COASTAL ANESTHESIA RELIEF

Post Office Box 6467
Florence, SC 29502
866.877.CRNA (2762)
843.679.3251 (office)
843.629.7144 (fax)
www.crnalocums.com

****ALL areas must be legible and accurate. Providing complete addresses, current phone and fax numbers, and appropriate contact individuals will help expedite the credentialing process and therefore your employment.**

Please return completed originals from this packet:

WORK PREFERENCES FORM

CRNA INFORMATION PACKET

SCOPE OF CLINICAL PRIVILEGES FORM

PROFESSIONAL REFERENCE FORMS (3) *fill out top portion only—we will mail these for you

INDEPENDENT CONTRACTOR AGREEMENT

Please enclose legible and current copies with your data packet application:

Curriculum Vitae

State Nursing License(s)

Advanced Practice Nursing card (If Applicable)

AANA Certification or Recertification Card

Malpractice Insurance Statement

NPI Billing Number—if applied for

ACLS and BLS Certification Card

Current Photo

Immunization Record (proof of Tb test required by most facilities)

Drivers License and SS Card (requested by facility in order to process Criminal Background Check)

A drug screen may be requested by a facility prior to or upon first day of assignment

References:

On the forms provided, please list names and addresses of three professional references that can provide information pertaining to your personal and professional knowledge and character. Please provide current and complete addresses.

SIGN and date the "Authorization for Release of Information" section on each of the three enclosed reference inquiries.

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WORK PREFERENCES

At Coastal Anesthesia Relief INC., we work hard to meet your clinical and working preferences.
Please help us to cater to these needs by completing your "Preferences."
Please e-mail to info@crnalocums.com or mail to PO BOX 6467; Florence, SC 29502.

DATE_____

Please place an (*) by preferred contact method.

NAME _____ Home _____

ADDRESS_____ Pager _____

_____ Fax _____

STATES CURRENTLY LICENSED: _____ Work _____

Mobile _____ E-mail _____

CURRENT STATUS

Are you currently employed?_____ Status: full-time_____ part-time_____ temp/prn_____ locums_____ other:_____

Do you carry your own liability insurance?_____ Limits_____ Carrier_____ Exp Date_____

Name of all facilities/group(s) in which you currently have privileges to practice (credentialed):_____

_____

REGIONAL PREFERENCE

In what state, regional area, or distance from home are you interested in working?_____

_____

HOURS

How often would you like to work (ie: 8hrs-40hrs/week, short-term/long term assignments)?_____

Please specify desired hours:

HOURS: Less than 20 / week
20 – 40 / week
40 + / week

CALL: no call
weekday call
weekend call

OTHER:

ANESTHESIA PRACTICE PREFERENCES

SETTING (circle all that apply):

"solo" practice setting
"team-based" setting (MDA/CRNA)
hospital setting
office-based anesthesia setting

CASES (circle):

OB	Trauma	Outpatient	Regional
Pediatrics	Transplant	General Surgery	OTHER (please specify):
Thoracic	Neuro	Plastics	
Hearts	Vascular	ENT	

AVAILABILITY

What is your earliest availability for a work assignment? (explanation may be necessary)

_____

_____

_____

Thank you for your interest and we hope to serve you soon! Welcome to our CRNA, owned, operated, and managed service company
Please visit our website at www.crnalocums.com and get ready to experience the difference.

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CRNA INFORMATION PACKET

PERSONAL INFORMATION

Full Name _____ Maiden/Former Name _____

Street Address _____ City, State, Zip _____ Home Phone _____

Business Name and Tax ID number _____ Mobile Phone_____

Marital Status _____ Citizenship: _____ Pager_____

Birth Place (City, County, State) _____ Fax_____

Birth Date _____ SSN _____ Email_____

Emergency Contact (relation to you) _____

CERTIFICATION/LICENSURE

AANA CERTIFICATION # _____ Initial date of certification _____ Expiration Date _____

DO YOU HAVE CURRENT CERTIFICATION: ACLS _____ **BLS**_____ **PALS**_____ **NALS**_____

PROFESSIONAL LICENSES	**State**	**License Number**	**Date Issued**	**Expiration Date**
*Please list ALL **current** state licenses and advanced practice if applicable.*				
Place an (*) next to Licensure that is pending approval.				

