



EMERGENCY ROOM SKILLS CHECKLIST

NAME: _____ DATE: _____

YEARS OF EXPERIENCE: _____

PLEASE INDICATE YOUR LEVEL OF EXPERIENCE

1. THEORY, NO PRACTICE - DIDACTIC INSTRUCTION ONLY, NO HANDS ON EXPERIENCE
2. LIMITED EXPERIENCE - KNOWS PROCEDURE/HAS USED EQUIPMENT, BUT HAS DONE SO INFREQUENTLY OR NOT WITHIN THE LAST SIX MONTHS.
3. MODERATE EXPERIENCE. - ABLE TO DEMONSTRATE EQUIPMENT/PROCEDURE, PERFORMS THE TASK/SKILL INDEPENDENTLY WITH ONLY RESOURCE ASSISTANCE NEEDED
4. PROFICIENT/COMPETENT - ABLE TO DEMONSTRATE/PERFORM THE TASK/SKILL PROFICIENTLY WITHOUT ANY ASSISTANCE AND CAN INSTRUCT/TEACH

					1	2	3	4	
A. PULMONARY									
1. ASSESSMENT:									
A. BREATH SOUNDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
B. RATE AND WORK OF BREATHING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
2. INTERPRETATION OF LAB RESULTS:									
A. ARTERIAL BLOOD GASES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
3. EQUIPMENT & PROCEDURES:									
A. AIRWAY MANAGEMENT DEVICES/ SUCTIONING									
1) ENDOTRACHEAL TUBE/SUCTIONING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
2) NASAL AIRWAY/SUCTIONING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
3) OROPHARYNGEAL/SUCTIONING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
4) SPUTUM SPECIMEN COLLECTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
5) TRACHEOSTOMY/SUCTIONING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
B. ASSIST WITH EXTUBATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
C. DISCHARGE TEACHING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
D. ASSIST WITH THORACENTESIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
E. CARE OF THE PATIENT ON A VENTILATOR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
F. CARE OF THE PATIENT WITH A CHEST TUBE:									
1) ASSIST WITH SET-UP & INSERTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
2) MEASURING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
3) REMOVAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
G. MEASURE PEAK FLOW	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
H. OBTAINING ARTERIAL BLOOD GASES:									
1) ARTERIAL LINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
2) FEMORAL ARTERY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
3) RADIAL ARTERY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
I. O2 THERAPY & MEDICATION DELIVERY SYSTEMS:									
1) BAG AND MASK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
2) ET TUBE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
3) EXTERNAL CPAP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
					4)				
					5)				
					6)				
					7)				
					8)				
					9)				
					10)				
					J.				
					K.				
					L.				
4. CARE OF THE PATIENT WITH:									
A. ASPIRATION					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
B. COPD					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
C. HEMOPNEUMOTHORAX					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
D. LARYNGOSPASM PNEUMONIA					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
E. PNEUMOTHORAX					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
F. PULMONARY EDEMA					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
G. PULMONARY EMBOLISM					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
H. TENSION PNEUMOTHORAX					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
I. TUBERCULOSIS					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. MEDICATIONS:									
A. AMINOPHYLLINE (THEOPHYLLINE)					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
B. BRONKOSOL (ISOETHARINE HYDROCHLORIDE)					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
C. EPINEPHRINE (ADRENALIN)					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
D. ISUPREL (ISOPROTERENOL HYDROCHLORIDE)					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
E. STEROIDS					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
F. TERBUTALINE					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
B. CARDIOVASCULAR									
1. ASSESSMENT:									
A. AUSCULTATION (RATE, RHYTHM)					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
B. DOPPLER					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
C. HEART SOUNDS/MURMURS					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

NAME: _____

2. EQUIPMENT & PROCEDURES:

A. ASSIST WITH INSERTION AND SET UP:

1) ARTERIAL LINE

2) CENTRAL VENOUS LINE

3) PA CATHETER/SWAN-GANZ INSERTION

4) PACEMAKER

B. CARDOVERSION

C. INTERPRETATION OF WAVEFORMS & VALUES:

1) A-LINE

2) CVP

D. MONITORING DISCHARGE PROCEDURE:

1) BASIC 12 LEAD INTERPRETATION

2) BASIC ARRHYTHMIA INTERPRETATION

3. CARE OF THE PATIENT WITH:

A. ACUTE MI

B. ANEURYSM

C. ANGINA

D. CARDIAC ARREST

E. CONGESTIVE HEART FAILURE (CHF)

F. MYOCARDITIS

4. MEDICATIONS:

A. ACLS DRUGS

1) ATROPINE

2) BRETYLIUM (BRETYLOL)

