

HOLY CROSS HOSPITAL CLINICAL PRIVILEGE REQUEST FORM

PRACTICE AREA: Certified Registered Nurse Anesthetist

DESCRIPTION: A qualified anesthesia provider involved in the administration of anesthesia and related services as delineated by the clinical and non-clinical responsibilities described herein.

BASIC CRITERIA:

Holds current NM license as a registered nurse and complies with any applicable state statutory requirements concerning the advanced practice of nursing.

Graduate of a nurse anesthesia educational program accredited by the American Association of Nurse Anesthetists (AANA) Council on Accreditation of Nurse Anesthesia Educational Programs or its predecessor.

Currently certified by the AANA Council on Certification of Nurse Anesthetists or its predecessors

Insured by an appropriate medical malpractice insurer for the limits required by the Board of Directors.

CLINICAL PRIVILEGES: Please check the procedures for which you are making an application.

- | | |
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| <input type="checkbox"/> Preanesthetic assessment | <input type="checkbox"/> Conscious and deep sedation techniques |
| <input type="checkbox"/> Requesting laboratory/diagnostic studies | <input type="checkbox"/> Perianesthesia management of patient using accessory drugs or fluids to maintain physiologic homeostasis through preventing or treating complications/emergencies. |
| <input type="checkbox"/> Preanesthetic medication | <input type="checkbox"/> Cardiopulmonary resuscitation management |
| <input type="checkbox"/> General anesthesia and adjuvant drugs | <input type="checkbox"/> Perianesthetic invasive and noninvasive monitoring |
| <input type="checkbox"/> Regional Anesthesia techniques | <input type="checkbox"/> Tracheal intubation/Extubation |
| <input type="checkbox"/> Subarachnoid | <input type="checkbox"/> Mechanical ventilation/oxygen therapy |
| <input type="checkbox"/> Epidural | <input type="checkbox"/> Fluid, electrolyte, acid-base management |
| <input type="checkbox"/> Caudal | <input type="checkbox"/> Blood, blood products, plasma expanders |
| <input type="checkbox"/> Upper Extremity | <input type="checkbox"/> Peripheral intravenous/arterial catheter placement |
| <input type="checkbox"/> Lower Extremity | <input type="checkbox"/> Central venous catheter placement |
| <input type="checkbox"/> Peripheral nerve blocks | <input type="checkbox"/> Acute and chronic pain therapy |
| <input type="checkbox"/> Local infiltration | <input type="checkbox"/> Postanesthesia care/release |
| <input type="checkbox"/> Topical | |
| <input type="checkbox"/> Periocular block | |
| <input type="checkbox"/> Transtracheal | |
| <input type="checkbox"/> Intracapsular | |
| <input type="checkbox"/> Intercostal | |

This is to verify that I am physically and mentally capable of providing the services indicated on the above list.

Signature _____

Date: _____

