

NASI Per Diem Malpractice

Dear Nurse Anesthetist,

We appreciate your interest in NASI's Per Diem Malpractice Insurance. This service is for those providers who need a supplemental policy for working an assignment outside of their regular employment practice. Our policy is a mature A+ rated claims-made policy with built in tail coverage. Limits will be tailored to meet specific state and hospital requirements and there is no deductible associated with claims.

Please return these completed forms to the credentialing office listed at the bottom of this letter. Please make sure to provide all the pertinent information on the facility in which you will be working. Our credentialing department will process this application and an approval can be made in approximately 36 hours. Once the facility verification and references are confirmed, you will be ready to request coverage for the days you will be working.

Fees will include an annual credentialing fee of \$150.00 and a coverage fee of \$50.00 per day worked. Coverage must be requested and paid for in advance. Please keep in mind that fees are non-refundable. To start this process, you may submit a check payable to Nationwide Anesthesia Services or use a Visa or MasterCard to make payment. Call 800-500-2634 or 800-862-6470 for all credit card transactions.

Please contact us with any questions or concerns. We thank you for your interest in NASI Per Diem insurance and look forward to working with you.

Best Regards,

The NASI Credentialing Team

Linda Lindsey

800-500-2634

Linda.lindsey@nasinc.net

Please Complete Application
and Return to NASI Credentialing Team:
P.O. Box 992
Sandersville, GA 31082
Toll Free Fax: 1-800-210-5545
Questions Call: (800) 500-2634 or (800) 862-6470
Email: linda.lindsey@nasinc.net

NASI Per Diem Malpractice

NURSE ANESTHETISTS PERDIEM PROFESSIONAL LIABILITY APPLICATION

Applicant's Instructions

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Submit all required copies per Section VI.
3. Application must be signed and dated by owner.

Date of Application _____

I. PERSONAL INFORMATION:

Full Name _____

Address _____

City _____ State _____ Zip Code _____

County of Residence _____

Home Phone _____ Cell Phone _____

Pager _____ E-mail _____

Date of Birth _____ Maiden / Former Name _____

Social Security No. _____ U.S. Citizen: Yes No

Place of Birth: City _____ State _____ Country _____

If Incorporated: Business Name _____ Tax ID No. _____

Address: _____

Referral Source: _____

Have you ever used a per diem malpractice insurance before? Yes No

If yes, through who _____ Date Used _____

II. EDUCATION AND LICENSURE:

Nursing School _____ Year Completion _____ Degree _____

Anesthesia School _____ Year Completion _____ Degree _____

Other Education _____ Year Completion _____ Degree _____

High School _____ Year Completion _____ Degree _____

Date of Certification? _____ Certification No. _____ Exp. Date _____

States Licensed _____

State of Original Licensure _____ Licenses Pending _____

Current Malpractice Carrier _____ Policy Limits _____

Are You Certified in BLS? Yes No ACLS? Yes No PALS? Yes No NALS? Yes No

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III. TYPES OF CASES COMFORTABLE WITH:

- Ortho Neuro Hearts Major Vascular Thoracic Uro OB GYN
 Transplants Eyes Burns Geriatrics Trauma ENT Abortions Peds

Comments: _____

IV. SKILLS PROFICIENT WITH:

- Epidurals Spinals Bier Axillary A-Lines C-Lines Swan Ganz

Other Skills or Comments: _____

V. IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS, PLEASE PROVIDE COMPLETE DETAILS ON A SEPARATE SHEET:

Do you have any illness, disease, mental or physical disability, or any other physical condition(s) which may limit or hinder your performance in the position for which you are applying? Yes No

Have you ever received treatment or are you currently receiving treatment for substance abuse, alcohol abuse, or nerves? 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 disciplinary proceedings 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 disciplinary proceedings 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)? Yes No

Have judgments or settlements been made against you in professional liability cases, or are claims pending?
 Yes No

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VI. PLEASE INCLUDE CLEAR COPIES OF THE FOLLOWING WITH COMPLETED APPLICATION:

- Completed Application
- Drivers License
- Social Security Card
- Signed Applicant's Statement of Consent and Release Form
- Typed Resume or Curriculum Vitae
- List of last three (3) places of employment, with complete addresses, phone numbers and contact names
- AANA Certification/Recertification Card
- All State Nursing/ARNP Licenses
- Nursing and Anesthesia School Diplomas/Certificates
- Three (3) completed Reference Inquiry Forms (enclosed in application)

VII. REMUNERATION:

When using this Per Diem coverage will you be remunerated as:

- Fee for Service/Contract Basis**
- Paid Directly by the Facility**

VIII. APPLICANT'S STATEMENT OF CONSENT AND RELEASE:

The facts set forth in this application are true and complete. False statements on this application shall be considered sufficient cause for termination of insurance. NASI Per Diem Malpractice and its representatives are hereby authorized to make any investigations of my personal and professional history through any agency or bureau necessary, including but not limited to, criminal background and criminal reports. NASI Per Diem Malpractice is also authorized to investigate my ability, employment records or character through inquiries to the individuals and/or employers mentioned in this application.

Signature: _____ Date: _____

Printed Name: _____ Social Security No.: _____

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CLINICAL SKILLS CHECKLIST

I am proficient in the techniques and procedures indicated:

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
- Other Peripheral Blocks
- Other (Describe): _____

DIAGNOSTIC & THERAPEUTIC BLOCKS:

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

SPECIALTIES OR SPECIFIC SKILLS:

- Open Heart
- Peds
- OB
- Pain Management

PROCEDURES:

- Intravenous Catheter Placement

Intravenous Administration of:

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

- Placement of CVP Lines
- Placement of Arterial Lines
- Placement of Right Heart & Pulmonary Lines
- Mechanical Ventilation
- Resuscitation Techniques & Therapy
- Cardiopulmonary Bypass Techniques
- Autotransfusion Techniques
- Hypotensive & Hypertensive Techniques
- Hypothermia
- Other (Describe): _____

CERTIFICATIONS:

- BLS
- ACLS
- PALS
- NALS
- Other (Describe): _____

Signature: _____

Date: _____

Printed Name: _____

APPLICANT'S STATEMENT OF CONSENT AND RELEASE

I hereby authorize NASI Per Diem Solutions and its representatives 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 NASI Per Diem Malpractice background histories as NASI Per Diem Malpractice deems appropriate. I hereby appoint NASI Per Diem Malpractice my attorney in fact to request any such criminal, credit, 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 NASI Per Diem Malpractice. I hereby release from liability NASI Per Diem Malpractice and its representatives for all acts performed in connection with evaluating my application for malpractice per diem insurance. 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: _____ Social Security No.: _____

NOTE TO APPLICANT: You should provide a signed copy of this Statement of Consent and Release to each reference who will be completing an inquiry/evaluation form or letter of reference on your behalf. A signed copy of this Statement should also be provided to NASI Per Diem Malpractice with your other application materials.

NASI Per Diem Malpractice

REFERENCE INQUIRY FORM

NASI Per Diem Malpractice is a per diem malpractice carrier for CRNA's and Anesthesiologist's. It is our policy that before an applicant can be considered for malpractice coverage they are screened thoroughly. We have spoken with the candidate who has directed us to you for your personal and professional opinions. Please take a moment to complete this evaluation form and return by mail, fax or email to:

NASI Per Diem Malpractice
P.O. Box 992
Sandersville, GA 31082
Fax toll-free to (800) 210-5545
Email: Linda.lindsey@nasinc.net

Thank you in advance for your response.

Candidate Name: _____

Reference Name: _____ Title: _____

Phone: _____ Cell: _____ Office: _____

Fax: _____ Email: _____

Hospital/Group: _____

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, 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

_____ Personal Appearance

_____ Attendance And Punctuality

_____ Attitude

_____ Seeks Consultation When Necessary

_____ Technical Skills

_____ Overall Professional Competence

_____ Ability To Get Along With Physicians, Coworkers & Patients

_____ Cooperation

_____ Knowledge And Ability To Practice "Safe Anesthesia"

_____ Physical Assessment And Management Of "High Risk Patients"

Comments: _____

Reference Signature: _____ **Date:** _____

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