Anesthesia Shadow Verification Form

Applicant Name: _____

I verify that the applicant named above has completed_____hours of shadowing with a CRNA or physician anesthesiologist providing direct patient care and has had the opportunity to ask questions about the Nurse Anesthesia profession and practice.

Please select all experiences the applicant had during this shadowing time:

□ Discussed the roles and responsibilities of a CRNA
□ Observed preoperative assessment and patient preparation
□ Observed induction of general anesthesia
□ Observed invasive line placement
□ Observed regional anesthesia
□ Observed intraoperative monitoring and anesthetic management
□ Observed emergence from general anesthesia
□ Observed postoperative assessment and handoff
□ Other experiences:

Shadowing Date(s): _____

Facility: _____

Anesthesia Provider Name: _____

Anesthesia Provider Signature: _____

Anesthesia Provider Email Address: _____