RESPIRATORY SKILLS CHECKLIST

Name:_____ Date:_____

By accurately filling out this checklist, you will help us best match your skills and interests with available assignments. Please place an "X" in the column that best describes your experience level with each skill.

LEVEL OF PROFICIENCY:

1 = Can function well independently 2 = Experience but may need review

3 = Limited or no experience

_____

	1	2	3
Floor Therapy			
Critical Care			
Ventilators			
Type:			
Type:			
Type:			
CARDIOVASCULAR			
Cardio/Resp Arrest Team			
Arterial Monitoring			
Pulmonary Artery Monitoring			
CVP			
EKG's			
Holter EKG			
Stress Testing			
Cardiac Output Monitoring			
IABP			
PEDIATRIC			
Resuscitation			
Intubation			
Extubation			
Ventilators:			
Type:			
Type:			
Type:			
NEONATAL			
Resuscitation			
Intubation			
Extubation			

	1	2	3
Assist in High Risk Delivery			
Aerosol Treatment			
CPT			
Ventilators:			
Type:			
Type:			
Type:			
OTHER SKILLS			
Ambulance Transport			
Portable Respiratory			
Equipment			
Ventilators			
Type:			
Type:			
Type:			
Pulmonary Function Testing			
Arterial Blood Gases			
Drawing			
Analysis			
Insertion of A-Lines			
Adult Intubation			
Adult Extubation			
SETTINGS			
Hospital			
Home Health			
Mobile Unit			
Clinic			
Research			
Other:			

Certified IKG Technician _____ (Yes or No) # of Years _____

Arterial Blood Gas Tech _____ (Yes or No) # of Years _____

Certification Eligible: _____ (Yes or No) CRTT#:_____

Registry Eligible: _____ (Yes or No) RRT#:_____

Signature:_____