Anesthesia Shadowing Verification Form

Instructions

Please complete this form to verify that you have participated in a shadowing experience with a practicing certified registered nurse anesthetist (CRNA) or physician anesthesiologist. This experience should be in the form of shadowing, or internship.

Applicant Information

Name_____

Current Address_____

City_____ State_____ Zip _____

Shadowing Experience

Institution/ Location_____

Dates of Experience_____

Total Number of Hours_____

Types of Surgeries_____

Types of Anesthesia_____

Was the observer present for the preoperative assessment, induction, maintenance, emergence, and PACU hand-off process? □ Yes □ No

Anesthesia Provider Information

Name_____

Workplace_____

Phone_____ Email _____

I verify that the above-named applicant participated in an opportunity to explore the anesthesia profession by spending time observing me in practice.

_____ _____

Anesthesia Provider Signature Date