Metric Anesthesia Consultants

FOR CRNAS | APPLY TO PRACTICE | PRINT AND COMPLETE BY HAND

# CRNA Application Packet

Employment and Independent Contractor Application for Certified Registered Nurse Anesthetists

Metric Anesthesia Consultants, PLLC | 102 Wiltshire Avenue, Louisville, KY 40207 | 502-640-8349 | chad@metricanesthesia.com

## INSTRUCTIONS: PRINT, COMPLETE BY HAND, SIGN, AND DELIVER IN PERSON

1. Print this entire packet single-sided on letter paper. Complete every form by hand in blue or black ink. Print clearly and write N/A where an item does not apply.
2. **Sign and date Form 2 (Attestation and Release) and Form 4 (Privileges Request). Unsigned packets cannot be processed.**
3. Attach clear copies of the documents in the checklist below. Copies only; keep your originals.
4. **Place the completed packet and copies in a sealed envelope marked CONFIDENTIAL: CRNA APPLICATION and deliver it in person to Chad Riddle, CRNA, at 102 Wiltshire Avenue, Louisville, KY 40207, or by another secure method Metric specifies to you in advance.**
5. Do NOT email, text, fax, or upload your Social Security number, date of birth, or other sensitive personal information. Metric will never ask you to send these by email.
6. Give one copy of Form 3 (Peer Reference Request) to each of your three references. References return it directly to Metric in a sealed envelope.

## Documents to include (copies)

- ☐ Government-issued photo ID
- ☐ RN and APRN licenses (all states; KY and IN)
- ☐ DEA registration (if held)
- ☐ BLS card
- ☐ PALS card (pediatric coverage)
- ☐ Malpractice certificate / face sheet
- ☐ Case logs, last 24 months
- ☐ CAQH ProView ID and NPI
- ☐ Current CV (month/year dates, no unexplained gaps)
- ☐ NBCRNA certificate and CPC status
- ☐ State controlled-substance registration (if held)
- ☐ ACLS card
- ☐ NRP card (OB / neonatal, if held)
- ☐ Malpractice claims history or loss runs
- ☐ Diplomas / transcripts (nurse anesthesia program)
- ☐ Immunization records (provided after an offer)

## What happens next

Metric reviews your packet for completeness, verifies your credentials directly with the issuing sources (licensing boards, NBCRNA, DEA, education, the National Practitioner Data Bank, and federal and state exclusion lists), contacts your references, and schedules an interview. Background checks and drug screening occur only after a conditional offer and only with your separate written authorization. Health information is requested only after an offer and is kept separate from your credentialing file.

*Metric Anesthesia Consultants, PLLC is an equal opportunity employer and engager of independent contractors. Veterans are encouraged to apply. If you need an accommodation during the application process, call 502-640-8349.*

**Packet contents: Form 1 CRNA Employment / Contractor Application | Form 2 Attestation, Disclosure, and Release of Information | Form 3 Peer Reference Request | Form 4 CRNA Clinical Privileges Request**

Metric Anesthesia Consultants

FORM 1 | CRNA APPLICATION PACKET

# CRNA Employment / Contractor Application

## A. Position and engagement

DATE OF APPLICATION

EARLIEST AVAILABLE START DATE

ENGAGEMENT TYPE

- ☐ W-2 Employee
- ☐ 1099 Independent Contractor

SCHEDULE

- ☐ Full time
- ☐ Part time
- ☐ Per diem / PRN
- ☐ Locums

FACILITY INTEREST

- ☐ Perry County Memorial Hospital (IN)
- ☐ Livingston Hospital (KY)
- ☐ ASINA (IN)
- ☐ Any

HOW DID YOU HEAR ABOUT METRIC?

