



**CRNA LOCUM TENENS APPLICATION**

**Please fax or mail your completed application. Fax Number: (414) 272-3852**  
**Concorde Staff Source, Inc. | 735 N. Water Street Suite 285 | Milwaukee, WI 53202**

**All questions must be completed in their entirety. A partial application will not be accepted.**  
**Attach any additional pages if necessary.**

**GENERAL INFORMATION** (Please Print or Type)

NAME (LAST)	(FIRST)	(MIDDLE NAME)	(SUFFIX)	DEGREE
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LIST OTHER NAMES BY WHICH YOU HAVE BEEN KNOWN	(LAST)	(FIRST)	(MIDDLE)
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IF YOU HAVE BEEN KNOWN BY OTHER NAMES, PLEASE EXPLAIN WHY YOUR NAME CHANGED

ORGANIZATION NAME

OFFICE ADDRESS	PHONE ( )
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CITY	STATE	ZIP
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MAILING ADDRESS	PHONE ( )	CELL ( )
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CITY	STATE	ZIP
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ANSWERING SERVICE NO.	FAX NO ( )
	E-MAIL

BIRTHDATE (MM/DD/YY) / /	BIRTHPLACE	CITIZENSHIP
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PAGER NO.	EMERGENCY CONTACT & PHONE NO.
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SEX	SOCIAL SECURITY NO.	MARITAL STATUS (CIRCLE ONE) S / M / D / W	NAME OF SPOUSE
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MEDICARE UNIQUE I.D. PROVIDER NO.	MEDICAID PROVIDER NO.	NATIONAL PROVIDER ID NO.
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(Contact your consultant if you do not have any of these numbers)

**EDUCATION**

NURSING EDUCATION	INSTITUTION		ADDRESS, CITY, STATE, ZIP	PHONE #
	DEGREE	YEAR OBTAINED	FROM (MM/DD/YY) / /	TO (MM/DD/YY) / /
NURSING EDUCATION	INSTITUTION		ADDRESS, CITY, STATE, ZIP	PHONE #
	DEGREE	YEAR OBTAINED	FROM (MM/DD/YY) / /	TO (MM/DD/YY) / /
CRNA TRAINING	INSTITUTION		ADDRESS, CITY, STATE, ZIP	PHONE #
	DEGREE	YEAR OBTAINED	FROM (MM/DD/YY) / /	TO (MM/DD/YY) / /

**LICENSURE: PLEASE LIST ALL LICENSES, CURRENT OR EXPIRED  
(ATTACH COPY OF LICENSE)**

STATE NO.	LICENSE UNLIMITED Y OR N	DATE ISSUED (MM/DD/YY) / /	DATE EXPIRES (MM/DD/YY) / /
OTHER STATE NO.	Y OR N	/ /	/ /
OTHER STATE NO.	Y OR N	/ /	/ /
OTHER STATE NO.	Y OR N	/ /	/ /

IF NO, PLEASE EXPLAIN LIMITATION:

**HOSPITAL AFFILIATIONS**

List past and present, names and locations of all hospital, clinics, health care facilities and organizations of which you have been a staff member. Include dates of affiliation.

FACILITY, ADDRESS, CITY, STATE, ZIP	AFFILIATION FROM (MM/DD/YY) / /	AFFILIATION TO (MM/DD/YY) / /
Phone #		
Phone #	/ /	/ /
Phone #	/ /	/ /
Phone #	/ /	/ /