State of Original RN Licensure_____ **Date**_____

PROFESSIONAL LIABILITY INSURANCE

INSURANCE CARRIER_____

Complete Address _____

Policy Number_____ Claim/Aggregate Limits_____

Effective Date _____ Expiration Date_____ Years with Company _____

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EDUCATION

UNDERGRADUATE NURSING

Name of Program_____

Address_____

Phone _____ Fax_____

Dates Attended_____ Degree_____

GRADUATE ANESTHESIA PROGRAM

Name of Program_____

Address_____

Phone _____ Fax_____

Dates Attended_____ Degree_____

OTHER

Name of Program_____

Address_____

Phone _____ Fax_____

Dates Attended_____ Degree_____

WORK HISTORY

*In chronological order, please list your professional health care work history for the **past 5 years** including all hospitals, corporations, government or military assignments. If additional space is needed, please use the back of this form or attach additional sheets.*

1) Dates _____ **Status of employment**_____

Name of Hospital _____

Address_____

Contact person _____ Title_____

Phone _____ Fax_____

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2) **Dates** _____ **Status of employment**_____

Name of Hospital _____

Address_____

Contact person _____ Title_____

Phone _____ Fax_____

3) **Dates** _____ **Status of employment**_____

Name of Hospital _____

Address_____

Contact person _____ Title_____

Phone _____ Fax_____

4) **Dates** _____ **Status of employment**_____

Name of Hospital _____

Address_____

Contact person _____ Title_____

Phone _____ Fax_____

5) **Dates** _____ **Status of employment**_____

Name of Hospital _____

Address_____

Contact person _____ Title_____

Phone _____ Fax_____

6) **Dates** _____ **Status of employment**_____

Name of Hospital _____

Address_____

Contact person _____ Title_____

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Phone _____ Fax_____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

If yes to any of the following questions, please attach a detailed information sheet

Have you ever had a state license or certification to practice your profession relinquished, denied, limited, revoked or suspended, either voluntarily or involuntarily?
YES_____ NO_____

Have any investigations or disciplinary actions ever been initiated and/or are any now pending against you by a state license board, certification agency or professional organization?
YES_____ NO_____

Have you ever been convicted of a felony or misdemeanor relating to the practice of your profession, other health care related matters, third-party reimbursement, violence, controlled substance violation, or anything other than a minor traffic violation?
YES_____ NO_____

Have you ever had hospital privileges denied, revoked, suspended, or voluntarily surrendered?
YES_____ NO_____

Have you ever had disciplinary action or been denied membership/renewal in any professional society organization?
YES_____ NO_____

Have you ever been the subject of investigation by or been suspended, sanctioned, or otherwise restricted from participating in any private, federal or state health insurance program (ie: Medicare or Medicaid)?
YES_____ NO_____

If yes to any of the following questions, please attach a detailed information sheet. Please include name of court in which suit was filed, caption and docket number of case, name and address of attorney defending you, and any other relevant details.

Have you ever been named as a defendant in any criminal proceeding?
YES_____ NO_____

Has your professional liability insurance ever been terminated by action of an insurance company?
YES_____ NO_____
If yes, state when and by what company.

Have you ever been denied professional liability coverage?
YES_____ NO_____
If yes, state when and by which company.

Have you ever been rated in a higher than average risk class for your profession, or had an additional premium imposed upon you because of your claims history?
YES_____ NO_____

Have any professional liability suits been filed against you?
YES_____ NO_____

Have any professional liability suits been filed against you of which are presently pending?
YES_____ NO_____

Have any judgments been made against you in a professional liability case/claim, or have you entered into any settlements?
YES_____ NO_____

If yes to any of the following questions, please include a sheet of detailed information.

Are you able to perform all physical and mental functions, with or without accommodation, necessary to provide patient care services for which you are seeking clinical privileges?
YES_____ NO_____ *If no, please explain.*

Are you presently taking medications or other substances that could limit your ability to perform the clinical privileges of which you are seeking?
YES_____ NO_____

Have you ever had treatment for alcohol abuse and/or substance abuse?
YES_____ NO_____

Are you currently engaged in any rehabilitation program?
YES_____ NO_____

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SCOPE OF CLINICAL PRIVILEGES

Please indicate, by a check, the procedure(s) in which you are proficient and/or those for which you request clinical privileges.

