



# APPLICATION FOR NURSES AND NURSE ANESTHETISTS

SEE LAST PAGE FOR PAPERWORK REDUCTION ACT, PRIVACY ACT AND INFORMATION ABOUT DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER.

**INSTRUCTIONS:** Please submit this application furnishing all information in sufficient detail to enable the Department of Veterans Affairs to determine your eligibility for appointment in Veterans Health Administration. Type, or print in ink. If additional space is required, please attach a separate sheet and refer to items being answered by number.

1. NAME (Last, First, Middle)		2. APPLICATION FOR (Check one) <input type="checkbox"/> GENERAL PRACTICE <input type="checkbox"/> SPECIALTY (Identify below)	
3. PRESENT ADDRESS (Include ZIP Code)		4. TELEPHONE NUMBER (Include Area Code)	
		4A. RESIDENCE	4B. BUSINESS
5. DATE OF BIRTH	6. PLACE OF BIRTH	7. SOCIAL SECURITY NUMBER	
8A. CITIZENSHIP <input type="checkbox"/> U.S. CITIZEN BY BIRTH <input type="checkbox"/> NATURALIZED U.S. CITIZEN <input type="checkbox"/> NOT A U.S. CITIZEN (Complete item 8B)		8B. COUNTRY OF WHICH YOU ARE A CITIZEN	
9A. HAVE YOU EVER FILED APPLICATION FOR APPOINTMENT IN THE VA <input type="checkbox"/> YES <input type="checkbox"/> NO    (If "YES" complete items 9B and 9C)		9B. NAME OF OFFICE WHERE FILED	9C. DATE FILED
10. WHEN MAY INQUIRY BE MADE OF YOUR PRESENT EMPLOYER		11. DATE AVAILABLE FOR EMPLOYMENT	

### I - ACTIVE MILITARY DUTY

12A. DATE FROM	12B. DATE TO	12C. SERIAL OR SERVICE NO.	12D. BRANCH OF SERVICE	12E. TYPE OF DISCHARGE <input type="checkbox"/> HONORABLE <input type="checkbox"/> OTHER (Explain on separate sheet)
----------------	--------------	----------------------------	------------------------	---

### II - REGISTRATION AND CLINICAL PRIVILEGES

13A. LIST ALL STATES/TERRITORIES IN WHICH YOU ARE NOW OR HAVE EVER BEEN REGISTERED AS A NURSE (If necessary, continue on separate sheet)	13B. REGISTRATION NUMBER	13C. EXPIRATION DATE

14. ARE YOU FULLY REGISTERED IN EVERY STATE IN WHICH YOU ARE NOW REGISTERED  <input type="checkbox"/> YES <input type="checkbox"/> NO    (If restricted, limited or probational in any State(s), explain on separate sheet)	15. DO YOU HAVE PENDING OR HAVE YOU EVER HAD ANY REGISTRATION TO PRACTICE REVOKED, SUSPENDED, DENIED, RESTRICTED, LIMITED, OR ISSUED/PLACED ON A PROBATIONAL STATUS OR VOLUNTARILY RELINQUISHED  <input type="checkbox"/> YES <input type="checkbox"/> NO    (If "YES" explain on separate sheet)	16. HAVE YOU EVER HELD A REGISTRATION TO PRACTICE THAT IS NO LONGER HELD OR CURRENT  <input type="checkbox"/> YES <input type="checkbox"/> NO    (If "YES" explain on separate sheet)
17A. DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD CLINICAL PRIVILEGES AT ANY HEALTH CARE INSTITUTION, AGENCY OR ORGANIZATION  <input type="checkbox"/> YES <input type="checkbox"/> NO    (If "YES" explain on separate sheet)	17B. NAME OF CURRENT OR MOST RECENT INSTITUTION, AGENCY OR ORGANIZATION WHERE HELD	17C. HAVE ANY OF YOUR STAFF APPOINTMENTS OR CLINICAL PRIVILEGES EVER BEEN DENIED, REVOKED, SUSPENDED, REDUCED, LIMITED, OR VOLUNTARILY RELINQUISHED  <input type="checkbox"/> YES <input type="checkbox"/> NO    (If "YES" explain on separate sheet)

### III - NURSE ANESTHETIST CERTIFICATION (To be completed by Nurse Anesthetists only)

18A. ARE YOU CERTIFIED AS A NURSE ANESTHETIST BY THE COUNCIL ON CERTIFICATION OF NURSE ANESTHETISTS (CCNA)  <input type="checkbox"/> YES <input type="checkbox"/> NO	18B. WHAT IS THE DATE OF YOUR CERTIFICATION OR MOST RECENT RECERTIFICATION (GIVE MONTH AND YEAR)	18C. WHAT IS YOUR AMERICAN ASSOCIATION OF NURSE ANESTHETISTS (AANA) IDENTIFICATION NUMBER	18D. HAS YOUR CCNA CERTIFICATION EVER BEEN REVOKED  <input type="checkbox"/> YES <input type="checkbox"/> NO    (If "YES" explain on separate sheet)
--	--	---	--

### IV - THIS SECTION TO BE COMPLETED BY FACILITY DIRECTOR OR DESIGNEE

**CERTIFICATION:** I certify that I have verified registration with State boards, and sighted visa or evidence of citizenship. Board certification has been verified (if appropriate).

19. EVIDENCE HAS BEEN SIGHTED IN REGARDS TO:

<input type="checkbox"/> CERTIFICATION AS A NURSE ANESTHETIST	<input type="checkbox"/> VISA
<input type="checkbox"/> REGISTRATION FOR ALL STATES LISTED BY APPLICANT	<input type="checkbox"/> NATURALIZED CITIZENSHIP
<input type="checkbox"/> CURRENT OR MOST RECENT CLINICAL PRIVILEGES	
<input type="checkbox"/> NO CURRENT OR PREVIOUS CLINICAL PRIVILEGES	

20A. SIGNATURE OF FACILITY DIRECTOR OR DESIGNEE	20B. TITLE	20C. DATE
---	------------	-----------