

RESPIRATORY SKILLS CHECKLIST

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

SETTINGS (LIST NUMBER OF YEARS EXPERIENCE IN EACH)

Hospital	Mobile Unit	Home Health
Clinic	Research	Other

Please be accurate when completing this checklist. It will help us match your strengths and skills with available assignments.

Put an "X" in the column that best describes your experience level with each skill

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

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

FLOOR THERAPY

Skills (check appropriate box)	1	2	3
Floor Therapy			

CRITICAL CARE

Skills (check appropriate box)	1	2	3
Ventilators (please list below):			
•			
•			
•			
•			
•			

CARDIOVASCULAR

Skills (check appropriate box)	1	2	3
Cardio/Resp Arrest Team			
Arterial Monitoring			
Pulmonary Arterial Monitoring			
CVP			
EKGs			
Holter EKG			
Stress Testing			
Cardiac Output Monitoring			
IABP			

PEDIATRICS

Skills (check appropriate box)	1	2	3
Resuscitation			
Intubation			
Extubation			
Ventilators (please list below):			
•			
•			
•			
•			
•			

NEONATAL

Skills (check appropriate box)	1	2	3
Resuscitation			
Intubation			
Extubation			
Assist High Risk Delivery			
Aerosol Treatment			
CPT			
Ventilators (please list below):			
•			
•			
•			
•			
•			

AMBULANCE TRANSPORTATION

Skills (check appropriate box)	1	2	3
Portable Response Equipment			
Ventilators (please list below):			
•			
•			
•			
•			
•			
Pulmonary Function Testing			
Arterial Blood Gases			
• Drawing			
• Analysis			
Insertion of A-Lines			
Adult Intubation			
Adult Extubation			