Anesthesia Shadowing Verification Document

The purpose of this document is to verify that the applicant has shadowed an anesthetist, anesthesia assistant, or anesthesiologist in the operating room during surgical anesthesia administration.

Applicant Portion:

Name:_____

Date(s) shadowed: _____ Total Hours:_____

Facility Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Provider/Supervisor Portion:

Name & Role: _____

Email: _____

Phone: (_____) _____ -_____

Signature:

_____