

RADIOLOGY SKILLS CHECKLIST

NAME: _____ **SIGNATURE:** _____ **DATE:** _____

1 - Highly skilled (can function well independently, strong experience)

2 - Proficient (experienced, may need occasional review/assistance) **3 - Limited Skill** (limited to no experience)

GENERAL DIAGNOSTIC

Skills (check appropriate box)	1	2	3
Abdomen			
Bilateral Mammogram			
Needle Localization			
Extremities			
Specimen Radiographs			
Therapy Replacement Film			
Small Bowel Series			
Hypotonic Duodenography			
Foreign Body Localization			
Hysterosalpingogram			
Voiding Cystogram			
T-Tube Cholangiogram			
Transhepatic Cholangiogram			
C-Arm Fluoroscope			
Thoracic Spine			
Lumbar Spine			
Skull			
Chest			
I.V.P.			
Bone Survey			
Bone Age			
Hip			
Barium Enema			
Barium Swallow			
Gall Bladder			
Esophagram			
GI Series			
ER Exams			
OR Exams			
Myelogram			
Mastoids			
Tomogram			
Lung Biopsy			
ERCP			
Portable Exams			
Pediatric Exams			
Salpingogram			
Sialography			
Cervical Spine			
Bronchogram			

CT

Skills (check appropriate box)	1	2	3
Brain with contrast			
Brain without contrast			
Biopsy Procedures			
Lumbar Spine			
Cervical Spine			
TM Joints			
Pancreas			
Abdomen			
Pelvis			
IAC			
Orbits			
Liver			
Larynx			
Chest			
Renal Cyst Puncture			
Type of Equipment (enter below):			
•			
•			
•			
•			

CT Licensing

State: _____ State: _____
 License #: _____ License #: _____
 Exp. Date: _____ Exp. Date: _____
 Type of Registration: _____
 Number: _____
 Years of Experience: _____

RADIATION THERAPY

Skills (check appropriate box)	1	2	3
Linear Accelerator			
Linear Accelerator with Electrons			
Simulation of Treatment Site			
Treatment Planning			
Hyperthermia TMT			
Dosimetry			
Brachy Therapy			
IMRT			
3D Planning			

NUCLEAR MEDICINE

Skills (check appropriate box)	1	2	3
Cerebral Blood			
GI Bleeding Study			
I-131 Therapy			
Thallium Stress Test			
SPECT Scanning			
I-123 Uptake			
Thyroid Therapy			
Bone Scan			
Gallium Scan			
Lung Scan			
Muga Scan			
Renal Scan			
Thyroid Scan			

SPECIAL PROCEDURES

Skills (check appropriate box)	1	2	3
Selective Angiography			
Carotid Angiogram			
Brachial Arteriogram			
Arch Arteriogram			
Renal Arteriogram			
Femoral Arteriogram			
Abdominal Arteriogram			
Mesenteric Arteriogram			
Peripheral Arteriogram			

Special Procedures Licensing

State: _____ State: _____
 License #: _____ License #: _____
 Exp. Date: _____ Exp. Date: _____
 Type of Registration: _____
 Number: _____
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ULTRASOUND – ABDOMINAL

Skills (check appropriate box)	1	2	3
Pancreas			
Liver			
Gall Bladder			
Biliary Tract			
Renal			
Aorta/Great Vessels			
Spleen			
UGI & Small Bowel			
Cyst Aspirations			
Biopsy Guidance			
Pelvic			

ULTRASOUND – OB/GYN

Skills (check appropriate box)	1	2	3
Uterus/Ovaries			
Transvaginal Probe			
Fetal Measurements for Age			
Gestation Sac Measurement			
Amniocentesis Guidance			

ULTRASOUND – SMALL PARTS

Skills (check appropriate box)	1	2	3
Thyroid			
Breast			
Prostate			
Transrectal Probe			
Scrotum			

ULTRASOUND – SPECIALS

Skills (check appropriate box)	1	2	3
Neonatal Head			
OPG Eye			
Trans-esophageal			
Trans Cranial Doppler			

CATH LAB

Skills (check appropriate box)	1	2	3
Pulmonary Arteriogram			
Atherectomy			
Balloon Pumps			
External Pacemakers			
Internal Pacemakers			
Coronary Angioplasty			

ECHO

Skills (check appropriate box)	1	2	3
Real Time			
Doppler			
M-Mode			
Color Flow			

VASCULAR

Skills (check appropriate box)	1	2	3
Carotids			
Upper Extremity Venous			
Upper Extremity Arterials			
Lower Extremity Venous			
Lower Extremity Arterials			
Venous for DVT			
Venous for Mapping			
Arterial Pressures & Imaging			
Color Flow			
Popliteal			
TCD			
Penile Doppler			
IPG (arms & legs)			
PVR (arms & legs)			

MRI

Skills (check appropriate box)	1	2	3
T-1 Weighted Images			
Surface Coils			
Partial Saturation Images			
T-2 Weighted Images			
Gradient Echo Imaging			
Multiplanar Reconstruction			
Spin-Echo Images			
MR Angiography			
Type of Equipment (enter below):			
•			
•			
•			
•			

MRI Licensing

Type of Registration: _____

Number: _____

Years of Experience: _____

Type of Registration: _____

Number: _____

Years of Experience: _____