Provider Information Form

Name:

Email:

Phone Number:

States Licensed as a CRNA:

Do you hold a compact RN license?

NPI Number (Find your NPI Number here: https://npiregistry.cms.hhs.gov/search):

Approximate years of CRNA experience:

Please list two references with full names and email addresses that you would be comfortable with us contacting:

I'm interested in working in these locations:

Earliest Available Date:

Preferred Length of Assignment:

Vacation Dates (if applicable):

Preferred shift schedule and other specific requests:

Travel Requirements:

Flight Lodging

Rental Car Mileage

Additional comments:

Upload your CV:

Locum Anesthesia Solutions Disclosure Questions

1. Has any of your professional licenses (CRNA, RN, DEA, CSR, or other licenses for your professional career) ever been denied, investigated, suspended, revoked, restricted, voluntarily surrendered while under investigation, or have you ever been subject to consent order, fine, probation, reprimand, or any other conditions or limitations?

☐ Yes ☐ No

2. Have your clinical privileges or Medical Staff membership at any hospital or healthcare institution ever been investigated, denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions?

☐ Yes ☐ No

3. Have you ever voluntarily surrendered or limited your privileges while they were under investigation?

☐ Yes ☐ No

4. Have you been subject to any disciplinary action, terminated for cause, or not renewed for cause by any managed care organization (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?

☐ Yes ☐ No

5. Have you ever been placed on probation, asked to resign, formally reprimanded or suspended from any clinical education program?

☐ Yes ☐ No

6. Have you ever voluntarily resigned any clinical education program?

☐ Yes ☐ No

7. Have you ever been investigated, disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs?

☐ Yes ☐ No

8. To your knowledge, has any information pertaining to you been reported to the National Practitioner Data Bank?

☐ Yes ☐ No

9. Have you ever been subject to investigation or sanction by any regulatory agencies (OSHA, CLIA, etc.)?

☐ Yes ☐ No

10. Have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation by a hospital or healthcare facility of any military agency?

☐ Yes ☐ No

11. Have you ever been charged with or convicted of a felony or misdemeanor other than a minor traffic violation?

☐ Yes ☐ No

12. Have you ever been treated for the addiction of alcohol or drugs of any kind?

☐ Yes ☐ No

13. Are you currently using any chemical substance that could potentially impair or limit your ability to complete job functions with reasonable skill and safety?

☐ Yes ☐ No

14. Do you have any reason to believe that you would pose a risk for the safety or well-being of any of your patients?

☐ Yes ☐ No

15. Do you have any reason to believe that you are unable to perform your job functions with or without reasonable accommodations?

☐ Yes ☐ No

16. Have you ever been named in any malpractice claim?
    If "Yes," include date of claim, nature of allegations, current status of claim, and payout if applicable.

    ☐ Yes ☐ No

Confirmation of accurate information:

By signing, you are confirming that all information included in this document is by the best of your knowledge accurate at the time of completion.

Signature: ______________________________

Full Name: ______________________________

Date Signed: ______________________________