## B. Personal information

LEGAL NAME (LAST, FIRST, MIDDLE)

OTHER NAMES USED

HOME ADDRESS (STREET, CITY, STATE, ZIP)

MAILING ADDRESS, IF DIFFERENT

MOBILE PHONE

PERSONAL EMAIL

DATE OF BIRTH (PAPER ONLY)

SOCIAL SECURITY NUMBER (PAPER ONLY, NEVER EMAIL)

EMERGENCY CONTACT, RELATIONSHIP, PHONE

WORK AUTHORIZATION

- ☐ U.S. Citizen
- ☐ Permanent Resident
- ☐ Other work authorization

MILITARY SERVICE

- ☐ Veteran
- ☐ Active duty / Reserve / Guard
- ☐ Not applicable

BRANCH AND DATES OF SERVICE (OPTIONAL)

1099 ONLY: BUSINESS ENTITY NAME, TYPE, AND EIN

*Date of birth and Social Security Number are used only for identity confirmation, primary source verification, NPDB query, exclusion screening, and, after an offer, background checks.*

## C. Professional licensure (list ALL current and past licenses in all states)

| STATE | TYPE (RN / APRN-CRNA / MULTISTATE) | LICENSE NUMBER | ISSUE DATE | EXPIRATION | STATUS |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

KY: KBN RN LICENSE # OR MULTISTATE PRIVILEGE

KY: KBN APRN LICENSE # (CRNA DESIGNATION), EXPIRATION

KY: CAPA-CS / PRESCRIPTIVE AUTHORITY AND KASPER (IF APPLICABLE)

IN: PLA RN LICENSE # (OR MULTISTATE) AND EXPIRATION

OTHER INDIANA CREDENTIALS OR REGISTRATIONS

PRIMARY STATE OF RESIDENCE (NURSE LICENSURE COMPACT)

## D. NBCRNA certification and Continued Professional Certification (CPC)

NBCRNA CERTIFICATION NUMBER

INITIAL CERTIFICATION DATE

CURRENT CPC PERIOD (START AND END)

CPC ASSESSMENT STATUS

☐ CPC Assessment not yet due ☐ CPC Assessment passed (date on line below) ☐ CPC Assessment due by (date below)

CPC ASSESSMENT DATE

OTHER CERTIFICATIONS (E.G., NSPM-C) AND DOCTORAL DEGREE

## E. DEA and state controlled-substance registrations

☐ I do not hold a DEA registration (I administer under the facility registration)

| TYPE (DEA / STATE CSR) | STATE | REGISTRATION NUMBER | SCHEDULES | EXPIRATION | STATUS |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

## F. Provider identifiers and enrollment

INDIVIDUAL NPI (TYPE 1)

CAQH PROVIEW ID

MEDICARE PTAN(S) AND STATES

KENTUCKY MEDICAID ID

INDIANA MEDICAID (IHCP) ID

CURRENT MEDICARE REASSIGNMENT (TO WHOM)

☐ Never opted out of Medicare ☐ Opted out of Medicare (dates on line below) ☐ I authorize Metric access to my CAQH profile

## G. Education and training

| LEVEL | INSTITUTION, CITY, STATE | DEGREE / PROGRAM | DATES (FROM, TO) | GRADUATED (Y/N, DATE) |
|---|---|---|---|---|
| Nursing (RN) | | | | |
| Undergraduate | | | | |
| Nurse anesthesia (COA accredited) | | | | |
| Doctoral / graduate | | | | |
| Fellowship / other | | | | |

**CRITICAL CARE EXPERIENCE BEFORE ANESTHESIA SCHOOL (UNIT, FACILITY, DATES)**

## H. Life support and specialty certifications

| CERTIFICATION | ISSUING ORGANIZATION | EXPIRATION DATE | COPY ATTACHED (Y/N) |
|---|---|---|---|
| BLS | | | |
| ACLS | | | |
| PALS (required for pediatric privileges) | | | |
| NRP (OB / neonatal coverage) | | | |
| Other | | | |

## I. Clinical experience, case types, and volume

*Approximate case volumes for the most recent 24 months and career total. Attach case logs or a facility-generated report where available.*

| CASE TYPE / TECHNIQUE | LAST 24 MO (#) | CAREER (#) | INDEPENDENT (Y/N) | LAST PERFORMED (MO/YR) |
|---|---|---|---|---|
| General anesthesia, adult (total) | | | | |
| MAC / deep sedation | | | | |
| Regional: spinal | | | | |
| Regional: epidural (non-OB) | | | | |
| Regional: peripheral nerve blocks (US guided) | | | | |
| Regional: continuous nerve catheters | | | | |
| Obstetric: labor epidurals | | | | |
| Obstetric: cesarean section | | | | |
| Pediatrics: age 2 to 12 | | | | |
| Pediatrics: under age 2 | | | | |
| Cardiac (on pump / off pump) | | | | |
| Thoracic / one-lung ventilation | | | | |
| Neurosurgery / craniotomy | | | | |
| Major vascular | | | | |

