



## Nurse Anesthesia Program Shadow Verification Form

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

I verify that the applicant named above has completed \_\_\_\_\_ hours of shadowing with a CRNA providing direct patient care and has had the opportunity to ask questions about the Nurse Anesthesia profession and practice.

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

- Discussed the roles and responsibilities of a CRNA
- Observed preoperative assessment and patient preparation
- Observed induction of general anesthesia
- Observed invasive line placement
- Observed regional anesthesia
- Observed intraoperative monitoring and anesthetic management
- Observed emergence from general anesthesia
- Observed postoperative assessment and handoff
- Other experiences:

Shadowing Date(s): \_\_\_\_\_

Facility: \_\_\_\_\_

CRNA Name: \_\_\_\_\_

CRNA Signature: \_\_\_\_\_

CRNA Email Address: \_\_\_\_\_