National UNIVERSITY
NURSE ANESTHESIOLOGY PROGRAM

**Nurse Anesthesiology Program Shadow Verification Form**

Applicant Name: _____

I verify that the applicant named above has completed _____ hours of shadowing with a Nurse Anesthesiologist (CRNA) or Physician Anesthesiologist (MD/DO) providing direct patient care and has had the opportunity to ask questions about the Nurse Anesthesiology profession and practice:

**Shadowing Experience:**

Practice Model:

☐ Independent CRNA Practice
☐ Anesthesia Care Team (medical direction)
☐ Autonomous/Non-Medically Directed (Not a Care Team but there are physician anesthesiologists)

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

☐ Discussed the roles and responsibilities & practice models of a CRNA
☐ Observed preoperative assessment and patient preparation
☐ Observed induction of general anesthesia
☐ Observed invasive line placement
☐ Observed regional anesthesia: Circle: Epidural, Spinal, Ultrasound Guided Nerve Block
☐ Observed intraoperative monitoring and anesthetic management
☐ Observed emergence from general anesthesia
☐ Observed postoperative assessment and handoff

Shadowing Dates: _____
Facility: _____
CRNA/MD/DO Name: _____
CRNA/MD/DO Signature: _____
CRNA/MD/DO Email Address: _____

Please email a scanned copy to Ms. Laura Lee: llee@nu.edu or include in packet.