CRNA INITIAL CREDENTIALING CHECKLIST

The following documents are requested to complete your credentialing application:

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

|  |  |
| --- | --- |
| [ ]  | Current Curriculum Vitae |
| [ ]  | Medical School Diploma and Training Certificates (If applicable) |
| [ ]  | Current Board Certificates (If applicable) |
| [ ]  | Current AANA Certificate |
| [ ]  | **ALL** Current State Medical License(s) |
|  | *(Wallet card with expiration date and number, if not available, the wall certificate)* |
| [ ]  | State Controlled Substance Registrations (If applicable) |
| [ ]  | CME’s for the Past Three Years  |
| [ ]  | BLS, ACLS, ATLS, PALS, NRP Certificates |
| [ ]  | Recent Photograph Signed and Dated in the margin |
| [ ]  | Color copy of current Driver’s License or Passport |
| [ ]  | Permanent Residence Card or VISA (non-US citizens) |
| [ ]  | Malpractice Claims History Form (If applicable)  |
| [ ]  | Current immunization records and recent test results (i.e. TB, MMR, etc.) |
| [ ]  | NPI Number and Confirmation Letter  |
| [ ]  | Case Logs for last 24 months (If applicable)  |
| [ ]  | Locum Tenens Practice Experience  |
| [ ]  | Completed Skills Checklist  |
| [ ]  | DD-214 (Military Service Discharge) (If applicable) |
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Please note: A response of “see CV” is not acceptable unless you submit a current CV

Containing the requested information to include month and year, no gaps.

**Attention: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Recruiter)**

|  |
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| **Attach recent photo here.****Indicate date taken****and sign in ink across the bottom****of photo.*****Note: Photo:***1. Original preferred
2. Current within one year of application
3. Color headshot
4. Email/text to cvo@locumtenens.com
 |

### CRNA INITIAL APPLICATION

|  |  |
| --- | --- |
| Name: |       |
| Specialty: |       |
| Date: |       |
| **Availability**: When are you available to work? |       |
| Where would you prefer to work? |       |
| How many weeks would you like to work Locum Tenens? |       |
| How did you become aware of us? |       |

|  |
| --- |
| Please type or print in black ink: please attach your curriculum vitae |
| Name |       | Specialty |       |
| Home Address |       | Home Phone |       |
| City/State/Zip |       | Work Phone |       |
| Date of Birth |       | Place of Birth |       | Cell Phone |       |
| Social Security Number |       |  | E-mail Address |       |
| Present Position |       | Fax Number |       |
| UPIN# |       | NPI# |       | Medicare # |       | Citizenship |       |
| Medicaid # |       | Federal Tax ID # |       | VISA Status |       |
| Emergency Contact Name/Relationship: |       | Phone: |       |
| GRADUATE SCHOOL:*Please list all institutions attended. Use separate sheet if necessary.* |
| Graduate School |       |  |  |  |  |
| Street Address |       |  |  |  |  |
| City/State/Zip |       |  |  | Dates (Month/Year) Attended From |       | to |       |
| Degree |       |  |  |  |  |
|  |  |  |  |  |  |
| ADDDITIONAL TRAINING:*Please list all institutions attended. Use separate sheet if necessary.* |
| Additional Training |  |  |  |  |  |
| Hospital |       |  |  |  |  |
| Street Address |       |  |  |  |  |
|  City/State/Zip |       |  |  | Dates (Month/Year) Attended From |       | to |       |
|  Specialty |       |  |  | Program Director |       |
| Additional Training |  |  |  |  |  |
| Hospital |       |  |  |  |  |
| Street Address |       |  |  |  |  |
|  City/State/Zip |       |  |  | Dates (Month/Year) Attended From |       | to |       |
|  Specialty |       |  |  | Program Director |       |
| Additional Training |  |  |  |  |  |
| Hospital |       |  |  |  |  |
| Street Address |       |  |  |  |  |
|  City/State/Zip |       |  |  | Dates (Month/Year) Attended From |       | to |       |
|  Specialty |       |  |  | Program Director |       |
| Additional Training |  |  |  |  |  |
| Hospital |       |  |  |  |  |
| Street Address |       |  |  |  |  |
|  City/State/Zip |       |  |  | Dates (Month/Year) Attended From |       | to |       |
|  Specialty |       |  |  | Program Director |       |

