

# *Regions Hospital*

## *Delineation of Privileges*

### *Certified Registered Nurse Anesthetist*

Applicant's Name: \_\_\_\_\_  
Last
First
M
Date

**Instructions:** Applicants must provide complete names and addresses for their references. Please DO NOT SEND letters of recommendation along with your application. These must be primary source verified by Regions Hospital. If documentation of cases or procedures is required, please attach case and/or procedural logs to your privilege delineation.

**CORE I- General Privileges Certified Nurse Anesthetist**

Privileges	Basic Education & Minimal Formal Training	Required Documentation and Experience
<p>Privileges are granted to nurse anesthetists who under the direction of an anesthesiologist are qualified by training to monitor patients during surgical, obstetrical and certain medical procedures using general anesthesia, regional anesthesia, and/or parenteral sedation to a level at which a patient's protective reflexes may be obtunded.</p>	<ol style="list-style-type: none"> <li>1. Registered Nurse in the State of Minnesota.</li> <li>2. Successful completion of a program approved by the AANA Council on Accreditation of Nurse Anesthesia Education programs.</li> <li>3. Successful completion of Nurse Anesthesia Board examination.</li> <li>4. BLS Certification</li> </ol>	<p><u>New Applicants:</u></p> <ol style="list-style-type: none"> <li>1. Name and address of an Anesthesiologist whom the applicant has worked with recently, and the name and address of a CRNA whom the applicant has worked with recently, who can comment on the applicant's current clinical competence and supply an estimation of the volume of cases the individual has personally been involved in over the past year. <b>or</b></li> <li>2. For recent graduates name and address of the program director of their Nurse Anesthesia School who can attest to their participation in the care of at least 250 patients within the past 12 months. This will be in lieu of actual documentation of patient names and procedures as well as letters from a peer and physician.</li> </ol> <p>Name: _____            Name of Facility: _____            Add: _____            Ph/Fax: _____</p> <p><u>Reappointment Applicants:</u></p> <ol style="list-style-type: none"> <li>1. Evaluation of your competency conducted by a CRNA peer of your choice and an anesthesiologist whom you have worked with recently. Please indicate names and addresses of the individuals whom we may contact.</li> </ol> <p>Name: _____            Name of Facility: _____            Add: _____            Ph/Fax: _____</p> <p>Name: _____            Name of Facility: _____            Add: _____            Ph/Fax: _____</p>

**TO BE COMPLETED BY APPLICANT:**

I agree to supply Regions Hospital Credentialing Office (or designee) with all of the information that has been requested of me for the privileges that I have applied for listed above. I also understand that my application for privileges will not proceed until which time that the information is received.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**TO BE COMPLETED BY REGIONS HOSPITAL DIVISION/SECTION HEAD AT TIME OF REVIEW AND APPROVAL:**

I have reviewed and/or discussed the privileges requested and find them to be commensurate with his/her training and experience, and recommend that his/her application proceed.

\_\_\_\_\_  
Regions Division/Section Head Signature

\_\_\_\_\_  
Date