

# MMU NURSE ANESTHESIA EDUCATIONAL DATA FORM

## Educational Data:

Applicants must possess an appropriate baccalaureate degree from a regionally accredited college or university and have maintained an overall GPA of 3.0 on 4.0 scale. Degrees must be completed with final transcripts submitted prior to enrollment in August. Appropriate degrees include a baccalaureate degree in nursing or an associate/diploma in nursing plus a baccalaureate degree in another related discipline.

Nursing Education	Institution	Date Conferred	GPA
Diploma in Nursing			
Associate Degree in Nursing			
Bachelor of Science in Nursing			

Other Degrees	Institution	Date Conferred	GPA

## Course Prerequisites:

Courses must be completed at a college or university level with a minimum grade of C. (2 points on 4 point scale)

**CHEMISTRY:** 1 chemistry course (minimum of 3 semester hours). Acceptable chemistry courses include: general, inorganic, organic, or biochemistry.

Chemistry Course Title#	Institution	Letter Grade	Semester hours

**STATISTICS:** 1 statistics or epidemiology course will satisfy the prerequisite. Please list statistics or epidemiology course taken.

Course Title#	Completion Date	Institution	Letter Grade	# of hours

## Missing Prerequisites:

Applicants who have not met all prerequisites by the application deadline must submit a plan with their application for completing any missing prerequisites.

☐ Yes ☐ No Have you ever attended another anesthesia school? If yes, use a separate sheet to fully explain.

If yes: Name: \_\_\_\_\_ Address: \_\_\_\_\_

Dates of Attendance: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_

MMU NURSE ANESTHESIA  
CRITICAL CARE EXPERIENCE/RN LICENSURE FORM

Applicant: \_\_\_\_\_

Last	First	Middle	Other

At least one year (2 preferred) of recent full-time critical care nursing experience as a RN is required prior to August 1 in the year of program enrollment. Acceptable critical care nursing experience includes: ICU, CCU, SICU, MICU, NICU and PICU. Please indicate critical care experience below.

Hospital	Type of Unit	# of Beds	Dates of Employment	Hours worked/week	Total months/years of experience
Total months/years an RN		Total months/years in critical care as an RN:			

Nursing Procedure/Skills	Frequency of Experience					Never /NA to my unit	
	Daily	Weekly	Monthly	Rarely/ Never			
Basic heart rhythm interpretation							
Arterial pressure monitoring							
Arterial blood gas interpretation							
Mechanical ventilation / weaning							
Titration of IV vasoactive drugs							
CVP monitoring							
12-lead EKG interpretation							
Invasive cardiac output							
PA pressure monitoring							
Recovery of immediate postoperative hearts							
Code blue team leader / rapid response nurse							
Continuous renal replacement therapy							
Cardioversion / defibrillation							
Intra- aortic balloon pump							
Ventricular assist device (LVAD)							
ICP monitoring							
Preceptor Role							
Shift charge nurse / leadership role							
# of times spent shadowing/learning role of a nurse anesthetist:	0	1	2	3	4	5	6

Answer the following questions. If yes, submit a letter of explanation.

☐ Yes ☐ No Have you ever been on probation or suspended from any place of employment?

☐ Yes ☐ No Within the last three years, have you ever experienced a physical, emotional or mental condition that endangered the health or safety of persons entrusted in your care?

## **CERTIFICATES/PROFESSIONAL ORGANIZATIONS:**

Please include photocopies of all certifications held.

BLS Certification ☐ Yes ☐ No Expiration Date: \_\_\_\_\_

ACLS Certification ☐ Yes ☐ No Expiration Date: \_\_\_\_\_

PALS Certification ☐ Yes ☐ No Expiration Date: \_\_\_\_\_

CCRN Certification ☐ Yes ☐ No Expiration Date: \_\_\_\_\_

Other Certifications: \_\_\_\_\_

List the professional organizations you are a member of: \_\_\_\_\_

## **RN PROFESSIONAL LICENSE:**

Applicants must provide proof of licensure as a professional Registered Nurse (RN). Please complete the requested information below. Include a photocopy of your current nursing license(s).

List all states where you have licensure as a professional Registered Nurse (RN)

State	Status	License # if active	Expiration Date
	<input type="checkbox"/> Active <input type="checkbox"/> Inactive		
	<input type="checkbox"/> Active <input type="checkbox"/> Inactive		
	<input type="checkbox"/> Active <input type="checkbox"/> Inactive		
	<input type="checkbox"/> Active <input type="checkbox"/> Inactive		
	<input type="checkbox"/> Active <input type="checkbox"/> Inactive		

☐ Yes ☐ No Have you ever had a nursing license suspended or revoke? If so submit a letter of explanation.

☐ Yes ☐ No Have you ever been the subject of a Nursing Board disciplinary action?  
If yes, submit a letter of explanation.

☐ Yes ☐ No Have you ever been refused a nursing license? If yes, submit a letter of explanation.

☐ Yes ☐ No Are you aware of any disciplinary action pending on your nursing license?

List the state in which you were originally licensed as an RN:

I attest that the information provided in this application is accurate.

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