**IF THE ANSWER TO ANY OF THE FOLLOWING IS "YES", GIVE DETAILS ON SEPARATE SHEET**

1. Has your nursing license in any jurisdiction ever been denied, restricted, limited, suspended, revoked, canceled and/or subject to probation either voluntarily or involuntarily, or has your application for a license ever been withdrawn? .....  Yes  No
2. Have you ever been reprimanded and/or fined, been the subject of a complaint and/or have you been notified in writing that you have been investigated as the possible subject of a criminal, civil or disciplinary action by any state or federal agency which licenses providers? .....  Yes  No
3. Have you been refused membership on a hospital medical staff? .....  Yes  No
4. Has your request for any specific clinical privileges ever been denied, granted with stated limitations, or not renewed? .....  Yes  No
5. Have your hospital privileges been changed? .....  Yes  No
6. Are there any clinical privileges you have voluntarily relinquished? .....  Yes  No
7. Have you been denied membership or renewal thereof, or been subjected to disciplinary action in any local, state or national medical organization? .....  Yes  No
8. Has your Certification status been altered (including if your Certification status has lapsed due to passage of time)? .....  Yes  No
9. Have you ever been convicted of a crime (other than a traffic offense), or are you currently under indictment for an alleged crime? .....  Yes  No
10. Have you ever been the subject of any administrative, civil or criminal complaint, or investigation regarding sexual misconduct? .....  Yes  No
11. Have you been hospitalized within the past five years? .....  Yes  No
12. Have you ever had any health problems (physical or mental, including substance abuse)? .....  Yes  No
13. Are you currently using illegal drugs? .....  Yes  No
14. Are there any other issues that should be disclosed that may have an adverse impact on your ability to deliver effective medical services? (If yes, please explain) .....  Yes  No
15. Have you ever had professional liability insurance refused, canceled, non-renewed, surcharged or restricted? .....  Yes  No

16. Have there ever been, or are these currently pending, any malpractice claims, suits, settlements, arbitration or other dispute resolution proceedings involving your professional practice (i.e., filing of a claim that was subsequently dropped or dismissed, request for review by medical mediation or other review panel, etc.)?.....

Yes  No

If yes, please provide the following information for each situation:

- Date suit or claim was initiated (month/year)
- Brief description of the nature of the claim
- Current status, including amount of any award made

**LIABILITY INSURANCE**

PRESENT CARRIER (ATTACH COPY OF INSURANCE CERTIFICATE)	EXPIRATION DATE (MM/DD/YY) / /
NAME, ADDRESS, CITY, STATE, ZIP	LIABILITY LIMITS /
Phone #	POLICY NO.
LIST CARRIERS WITHIN THE PAST FIVE YEARS	EXPIRATION DATE (MM/DD/YY) / /
NAME, ADDRESS, CITY, STATE, ZIP	LIABILITY LIMITS /
Phone #	POLICY NO.

(PLEASE INCLUDE ADDITIONAL CARRIER INFORMATION)

**CERTIFICATION**

Are you certified by the American Association of Nurse Anesthetists?

Yes  No

(ATTACH COPY OF CERTIFICATE)	CERTIFIED-DATE (MM/DD/YY) / /	RECERTIFIED-DATE (MM/DD/YY) / /
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If not certified, are you admissible for certification examination?

Yes  No

Are you a current member of AANA?

Yes  No

Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

**REFERENCES**

Provide a minimum of three professional references that have had an opportunity to extensively work with and observe your capabilities within the last two years, and can provide an evaluation of your professional competence and ethical character.

NAME	TITLE	PHONE
ORGANIZATION	ADDRESS, CITY, STATE, ZIP	FAX
NAME	TITLE	PHONE
ORGANIZATION	ADDRESS, CITY, STATE, ZIP	FAX
NAME	TITLE	PHONE
ORGANIZATION	ADDRESS, CITY, STATE, ZIP	FAX

**HEALTH STATUS**

DESCRIBE CURRENT HEALTH STATUS

LAST EXAMINATION (MM/DD/YY)  / /	BY (NAME, ADDRESS, CITY, STATE, ZIP)
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It is necessary to provide documentation of current immunization in some states.

Rubella Titer

Rubeola (measles)

Hepatitis B

Mumps

TB Skin Test

Chicken Pox (Varicella)

(PLEASE ATTACH A COPY OF RECORDS)

**RISK MANAGEMENT DOCUMENTATION CHECKLIST:**

In order to complete the Risk Management process for your assignment we need the following documents:

- Complete application including signed and dated scope of services and signed release and authorization page
- Curriculum Vitae
- Nursing School Diploma
- CRNA Certificate of Training
- Certification or Re-certification card (whichever is most current)
- Copies of all State Licenses
- Liability Insurance Certificate
- Immunization Documentation (if applicable)
- National Provider Identifier (NPI) – Copy of original email letter
- Driver’s license or Passport
- ACLS Certificate
- CME Certificates

# CRNA – Scope of Services

Please check the clinical areas and procedures in which you are qualified to perform:

