

Last Name	First Name	Middle Name
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Check appropriate box indicating which clinical capabilities you are willing and able to perform

Please list any limitations on a separate sheet

Anesthesiology		
<input type="checkbox"/>	General Inhalation Anesthesia	<input type="checkbox"/>
<input type="checkbox"/>	General Intravenous Anesthesia	<input type="checkbox"/>
<input type="checkbox"/>	Anesthesia Subspecialty Including:	<input type="checkbox"/>
<input type="checkbox"/>	Cardiac	<input type="checkbox"/>
<input type="checkbox"/>	OB/GYN	<input type="checkbox"/>
<input type="checkbox"/>	Pain	<input type="checkbox"/>
<input type="checkbox"/>	Chronic pain evaluation, including diagnostic and therapeutic procedures	<input type="checkbox"/>
<input type="checkbox"/>	Acute pain consultation and management including the use of continuous intravenous, epidural and intraspinal analgesics	<input type="checkbox"/>
<input type="checkbox"/>	ICU	<input type="checkbox"/>
<input type="checkbox"/>	Major Vascular	<input type="checkbox"/>
<input type="checkbox"/>	Thoracic	<input type="checkbox"/>
<input type="checkbox"/>	Major Regional Anesthesia Including:	<input type="checkbox"/>
<input type="checkbox"/>	Subarachnoid Anesthesia (Spinal)	<input type="checkbox"/>
<input type="checkbox"/>	Caudal Anesthesia	<input type="checkbox"/>
<input type="checkbox"/>	Thoracic Epidural	<input type="checkbox"/>
<input type="checkbox"/>	Lumbar Epidural	<input type="checkbox"/>
<input type="checkbox"/>	Cervical Epidural	<input type="checkbox"/>
<input type="checkbox"/>	Selective Major Nerve Blocks Including:	<input type="checkbox"/>
<input type="checkbox"/>	Axillary	<input type="checkbox"/>
<input type="checkbox"/>	Interscalene	<input type="checkbox"/>
<input type="checkbox"/>	Femoral	<input type="checkbox"/>
<input type="checkbox"/>	Sciatic	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>

Signing below indicates that I am qualified to perform the services chosen on the checklist

Signature

Date
