(706) 265-5045
(706) 265-5043 fax
evenson@kobormedsearch.com

Dear CRNA:

Welcome to Kobor Med Search, LLC, a leader in quality Anesthesia locum tenens and permanent staffing since 1998.

To ensure that your application is processed as quickly as possible, please note the following:

- In order for us to complete our verification / referencing we must receive legible copies of all items listed on the next page. This is also what we will work from to complete your hospital applications, provider enrollment applications, etc. If you cannot provide a requested document please tell us why and let us know if it will be forthcoming.

- The following application must be completed, signed and dated. Please do not leave any areas blank. If a question is not applicable please mark N/A.

Please return the completed application and credentials to us via email. If you have any questions regarding your application, please don't hesitate to contact me.

Thank you for allowing us the opportunity to work with you!

Sincerely,

Betty K Evenson
(706) 265-5045
(706) 265-5043 fax
evenson@kobormedsearch.com

Please complete and return the enclosed application along with copies of the documents listed below:

Current Curriculum Vitae (please include month and year with an explanation of any time gaps)
Copy of current State License(s)
(if Advanced Practice is required please provide both RN & Advanced Practice info)
List of expired State License(s) – including original issue and expiration dates
(if Advanced Practice is required please provide both RN & Advanced Practice info)
Copy of NBCRNA
Copy of current AANA Certification Card (if applicable)
Copy of current ACLS Certification (course should be through the American Heart Assoc)
Copy of current BLS Certification (course should be through the American Heart Assoc)
Copy of current PALS Cert (if applicable) (course should be through the American Heart Assoc)
Copy of NRP Cert (if applicable) (course must be through the American Assoc of Pediatrics)
Copy of current certificate of Malpractice Insurance and certificates for the past 10 years
4 prof references – include name, address (hospital address is fine), email and phone number
(please include at least two MDAs)
Copy of Nursing Diploma
Copy of Anesthesia Diploma
Color copy of State Driver's License (must be color copy)
Copy of Social Security Card
Copy of NPI Notification Letter (to include your log-in & password)
CAQH Provider #, Log-in & Password
Current Photo (cell phones are great – take a head shot selfie against a plain background and email it)
Copy / Listing of CME's received
Copy of Physician Health Statement, if applicable
Copy of current VISA or Alien Registration, if applicable
DEA (if applicable – not required for most assignments)
Copy #DD214 – Military Discharge, if applicable
Case Logs - 2 years
Current PPD Test Results
Current Flu Vaccination (if applicable)
Current Covid Vaccination (if applicable)
Current Immunization List (please use attached form and provide copies of all vaccinations, etc.)
Release and Authorization – attached to this email

I know it looks like an awful lot of paperwork. Once you complete the initial process, it is much easier the next time, as we will have copies of your credentials to forward to your future locum assignments.

IMMUNIZATION / HEALTH FORM

Name (Print): ____

Address: ____

____

Physical Exam	Date of Exam	______________________
	Results	______________________
Tuberculosis Testing	Date of Test	______________________
	Results	______________________
PPD (or Chest x-ray if history of +PPD)	Date of Test	______________________
	Results	______________________
Rubella and Rubeola Titer OR 2 MMR Vaccinations	Date of Test	______________________
	Results	______________________
Hepatitis B Immunization	Date of Tests	______________________
	Results	______________________
Immunity to Mumps	Date of Positive Mumps	______________
	or Date of Mumps Vaccine	___________
Varicella	Date of Varicella	______________________
	or Date of screen or titer	_____________
Flu Vaccination	Date	______________________

* Attach documentation / additional explanations as needed for above

Information Completed By (Print): ______________________________________

Signature: ______________________________________

Date: ______________________________________

Vaccination information must be updated on an annual basis

Kobor Med Search, LLC
PO Box 1931 - Dawsonville, GA 30534
(706) 265-5045 / (706) 265-5043 (fax)
evenson@kobormedsearch.com

CRNA Application

Name of Applicant: ____________________

Former or Maiden Name (and dates used): ____________________

Address: ____________________

City / State / Zip: ________ ____________________

Telephone: (cell) ____________________ **(other)** ____________________

E-Mail: ____________________

Date of Birth: ____________ **Social Security Number:** ____________________

City / County / State of Birth : ____________________

Driver's License Number: ____________________ **expiration:** ____________

Are you a US Citizen? ____________ **If no, Citizenship:** ____________________

Position Desired: **Locum Tenens?** ________ **Permanent?** ________ **Both?** ________

Date Available: ________ ____________________

Foreign Languages Spoken: ____________________

Geographical Preference: ____________________

Current Licensure: ____________________

Pending Licensure: ____________________

Nursing School Attended: ____________________

Address of Nursing School: ____________________

Phone # of Nursing School: ____________________ **Dates Attended:** ____________

Anesthesia School Attended: ____________________

Address of Anesthesia School: ____________________

Phone # of Anesthesia School: ____________________ **Dates Attended:** ____________

Anesthesia Program Director (if completed in past five years) ____________________