3) EPINEPHRINE (ADRENALIN)

4) LIDOCAINE (XYLOCAINE)

5) PROCAINAMIDE (PRONESTYL)

6) SODIUM BICARBONATE

B. OTHER:

1) ADENOSINE (ADENOCARD)

2) AMIODARONE (CORDARONE)

3) DIGOXIN (LANOXIN)

4) (DILTIAZEM (CARDIZEM)

5) DOBUTAMINE (DOBUTEX)

6) DOPAMINE (INTROPIN)

7) ESMOLOL (BREVIBLOC)

8) LASIX (FUROSEMIDE)

9) NITROGLYCERIN (TRIDIL)

10) NITROPRUSSIDE (NIPRIDE)

11) THROMBOLYTIC THERAPY

C. NEUROLOGICAL

1. ASSESSMENT:

A. ADVANCED NEURO ASSESSMENT:

1) GLASGOW COMA SCALE

2) REFLEX/MOTOR DEFICITS

3) VISUAL OR COMMUNICATIONS DEFICITS

B. LEVEL OF CONSCIOUSNESS

2. EQUIPMENT & PROCEDURES:

A. ASSIST WITH LUMBAR PUNCTURE

B. INCREASED ICP MANAGEMENT

1) MEDICATIONS

2) POSITIONING

3) REGULATION OF ICP

4) TEMPERATURE CONTROL

5) VENTILATION

C. INTRACRANIAL PRESSURE MONITORING

3. CARE OF THE PATIENT WITH:

A. BASAL SKULL FRACTURE

B. CLOSED HEAD INJURY

C. CVA

D. DTs

E. ENCEPHALITIS

F. EXTERNALIZED VP SHUNTS

G. MENINGITIS

H. NEUROMUSCULAR DISEASE

I. OVERDOSE

J. SEIZURES

K. SPINAL CORD INJURY

4. MEDICATIONS:

A. DECADRON (DEXAMETHASONE)

B. DILANTIN (PHENYTOIN)

C. MANNITOL (OSMITROL)

D. PHENOBARBITAL

E. SOLU-MEDROL (METHYLPREDNISOLONE SODIUM SUCCINATE)

D. ORTHOPEDICS

1. ASSESSMENT:

A. CIRCULATION CHECKS

B. GAIT

C. RANGE OF MOTION

D. SKIN

2. EQUIPMENT & PROCEDURES:

A. ASSIST WITH PLACEMENT OF CAST

B. SUPPORT DEVICES:

1) CANE/CRUTCH

2) CERVICAL COLLAR

3) SLING

4) TRANSFER BOARDS

3. CARE OF THE PATIENT WITH:

A. ANKLE BRACE

B. ANKLE SPLINT

C. CAST

D. KNEE IMMOBILIZER

E. PINNED FRACTURES

F. WRIST SPLINT

E. GASTROINTESTINAL

1. ASSESSMENT:

NAME: _____

- | | 1 | 2 | 3 | 4 |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| A. ABDOMINAL/BOWEL SOUNDS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. FLUID BALANCE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. NUTRITIONAL STATUS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. EQUIPMENT & PROCEDURES: | | | | |
| A. PLACEMENT OF NASOGASTRIC TUBE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. SALEM SUMP TO SUCTION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. SALINE LAVAGE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. CARE OF THE PATIENT WITH: | | | | |
| A. ABDOMINAL TRAUMA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. BOWEL OBSTRUCTION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. GI BLEEDING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. HEPATITIS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. LIVER FAILURE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. MEDICATIONS: | | | | |
| A. ANTIEMETICS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. ANTISPASMODIC | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. CHARCOAL | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. IPECAC | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. RENAL/GENITOURINARY | | | | |
| 1. ASSESSMENT: | | | | |
| A. FLUID BALANCE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. INTERPRETATION OF LAB RESULTS | | | | |
| A. BUN & CREATININE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. ELECTROLYTES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. EQUIPMENT & PROCEDURES | | | | |
| A. INSERTION & CARE OF STRAIGHT AND FOLEY CATHETER | | | | |
| 1) FEMALE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) MALE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. URINE SPECIMEN COLLECTION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. CARE OF THE PATIENT WITH: | | | | |
| A. ACUTE RENAL FAILURE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. PERITONEAL LAVAGE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. RENAL TRAUMA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. URINARY TRACT INFECTION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| G. ENDOCRINE/METABOLIC | | | | |
| 1. ASSESSMENT: | | | | |
| A. S/S DIABETIC COMA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. S/S INSULIN REACTION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. EQUIPMENT & PROCEDURES: | | | | |
| A. BLOOD GLUCOSE MONITORING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1) ELECTRONIC MEASURING DEVICE: | | | | |
| TYPE: _____ | | | | |
| 2) PERFORMING FINGER STICK | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. CARE OF THE PATIENT WITH: | | | | |
| A. DIABETIC KETOACIDOSIS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. MEDICATIONS: | | | | |
| A. INSULIN | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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|---------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| B. ORAL HYPOGLYCEMICS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| H. WOUND MANAGEMENT/SURGICAL | | | | |
| 1. EQUIPMENT & PROCEDURES: | | | | |
| A. APPLICATION OF STERISTRIPS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. ASSIST WITH STAPLES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. ASSIST WITH SUTURES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. CULDOCENTESIS TRAY | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. SET UP SUTURE TRAY | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. STAPLE REMOVAL | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| G. SUTURE REMOVAL | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I. EENT | | | | |
