



# LOW COUNTRY ANESTHESIA, P.A.

## Certified Anesthesiologist Assistant (CAA) Application

Date of Application: \_\_\_\_\_

### I. Personal Information:

Full Name \_\_\_\_\_ Nickname \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email \_\_\_\_\_ Pager/Alt. Email \_\_\_\_\_

Social Security No. \_\_\_\_\_

U.S. Citizen: Yes \_\_\_ No \_\_\_ City/State/Country of Birth \_\_\_\_\_

If Incorporated: Business Name \_\_\_\_\_ Tax ID No. \_\_\_\_\_

Maiden/Former Name \_\_\_\_\_

### II. Education and Licensure:

School/Program	Name	Yr. Completed	Degree
High School			
Bachelorette			
Anesthesia			
Other			

State of Original Licensure, License #, Expiration Date \_\_\_\_\_

State(s) of Current Licensure, License #(s), Expiration Date(s) \_\_\_\_\_

# LCA

## LOW COUNTRY ANESTHESIA, P.A.

State(s) of Former Licensure, License #(s), Expiration \_\_\_\_\_

Pending License(s) with Date(s) of Projected Issuance \_\_\_\_\_

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### III. Certifications:

BLS? Yes \_\_\_ No \_\_\_ ACLS? Yes \_\_\_ No \_\_\_ PALS? Yes \_\_\_ No \_\_\_ NALS? Yes \_\_\_ No \_\_\_

NCAA: ID # \_\_\_\_\_ Initial Certification Date \_\_\_\_\_ Expiration Date \_\_\_\_\_

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### IV. Work History - Please List All Previous Medical Employers (add pages if necessary).

<u>Name of Hospital or Facility</u>		<u>Dates Employed</u>
<u>Title &amp; Responsibilities</u>		
<u>Supervisor or Medical Director</u>	<u>Address</u>	<u>Phone or Email</u>
<u>Name of Hospital or Facility</u>		<u>Dates Employed</u>
<u>Title &amp; Responsibilities</u>		
<u>Supervisor or Medical Director</u>	<u>Address</u>	<u>Phone or Email</u>
<u>Name of Hospital or Facility</u>		<u>Dates Employed</u>
<u>Title &amp; Responsibilities</u>		
<u>Supervisor or Medical Director</u>	<u>Address</u>	<u>Phone or Email</u>



# LOW COUNTRY ANESTHESIA, P.A.

## V. Types of Cases Comfortable With:

Ortho\_\_\_ Neuro\_\_\_ Hearts\_\_\_ Major Vascular\_\_\_ Thoracic\_\_\_ URO\_\_\_ OB\_\_\_ GYN\_\_\_

Eyes\_\_\_ Burns\_\_\_ Trauma\_\_\_ Transplants\_\_\_ Abortions\_\_\_ GER\_\_\_ ENT\_\_\_ PEDS\_\_\_

Other Cases: \_\_\_\_\_

## VI. Background (If you answer “Yes” to any of the following questions, please provide complete details on a separate sheet):

Do you have any limitation that would hinder your performance as a CAA? Yes\_\_\_ No\_\_\_

Do you require an accommodation to work as a CAA? Yes\_\_\_ No\_\_\_

Have you ever been convicted of a felony or crime other than a traffic violation? Yes\_\_\_ No\_\_\_

Have your privileges at any healthcare facility ever been voluntarily or involuntarily relinquished, denied, suspended, diminished, revoked, or not renewed for any reason? Yes\_\_\_ No\_\_\_

Have you ever been the subject of a disciplinary proceeding(s), regardless of outcome, at any healthcare facility? Yes\_\_\_ No\_\_\_

Has your license or certification in any state ever been voluntarily or involuntarily relinquished, suspended, terminated, restricted, or is currently being challenged? Yes\_\_\_ No\_\_\_

Have you ever been the subject of a disciplinary proceeding(s), regardless of outcome, by any state licensure board? Yes\_\_\_ No\_\_\_

Have you ever been suspended, terminated, sanctioned or otherwise restricted from participating in any private, public, federal, or state health insurance program (e.g., Medicare, Medicaid, Blue Shield, etc.)? Yes\_\_\_ No\_\_\_

Have judgments or settlements been made against you in a professional liability case(s), or is(are) claim(s) pending? Yes\_\_\_ No\_\_\_

## VII. Please Include Clear Copies or Photos of the Following Material with Your Completed Application:

\_\_\_ Four (4) Letters of Reference or Reference Inquiry Forms (part of this application)

\_\_\_ Signed Applicant’s Statement of Consent and Release Form (part of this application)

\_\_\_ Social Security Card

\_\_\_ Current Driver’s License or State Issued Photo Identification



**LOW COUNTRY ANESTHESIA, P.A.**

**VIII. Applicant’s Statement of Confirmation and Release:**

I hereby acknowledge that my signature below is my affirmation that the facts set forth in this application for employment are true and complete. I further acknowledge that any false statement on this application shall be considered sufficient cause for dismissal. Low Country Anesthesia, P.A. and its representatives (hereinafter individually and collectively referred to as “Employer”) are hereby authorized to make any investigations of my personal and professional history through any agency, bureau or other organization necessary, including but not limited to, criminal background and criminal reports. Employer is also authorized to investigate my ability, employment records, or character through inquiries to the individuals and/or employers mentioned in this application. **I understand that Low Country Anesthesia, P.A. has the right to request a drug screen prior to and during any employment.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Low Country Anesthesia, P.A. is an Equal Opportunity Employer. It does not discriminate on the basis of race, gender, religion, age, sexual orientation, gender identity, nationality or ethnicity, disability, marital or veteran status, or any other classification protected by applicable law. It also complies with laws regarding reasonable accommodations for individuals with disabilities. **Nothing in the application should be construed as an offer or guarantee of employment.**

