 2026 Stillwater Drive

Gibsonia, PA 15044

1-855-GET-CRNA (438-2762)

724-449-CRNA (2762)

Thank you for your interest in becoming an Independent Contractor for Avania Anesthesia. Attached is our credentialing application. We must have a completed application on file in order to book you on an assignment.

Instructions:

1. Please fill out the application completely. Please do not write see CV on application.
2. Professional References (3): These must be signed by applicant then submitted to reference.
3. Licensing, Certifications, Etc : please photocopy and submit state licenses, anesthesia school certificate, copy of license, certification card, ACLS/BLS/PALS, CV, social security card, and driver’s license.
4. Please provide us with any ID numbers you may have such as: NPI #, CAQH# username and password, Medicare #, etc.
5. Insurance: Will be provided by Avania Anesthesia. Application will be sent directly to your after we receive you registration packet.
6. Release of Information: We must have a signed release on file in order to obtain items needed for credentialing.
7. Copy of most recent TB test
8. Completed W-9 form. We need this in order to issue paychecks. Download one from links page on website.

If you have any questions concerning the application, please feel free to call me or send me an email at karen@avaniaanesthesia.com. Thanks again for you interest in working with Avania Anesthesia; we look forward to working with you.

Karen Samuels CRNA, DNAP

President Avania Anesthesia



**Personal Data:**

Full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maiden name: \_\_\_\_\_\_\_\_\_\_Dates used: \_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Federal Tax ID #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Schooling:** **Name of School Dates Attended Degree Obtained**

Nursing School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anesthesia School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employment History:**

*Hospital/Group Name Address Dates Worked*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_to\_\_\_\_\_\_\_\_*

*Phone number Contact Person/Title Reason for leaving*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Hospital/Group Name Address Dates Worked*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_to\_\_\_\_\_\_\_\_*

*Phone number Contact Person/Title Reason for leaving*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Hospital/Group Name Address Dates Worked*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_to\_\_\_\_\_\_\_\_*

*Phone number Contact Person/Title Reason for leaving*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Hospital/Group Name Address Dates Worked*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_to\_\_\_\_\_\_\_\_*

*Phone number Contact Person/Title Reason for leaving*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Hospital/Group Name Address Dates Worked*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_to\_\_\_\_\_\_\_\_*

*Phone number Contact Person/Title Reason for leaving*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**List of all organizations, professional associations to which you belong:**

**Professional References:**

1. Name of Professional Title Hospital association Hospital phone

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Dates worked Hospital Address Professional’s Phone number

\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Name of Professional Title Hospital association Hospital phone

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Dates worked Hospital Address Professional’s Phone number

\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Name of Professional Title Hospital association Hospital phone

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Dates worked Hospital Address Professional’s Phone number

\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Licensing & Certification:**

What is your original state of licensure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Certified by (Name of Board): \_\_\_\_\_\_\_\_\_\_\_\_\_ Dates Certified/Recertified\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Certification Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a state license under review for any reason?\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a state license revoked or suspended?\_\_\_\_\_\_\_\_\_

NPI Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Has your license in any jurisdiction ever been denied, limited, suspended, or revoked or voluntarily relinquished? Yes NO
2. Have your hospital privileges ever been suspended, denied, diminished, revoked or not renewed? Yes NO
3. Has disciplinary action ever been taken against you? Yes NO
4. Do you have any physical disabilities that could limit your ability to practice? Yes NO
5. Have you ever been or are your currently being treated for alcoholism, narcotic addiction, mental illness? Yes NO
6. Are you presently involved in or named in any medical review panel malpractice suit or other accusation of negligent medical care? Yes NO
7. Has any medical review panel ever found that you have failed to meet the applicable standard of care a complained in the petition for review? Yes NO
8. Have you ever been convicted of a felony? Yes NO
9. Have you ever been denied certification by a specialty board? Yes NO \*\*\*Please provide explanation for any yes answers.

**Insurance:**

Do you have your own malpractice insurance? \_\_\_\_\_\_\_If yes, please provide company and policy number. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Limits of Liability & Expiration Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have any professional liability suits been filed against you? Yes NO
2. Have any settlements, judgments, or payments been made by you or on your behalf in a medical malpractice action or potential action (last 7 years)? Yes NO
3. Have you been named in any medical malpractice suit (last 7 yrs.)? Yes NO

\*\*\*Please provide explanation for any yes answers.

Application Attestation:

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Certify that the information I have provided and the statements I have made on this application are correct, true, and complete to the best of my knowledge. I will abide by the applicable bylaws, rules and regulation, and policies and procedures of all healthcare entities I am assigned to work.

Signature Date



**Reference Letter**

To:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_

The following CRNA has applied to Avania Anesthesia PC, as an independent contractor and has submitted your name for reference purposes. We would appreciate your input in rating the said anesthetist. Please be assured that your response will be kept in strictest confidence. Thank you in advance for this courtesy. Please mail directly back to Avania Anesthesia 2026 Stillwater Drive Gibsonia, PA 15044

Applicant’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employment Dates: From\_\_\_\_\_\_\_ To\_\_\_\_\_\_\_

Please evaluate the following with the following key: A= Above average

B= Satisfactory

C= Below average

1. Anesthetic Knowledge \_\_\_\_\_\_
2. Attendance/Punctuality \_\_\_\_\_\_
3. Ability to function in emergency situations ­­­­­\_\_\_\_\_\_
4. Seeks consultation when necessary \_\_\_\_\_\_\_
5. Technical skills\_\_\_\_­­
6. Rapport with physicians, co-workers, and patients\_\_\_\_\_\_\_
7. Overall professional competence\_\_\_\_\_

To your knowledge, has the MD/CRNA been named in a malpractice suit? Yes or No

Did MD/CRNA resign or was he/she terminated? Yes or No Reason for leaving;\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is MD/CRNA eligible for re-hire with your facility? Yes or No

Additional Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Signature, Title Print name legibly Date

I hereby authorize you to fulfill this request for information and authorize Avania Anesthesia to make any investigation of my personal or professional history through any agency or bureau necessary.

Signature of Applicant\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Agreement Authorizing Release of Information**

This agreement allows for the collection of information to evaluate my eligibility for credentialing to Avania Anesthesia. I authorize Avania Anesthesia to consult references named in my applications and persons, hospitals, institution, or practices with which I have been associated to obtain information regarding my professional competence and ability to deliver safe, quality anesthesia.

I hereby release from any and all liability Avania Anesthesia and their respective agents and employees, for acts performed in good faith without malice in connection with my credentialing process. I also release from any and all liability all individuals and organizations who, at any time, provide information to Avania Anesthesia in good faith and without malice concerning my competence, ethical character and other qualifications for clearance to work for Avania Anesthesia, in compliance with law and professional ethics.

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

Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Disclosure for Independent Contractors

**I hereby acknowledge that I am and independent contractor and that as such I am totally responsible for, including but not limited to, federal state and city taxes, social security, unemployment, disability insurance and workman’s compensation.**

**I further acknowledge that I am not an employee of Avania Anesthesia PC. I indemnify and hold harmless Avania Anesthesia from all claims for damages or injuries or other actions or occurrences incurred by the hospitals or groups in which I am placed, their employees, patrons, patients or visitors or any other person for any claims which they may have due to my actions or inactions.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Independent Contractor Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed name**