____ No _____

Professional Anesthesia Experience: (most recent first)

1. Employed by _____

Address _____

City _____ State _____ Zip code _____

Facility: _____

Position _____Period of Employment _____

2. Employed by _____

Address _____

City _____ State _____ Zip code _____

Facility: _____

Position _____Period of Employment _____

Other Professional Experience:

Employed by _____

Address _____

City _____ State _____ Zip code _____

Position _____Period of Employment _____

Health Status:

I am mentally and physically capable of performing the privileges, which I have requested. I consent to release of information necessary for the evaluation of my background, training, professional competence and ethical character. I affirm that the information included in this document is true to the best of my knowledge.

My last physical was _____ performed by _____

I attest that to the best of my knowledge, the information in this application has been answered correctly.

Signature _____ Date: _____

Important Note: Typing your name in the above space constitutes a legal signature with regard to this application. In addition, your failure to provide all information requested in this application may result in the denial or delay of your application. Please complete all applicable information.

To submit this form send an email with this saved application to jobs@pasna.net