## Clinical Areas

- |  |  |
|--|--|
| <input type="checkbox"/> Vascular Surgery      | <input type="checkbox"/> Orthopedics               |
| <input type="checkbox"/> Ambulatory Anesthesia | <input type="checkbox"/> Dental Surgery            |
| <input type="checkbox"/> Pediatric Anesthesia  | <input type="checkbox"/> Ophthalmologic Anesthesia |
| <input type="checkbox"/> Cardiac Surgery       | <input type="checkbox"/> General Surgery           |
| <input type="checkbox"/> Pain Management       | <input type="checkbox"/> Obstetrics                |
| <input type="checkbox"/> Critical Surgery      | <input type="checkbox"/> Neuro Surgery             |

## Clinical Procedures

- | <b>IV &amp; Inhalation</b>                           | <b>Conduction</b>                          |
|--|--|
| <input type="checkbox"/> Narcotics                   | <input type="checkbox"/> Spinals           |
| <input type="checkbox"/> Anesthetic Gases            | <input type="checkbox"/> Regional          |
| <input type="checkbox"/> Barbiturates                | <input type="checkbox"/> Caudal            |
| <input type="checkbox"/> Mask                        | <input type="checkbox"/> Epidural          |
| <input type="checkbox"/> Psychoactive Drugs          | <input type="checkbox"/> Subdural          |
| <input type="checkbox"/> Artificial Ventilation      | <input type="checkbox"/> Local Field Block |
| <input type="checkbox"/> Muscle Relaxants            | <input type="checkbox"/> Automatic Block   |
| <input type="checkbox"/> Volatile Liquid Anesthetics | <input type="checkbox"/> Plexus Block      |
| <input type="checkbox"/> Endotracheal (Oral / Nasal) | <input type="checkbox"/> Intravenous Block |
|  | <input type="checkbox"/> Nerve Block       |

## Special Areas

- |                                       |   |
|---------------------------------------|---|
| <input type="checkbox"/> Neonatal     | <input type="checkbox"/> Arterial Sampling                    |
| <input type="checkbox"/> GYN          | <input type="checkbox"/> Monitoring Techniques                |
| <input type="checkbox"/> ENT          | <input type="checkbox"/> Central Venous / Arterial Monitoring |
| <input type="checkbox"/> Thoracic     | <input type="checkbox"/> Abdominal                            |
| <input type="checkbox"/> Complex Pads | <input type="checkbox"/> Hypothermia                          |

This scope of services checklist is an attachment to, and is part of an agreement between the undersigned Provider and Concorde Staff Source. Provider warrants that he/she possesses the above skills, areas of competence and understanding, and agrees to provide a standard of care in accordance with these skills and standards of practice among the medical community generally in which he/she practices; and furthermore agrees to provide services to Client's patients as much as possible in the same manner and according to the same schedule as Client.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

**RELEASE, AUTHORIZATION AND ACKNOWLEDGMENT:**

In making application to Concorde Staff Source:

I certify that the above information I have provided on this application and attachments is true and accurate, that it can be used by Concorde for evaluating my potential as a Locum Tenens physician, and that Concorde will rely on the truthfulness of my application.

I acknowledge in making medical application for membership to the medical staff, I authorize Concorde and its representatives, to obtain any information that may be relevant to an evaluation of my professional qualifications, including information about disciplinary actions or other credentials or confidential information.

I hereby release Concorde, its officers, employees, and representatives, and third parties which provide or receive information regarding my credentials. Further, I agree to indemnify, defend and hold Concorde harmless, from any and all claims, causes of action, damages, judgments and expenses, including reasonable attorney's fees, arising from or related to the collection, verification and dissemination of my credentialing information.

I understand that I have the burden of providing accurate information to Concorde to demonstrate my qualifications. I understand that any misrepresentation on this application may constitute grounds for denial or referral to practice assignments.

I understand that I am responsible for notifying Concorde of any changes affecting my professional status. I certify that the information contained in this application is accurate and complete.

I understand that the decision to refer me to potential opportunities is at the discretion of Concorde. I agree that if I am referred by Concorde to any opportunity I will promptly notify Concorde each time I provide any Locum Tenens services to that Concorde client, or to any affiliate of that client, within two years of such initial referral or introduction or within two years of the performance of any covered locum tenens services, whichever is later.

I understand the information provided by references is confidential and will not be released without their consent.

I acknowledge that I am not an employee of Concorde and that any services I may provide to a Concorde client will be provided as an independent contractor.

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APPLICANT'S SIGNATURE

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DATE