



Nurse Anesthesiology Program

Verification of Shadowing Experience

Date: _____

This letter is to verify that the individual named below has completed shadowing hours under the direct supervision of a Certified Registered Nurse Anesthetist (CRNA) or a Physician Anesthesiologist. This experience was designed to provide insight into the full scope of practice and responsibilities in the field of nurse anesthesiology.

Name of Applicant: _____

Total Hours Shadowed: _____

The applicant had the opportunity to observe a variety of clinical duties and responsibilities, which included but were not limited to:

- Pre-anesthetic assessment and preparation of patients
- Induction, maintenance, and emergence from anesthesia
- Airway management techniques
- Administration of anesthetic agents and medications
- Monitoring of patient vital signs and physiological data
- Post-anesthesia care and patient handoff

The supervising provider attests to the applicant's professionalism, engagement, and sincere interest in the profession throughout the shadowing experience.

Signature of Supervisor: _____

Printed Name of Supervisor: _____

Title (CRNA/MD/DO): _____

Email: _____

Phone Number: _____

Instructions for Submission: This completed and signed form should be submitted directly with your application materials as instructed by your program to Nursing CAS or to CRNAnursing@uiwtx.edu