| CASE TYPE / TECHNIQUE | LAST 24 MO (#) | CAREER (#) | INDEPENDENT (Y/N) | LAST PERFORMED (MO/YR) |
|---|---|---|---|---|
| Trauma / emergency | | | | |
| Arterial line placement | | | | |
| Central venous catheter placement | | | | |
| Advanced airway (fiberoptic, awake) | | | | |
| Endoscopy / GI | | | | |
| Orthopedic / total joints | | | | |
| Outpatient ASC cases | | | | |
| Point-of-care ultrasound (POCUS) | | | | |
| Acute or chronic pain procedures | | | | |

**PERIPHERAL NERVE BLOCK TYPES PERFORMED (E.G., INTERSCALENE, SUPRACLAVICULAR, ADDUCTOR CANAL, POPLITEAL, TAP, ESP, PECS)**

**PRACTICE MODELS EXPERIENCED**

☐ Independent / opt-out practice ☐ Anesthesia care team / medical direction ☐ Supervision by operating practitioner

## J. Work history (last 10 years, most recent first): position 1

**EMPLOYER / FACILITY** | **CITY, STATE** | **DATES (MO/YR, FROM AND TO)**

**POSITION AND ENGAGEMENT TYPE (W-2, 1099, LOCUMS AGENCY)** | **SUPERVISOR NAME, TITLE, PHONE**

**REASON FOR LEAVING**

## J. Work history (last 10 years, most recent first): position 2

**EMPLOYER / FACILITY** | **CITY, STATE** | **DATES (MO/YR, FROM AND TO)**

**POSITION AND ENGAGEMENT TYPE (W-2, 1099, LOCUMS AGENCY)** | **SUPERVISOR NAME, TITLE, PHONE**

**REASON FOR LEAVING**

## J. Work history (last 10 years, most recent first): position 3

**EMPLOYER / FACILITY** | **CITY, STATE** | **DATES (MO/YR, FROM AND TO)**

**POSITION AND ENGAGEMENT TYPE (W-2, 1099, LOCUMS AGENCY)** | **SUPERVISOR NAME, TITLE, PHONE**

REASON FOR LEAVING

## J. Work history (last 10 years, most recent first): position 4

EMPLOYER / FACILITY | CITY, STATE | DATES (MO/YR, FROM AND TO)

POSITION AND ENGAGEMENT TYPE (W-2, 1099, LOCUMS AGENCY) | SUPERVISOR NAME, TITLE, PHONE

REASON FOR LEAVING

*Attach additional pages as needed. Locum tenens assignments may be grouped by agency with a list of facilities and dates.*

## K. Gaps in work or training history (3 months or more)

| FROM (MO/YR) | TO (MO/YR) | EXPLANATION |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## L. Professional references (minimum 3 peer references)

*At least three peers with direct knowledge of your clinical work within the last 24 months. At least one must be a physician anesthesiologist or CRNA; at least one should be a current or recent supervisor or chief. No relatives or personal friends.*

| # | NAME AND CREDENTIALS | TITLE / RELATIONSHIP | FACILITY | PHONE AND EMAIL | YRS KNOWN |
|---|---|---|---|---|---|
| 1 (MDA or CRNA) | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 (optional) | | | | | |

## M. Professional liability insurance and claims history

CURRENT CARRIER | POLICY NUMBER | LIMITS (PER CLAIM / AGGREGATE)

COVERAGE

☐ Occurrence ☐ Claims-made (tail arrangement below) ☐ Provided by self ☐ Provided by employer / facility

EFFECTIVE AND EXPIRATION DATES | TAIL ARRANGEMENT, IF CLAIMS-MADE

**All professional liability carriers for the last 10 years:**

| CARRIER | POLICY NUMBER | DATES OF COVERAGE | LIMITS | REASON FOR CHANGE |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**Every malpractice claim, suit, arbitration, or settlement (open, closed, dismissed, or paid) for your entire career. Attach a separate sheet for each claim with details.**

| DATE OF INCIDENT | DATE FILED | FACILITY | ALLEGATION | STATUS / OUTCOME | AMOUNT PAID |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