Phone Number of Director (if completed in past five years): ____________________

Year CRNA Certification received: ____________________

In case of emergency please notify: (name) ____

(phone) ____ (relation) ____

Health Status: Do you have any physical or mental condition, including chemical / substance dependency that would compromise your ability to practice as a CRNA or perform appropriate clinical duties? ____

Have you used drugs recreationally, or have you ever been treated for alcoholism, narcotic addiction of mental illness? ________

Do you need special accommodations to carry out your daily responsibilities as a CRNA? ______________

Malpractice Insurance Info:

Name of your current carrier: ____

Do you presently have occurrence coverage? ____

Did you purchase tail coverage from your present carrier? ____

Have you ever been a party in or been involved in any malpractice claim or suit? _______________ When? __________________

Do you have any knowledge of any occurrence or circumstance that may result in a malpractice claim / suit against you? _______

***If you answered yes to any of the above Malpractice Insurance questions, please provide details, on a separate sheet.**

Disciplinary Actions:

Have you even been the subject of any investigation by any private, state or federal health insurance program or other governmental agency? ____

Have you even been suspended from the Medicare / Medicaid Program?________________________________

Has your license to practice as an RN or CRNA ever been denied, revoked, suspended or in any way limited? __________________

Have you ever been censored by any committee of a state or county medical association with regard to ethics or fees? _________

Have your staff privileges ever been denied, suspended or in any way restricted at any facility? ______________________________

Have you ever been the subject of a licensing board inquiry? ____

Have you ever been denied a state medical license? ____

Has any insurance carrier ever declined, canceled or refused to renew your professional liability insurance? __________________

Have you ever been denied HMO, PPO, or other health plan participation? ______________________________

Have you ever voluntarily surrendered your CRNA license, staff privileges or consented to a limitation of the same pending a review or investigation? _______________________________________

Are there any other issues that should be disclosed that may have an adverse impact on your ability to deliver effective medical services? ____

***If you answered yes to any of the questions above, please provide details, on a separate sheet.**

Have you ever been convicted of any criminal offense (including motor vehicle offenses but not including minor traffic or parking violations) or are any proceedings currently pending? _______ If Yes … Please provide written details.

Payor Info:

Medicare # ______________________________________ Medicaid # ____

NPI Notification # _____________________________________ Please include a copy of your NPI letter

NPI Log-In ____ NPI Password _________________________________

***IF YOU DON'T KNOW YOUR NPI LOG-IN / PASSWORD PLEASE call (800) 465-3203 TO OBTAIN**

Do you have a CAQH account? _____________________ CAQH Log-In Provider ID: _______________________

CAQH Username: _____________________________ CAQH Password: ___________________________________

***IF YOU DON'T KNOW YOUR CAQH LOG-IN / PASSWORD PLEASE call (888) 599-1771 TO OBTAIN (7:00 a.m. – 9:00 p.m. eastern)**

Electronic Records:

What EMR (electronic medical record) system are you familiar with (i.e. Epic, etc.) and on a scale of 1 – 10 (with 10 being the highest) how comfortable are you with the system? _________________________________

____

____

Additional Notes / Comments:

Professional References: (please list at least 4).

Please include name, address (hospital affiliation address is fine), phone number and email address. We will send an email with our standard reference request. *Please include at least one anesthesiologist (or surgeon if you are practicing in an all CRNA practice).

1. ____

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2. ____

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3 ____

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4. ____

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5. ____

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Additional Education / Prior Employment:

Please attach a current CV with this application. You will also need to be able to provide contact info (name, phone and email or fax) for each place of employment or locums assignment.

This list of clinical privileges should be completed to reflect your pattern of practice. You should request the privileges on the basis of your training, experience and demonstrated competence. This list is intended as a guide, not as an all-inclusive list.

I, ____, CRNA request the following clinical privileges based on my training, experience and competence.

( ) Preanesthetic assessment
( ) Requesting laboratory / diagnostic studies
( ) Preanesthetic medication
( ) General anesthesia / adjunctive drugs
( ) Regional anesthesia techniques

- **( ) Subarachnoid**
- **( ) Epidural**
- **( ) Caudel**
- **( ) Upper extremity**
- **( ) Lower extremity**
- **( ) Diagnostic and therapeutic nerve blocks**
- **( ) Local infiltration**
- **( ) Topical**
- **( ) Periocular block**
- **( ) Transtracheal**
- **( ) Intracapsular**
- **( ) Intercostal**
- **( ) Other (please specify) ______________________________**
- **( ) Other (please specify) ______________________________**

( ) Cardiopulmonary resuscitation management
( ) Perianesthetic invasive and noninvasive monitoring
( ) Tracheal intubation / extubation
( ) Mechanical ventilation / oxygen therapy
( ) Fluid, electrolyte, acid-base management
( ) Administration of blood, blood products, plasma expanders
( ) Peripheral intravenous / arterial catheter placement
( ) Central venous catheter placement
( ) Pulmonary artery catheter placement
( ) Acute and chronic placement
( ) Post Anesthesia Care Unit (PACU) discharge
( ) Conscious and deep sedation techniques
( ) Perianesthesia mgmt. of patient using accessory drugs or fluids
( ) Adult
( ) Pediatric
( ) Other (please specify) ____
( ) Other (please specify) ____

____
Signature / Date