| 1. ASSESSMENT: | | | | |
| A. SET UP FLUORESCENT/WOODS LAMP EXAM | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. VISUAL ACUITY | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. EQUIPMENT & PROCEDURES: | | | | |
| A. APPLICATION OF EYE PATCH | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. EAR IRRIGATION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. EYE IRRIGATION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. MORGAN LENS IRRIGATION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. NASAL PACKING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. REMOVAL OF CONTACT LENS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| J. TRAUMA/SHOCK | | | | |
| 1. ASSESSMENT: | | | | |
| A. CHAMPION TRAUMA SCORE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. POISON INDEX | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. TRIAGE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. EQUIPMENT & PROCEDURES | | | | |
| A. AIR TRANSPORT OF TRAUMA PATIENT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. APPLICATION OF MAST SUIT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. GROUND TRANSPORT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. CARE OF THE PATIENT WITH: | | | | |
| A. BITES, ANIMAL | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. BITES, HUMAN | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. BITES, VENOMOUS SNAKE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. BITES, VENOMOUS SPIDER | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. BURNS | | | | |
| 1) RULE OF NINES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) FIRST DEGREE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) SECOND DEGREE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) THIRD DEGREE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. DEHYDRATION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| G. ELECTROCUTION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| H. GUNSHOT/STAB WOUND | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I. HAZARDOUS MATERIAL EXPOSURE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| J. HEAT EXHAUSTION/STROKE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| K. HYPOTHERMIA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| L. MAJOR TRAUMA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

NAME: _____

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|-------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| M. MINOR TRAUMA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| N. RADIATION EXPOSURE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| O. SHOCK: | | | | |
| 1) ANAPHYLACTIC | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) CARIOGENIC | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) HYPOVOLEMIC | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) NEUROGENIC | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) SEPTIC | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| P. TRAUMATIC AMPUTATION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

K. INFECTIOUS DISEASES

- | | | | | |
|----------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. INTERPRETATION OF LAB VALUES: | | | | |
| A. CBC | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. SMA 7 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. EQUIPMENT & PROCEDURES: | | | | |
| A. FEVER MANAGEMENT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. ISOLATION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. CARE OF THE PATIENT WITH AIDS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

L. PHLEBOTOMY/IV THERAPY/INVASIVE PROCEDURES

- | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. EQUIPMENT & PROCEDURES: | | | | |
| A. ADMINISTRATION OF BLOOD/BLOOD PRODUCTS: | | | | |
| 1) AUTOTRANSFUSION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) CRYOPRECIPITATE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) PACKED RED BLOOD CELLS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) PLASMA/ALBUMIN | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) WHOLE BLOOD | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. ASSIST WITH CUTDOWN | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. DRAWING VENOUS BLOOD | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. STARTING IVs: | | | | |
| 1) ANGIOCATH | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) BUTTERFLY | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) HEPARIN LOCK | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. CARE OF THE PATIENT WITH: | | | | |
| A. ANGIOGRAPHY | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. CENTRA LINE/CATHETER/DRESSING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1) BROVIAC/HICKMAN | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) GROSHONG | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) PICC | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) PORTACATH | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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|-----------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 5) PERICARDIOCENTESIS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

