

Middle Tennessee School of Anesthesia

DNAP-Practice Doctorate Survey

Name _____ Date _____

How frequently do you PERSONALLY Perform the following Skills? (check the appropriate box)

Skill	Never	Daily	2-3 Times/Week	Weekly	Biweekly	Monthly
Intravenous line insertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arterial line monitoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Central venous pressure monitoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary artery pressure monitoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mixed venous blood saturation monitoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac output monitoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Monitor neuromuscular blockade	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Management of ventilator patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Management of patients with IABP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Monitor during conscious sedation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Systemic vascular resistance monitoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How frequently do you administer the following pharmacologic agents?

Agent	Never	Daily	2-3 Times/Week	Weekly	Biweekly	Monthly
Nitroglycerine infusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nitroprusside infusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phenyephtrin infusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phenylephrine bolus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dopamine infusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dobutamine infusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Levophed infusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epinephrine infusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ephedrine bolus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neuromuscular blocking agents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sedation agents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rhythm control agents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please tell us about your primary site of employment.

Hospital Name, City, State (provide below)

How many beds are in the unit in which you currently work?	1-5 <input type="checkbox"/>	6-10 <input type="checkbox"/>	11 or more <input type="checkbox"/>			
Approximately how many hours per week are you working?	<input type="checkbox"/> 10-20	<input type="checkbox"/> 21-30	<input type="checkbox"/> 31-40	<input type="checkbox"/> 41-50	<input type="checkbox"/> 51-60	<input type="checkbox"/> > 60
How many beds are in the HOSPITAL in which you currently work?	<input type="checkbox"/> 1-50	<input type="checkbox"/> 51-100	<input type="checkbox"/> 101-150	<input type="checkbox"/> 151-200	<input type="checkbox"/> 201-250	<input type="checkbox"/> >250
Characterize your hospital	Rural <input type="checkbox"/>	Suburban <input type="checkbox"/>	Urban <input type="checkbox"/>			

What trauma classification is the hospital where you are currently employed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Level I	Level II	Level III	Level IV	unclassified	
Type of ICU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Open-heart recovery	Neurologic	Trauma	Medical	Surgical Pediatric	Neonatal
Which ICU do you currently work in?						
How long have you worked in the critical care unit(s), after orientation prior to May 31 application deadline?						
			Year(s)	Month(s)		
What shift do you work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	Day	Night	Combination			
Have you applied to MTSA in the past?	<input type="checkbox"/>		<input type="checkbox"/>			
	Yes		No	Year		
Have you ever attended another nurse anesthesia program?	<input type="checkbox"/>		<input type="checkbox"/>			
	Yes		No			
Are you currently enrolled or plan to enroll in any courses prior to interview?	<input type="checkbox"/>		<input type="checkbox"/>			
	Yes		No			
If yes, please list course and name of institution.						
Has your employment at any organization ever voluntarily or involuntarily been relinquished, suspended, restricted, revoked or not renewed?	<input type="checkbox"/>		<input type="checkbox"/>			
	Yes		No			
Have you ever had any disciplinary issues during your employment at any organization?	<input type="checkbox"/>		<input type="checkbox"/>			
	Yes		No			
Have you ever been charged with or convicted of a criminal offense other than a minor traffic violation including those offenses that have been expunged?	<input type="checkbox"/>		<input type="checkbox"/>			
	Yes		No			

If yes, please provide an explanation.

Have you ever abused drugs/ alcohol or been treated for dependency to alcohol or illegal chemical substances?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
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If yes, provide an explanation.

Have you ever been charged, arrested or convicted of driving under the influence of drugs/ alcohol including those offenses that have been expunged?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
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If yes, please provide an explanation.

Have you ever been dismissed from a clinical facility that is one of the MTSA clinical affiliates? (Please refer to MTSA student handbook, mtsa.edu.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
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Please attach completed form under "Other" field of your NursingCAS application documents.
Please contact the Admissions Office at admissions@mtsa.edu or (615) 732-7662 if you have any questions.