

**Initial**

**Credentialing Application:**

**Certified Registered Nurse Anesthetist**

Dear Anesthesia Provider,

Thank you for your interest in providing services at our facility. Tennessee Surgery Center (TSC) is an Ambulatory Surgery Center that is certified by the Center for Medicare/Medicaid Services (CMS) as well as the Accreditation Association for Ambulatory Healthcare Facilities (AAAHC) as a premier provider of outpatient surgical care in middle Tennessee. The following application is required by state regulations and facility bylaws. In addition to this application, you will need to submit the following documentation before your application is considered complete.

\_\_\_\_\_Copy of Recent photo ID (Driver’s License is acceptable)

\_\_\_\_\_Copy of current Tennessee issued APRN license (if applicable)

\_\_\_\_\_Copy of current Professional Liability Insurance Certificate

\_\_\_\_\_Copy of Loss History related to your Liability Insurance

\_\_\_\_\_Copy of current ACLS/PALS/BLS/CPR certification (if applicable)

\_\_\_\_\_Copy of Anesthesia School Diploma

\_\_\_\_\_Primary source verification of degree and graduation date (obtained via university

 registrar’s office)

\_\_\_\_\_List of facilities where you currently hold active privileges (if applicable)

\_\_\_\_\_Curriculum Vitae (Resume)

The credentialing process will begin upon receipt of your complete Initial Credentialing Application. Temporary Privileges can be granted within 2 weeks, whereas your full appointment could take up to 6 weeks. Once full privileges are granted, they are active for a period of two (2) years.

If you have any questions or need assistance with this application, please feel free to contact scooke@ssctn.com or call (615)525-8998. We look forward to receiving your completed application and to working with you.

Sincerely,

 **Sandra Cooke, BSN, RN**

 **Administrator**

 Tennessee Surgery Center

 410 42nd Avenue N Suite 300

 Nashville, TN 37209

 P: (615) 321.6161

 F: (615) 645.9870

**Initial Credentialing Application:**

# Certified Registered Nurse Anesthetist

**Section I: Demographic Information**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name First Name Middle Initial Gender

\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_ Preferred Contact Method: Email Phone Fax

Social Security Number Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address Telephone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Practice Name Office Manager/Contact

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Practice Address City State Zip

(\_\_\_\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_ (\_\_\_\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice Telephone Practice Fax Email Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Person Emergency Contact Phone Emergency Contact Relation To You

 **Section II: Professional License/Certification Information**

 (Attach copies of all licenses and certifications if applicable)

License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Issued: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ Expiration: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_

License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Issued: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ Expiration: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_

DEA/ Controlled Substance #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ NPI #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BLS Certification Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ ACLS Certification Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_

PALS Certification Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ CPR Certification Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_

Specialty Board(s) by which you are certified: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date certified: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_

Date Recertification Expires: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ Have you ever taken & failed a professional certification examination? YES NO

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section III**

**:**

**Supervising Physician Information**

Name of Physician currently on staff at Tennessee Surgery Center who will be supervising you:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervising Physician Name (please print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervising Physician Signature Date

 **Section IV: Professional Liability Information**

 **(Attach Proof of Liability Insurance and Loss History)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Liability Carrier Name Policy Number

\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Effective Date Expiration Date Per Occurrence Amount ($) Aggregate Amount ($)

**Attach current Curriculum Vitae**

 **Section V: Education, Training & Employment Information**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nursing School Dates Attended

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anesthesia School Dates Attended

*Please list your employment history for the previous five years, including your current employer:*

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates Employed: \_\_\_\_\_\_\_\_\_\_\_\_\_ To \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates Employed: \_\_\_\_\_\_\_\_\_\_\_\_\_ To \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates Employed: \_\_\_\_\_\_\_\_\_\_\_\_\_ To \_\_\_\_\_\_\_\_\_\_\_\_\_\_

If there has been any lapse in employment (>6 months) during the past five years, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you answer “yes” to any of the following questions, please explain on a separate sheet of paper)**

 **Section VI: Health Status**

Do you presently have any physical or mental condition, illness or injury (including use of or YES NO dependency on any chemical substance or alcohol) that in any way impairs or limits your ability

to practice or perform procedures for the privileges you are requesting at Tennessee Surgery

 Center with reasonable skill and safety? (with or without accommodation)?

Are you currently participating in a supervised rehabilitation program or professional assistance YES NO program that monitors you?

Are you currently engaged in illegal use of controlled dangerous substances? YES NO

Have you received treatment or been advised to receive treatment for alcohol or substance dependency? YES NO

Are you currently taking any medications that may affect either your clinical judgment or motor skills? YES NO

**If you answer “yes” to any of the following questions, please explain on a separate sheet of paper)**

 **Section VII: Professional Information**

Has your license, DEA, or certification to practice in this state or any other state ever been  YES NO

suspended, revoked, voluntarily relinquished, or put on probation status; or, are any of these

actions pending with respect to your license, DEA, registration, or certification?