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| MILITARY EXPERIENCE |
| Branch/Service |       | Date of Discharge |       | Type of Discharge |       |

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| PRACTICE EXPERIENCE*List all practice locations at minimum for the past 10 years. Provide explanation for gaps over 60 days.* |
| **1. Practice Location** |       | Month/Year from |       | to |       |
| Address |       | Phone       | Fax       |
| City/State/Zip |       | Contact Person |       |
| **2. Practice Location** |       | Month/Year from |       | to |       |
| Address |       | Phone       | Fax       |
| City/State/Zip |       | Contact Person |       |
| **3. Practice Location** |       | Month/Year from |       | to |       |
| Address |       | Phone       | Fax       |
| City/State/Zip |       | Contact Person |       |
|  |
| HOSPITAL AFFILIATIONS*List all hospital privileges you have held in the past 10 years except for training programs Please list all dates. Attach separate sheet if necessary.* |
| **1. Hospital Name** |       | Dates from (Month/Year)  |       | to |       |
| Hospital Address |       |
| City/State/Zip |       |
| Phone/Fax |       |
| **2. Hospital Name** |       | Dates from (Month/Year) |       | to |       |
| Hospital Address |       |
| City/State/Zip |       |
| Phone/Fax |       |
| **3. Hospital Name** |       | Dates from (Month/Year) |       | to |       |
| Hospital Address |       |
| City/State/Zip |       |
| Phone/Fax |       |
| **4. Hospital Name** |       | Dates from (Month/Year) |       | to |       |
| Hospital Address |       |
| City/State/Zip |       |
| Phone/Fax |       |

### GAPS IN WORK HISTORY|TRAINING EXPLANATION

*Please provide an explanation for gaps in work history and training over*

*60 days within the past 10 years; attach separate sheet if necessary.*

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| CERTIFICATION |
| Board Certified | Yes |       | No |       | **Issuing****Board** |       | Date Issued |       | DateExpired: |       | CertificationNumber: |       |
| Re-Certification | Yes |       | No |       | **Recertified Date:** |       | Expiration Date |       |
| Board Qualified | Yes |       | No |       |  |
| If yes, have you completed and passed your written examination? | Yes (Date) |       | No |       |
| If no, when are you scheduled to take the examination? | Date of Exam |       |
|  |  |  |  |  |  |  |  |
| ATLS | Yes |       | No |       | Expiration Date |       |  |
| ACLS | Yes |       | No |       | Expiration Date |       |  |
| BLS | Yes |       | No |       | Expiration Date |       |  |
| PALS | Yes |       | No |       | Expiration Date |       |  |

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| LICENSURE: *Please list all licenses held, both inactive and active. Use separate sheet if required.* |
| State | Number | Date Issued | Date Expires | Active, Inactive or Pending | Controlled Substance Number |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
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|       |       |       |       |       |       |
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|       |       |       |       |       |       |
| DEA |       |       |       |       |       |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| NRP | Yes |       | No |       | Expiration Date |       |  |

PROFESSIONAL SOCIETIES: *Please list all memberships.*

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### REFERENCES

*List the names and addresses of professional references for training programs and/or current associates. One should be a department director or physician of comparable authoritative status. Two of these references should have worked with you in the past year, preferably in your specialty.**References should be directly familiar with your clinical abilities.*

