

**Albany Medical College
Center for Nurse Anesthesiology Program
Professional Credentialing Form**

Applicant's Name: _____

Specialty: _____ Nurse Anesthesiology _____

Please check the applicable answer to the following. If your response to any of the questions is Yes, please provide a detailed explanation.

- | | | |
|----|---|---|
| 1. | Have you ever had any clinical privilege(s), membership, association, employment, or practice at your facility or any other facility subject to denial, limitation, reduction, loss, or suspension? | Yes [<input type="checkbox"/>] No [<input type="checkbox"/>] N/A [<input type="checkbox"/>] |
| 2. | Have you been involved in any professional liability suits now or in the past? | Yes [<input type="checkbox"/>] No [<input type="checkbox"/>] N/A [<input type="checkbox"/>] |
| 3. | Have you had any ethical or moral problems now or in the past? | Yes [<input type="checkbox"/>] No [<input type="checkbox"/>] N/A [<input type="checkbox"/>] |
| 4. | Have you ever been involved in any professional misconduct action? | Yes [<input type="checkbox"/>] No [<input type="checkbox"/>] N/A [<input type="checkbox"/>] |
| 5. | Have you ever had your RN license limited, suspended, or revoked? | Yes [<input type="checkbox"/>] No [<input type="checkbox"/>] N/A [<input type="checkbox"/>] |
| 6. | Have you ever committed an act that would place your RN license in jeopardy? | Yes [<input type="checkbox"/>] No [<input type="checkbox"/>] N/A [<input type="checkbox"/>] |
| 7. | Have you ever been indicted or convicted of a felony? | Yes [<input type="checkbox"/>] No [<input type="checkbox"/>] N/A [<input type="checkbox"/>] |
| 8. | Have you ever been subject to disciplinary action by any nursing or professional organization? | Yes [<input type="checkbox"/>] No [<input type="checkbox"/>] N/A [<input type="checkbox"/>] |
| 9. | Have you: | |
| | a. any physical or health impairment? | Yes [<input type="checkbox"/>] No [<input type="checkbox"/>] N/A [<input type="checkbox"/>] |
| | b. been addicted to or abusive of drugs or alcohol? | Yes [<input type="checkbox"/>] No [<input type="checkbox"/>] N/A [<input type="checkbox"/>] |

If yes, please explain _____

Signature

Date