Have your hospital or surgical facility privileges ever been revoked, suspended, limited YES NO

reduced, non-renewed; or have disciplinary proceedings ever been instituted against you

by a hospital or surgical facility, or, are any of these actions now pending with respect to your

hospital or surgical facility privileges?

Have any complaints or adverse action reports been filed against you with a local, state, YES NO

or national professional society or license board?

Are you now or have you ever been involved in any malpractice actions(s), including litigation, YES NO

arbitration mediation; or have you ever received any notice of any claim or complaint against you?

Has your professional liability insurance ever been canceled, non-renewed or have you ever YES NO

been denied professional liability insurance?

Have you ever been sanctioned or disciplined by Medicare/ Medicaid? YES NO

Have you ever been prosecuted for, convicted of or charged with a felony or misdemeanor

(other than minor traffic violations)?

 **Section VIII: Professional Release Information**

Please list the name, address, phone number, email address and title or relationship of two professional peer references and one physician who have observed you during your practice or procedures that can attest to your current clinical abilities, ethical character, and health status.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Peer Reference #1 Name Title

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address City State Zip Code

(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number Email Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Peer Reference #2 Name Title

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address City State Zip Code

(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number Email Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Reference Name Title

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address City State Zip Code

(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number Email Address

 **Section IX: Conditions of Application**

I attest that the information contained in this profile and all enclosed/attached documents, which I agree to provide to support this profile, are complete and accurate. I agree to notify TSC of any change in the information contained in this profile and any attached documents within thirty (30) days of the date that I am aware of the change. Furthermore, I consent to the inspection and copying of all records and documents that may be relevant to my pending credentialing review and decision.

A copy of this authorization and release has the same effect as the original.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of Nurse Anesthetist Applicant Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Nurse Anesthetist Applicant

 **Certified Registered Nurse Anesthetist**

 DELINEATION OF PRIVILEGES

Name of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby request clinical privileges in the specialty of a CRNA as reflected on this form. I understand that privileges granted are subject to a review coinciding with Medical Staff Bylaws. I also understand that application or re-application for additional or new procedures can be made at any time with proper documentation.

The following Anesthesia privileges are requested and are consistent with my education, clinical training, demonstrated skills and capacity to manage procedurally related complications.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  **PRIVILEGES** | Requested | Not Requested | Approved | Denied |
| Administration of General Anesthesia (all agents), including pre-op and post-op care |  |  |  |  |
| Administration of Moderate Sedation |  |  |  |  |
| Administration of IV Conscious Sedation |  |  |  |  |
| Administration of Regional Anesthesia |  |  |  |  |
| Administration of Spinal (including continuous)  |  |  |  |  |
| Administration of Epidural (including continuous)  |  |  |  |  |
| Administration of Peripheral Nerve Blocks  |  |  |  |  |
| Administration of IV Regional Block |  |  |  |  |
| Administration of TAP Block  |  |  |  |  |
| Administration of Popliteal Block |  |  |  |  |
| Administration of Adductor Block |  |  |  |  |
| Administration of Interscalene Block  |  |  |  |  |
| Administration of Brachial Plexus Block Axilla |  |  |  |  |
| Administration of Supraclavicular Block |  |  |  |  |
| Administration of Femoral Block  |  |  |  |  |
| Administration of IPACK Block |  |  |  |  |
| Works under the supervision & management of Physician |  |  |  |  |
| Read and interpret ultrasonic images for nerve blocks |  |  |  |  |
| Evaluation, diagnosis & documentation of medical conditions to determine status for anesthesia services |  |  |  |  |
| Obtain comprehensive informed consent for anesthesia & related services |  |  |  |  |
| Select, obtain, order, & administer pre & post anesthesia medications, test & treatments  |  |  |  |  |
| \*Other: |  |  |  |  |
| \*Other: |  |  |  |  |

 (Please check **EITHER** requested or not requested column for **EACH** procedure.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anesthesiologist Applicant Signature Initials Date Signed

(as used in Medical Records) (as used in Medical Records)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*(For official use only under line)*

Delineation of Privileges has been reviewed. Action by Board:

\_\_\_\_\_ Appointment Granted \_\_\_\_\_ Appointment Declined

\_\_\_\_\_ Appointment granted with the following modifications\*

\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL DIRECTOR Signature**  **Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**GOVERNING BOARD Signature Date**

**Release of Information**

By making application to the Tennessee Surgery Center as a Certified Registered Nurse of Anesthesia, I hereby authorize the Corporate Compliance Officer, or their designee, to make an inquiry of any of my references and institutions in which I have been enrolled or by whom I have been employed or extended privileges, as to my qualifications. This also includes, obtaining a claims history report for my current liability insurance.

I further authorize any of the above persons or institutions to forward any and all information their records may contain and agree to hold them harmless from any action by me for their acts. This release is valid for two years from the below signed date.