## N. Independent contractor attestations (1099 applicants only)

- ☐ I operate an independent business, control the manner and means of my work consistent with facility policies and professional standards, and am responsible for my own taxes, benefits, and business expenses.
- ☐ I will maintain professional liability insurance at the limits required by Metric and the client facility and name Metric as a certificate holder.
- ☐ I will provide a completed IRS Form W-9 and maintain my credentials at my own expense unless otherwise agreed in writing.

| CONTRACTOR INITIALS | DATE |
|---|---|
| | |

Metric Anesthesia Consultants

FORM 2 | CRNA APPLICATION PACKET

# Attestation, Disclosure, and Release of Information

APPLICANT LEGAL NAME

CREDENTIALS

## Disclosure questions

*Answer every question by checking Yes or No. Explain any "Yes" answer (other than question 15) on a separate signed page with dates, jurisdiction, and outcome. A "Yes" answer does not automatically disqualify an applicant.*

| # | QUESTION | YES | NO |
|---|---|---|---|
| 1 | Has any professional license, certification, or registration you have held in any state ever been denied, limited, restricted, suspended, revoked, placed on probation, reprimanded, fined, not renewed, or voluntarily or involuntarily relinquished? | ☐ | ☐ |
| 2 | Are any investigations, charges, or disciplinary proceedings currently pending against you before any licensing board, certifying body, or governmental agency? | ☐ | ☐ |
| 3 | Has your NBCRNA certification ever been denied, revoked, suspended, or allowed to lapse, or are you subject to any NBCRNA disciplinary action? | ☐ | ☐ |
| 4 | Has your DEA registration or any state controlled-substance registration ever been denied, restricted, suspended, revoked, or surrendered? | ☐ | ☐ |
| 5 | Have your clinical privileges or medical staff membership at any facility ever been denied, reduced, restricted, suspended, revoked, not renewed, or subject to FPPE for cause, or have you resigned or withdrawn an application while under investigation? | ☐ | ☐ |
| 6 | Have you ever been terminated, asked to resign, or not renewed by an employer, staffing agency, or contracting entity for reasons related to clinical competence or professional conduct? | ☐ | ☐ |
| 7 | Are you currently, or have you ever been, excluded, suspended, debarred, or otherwise sanctioned from participation in Medicare, Medicaid, TRICARE, the VA, or any other federal or state healthcare program? | ☐ | ☐ |
| 8 | Have you ever been the subject of a civil monetary penalty, corporate integrity agreement, or False Claims Act action, or had a payor contract terminated for cause? | ☐ | ☐ |
| 9 | Have you ever been convicted of, or pled guilty or no contest to, any felony or misdemeanor (excluding minor traffic violations), or are any criminal charges currently pending against you? | ☐ | ☐ |
| 10 | Have you ever been reported to the National Practitioner Data Bank? | ☐ | ☐ |
| 11 | Has any professional liability insurer ever denied, cancelled, surcharged, or refused to renew your coverage? | ☐ | ☐ |
| 12 | Are you currently engaged in the illegal use of drugs or controlled substances, or the misuse of alcohol or prescription medications in a manner that would affect your ability to practice safely? ("Currently" means recently enough that the condition may have an ongoing impact.) | ☐ | ☐ |
| 13 | Have you ever been the subject of an investigation or finding related to drug diversion or a controlled-substance discrepancy? | ☐ | ☐ |
| 14 | Are you currently participating in, or have you within the past 5 years participated in, an alternative-to-discipline, peer assistance, or monitoring program? (Answer is confidential and evaluated individually.) | ☐ | ☐ |
| 15 | Are you able to perform the essential functions of a CRNA, including the clinical privileges you are requesting, safely and competently, with or without reasonable accommodation? (Answer "Yes" if able.) | ☐ | ☐ |
| 16 | Have you ever been denied professional certification or been the subject of an academic disciplinary action during professional training? | ☐ | ☐ |

*Question 15: disclosure of a specific diagnosis or disability is not required. Medical inquiries occur only after a conditional offer. To request an accommodation, call 502-640-8349.*

## Attestation, acknowledgment, and release of information authorization

**Attestation of accuracy.** I attest that the information in this application and all attachments is true, correct, and complete to the best of my knowledge. I understand that any material misstatement or omission is grounds for denial of my application or termination of my employment, contract, or privileges at any time, regardless of when discovered.