CLINICAL PRIVILEGES	PROFICIENT	REQUESTED
GENERAL ANESTHESIA:		
Preop preparation and medication		
Inhalation agents		
Intravenous agents		
Intramuscular medications		
TIVA		
REGIONAL ANESTHESIA:		
Topical		
Subarachnoid block		
Epidural		
Caudal		
Intravenous regional		
Upper extremity blocks		
Lower extremity blocks		
Field blocks		
DIAGNOSTIC/THERAPEUTIC BLOCKS:		
Sympathetic blocks		
Spinal-differential blocks		
Epidural		
Steroid, alcohol, phenol blocks		
PROCEDURES:		
IV catheter placement		
Central venous line management		
Central venous line placement		
PA catheter management		
PA catheter placement		
Aline management		
Aline placement		
Mechanical ventilation		
Hypotensive technique		
Autotransfusion technique		
Hypothermic technique		
Cardiopulmonary bypass technique		
Resuscitation technique and therapy		
SSEP monitoring		
IV ADMINISTRATION OF:		
Crystalloid fluid		
Colloid/plasma expanders		
Blood/Blood components		
Coagulants		
Anticoagulants		
Cardiac drugs		
Muscle relaxants		
Narcotics		
Antibiotics		
Vasoactive drugs		

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STATEMENT OF CRNA APPLICANT
(Authorization for Release of Information)

I, _____, HEREBY CONFIRM THAT ALL INFORMATION GIVEN IN OR ATTACHED TO THIS CRNA DATA SHEET IS ACCURATE AND VOLUNTARILY SUPPLIED BY MYSELF.

I hereby authorize Coastal Anesthesia Relief, its affiliates and successors, to obtain any information that may be relevant to an evaluation of my professional qualifications, including information pertaining to disciplinary actions, criminal background and history, or other confidential or privileged information, and other credentials.

I authorize Coastal Anesthesia Relief to disclose to current, prior, or potential employers making a reasonable inquiry, information relating to my qualifications, ability, and character.

Only to the extent requested and required by the practices, facilities, groups and hospitals staffed by Coastal Anesthesia Relief where I will be providing clinical services, I agree to provide and authorize the release of the same by Coastal Anesthesia Relief to Coastal Anesthesia Relief clients, the following: a) vaccination records; b) reasonable documentation evidencing that I am in good health and free of communicable diseases; c) the result of and/or a copy of my criminal background check, if any; and d) the result of and/or a copy of my drug screen, if any.

I hereby release Coastal Anesthesia Relief, its officers, employees, and agents, and third parties which provide or receive information regarding my credentials, including, but not limited to, all credentialing information sources, individuals or companies who provide references, companies or agencies that perform criminal background checks, and companies that perform drug screens, from any claims, causes of action, damages and expenses, including reasonable attorney's fees arising from or relating to the collection, verification, and dissemination of my credentialing and other information.

I agree to hold Coastal Anesthesia Relief harmless from and against any and all claims, causes of action, damages, judgments and expenses, including reasonable attorney's fees, arising from or related to the accuracy of the information provided by me. I understand that this does not contemplate a duty to hold Coastal Anesthesia Relief harmless from claims, causes of action and damages which may arise as a result of information provided about me from sources other than me.

This is a continuing authorization and shall be effective from the date of signature below until such time as I have specifically revoked the same in writing.

If any material changes occur affecting my professional status, it is my obligation to notify Coastal Anesthesia Relief or the appropriate affiliate or successor as soon as possible. I understand that the decision to employ me or refer me to practice opportunities is solely at the discretion of Coastal Anesthesia Relief.

I understand that any information received from references is confidential and may not be released to me without the consent of the reference. I understand, agree and acknowledge that references are not part of my personnel file.

A copy or facsimile of this document shall have the same effect as the original.

This document shall be interpreted according to the laws of the state of South Carolina.

Name_____ Social Security number _____

Signature_____ Date_____

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PROFESSIONAL REFERENCE REQUEST

AUTHORIZATION FOR RELEASE OF INFORMATION:
I hereby authorize the investigation and release of any information requested by Coastal Anesthesia Relief, regarding my employment history. I hereby release you (the reference) and your employer from all liabilities of any nature for furnishing the requested information. I agree that a copy of the request and release is valid and binding as the original.

_____ _____ _____
Applicant Name (print) **Signature** **Date**

The above named practitioner has applied for a position in our agency registry. Please answer all questions based on your personal knowledge and direct observations. Your candor will be greatly appreciated and your answers will be confidential, except as is necessary for accomplishing the credentials process or for any related due process procedures. If you need additional space, please use the back of this form or attach additional sheets. *Thank you for your time and attention.*

TO:_____ Phone:_____
_____ Fax:_____
_____

How long have you known the above named applicant?_____

In what setting did you know this individual:
Employed by you at: _____ from _____ to _____.
As a peer or Staff CRNA at _____ from_____ to_____.
Other: (describe):_____ from_____ to _____.