A photocopy of this shall serve as the original.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name (Printed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**Right of Confidentiality**

As a member of the Credentialed Health Staff of the Tennessee Surgery Center, I recognize the patient’s right to confidentiality and agree to abide by the Patient’s Bill of Rights as posted within the Tennessee Surgery Center. Additionally, I agree that information relating to a patient’s physical, mental, and/or emotional status will not be released except as set forth within the policies and procedures of the Tennessee Surgery Center.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name (Printed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**Total Release of Liability**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, an Health Professional of the Tennessee Surgery Center (TSC), understand that TSC’s first priority is to meet the needs of the patient. In meeting this goal, I understand that Tennessee Surgery Center cannot be held responsible for any injury I may incur during my attending and/or assisting on surgeries while at their surgery center. In signing this form, I am relinquishing Tennessee Surgery Center from any liability during my stay as an Health Professional at Tennessee Surgery Center.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name (Printed)

|  |  |
| --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Signature    | Date  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Witness Signature  | Date  |

**Temporary Staff Privileges for:**

 **Certified Registered Nurse Anesthetists (CRNA)**

Medical/Credentialing Director:

Please find my attached, completed, application for staff privileges as a Certified Registered Nurse Anesthetist. I subsequently request temporary privileges for procedures delineated in my application so that I may perform procedures at the Tennessee Surgery Center for a period of ninety (90) days or until such time as my application has been approved by the governing board.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name (Printed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

*(Official Use Only Below Line)*

Approved:\_\_\_\_\_\_\_\_ Denied:\_\_\_\_\_\_\_\_ Effective:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ through \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Compliance Officer Date

**Full Approval of Appointment for:**

**Certified Registered Nurse Anesthetist (CRNA)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name (Printed)

The above nurse anesthetist is granted the full privileges which she/he has requested with the following exceptions and/or limitations:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(This Page Official Use Only)*

**Approved By Medical/ Credentialing Staff:**

|  |  |
| --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Anesthesia Service Coordinator’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Medical/ Credentialing Director’s Signature     **Approved By Governing Body:**    | Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Board of Governor Chair | Date  |



 **HEALTH SCREENING**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HEALTH HISTORY:

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have or have you ever had the following: (yes or no)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  Heart disease  | \_\_\_\_\_\_\_\_  |   | Liver disease  | \_\_\_\_\_\_\_\_  |
|  Lung disease  | \_\_\_\_\_\_\_\_  |   | Mental illness  | \_\_\_\_\_\_\_\_  |
|  Diabetes  | \_\_\_\_\_\_\_\_  |   | Depression  | \_\_\_\_\_\_\_\_  |
|  Epilepsy  | \_\_\_\_\_\_\_\_  |   | Musculoskeletal  | \_\_\_\_\_\_\_\_  |
|  Seizures  | \_\_\_\_\_\_\_\_  |   | disease or injury  | \_\_\_\_\_\_\_\_  |
|  Cancer  | \_\_\_\_\_\_\_\_  |   | Stomach or bowel  | \_\_\_\_\_\_\_\_  |
|  Tuberculosis  | \_\_\_\_\_\_\_\_  |   | Renal disease  | \_\_\_\_\_\_\_\_  |
|  Hypertension  | \_\_\_\_\_\_\_\_  |   | Fever/night sweats  | \_\_\_\_\_\_\_\_  |
|  |  |  |  |  |

Current Immunizations:

Influenza:\_\_\_\_\_\_\_\_\_ Hep B:\_\_\_\_\_\_\_\_\_ COVID-19:\_\_\_\_\_\_\_\_\_

 Date Date Date

List any major hospitalizations and any previous surgeries including year. Exclude

childbirth.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICAL EXAM:

HT: \_\_\_\_\_ WT: \_\_\_\_\_ BP: \_\_\_\_\_ P: \_\_\_\_\_ R: \_\_\_\_\_ Temp: \_\_\_\_\_ Sat: \_\_\_\_\_

Any recent illness? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recent exposure to communicable diseases? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recent unexplained weight loss? \_\_\_\_\_\_ lbs \_\_\_\_\_\_\_\_\_\_over \_\_\_\_\_\_\_\_\_\_ months

Hepatitis B Series: Yes \_\_\_\_\_ No \_\_\_\_\_\_ Hep Titer results: \_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_

T.B. skin test date: \_\_\_\_\_\_\_\_\_\_ Site: \_\_\_\_\_\_\_\_\_\_Results: \_\_\_\_\_\_\_\_\_\_\_\_ Comments:

Examiners Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_

410 42nd Avenue North

Suite 300

Nashville, TN 37209

Phone: (615) 321.6161

Fax: (615) 645.9870

Bring Your Whole Self to Work

Tennessee Surgery Center is passionate about creating an inclusive workplace. A place where employees are engaged, knowing they are included and valued. An inclusive workplace that promotes and values diversity. Ambulatory Surgery Centers that are diverse in age, gender identity, race, sexual orientation, physical or mental ability, ethnicity, and perspective are proven to be better patient caregivers.

More importantly, creating an environment where everyone, from any background, can do their best work is the right thing to do. Thank you for not only bringing your whole self to work, but respecting others who do the same.

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_