

This form must be typed

1. **Applicant:** _____
(Last) (First) (Middle)

2. **Address:** _____
(Number and Street) (City) (State) (Zip Code)

3. **Daytime telephone number:** _____ **Fax number:** _____ **Email:** _____
(Area Code/Number)

4. **AANA ID #:** _____ **5. Date last engaged in anesthesia practice:** _____
(Month/Day/Year)

6. **Clinical Anesthesia Refresher Site Sponsor:** _____
(Nurse Anesthetist or Anesthesiologist) Daytime Phone No. (Area Code/Number)

Clinical Anesthesia Refresher Facility: _____

Address: _____
(Number and Street) (City) (State) (Zip Code)

Date Enrolled: _____ **Expected Completion:** _____
(Month/Day/Year) (Month/Day/Year)

7. Materials to submit with application:

Typed statement concerning clinical facility and resources. The statement is to include the following information: (1) the beginning start date and projected ending date for clinical component; (2) a description of the accredited medical facility; (3) a brief outline of the kinds of cases available to the nurse anesthetist in fulfilling the clinical requirements; (4) how the nurse anesthetist will be expected to meet the clinical requirements; and (5) the faculty involved in the clinical area.

8. Sponsor/Applicant Agreement: I declare that, to the best of my knowledge, all statements made in this application and in any accompanying materials are true. I understand that any willful false statements made may jeopardize the validity of this application.

Clinical Site Sponsor Signature: _____ Date: _____

Nurse Anesthetist Refresher Applicant Signature: _____ Date: _____

Office Use Only

Clinical Anesthesia Refresher Component

↑3 ↓5 yrs _____ ↑5 ↓7 yrs _____ ↑7 yrs _____

Expected Date of Refresher Completion: _____ Approval Date: _____

Approval Signature: _____