Please evaluate this applicant in the following areas:

	MARGINAL	FAIR	AVERAGE	OUTSTANDING	UNABLE TO EVALUATE
Didactic Knowledge					
Professional Judgment					
Clinical Competence					
Work Habits					
Responsibility/ Accountability					
Ethical Conduct					
Professional Attitude					
Emotional Stability					
Relationship with					
*Peers/Faculty					
*Physicians					
*Administration					
*Support Staff					

To your knowledge, has this applicant failed to comply with applicable bylaws and policies? Yes____ No____ If yes, please specify:

To your knowledge, does this applicant have any physical, emotional, or psychological disability which might limit his/her performance during anesthesia practice? Yes____ No____ If yes, please specify.

Overall recommendation based on personal assessment of this applicant's intellectual and professional ability to perform anesthetic duties:
____Highly recommended
____Recommended
____Recommend with reservation; specify:
____Do not recommend
____Do not know the applicant well enough to respond

Signature_____ Position _____ Date_____

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Professional Judgment					
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Work Habits					
Responsibility/ Accountability					
Ethical Conduct					
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Emotional Stability					
Relationship with					
*Peers/Faculty					
*Physicians					
*Administration					
*Support Staff					

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____Recommended
____Recommend with reservation; specify:
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Signature_____ Position _____ Date_____

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_____ _____ _____
Applicant Name (print) **Signature** **Date**

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_____

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As a peer or Staff CRNA at _____ from_____ to_____.
Other: (describe):_____ from_____ to _____.

Please evaluate this applicant in the following areas:

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Didactic Knowledge					
Professional Judgment					
Clinical Competence					
Work Habits					
Responsibility/ Accountability					
Ethical Conduct					
Professional Attitude					
Emotional Stability					
Relationship with					
*Peers/Faculty					
*Physicians					
*Administration					
*Support Staff					

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____Highly recommended
____Recommended
____Recommend with reservation; specify:
____Do not recommend
____Do not know the applicant well enough to respond

Signature_____ Position _____ Date_____

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INDEPENDENT CONTRACTOR AGREEMENT

This agreement is made on _____, between _____(hereinafter referred to as the "Contractor") and Coastal Anesthesia Relief, INC. (hereinafter referred to as "Coastal").

In consideration of the mutual covenants of the parties, and for other good and valuable consideration, and intending to be legally bound, the Contractor and Coastal agree as follows:

1. Coastal shall search for work assignments for the Contractor as a Certified Registered Nurse Anesthetist ("CRNA") at hospitals or related healthcare facilities. This defines the Contractor as a subcontracted entity and not an employee of Coastal. Coastal shall use its best efforts to negotiate the most competitive contract rates and/or other remuneration on behalf of the Contractor.

2. The Contractor is free to accept or reject any work assignment offered by Coastal. The Contractor shall have sole control over the manner and means of the services performed. All scheduling of the Contractor services with assigned facilities shall be done through Coastal. Any work assignment that is accepted by Contractor shall be completed in a professional manner. If the Contractor fails to complete a work assignment after having accepted the assignment, the Contractor shall be regarded as having breached this Agreement.

3. The anesthesia provider shall ensure that he or she, in performing services under this Agreement, uses his or her best and most diligent efforts and professional skills, performs professional and supervisory services, and renders care to patients in accordance with and in a manner consistent with the highest standards of the specialty of anesthesia and complies with the bylaws, rules and regulation of the Medical Staff and Coastal. This will be evaluated on hiring and yearly based on competency reviews. The Contractor is also responsible for adhering to the policies and procedures set forth by Coastal and provided on orientation.

4. Billing for the Contractor services shall be done through Coastal. An online timesheet is provided in order to calculate your compensation and expenses. Assignments through Coastal consist of a Sunday through Friday workweek. The Contractor must submit a timesheet to Coastal via email, fax or phone message no later than 12:00AM EST, the Friday of the workweek. If an invoice is not received from the Contractor within this time, there will be a delay of proper compensation to the Contractor onto the following scheduled pay period. Compensation from Coastal to the Contractor is on a regular basis. Checks to the Contractor are sent, directly from Coastal, when payment is received form the facility.

5. The Contractor shall be fully responsible for and shall furnish proof of liability insurance, with a 1million/3million minimum, and current licensure by individual nursing boards and American Association of Nurse Anesthetists ("AANA") recertification. When requested, the Contractor will provide a certificate of insurance to the Hospital evidencing such coverage and will notify Coastal immediately if any change in coverage occurs for any reason.

6. The Contractor authorizes Coastal and any of its agents or representatives to release any information which Coastal determines may be material to the Contractor's placement and releases Coastal and any hospitals or healthcare facilities to which such information is disclosed, from and against any liability related thereto.

