Otterbein University / Grant Medical Center
Nurse Anesthesia Program

Validation of Anesthesia Observation Experience
(a total of 8 hrs of observation is required)

Applicant Name ____________________________________________________________

Date(s) of Observation __________ Hour(s) observed (8 hrs total required) __________

Facility where observation took place __________________________________________

I verify that the above named individual spent time observing anesthesia practice with me.

Name ____________________________ CRNA Anesthesiologist
Print name ____________________________
(Circle title)

Signature of CRNA or Anesthesiologist: ____________________________

Applicant Signature: _______________________________________________________

Applicant reflections (To be completed by the prospective student) ___________________

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