DOCUMENTATION OF FAMILIARITY WITH ANESTHESIA PRACTICE

The Anesthesiology Program requires that every applicant be familiar with the practice of anesthesia and the operating room environment. Some applicants can meet this requirement with previous work experience or clinical experience. Others will have to arrange to spend at least one day with an anesthetist or anesthesiologist in an operating room observing the administration of anesthesia and other patient care activities.

APPLICANT

(1) Complete this page above the triple line.

(2) Enter your full name: _____

(3) Check the reason that you are familiar with the practice of anesthesia and the OR environment:

- ❑ I have worked in an anesthesiology department or service.
- ❑ I have had an anesthesiology rotation as part of previous clinical training.
- ❑ I have spent at least 8 hours with an anesthetist or anesthesiologist in the operating room observing the administration of anesthesia. Enter date: ____/____/_____.

(4) Enter the name, hospital, address, and phone number of the person responsible for the activity which you checked:

Name: _____
Hospital: _____
Address: _____
_____
_____, ____ _____
Phone: (____) ____ _____

(5) When you print out this application document, provide a copy of this page to your preceptor or supervisor.

PRECEPTOR OR SUPERVISOR

(1) Please sign below to acknowledge the anesthesia-based exposure which the applicant has checked above.

(2) Please return this form to that individual for inclusion in their application.

(3) Please check the following box if you are providing a letter of recommendation for this person: ❑

(4) Please date and sign this form:

_____ ____-____-_____
SIGNATURE DATE

Thank you.

Master of Medical Science Program in Anesthesiology
57 Executive Park South - Suite 300
Atlanta, GA 30329

WAIVER:

DOCUMENTATION OF FAMILIARITY WITH ANESTHESIA PRACTICE

If you are unsuccessful in finding a shadowing opportunity, you must submit **three** waivers, one for each facility where you were denied permission to shadow. This waiver must be signed by a staff member in the anesthesiology department, indicating that you are not permitted to observe the administration of anesthesia in that facility.

APPLICANT

(1) Complete this page above the triple line.

(2) Enter your full name: _____

(3) Enter the name, hospital address, and phone number of the person you contacted at the facility: :

Name: _____
Hospital: _____
Address: _____
_____
_____, ____ _____
Phone: (____) ____ _____

(4) Print out this document and obtain the signature of a staff member within the anesthesia department.

DEPARTMENT OF ANESTHESIOLOGY STAFF MEMBER

(1) Please sign below to acknowledge that the applicant is not permitted to observe the administration of anesthesia in your facility.

(2) Please return this form to that individual for inclusion in their application.

(3) Please date and sign this form:

_____
PRINT NAME

_____ ____-____-_____
SIGNATURE DATE

Thank you.

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Atlanta, GA 30329

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Thank you.

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