**Burden of proof.** I understand that I have the burden of producing adequate information for a proper evaluation of my competence, character, ethics, and qualifications, and of resolving any doubts about such qualifications.

**Authorization to verify and release.** I authorize Metric Anesthesia Consultants, PLLC, its Credentialing Committee, its agents including Insurance Billing Company, and its client facilities to contact and obtain information from any individual or organization with knowledge of my qualifications, including licensing boards, certifying bodies, educational institutions, hospitals and health systems, employers, staffing agencies, professional liability carriers, peer references, background screening agencies, the National Practitioner Data Bank, the DEA, state controlled-substance agencies, CAQH, and federal and state program integrity agencies. I authorize these sources to release such information to Metric.

**Sharing with clients and payors.** I authorize Metric to share my credentialing information, verification results, and quality data with client facilities where I am placed or proposed for placement, and with health plans and government payors for enrollment, credentialing, and audit purposes.

**Release from liability.** To the fullest extent permitted by law, I release from liability Metric, its representatives, and all individuals and organizations that provide information in good faith and without malice in connection with the evaluation of my application or ongoing credentialing. This release is in addition to any immunity provided by law, including the Health Care Quality Improvement Act of 1986 and applicable state peer review statutes.

**Consumer reports.** I understand that a background check (consumer report) will be obtained only after I receive a separate, stand-alone FCRA disclosure and provide separate written authorization.

**Continuing duty to report.** I agree to notify Metric in writing within 5 business days (and within 24 hours for any exclusion, license suspension, DEA action, or arrest) of any change to the information in this application, including any new claim, investigation, board action, privilege action, or change in health status that affects my ability to practice safely.

**Compliance with policies.** I agree to abide by Metric policies, client facility bylaws, rules, and policies, and applicable professional standards, including the AANA Scope of Nurse Anesthesia Practice and Standards for Nurse Anesthesia Practice.

**Validity of copies.** A photocopy, facsimile, or electronic copy of this authorization is as valid as the original. This authorization remains in effect for the duration of my application, employment or contract, and any recredentialing, and for responding to verification requests after separation.

APPLICANT SIGNATURE

DATE

PRINTED NAME AND CREDENTIALS

LAST 4 DIGITS OF SSN (IDENTITY MATCH)

Metric Anesthesia Consultants

FORM 3 | CRNA APPLICATION PACKET

# Confidential Peer Reference Request

**Applicant: complete Part 1 and give one copy of this form to each reference. Reference: please complete Part 2, sign, and return it directly to Chad Riddle, CRNA, Metric Anesthesia Consultants, PLLC, 102 Wiltshire Avenue, Louisville, KY 40207, in a sealed envelope marked CONFIDENTIAL, within 10 business days. Your candid response is confidential, used only for peer review and credentialing, and protected to the extent permitted by law. Questions: 502-640-8349.**

PART 1. APPLICANT NAME AND CREDENTIALS

APPLICANT SIGNATURE (AUTHORIZES RELEASE)

DATE

## Part 2. Reference (rate each area based on direct observation)

REFERENCE NAME, CREDENTIALS, AND TITLE

FACILITY / ORGANIZATION

RELATIONSHIP TO APPLICANT

DATES AND FREQUENCY OF DIRECT OBSERVATION

PHONE

| COMPETENCY | EXCELLENT | GOOD | FAIR | POOR | UNABLE TO RATE |
|---|---|---|---|---|---|
| Medical knowledge and clinical judgment | ☐ | ☐ | ☐ | ☐ | ☐ |
| Pre-anesthetic assessment and planning | ☐ | ☐ | ☐ | ☐ | ☐ |
| Airway management | ☐ | ☐ | ☐ | ☐ | ☐ |
| Neuraxial and regional anesthesia | ☐ | ☐ | ☐ | ☐ | ☐ |
| Pediatric anesthesia | ☐ | ☐ | ☐ | ☐ | ☐ |
| Obstetric anesthesia | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cardiac and high acuity cases | ☐ | ☐ | ☐ | ☐ | ☐ |
| Crisis management and vigilance | ☐ | ☐ | ☐ | ☐ | ☐ |
| Documentation and controlled-substance accountability | ☐ | ☐ | ☐ | ☐ | ☐ |
| Communication and teamwork | ☐ | ☐ | ☐ | ☐ | ☐ |
| Professionalism, ethics, and reliability | ☐ | ☐ | ☐ | ☐ | ☐ |
| Patient safety practices and adherence to policy | ☐ | ☐ | ☐ | ☐ | ☐ |
| Responsiveness to feedback | ☐ | ☐ | ☐ | ☐ | ☐ |