7. The Contractor agrees to indemnify and hold harmless Coastal from and against all loss, claims, demands, damages, or costs which Coastal my incur by reason of the anesthesia services provided by the Contractor while on assignment, including but not limited to: attorney fees, court costs, any litigation expenses, and judgment or award of damages entered against Coastal arising out of the provisions of anesthesia services by the Contractor or any acts or omissions to act attendant thereto. The Contractor agrees that in the event a situation occurs while on a work assignment referred by Coastal that could possibly lead to a threat of a malpractice suit, the Contractor will ensure that proper notice is given to the insurance carrier.

8. During the term of this Agreement, and for a period of one year after the termination of this Agreement, the Contractor shall not for any reason whatsoever, directly or indirectly, compete with Coastal with any facility/group that contracts anesthesia coverage through Coastal. The CRNA has the right to pursue a permanent placement with a facility that the Company did not provide credentialing towards, even if the Company has contracted interests with said facility. The CRNA agrees not to work as a "private contractor" in any facility that the Company has a contracted interest. The CRNA further agrees that if the CRNA was credentialed in a facility by the Company they may not pursue a "private contractor" or permanent position status without the direct written consent by the Company. The Company would be exclusive in the rights of such situations. These restrictions apply for a one year time period beginning from a written request by the CRNA. Exceptions may be made by the company on a case by case situation, allowing for greater leniency toward the Contractor.

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In addition to any other rights and remedies available at law, or at equity, or otherwise, Coastal shall be entitled to an injunction to be issued by any court of competent jurisdiction, without the filing of a bond, enjoining and restraining the Contractor from violating any of the restrictions of this paragraph. In addition to, and not in lieu of, any other damages or relief available in law, equity or otherwise, the Contractor will pay Coastal Ten Thousand Dollars ($10,000) as liquidated damages for violating any of the restrictions in this paragraph.

9. Either party may elect to terminate this Agreement at any time, in writing, for any reason, with or without reason, notice, or cause, subject to the restrictions and obligations assumed under this Agreement, provided, however, that the restrictions set forth in paragraph eight shall be deemed to have no effect and shall be null and void if this agreement is terminated by Coastal within thirty (30) days after its execution. This Agreement shall be fully enforceable if the Contractor terminates this Agreement at any time for any reason.

10. In the event of a breach of this Agreement, Coastal may, at its election: a) terminate this Agreement, and thereafter bring such action as it may deem proper to protect its rights, b) bring such action, including injunctive, as may be necessary to compel the Contractor to comply with his/her obligations under the Agreement, and c) pursue such other remedies as may be available to it.

11. The Contractor shall keep Coastal's information confidential, whether or not prepared or developed by Coastal, in the strictest confidence. The Contractor will not disclose such information to anyone outside Coastal without Coastal's prior written consent. Nor will the Contractor make use of any confidential information for the Contractor's own purposes or for the benefit of anyone other than Coastal. This includes but is not limited to:

A. All software services and usage including but not limited to all password secured pages/ websites, scheduling server, scheduling information, printouts, and most specifically passwords. These passwords and scheduling servers/software may only be used solely for staffing with and those directly provided by Coastal Anesthesia Relief, INC.

B. All employee and Coastal personal and professional information including but not limited to all promotional plans, business plans and files, contract information, policies and practices.

C.) Each party agrees that the confidential information of the other party has significant value and that knowledge of all or any part of the confidential information would potentially yield a competitive advantage over others not having such knowledge. Accordingly, each party will take reasonable security precautions to protect the other party's confidential information, at least as great as the precautions it takes to protect its own confidential information of a similar nature, but in no event less than commercially reasonable security precautions.

D.) Each party acknowledges that monetary damages may no be a sufficient remedy for unauthorized disclosure of confidential information or confidential materials of the other party, and that the disclosing party is entitled, without waving any other rights or remedies, to such injunctive or equitable relief as may be deemed proper by a court of competent jurisdiction.

12. The Contractor shall not be deemed an employee of Coastal for any purpose, including, but not limited to, any local, state or federal laws regarding employment or compensation for employment. The Contractor has full and sole responsibility for any and all applicable local, state and federal income tax withholding, state and federal unemployment and disability insurance withholding and contributions, social security tax withholding and contributions, and workers' compensation insurance. The Contractor shall indemnify and hold harmless Coastal and Coastal's responsible officers, directors, and agents from and against any and all liability for such obligations.

13. This Agreement shall be governed by and construed in accordance with the laws of the state of South Carolina, except to the extent such laws are superseded by federal law.

14. Any amendments to this Agreement will be effective only if in writing and signed by the parties hereto.

15. The invalidity or unenforceability of any provisions of this Agreement will not affect the validity or enforceability of any other provision.

_____

Coastal CRNA Representative Date

_____

Contractor: Date