**Anesthesia Validation Form**

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| Date: | Click or tap to enter a date. | | Facility ID: | [Facility ID] |
| Facility Name: | [Company] | | Medical Director name: | Click or tap here to enter text. |
| Facilities seeking initial survey must have performed at least ten (10) cases.  To obtain full accreditation, the Medical Director must complete this mandatory form validating that the facility has performed at least 6 cases using the highest level of sedation in the class applied for.  I attest that the six (6) surgical/procedural cases below were performed with the highest level of anesthesia provided in our facility prior to submission of this application. | | | | |
| Signature of  Medical Director: | |  | | |

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| Surgical date: | Click or tap to enter a date. | Operating Surgeon: | Click or tap here to enter text. |
| Patient initials: | Click or tap here to enter text. | Type of anesthesia: | Click or tap here to enter text. |
| Procedure: | Click or tap here to enter text. | | |

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