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				
	Daily	Weekly	Monthly	Rarely/ Never	Never /NA to my unit
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**
	❒ Active ❒ Inactive		
	❒ Active ❒ Inactive		
	❒ Active ❒ Inactive		
	❒ Active ❒ Inactive		
	❒ Active ❒ 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: _____