

**ROCKFORD ANESTHESIOLOGISTS ASSOCIATED, L.L.C.  
 CERTIFIED REGISTERED NURSE ANESTHETIST  
 INITIAL APPLICATION FORM**

Name: \_\_\_\_\_ Date Available: \_\_\_\_\_

Last                      First                      Initial

List other names by which you have been known and reason for change: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

City                      State                      County                      Country

Preferred Method of Contact: \_\_\_\_\_ Email Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date Certified and Certificate Number: \_\_\_\_\_

U.S. Citizen? \_\_\_\_\_ If no, do you have the legal right to reside permanently and work in the United States? \_\_\_\_\_. If yes, provide resident visa number: \_\_\_\_\_.

**LIST ALL RN/APN LICENSES (PREVIOUS AND CURRENT):**

State	Number	Issue Date	Expiration Date

**EDUCATION:**

High School \_\_\_\_\_ Dates From/To \_\_\_\_\_

RN \_\_\_\_\_ Degree \_\_\_\_\_ Dates From/To \_\_\_\_\_

CRNA \_\_\_\_\_ Degree \_\_\_\_\_ Dates From/To \_\_\_\_\_

Other \_\_\_\_\_ Degree \_\_\_\_\_ Dates From/To \_\_\_\_\_

**LIST ALL FACILITIES WHERE YOU CURRENTLY HAVE OR HAVE HAD PRIVILEGES:**

Facility \_\_\_\_\_

Address \_\_\_\_\_

Dates From/To \_\_\_\_\_ Nature of Privileges \_\_\_\_\_

Facility \_\_\_\_\_

Address \_\_\_\_\_

Dates From/To \_\_\_\_\_ Nature of Privileges \_\_\_\_\_

Facility \_\_\_\_\_

Address \_\_\_\_\_

Dates From/To \_\_\_\_\_ Nature of Privileges \_\_\_\_\_

Facility \_\_\_\_\_

Address \_\_\_\_\_

Dates From/To \_\_\_\_\_ Nature of Privileges \_\_\_\_\_

Facility \_\_\_\_\_

Address \_\_\_\_\_

Dates From/To \_\_\_\_\_ Nature of Privileges \_\_\_\_\_

**WORK HISTORY:**

Provide information regarding **all** past employment **from completion of training until present**. Explain all time gaps over thirty (30) days, and indicate if you do not wish your current employer to be contacted.

Employer \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip Code \_\_\_\_\_  
Dates From/To \_\_\_\_\_ Title/Job Responsibilities \_\_\_\_\_

Employer \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip Code \_\_\_\_\_  
Dates From/To \_\_\_\_\_ Title/Job Responsibilities \_\_\_\_\_

Employer \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip Code \_\_\_\_\_  
Dates From/To \_\_\_\_\_ Title/Job Responsibilities \_\_\_\_\_

Employer \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip Code \_\_\_\_\_  
Dates From/To \_\_\_\_\_ Title/Job Responsibilities \_\_\_\_\_

**If you have additional licenses, facilities, and work history, please list on a separate sheet of paper and attach to this application.**

**DISCLOSURE QUESTIONS:**

Have you ever had a professional liability judgment against you, had a claim settlement paid on your half, or are there any currently pending professional liability suits, actions, or claims filed against you? \_\_\_\_\_

Have you ever been charged with or convicted of a crime in any state or country, and/or are there any criminal charges pending against you in any state or country (other than minor traffic violations)? \_\_\_\_\_

Have you ever been disciplined, investigated, reprimanded, had privileges or a license denied, suspended or revoked by a licensing agency, accrediting body, health care entity or society, or are any such actions pending? \_\_\_\_\_

Do you have a medical condition, physical defect or emotional impairment which in any way impairs and/or limits your ability to perform your job duties with reasonable skill and safety? \_\_\_\_\_

Are you currently engaged in the illegal use of any legal or illegal substance, do you currently overuse and/or abuse alcohol or a controlled substances, and/or are you currently participating in a rehabilitation program? \_\_\_\_\_

I am not suffering any emotional or physical disorders which might impair my ability to carry out all job responsibilities. I am not addicted to alcohol or drugs which might impair my functions.

**If you answer yes to any of the above questions, please provide an explanation on a separate sheet of paper and attach to this application.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Please attach a current Curriculum Vitae/Resume to this form.**

## RELEASE

I hereby authorize the educational facilities, the chief(s)/director(s)/Human Resources Departments of the clinical department(s), the hospital(s) and other facilities in which I currently have or formerly have had staff privileges, professional certification boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, and present and past employers to submit information requested by Rockford Anesthesiologists Associated, L.L.C. including otherwise privileged or confidential material relative to my professional qualifications, credentials, past and present malpractice coverage, claims and suit information, clinical and/or professional competence, character, ethics, or any other matter having bearing on the credentialing procedure. I hereby further release and agree to hold harmless all such entities, their representatives, employees and agents from any and all liability for any damages which may result from providing this information as long as such release of information is done in good faith and without malice.

I agree that a copy of the authorization has the same effect as an original.

I understand that a condition of this application is that any misrepresentation, misstatement or omission from this application, whether intentional or not, is cause for automatic and immediate rejection of this application by Rockford Anesthesiologists Associated, L.L.C. and may lead to immediate termination and/or render any signed employee agreement null and void.

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Signature

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Date

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Printed Name