

UNIVERSITY OF MARYLAND MEDICAL CENTER
Delineation of Privileges for
Certified Registered Nurse Anesthetists

Name: _____ Date: _____
 Department: _____

Certification Status: **National Board on Certification
 and Recertification of Nurse Anesthetists** _____ Yes Date: _____
 _____ No
 Training Program Accredited by Council on Accreditation of
 Nurse Anesthesia Educational Programs _____ Yes _____ No

NOTE: All privileges approved are under the direct supervision of an Attending Anesthesiologist.
CRNAs are clinically accountable to the Chief of Anesthesiology or Designee

Specified Services	Check (✓) if Requested	Chair Approval Initial if Yes Write Not Approved if No
<p>Category 1 (Core) Privileges: To be eligible for core privileges, applicants must have completed a nurse anesthesia program accredited by the AANA Council on Accreditation of Nurse Anesthesia Educational Programs, be certified by the CCNA or recertified by the Council on Recertification, or by the predecessor or successor agency to either. If initial certification is pending, applicants must have graduated from an approved nurse anesthesia program.</p> <p>Core Privileges include the following:</p> <ul style="list-style-type: none"> - Administration of specific types of anesthesia for assigned cases under supervision - Pre-anesthesia evaluation and preparation - Administration of general anesthesia including adjunct drugs and regional anesthesia/analgesia techniques - Administration of emergency ancillary drugs and fluids to maintain physiological homeostasis and prevent or treat emergencies during the perianesthesia period - Airway management techniques - Perianesthetic invasive and non-invasive monitoring - Tracheal intubation/extubation - Placement of central venous catheters - Placement of intra-arterial catheters - Regional Anesthesia - Advanced airway management - Mechanical ventilation/oxygen therapy - Initiate and modify therapies, including drug and pain therapy - Provide initial management and implementation of respiratory and ventilatory care in the PACU or ICU 	_____	_____

Name: _____

Date: _____

Applicant's Signature

Date

Peter Rock, MD, Chair, Department of Anesthesiology

Date

Applicant's Confirming Signature
(required if any requested privilege is not approved)

Date

Rev'd 1/10