

ARTESIA GENERAL HOSPITAL

NAME: \_\_\_\_\_ Functions Requested: C.R.N.A.

THIS LISTING OF PROCEDURES IN ANESTHESIA FOR CRNA'S FOR WHICH RECOGNITION IS REQUIRED IS NOT ALL INCLUSIVE AND MAY BE CHANGED FROM TIME TO TIME THROUGH ADDITION OR DELETION.

I HOLD A CURRENT NEW MEXICO LICENSE \_\_\_ YES \_\_\_ NO Number: \_\_\_\_\_

I AM QUALIFIED FOR AND REQUEST THE PRIVILEGES CHECKED BELOW:

	Recommended	Not Recommended
_____ General Anesthesia ( all agents) (Including preop and postop care		
_____ Regional Anesthesia		
_____ Spinal (including continuous)	( )	( )
_____ Peripheral Nerve Blocks	( )	( )
_____ IV Regional Block	( )	( )
_____ Special Techniques		
_____ Anesthesia using hypotension	( )	( )
_____ Anesthesia for Obstetrics	( )	( )
_____ Anesthesia for Neonatal Surgery	( )	( )
_____ Anesthesia for Endoscopy	( )	( )
_____ Arterial Cannulation	( )	( )
_____ Insertion Central Venous Catheters	( )	( )
OTHER:		
_____	( )	( )
_____	( )	( )

Signature \_\_\_\_\_

Date \_\_\_\_\_

Do not write below this Line -- For Committee Use Only

RECOMMENDED  NOT RECOMMENDED

Chairman, Credentials Committee \_\_\_\_\_ Date \_\_\_\_\_

Chairman, Executive Committee \_\_\_\_\_ Date \_\_\_\_\_

Chief of Medical Staff \_\_\_\_\_ Date \_\_\_\_\_

Chairman, Board of Trustees \_\_\_\_\_ Date \_\_\_\_\_



## CONFIDENTIALITY STATEMENT

I, \_\_\_\_\_, understand that in performance of my duties at Artesia General Hospital, I am required to have access to and am involved in the processing of patient care data. I understand that I am obligated to maintain the confidentiality of these data at all times, both at work and off duty. I understand that a violation of these confidentiality considerations may result in disciplinary action, including termination. I further understand that I could be subject to legal action. I agree to comply with information security policies for Artesia General Hospital concerning the privacy and confidentiality consideration of patient care.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



**MEDICAL STAFF SIGNATURE AUTHENTICATION FORM**

Medicare regulation 482.24, authentication of signature, requires that the medical records department maintain a current list of authenticated signature, written initials, codes and stamps, when such are used for authorship.

\_\_\_\_\_  
**Physician Name and Title (PRINTED)**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Physician Initials

**Approved Signature Stamps or Seals:**

Original: Credential File  
CC: Pharmacy, Medical Records



## PHYSICIAN'S ACKNOWLEDGEMENT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) requires hospitals to obtain a signed ***Physician's Acknowledgement Statement*** from any physician who is being granted admitting privileges at that Hospital.

Your signature acknowledges that you have received the following notice [42 CFR 41246 (b)]:

*Notice to Physicians: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnosis, and the major procedure performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds, may be subject to fine, imprisonment, or civil penalty under applicable federal laws.*

\_\_\_\_\_  
**Physician Name and Title (PRINTED)**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
UPIN/NPI #



**BYLAWS ACKNOWLEDGEMENT OF RECEIPT**

I, \_\_\_\_\_, acknowledge that I have read and understood the Medical Staff Bylaws, Rules and Regulations of Artesia General Hospital.

Furthermore, I agree to abide by all such Bylaws, Rules and Regulations, Hospital Policies and Directives during the time I remain appointed to the Medical Staff or Allied Health Professional Staff of Artesia General Hospital.

\_\_\_\_\_  
**Physician Name and Title (PRINTED)**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature