



Locum Tenens Application

Name: _____

Date: _____

ODYSSEY STAFFING DOCUMENTS CHECKLIST – NURSE ANESTHETIST

Please mail the following documents as soon as possible to complete your file in self addressed envelope or fax it to (866) 321-0683

- **APPLICATION FORM** – signed and dated
- **SKILLS CHECKLIST** – signed and dated
- **RELEASE AND AUTHORIZATION FORM** - signed and dated
- **COPY OF CV**- must be up to date, with the current date at the top, must include all locums assignments within the past five (5) years
- **ADDITIONAL DOCUMENTATION** – if you answered yes to any question that required additional information or liability addendum
- **FORM W- 9** – completed, signed and dated
- **DIRECT DEPOSIT FORM** – attach copy of voided check
- **REFERENCE FORMS**- please give to 3 people that you have worked with within the last 12 months
- **COPIES OF DRIVERS LICENSE, CURRENT PHOTO AND SOCIAL SECURITY CARD**
- **COPIES OF ALL CURRENT STATE LICENSE RENEWAL CARDS**
- **COPY OF GRADUATE TRAINING CERTIFICATE OR GRADUATE DEGREE**
- **COPY OF AANA CERTIFICATION/RE-CERTIFICATION**
- **COPIES OF CURRENT CME CERTIFICATES**
- **COPY OF IMMUNIZATION RECORD (PPD, MMR, AND/OR CHEST X-RAY**
- **COPIES OF CURRENT BLS, ACLS, PALS CARDS (IF APPLICABLE)**
- **COPY OF CURRENT MALPRACTICE BINDER (IF APPLICABLE)**
- **COPY OF CONFIRMATION EMAIL/LETTER FOR NPI NUMBER**

HOSPITAL AFFILIATIONS

Please list all present and previous hospital affiliations and medical staff memberships, in chronological order

NAME, CITY AND STATE OF INSTITUTION	CAPACITY	DATES: MO/YR
NAME, CITY AND STATE OF INSTITUTION	CAPACITY	DATES: MO/YR
NAME, CITY AND STATE OF INSTITUTION	CAPACITY	DATES: MO/YR
NAME, CITY AND STATE OF INSTITUTION	CAPACITY	DATES: MO/YR
NAME, CITY AND STATE OF INSTITUTION	CAPACITY	DATES: MO/YR

PROVIDER REFERENCES

- The references must be professional and you must have had contact with them within the last 12 months

NAME	POSITION/RELATIONSHIP	PHONE
ADDRESS	CITY	STATE
WORKED WITH	FROM	TO
NAME	POSITION/RELATIONSHIP	PHONE
ADDRESS	CITY	STATE
WORKED WITH	FROM	TO
NAME	POSITION/RELATIONSHIP	PHONE
ADDRESS	CITY	STATE
WORKED WITH	FROM	TO
NAME	POSITION/RELATIONSHIP	PHONE
ADDRESS	CITY	STATE
WORKED WITH	FROM	TO



PROVIDER QUESTIONNAIRE

IF THE ANSWER TO ANY OF THE FOLLOWING IS YES, GIVE DETAILS ON SEPARATE SHEET IF NEEDED

1. DO YOU HAVE ANY ILLNESS, DISEASE, MENTAL OR PHYSICAL ABILITY OR ANY OTHER PHYSICAL CONDITION(S) WHICH MAY LIMIT OR HINDER YOUR PERFORMANCE?.....	<input type="checkbox"/> yes	<input type="checkbox"/> no
2. DO YOU HAVE ANY COMMUNICABLE DISEASES?.....	<input type="checkbox"/> yes	<input type="checkbox"/> no
3. HAVE YOU EVER RECEIVED TREATMENT OR ARE YOU CURRENTLY RECEIVING TREATMENT FOR SUBSTANCE ABUSE, ALCOHOL ABUSE, OR NERVES?.....	<input type="checkbox"/> yes	<input type="checkbox"/> no
4. HAVE YOU HAD A POSITIVE RUBELLA TITER? IF YES, WHAT DATE?.....	<input type="checkbox"/> yes	<input type="checkbox"/> no
5. HAVE YOU HAD A POSITIVE RUBELLA IGG TITER? IF YES, WHAT DATE?.....	<input type="checkbox"/> yes	<input type="checkbox"/> no
6. HAVE YOU RECEIVED RUBELLA VACCINE? IF YES, WHAT DATE?.....	<input type="checkbox"/> yes	<input type="checkbox"/> no
7. HAVE YOU RECEIVED VARICELLA IGG TITER? IF YES, WHAT DATE?.....	<input type="checkbox"/> yes	<input type="checkbox"/> no
8. HAVE YOU HAD A PURIFIED PROTEIN DERIVATIVE TEST WITHIN THE LAST YEAR?..... IF TEST WAS POSITIVE, THE RESULTS OF A BASELINE CHEST X-RAY LESS THAN FIVE YEARS OLD, SHOULD BE ATTACHED ALONG WITH A DOCUMENT SIGNED FROM YOUR PHYSICIAN STATING YOU HAVE NO ACTIVE SYMPTOMS OF ACTIVE TUBERCULOSIS.	<input type="checkbox"/> yes	<input type="checkbox"/> no
9. HAVE YOU HAD A HEPATITIS B ANTIGEN ANTIBODY TEST? IF YES, WHAT DATE, AND WHAT WERE THE RESULTS?.....	<input type="checkbox"/> yes	<input type="checkbox"/> no

10. HAVE YOU EVER BEEN CONVICTED OF A FELONY OR CRIME OTHER THAN A TRAFFIC VIOLATION?.....	<input type="checkbox"/> yes	<input type="checkbox"/> no
11. HAS YOUR NURSING LICENSE EVER BEEN LIMITED, SUSPENDED OR REVOKED IN ANY JURISDICTION?..	<input type="checkbox"/> yes	<input type="checkbox"/> no
12. HAVE YOU EVER BEEN THE SUBJECT OF DISCIPLINARY PROCEEDINGS AT ANY HEALTHCARE FACILITY?..	<input type="checkbox"/> yes	<input type="checkbox"/> no
13. HAVE YOU BEEN REFUSED MEMBERSHIP ON A MEDICAL STAFF?.....	<input type="checkbox"/> yes	<input type="checkbox"/> no

14. HAVE YOU EVER BEEN SUSPENDED, TERMINATED, SANCTIONED OR OTHERWISE RESTRICTED FROM PARTICIPATING IN ANY PRIVATE, FEDERAL OR STATE HEALTH INSURANCE PROGRAM?.....	<input type="checkbox"/> yes	<input type="checkbox"/> no
15. HAVE JUDGMENTS OR SETTLEMENTS BEEN MADE AGAINST YOU IN PROFESSIONAL LIABILITY CASES, OR ARE CLAIMS PENDING?.....	<input type="checkbox"/> yes	<input type="checkbox"/> no
16. HAVE YOU EVER HAD PROFESSIONAL LIABILITY INSURANCE REFUSED, CANCELED, NON-RENEWED, SURCHARGED OR RESTRICTED?.....	<input type="checkbox"/> yes	<input type="checkbox"/> no

PROVIDER SIGNATURE: _____ DATE _____

RELEASE, AUTHORIZATION AND ACKNOWLEDGMENT:

In regards to my application to Odyssey Staffing:

I certify that the above information I have provided on this application and attachments is true and accurate, that it can be used by Odyssey Staffing for evaluating my potential as a Locum Tenens nurse anesthetist, and that Odyssey Staffing will rely on the truthfulness of my application.

I acknowledge in making medical application for membership to the medical staff, I authorize Odyssey Staffing and its representatives, to obtain any information that may be relevant to an evaluation of my professional qualifications, including information about disciplinary actions or other credentials or confidential information.

I hereby release Odyssey Staffing, its officers, employees, and representatives, and third parties which provide or receive information regarding my credentials. Further, I agree to indemnify, defend and hold Odyssey Staffing its officers, employees, and representatives, and third parties harmless, from any and all claims, causes of action, damages, judgments and expenses, including reasonable attorney's fees, arising from or related to the collection, verification and dissemination of my credentialing information.

I understand that I have the burden of providing accurate information to Odyssey Staffing to demonstrate my qualifications. I understand that any misrepresentation on this application may constitute grounds for denial or referral to practice assignments.

I understand that I am responsible for notifying Odyssey Staffing of any changes affecting my professional status. I certify that the information contained in this application is accurate and complete.

I acknowledge that I am not an employee of Odyssey Staffing and that any services that I provide to an Odyssey Staffing client will be provided as an independent contractor.

I understand the information provided by references is confidential and will not be released without their consent.

I agree that if I am referred by Odyssey Staffing to any opportunity, I will promptly notify Odyssey Staffing each time I provide locum tenens services to the Odyssey Staffing client, within two years of the performance of any covered locum tenens services.

APPLICANTS SIGNATURE

DATE

CLINICAL SKILLS CHECKLIST ♦ (ANESTHESIA)

NAME: _____ DATE: _____
(Please Print)

I AM PROFICIENT AND COMFORTABLE IN THE PROCEDURES INDICATED:

GENERAL ANESTHESIA AND ANALGESIA

- Pre - Post Operative Prep & Medication
- Intravenous Agents
- Inhalation Agents
- Intramuscular Agents
- Other (Describe)

REGIONAL ANESTHESIA

- Topical
- Infiltration
- Spinal
- Epidural & Caudal
- Intravenous
- Upper Extremity
- Lower Extremity
- Field Blocks
- Other Peripheral Blocks
- Other (Describe)

DIANOSTIC & THERAPEUTIC BLOCKS

- Sympathetic Blocks
- Epidural
- Spinal – Differential
- Steroid, Alcohol & Drug Phenol Blocks
- Filed Blocks
- Other (Describe)

SPECIALTIES OR SPECIFIC SKILLS

- Open Hearts
- Peds
- OB
- Pain Management
- Transplants
- Trauma/Burns
- Vascular
- Gen Surgery
- Ortho
- Neuro
- Thoracic
- Uro
- GYN
- ENT
- Eye
- Other (Describe)

PROCEDURES

- Intravenous Catheter Placement
- Intravenous Administration of:
 - Fluids
 - Blood
 - Plasma
 - Plasma Expanders
 - Muscle Relaxants
 - Vasoactive Drugs
 - Cardiac Drugs
 - Other (Describe)
- Placement of Central Venous Lines
- Placement of Arterial Lines
- Placement of Right Heart & Pulmonary Lines
- Mechanical Ventilation
- Resuscitation Techniques & Therapy
- Cardiopulmonary Bypass Technique
- Autotranfusion Techniques
- Hypotensive & Hypertensive Technique
- Hypothermia
- BLS Certified
- ACLS Certified
- PALS Certified
- NALS Certified
- Other (Describe)

CLINICAL SETTINGS

- Solo
- MDA/Supervised
- Teaching
- Hospital/Office

SIGNATURE: _____



808 Office Park Circle #300
 Lewisville, TX 75057
 Toll Free: (866) 795-9045
 Fax: (866) 321-0683

LIABILITY INSURANCE

LIABILITY INSURANCE: (attach copy of declaration page)		POLICY NO./ EXP DATE	
ADDRESS:		CITY:	STATE:
ZIP:	PHONE:	LIABILITY LIMITS:	
PREVIOUS CARRIERS: PAST TEN YEARS		POLICY NO.	
ADDRESS:		CITY:	STATE:
ZIP:	PHONE:	EXP DATE:	
PREVIOUS CARRIER		POLICY NO.	
ADDRESS:		CITY:	STATE:
ZIP:	PHONE:	EXP DATE:	

1. HAVE ANY JUDGEMENTS OR SETTLEMENTS BEEN MADE AGAINST YOU IN A PROFESSIONAL LIABILITY CASE OR ARE THERE ANY CLAIMS PRESENTLY PENDING?

yes no

2. IF YES, HOW MANY? _____

IF YES, PLEASE FILL OUT LIABILITY ADDENDUM IN ITS ENTIRETY FOR EACH CASE OR CLAIM AND SUPPLY SUPPORTING DOCUMENTS

3. HAVE YOU EVER HAD PROFESSIONAL LIABILITY INSURANCE REFUSED, CANCELLED, NON-RENEWED, SURCHARGED OR RESTRICTED?

yes no

BY SIGNING THIS APPLICATION, YOU AGREE THAT ALL INFORMATION IS TRUE AND ACCURATE TO THE BEST OF YOUR KNOWLEDGE.

 Signature

_____/_____/_____
 Month / Day / Year

**SUPPLEMENT FOR NURSE ANESTHETISTS (CRNA) FOR
PROFESSIONAL LIABILITY INSURANCE FOR SPECIFIED MEDICAL PROFESSIONS**

All questions MUST be completed in full.

If space is insufficient to answer any question fully, attach a separate sheet.

1. Full name of Applicant: _____

2. During administration of all anesthetics, do you use a pulse oximeter monitor? [] Yes [] No

If No, explain. _____

3. During all anesthetics,

(a) Is an electrocardiogram continuously displayed? [] Yes [] No

If No, explain. _____

(b) How often is the arterial blood pressure determined and evaluated? _____

(c) How often is the heart rate determined and evaluated? _____

(d) How is the circulatory function evaluated? _____

4. During all general anesthetics, do you use an end tidal CO2 monitor? [] Yes [] No

If No, explain. _____

5. During all general anesthetics using an anesthesia machine, do you:

(a) Use an oxygen analyzer with a low concentration limit alarm? [] Yes [] No

If No, explain. _____

(b) Test proper functioning of alarms prior to each use? [] Yes [] No

If No, explain. _____

6. When ventilation is controlled by a mechanical ventilator, do you:

(a) Use a device equipped with a full set of safety alarms? [] Yes [] No

If No, explain. _____

(b) Test proper functioning alarms prior to each use? [] Yes [] No

If No, explain. _____

7. Are you present in the operating room throughout the conduct of all general anesthetics, regional anesthetics and monitored anesthesia care? Yes No

If No, explain. _____

8. Are you supervised by an anesthesiologist? Yes No _____

9. What is the average number of patients seen? _____ Weekly _____ annually

10. What is the average number of hours of practice time? _____ Weekly

Signing this Supplement does not bind the Company to provide or the applicant to purchase the insurance.

It is understand that information submitted herein becomes a part of our application for insurance and is subject to the same declarations, representations and conditions.

Must be signed by the applicant, officer, partner or equivalent (within 60 days of the proposed effective date).

Name of Applicant

Title

Signature of Applicant

Date

LIABILITY ADDENDUM

Please supply the following information regarding any instance of claim, suit or incident, which may give rise to a claim whether dismissed, settled out of court, judgment or pending. This form should be used for each claim. Please include a narrative description or attorney's correspondence regarding any claim.

Claims

Applicant (Defendant's) Name: _____

Claimant (Plaintiff's) Name: _____

Date of Alleged error: _____

Is this a claim? yes no Suit? yes no

Incident that has been reported to your insurance carrier: yes no

Name of Insurer: _____ Agent: _____

Phone: _____

Nature of suit: (Please describe: _____

Status of Complaint

Court Judgement

Finding for You Plaintiff Determined by Judge Jury

Date: _____

Out-of Court Judgment

Amount Paid on your behalf: \$ _____ Compensation: \$ _____

Total Settlement Amount: \$ _____ Date of Settlement: _____

Pending

Claimants Settlement Demand: \$ _____ Defendant's Offer: \$ _____

Insurer's loss revenue \$ _____ Defense Reserve \$ _____

Deductible \$ _____

Claim in Suit? yes no If yes, asked amount in Summons \$ _____

Compensation \$ _____ Punitive \$ _____

**EMPLOYEE DIRECT DEPOSIT PAYROLL AUTHORIZATION – PLEASE
FILL OUT AND RETURN TO ODYSSEY STAFFING**

I authorize you and the Bank listed to deposit my paycheck to my account each payday. If funds to which I am not entitled are deposited to my account, I authorize you to direct the bank to return said funds. This authority will remain in effect until I give written notice to terminate in sufficient time to allow the Payroll Office to act upon it. I will provide adequate notice if I close this bank account.

*****Attach a voided check to this authorization for the account involved*****

Please note your first check will be live unless we have this paperwork at least 2 weeks before your first paycheck.

DEPOSIT INFORMATION

Deposit my total net pay to (check one):

_____ Checking Account _____ Savings Account

_____ Routing Number _____ Account Number

_____ Bank Name _____ Employee Name (please print)

_____ Branch _____ Signature _____ Date

_____ City _____ State _____ Zip

Attach copy of voided check here

ODYSSEY STAFFING
REQUEST FOR TAXPAYER IDENTIFICATION
SUBSTITUTE W-9 FORM

Pursuant to Internal Revenue Service regulations, vendors/contractors must furnish their Taxpayer Identification Number (TIN). If this number is not provided, you may be subject to a 31% withholding on each payment. To avoid this 31% withholding and to insure that accurate tax information is reported to the Internal Revenue Service, please use this form to provide the requested information.

Legal Name: _____ (This name will be on your checks)

Address: _____

9 DIGIT TAXPAYER IDENTIFICATION NUMBER (COMPLETE ONE):
SOCIAL SECURITY NUMBER

FEDERAL EMPLOYER IDENTIFICATION NUMBER***

BUSINESS DESIGNATION (CHECK ONE) ** Please note that if you file under a federal employer ID number then you will NOT receive a 1099 at the end of the year. Please check the box below if you are a business and need to receive a 1099 at the end of the year which will be reported to the IRS. **

- Individual
- Foreign Individual
- Partnership
- Corporation
- Not-for-Profit Corporation
- Sub-Chapter S Corporation
- Medical/Health Corporation
- Real Estate
- 1099

Under penalties of perjury, I declare that I have examined this request and to the best of my knowledge and belief, it is true, correct and complete.

Name: _____

Title: _____

Signature: _____

Date: _____

Reference Form

As an Independent Practitioner I am often asked for references from previous employers. I would appreciate your assistance by completing this form. Please feel free to express your personal and professional experiences regarding our association. Thank you for your help.

Please Print

CRNA NAME: _____

REFERENCE NAME: _____ DATE: _____

TITLE: _____ TELEPHONE: _____

HOSPITAL/GROUP: _____

ADDRESS: _____ CITY: _____

DATES EMPLOYED: FROM _____ TO: _____

WAS CANDIDATE TERMINATED? _____ WOULD YOU REHIRE? _____

WAS THERE ANY SUSPECTED PROBLEMS WITH DRUGS, ALCOHOL, NERVES, ETC, IF YES, EXPLAIN:

PLEASE EVALUATE ACCORDING TO THE FOLLOWING SCALE:

A=ABOVE AVERAGE B=AVERAGE C=BELOW AVERAGE D=UNACCEPTABLE

_____ ADAPTABILITY TO WORK SITUATIONS

_____ EMOTIONAL STABILITY

_____ PERSONAL APPEARANCE

_____ ATTENDANCE AND PUNCTUALITY

_____ ATTITUDE

_____ SEEKS CONSULTATION WHEN NECESSARY

_____ ABILITY TO GET ALONG WITH PHYSICIANS, CO-WORKERS, PATIENTS

_____ KNOWLEDGE AND ABILITY TO PRACTICE "SAFE ANESTHESIA"

_____ PHYSICAL ASSESSMENT AND MANAGEMENT OF "HIGH RISK PATIENT"

_____ TECHNICAL SKILLS

_____ OVERALL PROFESSIONAL COMPETENCE, TIMELINESS AND COMPLETENESS OF MEDICAL RECORDS

COMMENTS: _____

SIGNATURE: _____

****PLEASE MAIL TO: ODYSSEY STAFFING**

808 OFFICE PARK CIRCLE, SUITE 300

LEWISVILLE, TX 75057

TOLL FREE: (866) 795-9045

****OR FAX TO: (866) 321-0683**



Reference Form

As an Independent Practitioner I am often asked for references from previous employers. I would appreciate your assistance by completing this form. Please feel free to express your personal and professional experiences regarding our association. Thank you for your help.

Please Print

CRNA NAME: _____

REFERENCE NAME: _____ DATE: _____

TITLE: _____ TELEPHONE: _____

HOSPITAL/GROUP: _____

ADDRESS: _____ CITY: _____

DATES EMPLOYED: FROM _____ TO: _____

WAS CANDIDATE TERMINATED? _____ WOULD YOU REHIRE? _____

WAS THERE ANY SUSPECTED PROBLEMS WITH DRUGS, ALCOHOL, NERVES, ETC, IF YES, EXPLAIN:

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COMMENTS: _____

SIGNATURE: _____

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Please Print

CRNA NAME: _____
REFERENCE NAME: _____ DATE: _____
TITLE: _____ TELEPHONE: _____
HOSPITAL/GROUP: _____
ADDRESS: _____ CITY: _____
DATES EMPLOYED: FROM _____ TO: _____
WAS CANDIDATE TERMINATED? _____ WOULD YOU REHIRE? _____
WAS THERE ANY SUSPECTED PROBLEMS WITH DRUGS, ALCOHOL, NERVES, ETC, IF YES, EXPLAIN:

PLEASE EVALUATE ACCORDING TO THE FOLLOWING SCALE:

A=ABOVE AVERAGE B=AVERAGE C=BELOW AVERAGE D=UNACCEPTABLE

_____ ADAPTABILITY TO WORK SITUATIONS
_____ EMOTIONAL STABILITY
_____ PERSONAL APPEARANCE
_____ ATTENDANCE AND PUNCTUALITY
_____ ATTITUDE
_____ SEEKS CONSULTATION WHEN NECESSARY
_____ ABILITY TO GET ALONG WITH PHYSICIANS, CO-WORKERS, PATIENTS
_____ KNOWLEDGE AND ABILITY TO PRACTICE "SAFE ANESTHESIA"
_____ PHYSICAL ASSESSMENT AND MANAGEMENT OF "HIGH RISK PATIENT"
_____ TECHNICAL SKILLS
_____ OVERALL PROFESSIONAL COMPETENCE, TIMELINESS AND COMPLETENESS OF MEDICAL RECORDS

COMMENTS: _____

SIGNATURE: _____

****PLEASE MAIL TO: ODYSSEY STAFFING
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