|  |  |  |  |
| --- | --- | --- | --- |
| **1. Name** |       | Specialty |       |
| Address |        | Relationship |       |
| City/State/Zip |       | Phone |       | Fax |       |
| Email |       | Cell Phone |       |  |  |
| Did referee have direct contact with you? | Yes |       | No |       |  Date of contact from |       | to |       |
| **2. Name** |       | Specialty |       |
| Address |        | Relationship |       |
| City/State/Zip |       | Phone |       | Fax |       |
| Email |       | Cell Phone |       |  |  |
| Did referee have direct contact with you? | Yes |       | No |       |  Date of contact from |       | to |       |
| **3. Name** |       | Specialty |       |
| Address |        | Relationship |       |
| City/State/Zip |       | Phone |       | Fax |       |
| Email |       | Cell Phone |       |  |  |
| Did referee have direct contact with you? | Yes |       | No |       |  Date of contact from |       | to |       |
| **4. Name** |       | Specialty |       |
| Address |        | Relationship |       |
| City/State/Zip |       | Phone |       | Fax |       |
| Email |       | Cell Phone |       |  |  |
| Did referee have direct contact with you? | Yes |       | No |       |  Date of contact from |       | to |       |
| **5. Name** |       | Specialty |       |
| Address |        | Relationship |       |
| City/State/Zip |       | Phone |       | Fax |       |
| Email |       | Cell Phone |       |  |  |
| Did referee have direct contact with you? | Yes |       | No |       |  Date of contact from |       | to |       |

### CONTINUING MEDICAL EDUCATION

On a separate sheet, list postgraduate activities attended or for which you have received credit in the past three years. Do not include meetings
attended as part of additional training. Include printed name and signature, list program, title, date, organization, number of CMEs.

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### DISCIPLINARY ACTIONS

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| If your answer to any of the following questions is “Yes”, please provide a full explanation on additional sheet and include any additional documentation.Have any of the following **ever been**, or **currently are** in the process of being **(voluntarily - while under investigation or involuntarily**,  **public or private)** **denied**, **revoked**, **suspended**, **reduced**, **limited**, **placed** **on probation**, **not renewed**, **surrendered**, **investigated**, **terminated**, **lost**, **withdrawn**, **restricted**, **reprimanded**, **disciplined, stipulated, fined, excluded or discharged** made subject to a **consent order** or **relinquished**? Willful and substantial omissions or misrepresentation may result in denial.  |
| 1. Medical License in any state?

 [ ] Yes [ ]  No | 6. Institutional affiliation / status?[ ] Yes [ ]  No |
| 1. DEA Registration (federal or state programs)?

 [ ] Yes [ ]  No | 7. Professional society membership or fellowship / Board certification?[ ] Yes [ ]  No |
| 1. Other Professional Registration / License?

[ ] Yes [ ]  No | 8. Any professional sanction (e.g. government, administrative agency or other)? [ ] Yes [ ]  No |
| 1. Clinical Privileges?

[ ] Yes [ ]  No | 9. Participation in any private, federal, or state health insurance program (e.g. Medicare, Medicaid)? [ ] Yes [ ]  No |
| 1. Membership / Rights on any medical staff?

[ ] Yes [ ]  No |
| 10. Have you ever had any physical or mental condition including alcohol or drug dependency that may affect your ability to practice or exercise the privileges typically associated with the specialty and position for which you are applying?[ ] Yes [ ]  No |
| 11. Are you currently using or have you ever used illegal drugs or legal drugs in an illegal manner?[ ] Yes [ ]  No |
| 12. Is there any reason that you are unable to perform the essential functions of the position for which you are applying safely and according to accepted standards of performance with or without reasonable accommodation?(If yes, explain on the attached form) [ ] Yes [ ] No |
| 13. Have you ever been convicted, pled guilty or pled nolo contendere, for any criminal offense (excluding parking tickets)?[ ] Yes [ ]  No |
| 14. Are any criminal charges currently pending against you or have ever been brought against you in any jurisdiction?[ ] Yes [ ]  No |
| 15. Have you ever been arrested for or charged with a crime involving children?[ ] Yes [ ]  No |
| 16. Have you ever been arrested for or charged with a sexual offense including sexual harassment?[ ] Yes [ ]  No |
| 17. Have you ever been arrested for or charged with a crime involving moral turpitude?[ ] Yes [ ]  No |
| 18. Is there any other issue which should be disclosed that may have an adverse impact on your ability to deliver effective clinical health care services?[ ] Yes [ ]  No |
| 19. Has any information pertaining to you ever been reported to the National Practitioner Data Bank (NPDB) or Healthcare Integrity and Protections Data Bank (HIPDB)?[ ] Yes [ ]  No  |

