Initial Credentialing Application:
Certified Registered Nurse Anesthetist (CRNA)

Dear Anesthesia Provider,

Thank you for your interest in providing services at our facility. Specialty Surgery Center (SSC) 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 Professional License (APRN License)
- Copy of current Professional Liability Insurance (Malpractice Insurance)
- Copy of Loss History Report related to your Professional Liability Insurance
- Copy of current BLS/CPR certification, ACLS &/or PALS (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)
- Competency Evaluation (performed by Alan Davenport)
- $150 application fee

The credentialing process will begin upon receipt of your complete Initial Credentialing Application as well as the initial application fee of $150. 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 me via email at cdavenport@ssctn.com or phone at (615) 340-8510. We look forward to receiving your completed application and to working with you.

Sincerely,

Christina Davenport
Specialty Surgery Center
## Initial Credentialing Application:
Certified Registered Nurse Anesthetist (CRNA)

### Section I: Demographic Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Gender</th>
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Social Security Number: _____-_____-____
Date of Birth: ____/____/________

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<tr>
<th>Preferred Contact Method:</th>
<th>E-mail</th>
<th>Phone</th>
<th>Fax</th>
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Primary Practice Name: ____________________________________________
Office Manager/Contact: __________________________

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<tr>
<th>Primary Practice Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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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: ___/___/_____

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

If yes, please provide details: ________________________________________________________________

**Section III: Supervising Physician Information**

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

___________________________________________________________  ___/___/______ Supervising Physician’s Name (Please Print) Supervising Physician’s Signature  Date

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

(Attach current Curriculum Vitae)

Nursing School  ____________________________  To  ____________________________ Dates attended

Anesthesia School  ____________________________  To  ____________________________ 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:

________________________________________________________________________________________________________

Section VI: Health Status
(If you answer “yes” to the following questions, please explain on separate sheet of paper)

1. Do you presently have any physical or mental condition, illness or injury (including use of or 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 Specialty Surgery Center with reasonable skill and safety? (with or without accommodation)?

2. Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you?

3. Are you currently engaged in illegal use of controlled dangerous substances?

4. Have you received treatment or been advised to receive treatment for alcohol or substance dependency?

5. Are you currently taking any medications that may affect either your clinical judgment or motor skills?

Section VII: Professional Information
(If you answer “yes” to the following questions, please explain on separate sheet of paper)

1. Has your license, DEA, or certification to practice in this state or any other state ever been 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?
2. Have your hospital or surgical facility privileges ever been revoked, suspended, limited reduced, non-YES NO 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?

3. Have any complaints or adverse action reports been filed against you with a local, state, or national professional society or licensure board? YES NO

4. Are you now or have you ever been involved in any malpractice action(s), including litigation, arbitration or mediation; or have you ever received any notice of any claim or complaint against you? YES NO or

5. Has your professional liability insurance ever been cancelled, non-renewed or have you ever been denied professional liability insurance? YES NO

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

7. Have you ever been prosecuted for, convicted of or charged with a felony or misdemeanor (other than minor traffic violations)? YES NO

Section VIII: Professional Reference Information

Please list the name, address, phone number, and title or relationship of two (2) professional peer references and one (1) physician who have observed you during your practice or procedures who can attest to your current clinical abilities, ethical character and health status.

__________________________________________________________  ____________________________________________
Peer Reference #1 Name                               Title

__________________________________________________________  ____________________________________________
Address                                           City          State         Zip Code

(____) _____-_______   ______________________________
Phone                                           Phone

E-mail (if available)

__________________________________________________________  ____________________________________________
Peer Reference #2 Name                               Title

__________________________________________________________  ____________________________________________
Address                                           City          State         Zip Code

(____) _____-_______   ______________________________
Phone                                           Phone

E-mail (if available)
Section IX: Conditions of Application

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 Nurse Anesthetist Applicant Date

__________________________________________________________ Signature
of Nurse Anesthetist Applicant
Clinical Privileged Delegation Form For:
Certified Registered Nurse Anesthetists (CRNA)

Name:_________________________________________________ Date:________________________________________

Please check the procedures for which you are making application:

_____ Pre-anesthetic assessment _________________________ Requesting laboratory/Diagnostic studies

_____ Pre-anesthetic medication __________________________ General anesthesia and adjuvant drugs

_____ Cardiopulmonary resuscitation management _________ Tracheal intubation/extubation

_____ Peri-anesthetic invasive and noninvasive monitoring _____ Mechanical Ventilation/oxygen therapy

_____ Fluid electrolyte, acid-base management ____________ Peripheral intravenous/arterial catheter placement

_____ Central venous catheter placement __________________ Acute and chronic pain therapy

_____ Post-anesthesia care and discharge ________________ Conscious and deep sedation techniques

_____ Peri-anesthesia management of patient using accessory drugs or fluids

_____ *Other ________________________________

I am mentally and physically capable of performing the privileges I have requested:

_________________________________________________ ____________________________
Applicant’s Signature Date
These privileges are granted initially for one year following approval and must be renewed on a biennial basis thereafter. The applicant may request to have privileges changed as required during this period.

____________________________  ____________________  ____________________
Governing Board Signature  Date  Approved? (YES or NO)
Release of Information

By making application to the Specialty Surgery Center as an Allied Health Professional, 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.

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
Right of Confidentiality

As a member of the Allied Health Staff of the Specialty 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 Specialty 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 Specialty Surgery Center.

____________________________________________________
Full Name (Printed)

____________________________________________________
Signature Date
Total Release of Liability

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

Avenue North | Nashville, TN 37203 (615) - 9612 | www.ssctn.com
Medical/Credentialing Director:

Please find my attached, completed, application for staff privileges as a Certified Registered Nurse Anesthetist. I subsequently request temporary privileges for surgical procedures delineated in my application so that I may perform procedures at the Specialty 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 Anesthetists (CRNA)

__________
Full Name (Printed)

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

(This Page Official Use Only)

Approved By Medical/Credentialing Staff:

_______________________________________________
Anesthesia Service Coordinator’s Signature Date:

_______________________________________________
Medical/Credentialing Director’s Signature Date

Approved By Governing Body:

_______________________________________________
Board of Governor Chair Date
SPECIALTY SURGERY CENTER PHYSICIAN/CRNA HEALTH SCREENING

Name: _________________________________________ SS#: ___________________

Address: _______________________________________________________________

Phone: ___________________________ DOB: _______________

Family Doctor: ___________________________ Address: __________________________________________

______________________________________________________________________________

PHYSICAL EXAM:

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: ______ Result: _____________________________

Influenza vaccine: Yes _____ No _____ Date ________ Comments:

Examiners Signature: ____________________________ Date___________
Employee Signature: 
______________________________________ Date ___