Saint Alphonsus

CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA) STUDENT ROTATION FORM

I. DEMOGRAPHICS – Please Print Clearly

Last Name, First Name:		**Last 4 digits of Social Security Number:**
Previously Employed by Saint Alphonsus (check one) Yes ☐ No ☐		**If yes, include dates of employment:**
Anticipated Graduation Date Month:	**Anticipated Graduation Date Year:**	**Name of Professional School:**

II. CRNA STUDENT SCOPE OF PRACTICE

I hereby certify that I agree to perform the following duties only under the direct supervision of a supervising provider (Anesthesiologist or CRNA) currently on the medical staff at a Saint Alphonsus Health System (SAHS) facility:

SCOPE OF ACTIVITIES:

- **Participate in and be responsible for the direct care and relevant or associated charting of patients under the supervision of the Supervising Provider;**
- **Perform and discuss the History and Physical under the supervision of the Supervising Provider;**
- **Create orders, including laboratory tests, medication, admit and discharge to PACU orders and anesthesia documentation, in the electronic medical record, under the supervision of the Supervising Provider with countersignature prior to implementation;**
- **Write progress notes co-signed by the Supervising Provider;**
- **At the discretion and determination of the Supervising Provider, perform or assist in anesthesia procedures.**

III. ACKNOWLEDGEMENT

I hereby agree to observe and abide by the terms of the Educational Affiliation Agreement, bylaws, policies and procedures, and rules and regulations of Saint Alphonsus Regional Health System and Medical Staff.

Dates of Rotation:	**Please Print - Supervising Provider Name / Department:**
Student Signature / Date:	**Supervising Provider's Signature / Date:**