



CIBOLA GENERAL HOSPITAL

1016 ROOSEVELT • GRANTS, NM 87020 • (505) 287-4446 • FAX (505) 287-5309

APPLICATION FOR SURGICAL SERVICE PRIVILEGES CERTIFIED REGISTERED NURSE ANESTHETIST

Name: _____
(please print)

Please check (x) the procedure(s) in which you are proficient:

GENERAL ANESTHESIA & ANALGESIA

- Pre-operative Preparation & Medication
 - Intravenous Agents
 - Inhalation Agents
 - Intramuscular Agents
 - Other (describe)
- _____

DIAGNOSTIC & THERAPEUTIC BLOCKS

- Sympathetic Blocks
 - Epidural
 - Spinal - Differential
 - Steroid, Alcohol & Phenol Blocks
 - Other (describe)
- _____

REGIONAL ANESTHESIA

- Topical
 - Infiltration
 - Spinal
 - Epidural & Caudal
 - Intravenous
 - Upper Extremity Blocks
 - Lower Extremity Blocks
 - Field Blocks
 - Other Peripheral Blocks
 - Other (describe)
- _____

PROCEDURES

- Intravenous Catheter Placement
 - Intravenous Administration of:
 - Fluids
 - Blood
 - Plasma
 - Plasma Expander
 - Muscle Relaxants
 - Vasoactive Drugs
 - Cardiac Drugs
 - Procedural Sedation
 - Other
- _____

- | | |
|--|--|
| <input type="checkbox"/> Placement of Central Venous Lines | <input type="checkbox"/> Cardiopulmonary Bypass Technique |
| <input type="checkbox"/> Placement of Arterial Lines | <input type="checkbox"/> Autotransfusion Techniques |
| <input type="checkbox"/> Placement of Right Heart & Pulmonary Artery Lines | <input type="checkbox"/> Hypotensive & Hypertensive Techniques |
| <input type="checkbox"/> Mechanical Ventilation | <input type="checkbox"/> Hypothermia |
| <input type="checkbox"/> Resuscitation Techniques & Therapy | <input type="checkbox"/> Other |

I am mentally and physically capable of performing the privileges which I have requested.

Signature: _____ Date: _____

- Appointment Recommended Appointment Not Recommended Appointment Deferred

Date

Chairman, Executive Committee

- Appointed Disapproved Deferred

Date

Chairman, Board of Directors



HEALTH STATEMENT

Do you presently have a physical or mental health condition which would affect or is likely to affect your ability to perform professional or medical staff duties as a physician/allied health professional?:

_____ Yes _____ No

If yes, please explain: _____

During the last two years, have you been hospitalized or received any other type of institutional care for a health problem?:

_____ Yes _____ No

Significant finding: _____

Signature

Date

*******IMPORTANT – MUST BE SIGNED BY VERIFYING PHYSICIAN*******

I affirm to the best of my knowledge that the above mentioned physician has no physical or psychological impairments that would impede his/her ability to perform quality health care services.

(Signature of verifying physician)

Date: _____