MALPRACTICE CLAIMS HISTORY

|  |
| --- |
| **1. Have you ever been denied professional liability insurance or denied renewal of an existing policy?**  If the answer to the above question is “YES” please attach a brief explanation.[ ] Yes [ ]  No |
| **2. Have any malpractice claims, suits, settlements, or arbitration proceedings ever been made against you including** **any that have been dismissed?** [ ] Yes [ ]  No |
| **3. Are you aware of any claims, suits, or settlements currently pending or of any intent to file a claim or suit?** [ ] Yes [ ]  No |
| ***If your answer to either of the above questions is “Yes” please provide the following information******on each claim and provide a brief clinical summary of each case and attach.*** |
|  | Plaintiff Name and Insurance Carrier | **Location (County, State)** | **Status****(Dismissed / Settled / Judgment / Pending )**  | **Date** **of Incident****(mm/yy)** | **Amount of Award****or Settlement****(if appropriate)** |
| **# 1** |       |       |       |       | Summary Included [ ]  |
| **# 2** |       |       |       |       | Summary Included [ ]  |
| **# 3** |       |       |       |       | Summary Included [ ]  |
| **# 4** |       |       |       |       | Summary Included [ ]  |
| [ ] Additional Malpractice Claims or incidents are listed on attached sheet |
| ***Please list your current malpractice insurance carrier and the associated information for the last 10 years. If you currently do not carry any malpractice insurance, please list the last malpractice insurance carrier which provided coverage for you. In addition, please list any malpractice insurance carrier who has been associated with any malpractice claim, suit or settlement listed above.*** |
| Malpractice Insurance Carrier | Policy Number | **Policy Dates****From (mm/yy)** | **Policy Dates****To (mm/yy)** | **Amount of** **Coverage** |
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### LOCUM TENENS PRACTICE EXPERIENCE

List professional locum tenens experience in chronological order. Attach a separate sheet if necessary.

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| --- | --- |
| **1. Facility:**       | Phone:       |
|  Address:       | City/State/Zip:       |
|  Contact:       | Date from       to       |
| **2. Facility:**       | Phone:       |
|  Address:       | City/State/Zip:       |
|  Contact:       | Date from       to       |
| **3. Facility:**       | Phone:       |
|  Address:       | City/State/Zip:       |
|  Contact:       | Date from       to       |
| **4. Facility:**       | Phone:       |
|  Address:       | City/State/Zip:       |
|  Contact:       | Date from       to       |
| **5. Facility:**       | Phone:       |
|  Address:       | City/State/Zip:       |
|  Contact:       | Date from       to       |
| **6. Facility:**       | Phone:       |
|  Address:       | City/State/Zip:       |
|  Contact:       | Date from       to       |
| **7. Facility:**       | Phone:       |
|  Address:       | City/State/Zip:       |
|  Contact:       | Date from       to       |

List Hospital(s) where you are privileged:

|  |  |
| --- | --- |
| **1. Facility:**       | Phone:       |
|  Address:       | City/State/Zip:       |
|  Administrator:       | Date from       to       |
| **2. Facility:**       | Phone:       |
|  Address:       | City/State/Zip:       |
|  Administrator:       | Date from       to       |
| **3. Facility:**       | Phone:       |
|  Address:       | City/State/Zip:       |
|  Administrator:       | Date from       to       |

AUTHORIZATION, ATTESTATION AND RELEASE

I acknowledge that LocumTenens.com CVO, LLC (“LTCVO”) has been engaged to provide (i) certain services in the furtherance of one or more applications to state medical boards or other designated bodies (“Boards”) to secure for me a license to practice medicine in one or more states (“License Applications” and, together with any credentialing applications, the “Applications”) and (ii) certain credentialing services from time to time on an on-going basis in connection with my candidacy for locum tenens or full-time placement with hospitals, clinics or other healthcare clients (each a “Client”) of a placement agency or other third-party working for my benefit. I understand that, as part of both processes, LTCVO must collect Information (defined below) from me and from third parties and share all or part of that Information. “Information” includes, but is not limited to, otherwise privileged or confidential information concerning my professional qualifications, credentials, current licensure, education, training, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnoses and treatment, ethics, behavior, or any other matter having a bearing on my qualifications for a license to practice medicine or for credentialing with LTCVO and the Clients (whether it has such a bearing may be presumed by such third parties solely by receipt of a request of Information from an Agent).

I further acknowledge and understand that my cooperation in providing and assisting LTCVO in obtaining my Information and my consent to the release of Information does not guarantee that any state will grant me a license to practice medicine or that a Client will grant me clinical privileges or contract with me as a provider of healthcare services. I understand that my credentialing application is not an application for employment and that acceptance of my application will not in itself result in my employment.

**Agreement to Provide Information**

I agree to provide on a timely basis sufficient and accurate accounts of my Information as deemed necessary or appropriate by LTCVO for the completion, submittal and support of one or more of my Applications.

**Authorization of Investigation Concerning Application**

I authorize LTCVO and any Client, and their respective employees, affiliated entities and representatives and agents (together and individually the “Agents”), to collect, hold, and investigate both oral and written statements, records, and documents containing my Information, concerning or to be included in any of my Applications. I agree to allow the Agents to inspect and copy all records and documents relating to any Application and to disclose any such Information to a Client, any Board and other appropriate third parties and to share any such Information among themselves in connection with their investigations.

**Authorization of Third-Party Sources to Release Information**

I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, promptly upon an Agent’s request to release Information to the Agent(s). I authorize my current and past professional liability carrier(s) to release to Agents my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide Information based upon this Authorization, Attestation and Release.

**Release from Liability**

I release from all liability and hold harmless the Agents, any entity responding to a request for Information by an Agent as authorized hereunder and any other third party, and their respective owners, managers, directors, officers, employees, agents and representatives, for their acts performed in good faith and without malice, unless such acts are due to the gross negligence or willful misconduct of such Agent or other third party, in connection with the gathering, holding, use, sharing and interpretation of, and reliance upon, Information. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for credentialing activities.

**Attestation**

I certify that all Information provided by me in connection with the Applications is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify LTCVO (and any Client, if requested) within 10 days of any material changes to the Information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided or authorized to be released to Agents in connection with the Applications.

I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

##### Applicant’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

|  |
| --- |
|  CRNA SKILLS CHECKLIST |

|  |  |
| --- | --- |
| Provider Name |       |

*Please indicate by a check below those privileges which commensurate with your clinical
ability, training and experience, and for which you maintain current clinical competence.*

|  |
| --- |
| **CRNA Core Skills & Procedures** |
| [ ]  | Adults |
| [ ]  | Pediatric |
| [ ]  | Neonatal |
| [ ]  | Cardiac |
| [ ]  | Orthopedic |
| [ ]  | Neurosurgical |
| [ ]  | Obstetrical |
| [ ]  | General Anesthesia |
| [ ]  | Regional Anesthesia |
| [ ]  | Pre-anesthesia evaluation & preparation |
| [ ]  | Tracheal intubation/extubation |
| [ ]  | Placement of central venous catheters |
| [ ]  | Advanced airway management |
| [ ]  | Mechanical ventilation / airway management |
| [ ]  | Post-anesthesia care / discharge |
| [ ]  | Management of respiratory/ventilator care |
| [ ]  |       |
| [ ]  |       |
| [ ]  |       |
| [ ]  |       |
| [ ]  |       |

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 **Provider Signature Date**