

Name_____

Privileges for Yale-New Haven Hospital

I request the following clinical privileges in the Department of Anesthesiology-CRNA of Yale- New Haven Hospital.

Requested

Approved

Anesthesiology-CRNA

PRIVILEGES

_____	_____	A 1 General Anesthesia
_____	_____	A 2 Invasive Hemodynamic Monitoring
_____	_____	A 3 Local Anesthesia, with Sedation
_____	_____	A 4 Management of Chronic Pain
_____	_____	A 5 Regional Anesthesia
_____	_____	A 6 Pulmonary Catheter Placement with Attending Present
_____	_____	A 7 Conscious Sedation

Name_____

I certify and can document that I have administered or directly supervised clinical care in those categories in which privileges are requested.

I acknowledge that I have received and read the Bylaws and the Rules and Regulations of the Medical Staff and agree to be bound by the terms thereof.

I understand that this statement of conditions of clinical privileges will remain in effect for the duration of my service as an Affiliated member of the Yale-New Haven Hospital Staff unless amended during subsequent annual reviews of my appointment.

Certified Nurse Anesthetist's Signature

Date

DEPARTMENTAL REVIEW

Except where indicated, the privileges requested above are approved by the undersigned.

Further, although I have not personally examined the applicant/reappointee or his/her medical records, I **have** / **do not have** reason to believe that he/she suffers from a physical, emotional, or other health problem which impairs his/her ability to practice. Should I acquire information which changes this opinion, I will promptly notify the Chief of Staff.

Name _____

For Re-Appointments Only

Additionally in consideration of this request for privileges, I have reviewed the reappointee's performance with respect to the ACGME six general competencies indicated below based upon direct knowledge or information available via peer reference. Areas of concern which I have addressed with the reappointee, if applicable, are noted below: *(Please initial/ explain as applicable)*

Patient Care _____

Medical / Clinical Knowledge _____

Practice Based Learning and Improvement _____

Interpersonal & Communication Skills _____

Professionalism _____

Systems Based Practice _____

No issues with any of the above. (Please check as applicable)

FOR DEPARTMENTAL COMMENTS:

Approved:

Roberta Hines, M.D.
Chief, Anesthesiology

Date

Name_____