M. PAIN MANAGEMENT

- | | | | | |
|---------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. ASSESSMENT OF PAIN LEVEL/TOLERANCE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. CARE OF THE PATIENT WITH: | | | | |
| A. EPIDURAL ANESTHESIA/ANALGESIA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. IV CONSCIOUS SEDATION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

N. PEDIATRICS

- | | | | | |
|--------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. EQUIPMENT & PROCEDURES: | | | | |
| A. CHILD ABUSE/RECOGNITION/REPORTING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. OBTAINING CONSENT TO TREAT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. PEDIATRIC ARREST | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. CARE OF THE PATIENT WITH: | | | | |
| A. EPIGLOTTITIS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. NEAR DROWNING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. OVERDOSE/POISON INGESTION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. STATUS ASTHMATICUS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. STATUS EPILEPTICUS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

O. WOMEN'S HEALTH

- | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. ASSESSMENT - ASSIST WITH PELVIC EXAM | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. EQUIPMENT & PROCEDURES: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| A. PELVIC TRAY | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. RAPE KIT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. REPORTING ACTS OF VIOLENCE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. CARE OF THE PATIENT WITH: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| A. ABRUPTIO PLACENTA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. DIC | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. HEMORRHAGE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. PLACENTA PREVIA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. PRECIPITOUS DELIVERY | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. PREECLAMPSIA/ECLAMPSIA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| G. SPONTANEOUS ABORTION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

P. MISCELLANEOUS

- | | | | | |
|------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. AMA PROCEDURES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. SUICIDE PRECAUTIONS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

NAME: _____

AGE SPECIFIC PRACTICE CRITERIA:

PLEASE CHECK THE BOXES BELOW FOR EACH AGE GROUP FOR WHICH YOU HAVE EXPERTISE IN PROVIDING AGE-APPROPRIATE NURSING CARE.

A. NEWBORN/NEONATE (BIRTH - 30 DAYS)	D. PRESCHOOLER (3 - 5 YEARS)	G. YOUNG ADULTS (18 - 39 YEARS)
B. INFANT (30 DAYS - 1 YEAR)	E. SCHOOL AGE CHILDREN (5 - 12 YEARS)	H. MIDDLE ADULTS (39 - 64 YEARS)
C. TODDLER (1 - 3 YEARS)	F. ADOLESCENTS (12 - 18 YEARS)	I. OLDER ADULTS (64+)

	A	B	C	D	E	F	G	H	I
ABLE TO ADAPT CARE TO INCORPORATE NORMAL GROWTH AND DEVELOPMENT.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ABLE TO ADAPT METHOD AND TERMINOLOGY OF PATIENT INSTRUCTIONS TO THEIR AGE, COMPREHENSION AND MATURITY LEVEL.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CAN ENSURE A SAFE ENVIRONMENT REFLECTING SPECIFIC NEEDS OF VARIOUS AGE GROUPS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MY EXPERIENCE IS PRIMARILY IN:
(PLEASE INDICATE NUMBER OF YEARS.)

TRAUMA REFERRAL CENTER
(LEVEL I ER) _____ YEAR(S)

COMMUNITY ER
(LEVEL II ER) _____ YEAR(S)

RURAL ER) _____ YEAR(S)

CERTIFICATION:		EXP DATE:	CERTIFICATION:		EXP DATE:
<input type="checkbox"/>	BCLS		<input type="checkbox"/>	OTHER	
<input type="checkbox"/>	CEN		<input type="checkbox"/>	OTHER	
<input type="checkbox"/>	TNCC		<input type="checkbox"/>	OTHER	
<input type="checkbox"/>	ACLS		<input type="checkbox"/>	OTHER	

THE INFORMATION I HAVE GIVEN IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE AS NEEDED STAFFING TO RELEASE THIS EMERGENCY ROOM SKILLS CHECKLIST TO CLIENT FACILITIES OF AS NEEDED STAFFING IN RELATION TO CONSIDERATION OF MY EMPLOYMENT WITH THOSE FACILITIES.

SIGNATURE

DATE