### APPLICANT'S STATEMENT OF CONSENT AND RELEASE

I hereby authorize Low Country Anesthesia, P.A. and its representatives (hereinafter individually and collectively referred to as "Employer") to consult any person or organization and to inspect any materials having or containing information which may have any bearing on my professional, ethical, and moral qualifications, including my personal character and professional competence. I hereby authorize Employer to request such criminal background histories, drug screen tests and credit reports as Employer deems appropriate. I hereby appoint Employer my attorney in fact to request any such criminal, credit, drug, professional, and personal reports, at any time, without the need to seek further authorization from me. I hereby agree that this authorization and appointment shall be valid until revoked by me in a written revocation delivered to Employer at the address set forth in the footer of this document. I hereby release Employer from any and all liability arising from all acts performed in connection with evaluating my application for employment. **I hereby release from liability all persons and organizations who furnish information concerning my professional competence, ethics, character, and other qualifications, and consent to the release of such information.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

*NOTE TO APPLICANT: You should provide a signed copy of this Statement of Consent and Release to each reference who will be completing the attached Reference Inquiry Form or preparing a letter of reference on your behalf. A signed copy of this Statement should also be provided to Low Country Anesthesia P.A. with your other application materials.*



# LOW COUNTRY ANESTHESIA, P.A.

## CAA Reference Inquiry Form

Low Country Anesthesia, P.A., (“LCA”) is a private anesthesiology group who practices in South Carolina. It strives to deliver the highest quality medical care to our patients. In order to fulfill its mission, LCA and its representatives thoroughly screen every candidate for employment. We recently spoke to the below named candidate who directed us to you for your professional and personal opinions. Please take a moment to complete this evaluation form and return it to the address listed below. Thank you in advance for your assistance.

Candidate’s Name: \_\_\_\_\_

Reference’s Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Title: \_\_\_\_\_ Email: \_\_\_\_\_

Hospital/Group: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

Dates of Candidate’s Employment: \_\_\_\_\_

Was Candidate Terminated? Yes\_\_\_ No\_\_\_      Would You Rehire? Yes\_\_\_ No\_\_\_

Were There Any Suspected Problems with Drugs, Alcohol, Nerves, etc? Yes\_\_\_ No\_\_\_

If Yes to any of the Above, Please Explain: \_\_\_\_\_

**Please Evaluate the Candidate Below According to the Following Scale:**

**A** = Above Average      **B** = Average      **C** = Below Average      **D** = Unacceptable

- |   |                              |
|---|------------------------------|
| _____ Adaptability to Work Situations                   | _____ Emotional Stability    |
| _____ Rapport with Physicians, Coworkers and Patients   | _____ Attitude               |
| _____ Assessment and Management of “High Risk Patients” | _____ Technical Skill        |
| _____ Seeks Consultation When Necessary                 | _____ Personal Appearance    |
| _____ Overall Professional Competence                   | _____ Attendance/Punctuality |

Comments: \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### CAA Clinical Skills Checklist

My signature below certifies that I am proficient in the techniques and procedures indicated below:

#### GENERAL ANESTHESIA AND ANALGESIA:

- Preoperative Evaluation and Meds
- Intravenous Agents
- Inhalation Agents
- Intramuscular Agents
- Other (Describe): \_\_\_\_\_
- \_\_\_\_\_

#### REGIONAL ANESTHESIA:

- Topical
- Infiltration
- Spinal
- Epidural & Caudal
- Intravenous
- Upper Extremity Blocks
- Lower Extremity Blocks
- Field Blocks
- Ultrasound Guided Regional Blocks
- Other (Describe): \_\_\_\_\_
- \_\_\_\_\_

#### DIAGNOSTIC & THERAPEUTIC BLOCKS:

- Sympathetic Blocks
- Epidural
- Bier
- Spinal – Differential
- Steroid, Alcohol & Drug Phenol Blocks
- Other (Describe): \_\_\_\_\_
- \_\_\_\_\_

#### INTRAVENOUS ADMINISTRATION OF:

- Fluids
- Blood
- Plasma
- Plasma Expanders
- Muscle Relaxants
- Vasoactive Drugs
- Cardiac Drugs
- Other (Describe): \_\_\_\_\_
- \_\_\_\_\_

#### PROCEDURES:

- Intravenous Catheter Placement
- Swan Ganz
- Placement of CVL Lines
- Placement of Arterial Lines
- Placement Right Heart
- Placement of Pulmonary Lines
- Placement of Axillary Lines
- Mechanical Ventilation
- Resuscitation Techniques & Therapy
- Cardiopulmonary Bypass Techniques
- Autotransfusion Techniques
- Hypotensive Techniques
- Hypertensive Techniques
- Hypothermia
- Other (Describe): \_\_\_\_\_
- \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_