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 _______________ Hours 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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