Dear CRNA,

Thank you for your continued interest in providing services at our facility. We have enjoyed participating in the care of your patients undergoing treatment at Specialty Surgery Center (SSC). In an effort to comply with State and Federal guidelines governing Ambulatory Surgery Centers, our Governing Board requires that all providers submit a re-credentialing application every two (2) years. Much of this application is an attestation and update of your Initial Application for Privileges. A copy of your Initial Application for Privileges can be provided upon request. In addition to the following application, you will need to submit the following documentation before your application is considered complete:

- Updated copy of current Tennessee issued Professional License (APRN License)
- Updated copy of current Professional Liability Insurance (Malpractice Insurance)
- Updated copy of Loss History Report related to your Professional Liability Insurance
- Copy of current BLS/CPR certification, ACLS &/or PALS (if applicable)
- Updated list of facilities where you currently hold active privileges (if applicable)
- $100 Re-credentialing application fee

The re-credentialing process will begin upon receipt of your complete Re-Credentialing Application as well as the Re-Credentialing Application fee of $100. This application should be submitted prior to expiration of your previously granted privileges. Once this application has been processed, privileges are again active for a period of two (2) years.

If you have any questions or need assistance with this application, please feel free to contact me via email at pitts@tnosi.com or phone at (615) 321-6162. We look forward to receiving your completed application and to working with you.

Sincerely,

Adam S. Pitts, M.D., D.D.S.
Credentialing Director, Specialty Surgery Center
**Section I: Demographic Information**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Gender</th>
</tr>
</thead>
</table>

Social Security Number [____-____] Date of Birth [____/____/____]

Preferred Contact Method: E-mail, Phone, Fax

Primary Practice Name

Primary Practice Address

City

State

Zip

Practice Telephone [____-____]

Practice Fax [____-____]

E-mail 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)

License Number: __________ Type: __________ Date Issued: [____/____/____] Expiration: [____/____/____]

License Number: __________ Type: __________ Date Issued: [____/____/____] Expiration: [____/____/____]

DEA/Controlled Substance Number: __________ Expiration Date: [____/____/____]

BLS Certification Expiration Date: [____/____/____]

ACLS Certification Expiration Date: [____/____/____]

PALS Certification Expiration Date: [____/____/____]

Specialty Board(s) by which you are certified: __________ Date certified: [____/____/____]

Recertification Date: [____/____/____]

Have you ever taken & failed a professional certification examination? YES NO

If yes, please provide details: ____________________________________________________________
Section III: Professional Liability Information
(Attach proof of liability insurance and loss history if applicable)

Current Liability Carrier Name _____________________________________________________________________________

Policy Number ________________________________________________________________________________________

/__/__/ _______ /__/__/ _______
Policy Effective Date Expiration Date _______________________________________________________________________

Per Occurrence Amount ($) Aggregate Amount ($) ________________________________________________________________

Section IV: Additional Education & Employment Information
(Attach current Curriculum Vitae)

Since submitting your Initial Application for Privileges have you completed additional training
recognized by an Accrediting Body (ie ACGME, CODA) YES NO

_____________________________ ______________________
Training Program Dates attended To ______________________

_____________________________ ______________________
Training Program Dates attended To ______________________

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

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 two years, please explain:

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

S:\SSC\SSC Credentialing\Applications for Privileges\Re-Credentialing Application (CRNA).docx
Section V: Health Status & Personal/Professional Information
(If you answer “yes” to the following questions, please explain on separate sheet of paper)

Since your initial appointment, or last reappointment to Specialty Surgery Center, have any of the following been, or are actions pending or are any in the process of being: denied, revoked, suspended, reduced, limited, placed on probation, modified, not renewed, voluntarily or involuntarily relinquished?

1. State medical/dental license (any state) YES NO
2. Any other professional registration YES NO
3. DEA Registration YES NO
4. Membership on Active Staff (any facility) YES NO
5. Clinical Privileges (any facility) YES NO
6. Rights on any Medical Staff YES NO
7. Other institutional affiliations or status YES NO
8. Professional society membership YES NO
9. Fellowship/Board certification or eligibility YES NO
10. Professional liability insurance (malpractice insurance)* YES NO
11. Driver’s License YES NO

*Any liability claim information should include names, dates, parties, clinical Summary, of events, disposition, current status and/or settlement amounts.

Since your initial appointment, or last re-appointment to Specialty Surgery Center:

1. Have you been involved in any liability judgments, awards, or out of court settlements, or is any malpractice action currently pending? If “yes,” answer how many below, if “No”, skip to next question.
   How Many in last two (2) years? ______________

2. Have you been convicted of any crime, other than a minor traffic violation? YES NO
I attest that the information contained in this profile and all enclosed/attached documents, which are agree to provide to support this profile, are complete and accurate. I agree to notify SSC 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 CRNA Applicant ________________________________ Date __________________

Signature of CRNA Applicant

Section VIII: Conditions of Application
Release of Information

By making application to the Specialty Surgery Center as an Allied Health Professional, I hereby authorize the Director of Nursing, 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.

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.

A photocopy of this shall serve as the original.

___________________________
Full Name (Printed)

___________________________  ________________________
Signature                      Date
I, ______________________, an Allied Health Professional of the Specialty Surgery Center (SSC), understand that SSC’s first priority is to meet the needs of the patient. In meeting this goal, I understand that Specialty 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 Specialty Surgery Center from any liability during my stay as an Allied Health Professional at Specialty Surgery Center.

Full Name (Printed)

Signature ______________________ Date ______________________

Witness Signature ______________________ Date ______________________
Full Approval of Re-Appointment for:
Certified Registered Nurse Anesthetist (CRNA)

(This Page Official Use Only)

________________________________________
Full Name (Printed)

Re-Appointment Begins                      Re-Appointment Expires

Approved By Medical/Credentialing Staff:

Medical/Credentialing Director Signature    Date

Approved By Governing Body:

President, Specialty Surgery Center         Date