| # | QUESTION | YES | NO |
|---|---|---|---|
| 1 | To your knowledge, has the applicant ever been subject to any disciplinary action, privilege restriction, or investigation? | ☐ | ☐ |
| 2 | Do you have any concerns about the applicant's ability to perform the duties of a CRNA safely, with or without reasonable accommodation? | ☐ | ☐ |
| 3 | Are you aware of any concerns regarding controlled-substance handling or impairment? | ☐ | ☐ |
| 4 | Would you rehire or work with this applicant again? | ☐ | ☐ |

☐ Overall: Highly recommend ☐ Recommend ☐ Recommend with reservations ☐ Do not recommend

COMMENTS

REFERENCE SIGNATURE

DATE

Metric Anesthesia Consultants

FORM 4 | CRNA APPLICATION PACKET

# CRNA Clinical Privileges Request

*Complete one form for each facility where you are requesting privileges. Request only privileges for which you meet the criteria and can document recent experience. Each facility's medical staff and governing body make the final privileging decision, and privileges are exercised within state scope of practice, facility bylaws, and applicable supervision requirements.*

**CRNA NAME AND CREDENTIALS**

**IF OTHER, FACILITY NAME AND CITY**

**FACILITY**

☐ Perry County Memorial Hospital ☐ Livingston Hospital ☐ ASINA ☐ Other

☐ Request type: Initial ☐ Renewal ☐ Additional privileges

Core privileges: pre-anesthetic evaluation and plan; anesthesia informed consent per facility policy; selecting, ordering, and administering anesthetic agents, adjuvants, fluids, and blood products; general anesthesia including supraglottic devices and endotracheal intubation; MAC and deep sedation; monitoring; emergence and post-anesthesia care; peripheral IV access; and response to airway and resuscitation emergencies.

| REQUESTED | PRIVILEGE | SUGGESTED CRITERIA (INITIAL) | CASES, LAST 24 MO |
|---|---|---|---|
| ☐ | Core CRNA privileges (adult, ASA I to III) | Core criteria; 50 cases in prior 24 months | |
| ☐ | ASA IV and emergency cases | Documented high acuity experience | |
| ☐ | Spinal anesthesia | 25 in prior 24 months or training documentation | |
| ☐ | Epidural / combined spinal-epidural (non-OB) | 15 in prior 24 months | |
| ☐ | Obstetric labor epidural analgesia | 25 labor epidurals in prior 24 months | |
| ☐ | Cesarean section anesthesia | 15 in prior 24 months; NRP recommended | |
| ☐ | Peripheral nerve blocks, ultrasound guided | 20 in prior 24 months; list types | |
| ☐ | Continuous peripheral nerve catheters | 10 in prior 24 months | |
| ☐ | Pediatric anesthesia, age 2 to 12 | PALS; 15 in prior 24 months | |
| ☐ | Pediatric anesthesia, under age 2 | PALS; 10 in prior 24 months; facility capability | |
| ☐ | Cardiac anesthesia (cardiopulmonary bypass) | Cardiac training; 10 in prior 24 months | |
| ☐ | Thoracic / one-lung ventilation | 10 in prior 24 months | |
| ☐ | Arterial line placement | 10 in prior 24 months | |
| ☐ | Central venous catheter (ultrasound guided) | 10 in prior 24 months | |
| ☐ | Advanced airway (fiberoptic, awake intubation) | 10 in prior 24 months | |
| ☐ | Point-of-care ultrasound (diagnostic) | Documented training and case review | |
| ☐ | Acute and chronic pain procedures | Documented training; NSPM-C for interventional pain | |
| ☐ | Sedation and airway support outside the OR | Core criteria | |

**NERVE BLOCK TYPES REQUESTED**

I request only those privileges for which I am qualified by training and current experience, and I agree to practice within facility bylaws, rules, and policies.

**CRNA SIGNATURE**

**DATE**

*For Metric and facility use only: recommendation, approval, conditions, and FPPE are documented on the facility's privileging record. Draft template pending review by healthcare counsel licensed in Kentucky and Indiana; not legal advice.*