

TO BE COMPLETED BY PHYSICIAN

First Name	Middle Name	Last Name
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Email Address

CERTIFICATIONS

BLS <input type="checkbox"/> Yes <input type="checkbox"/> No	BLS Exp. Date / /	ACLS <input type="checkbox"/> Yes <input type="checkbox"/> No	ACLS Exp. Date / /
ATLS <input type="checkbox"/> Yes <input type="checkbox"/> No	ATLS Exp. Date / /	ABLS <input type="checkbox"/> Yes <input type="checkbox"/> No	ABLS Exp. Date / /
PALS <input type="checkbox"/> Yes <input type="checkbox"/> No	PALS Exp. Date / /	NRP <input type="checkbox"/> Yes <input type="checkbox"/> No	NRP Exp. Date / /

Please check the appropriate boxes to indicate which clinical capabilities you are able to perform.

Practice Settings

<input type="checkbox"/> Inpatient	<input type="checkbox"/> Ambulatory	<input type="checkbox"/> Occupational Medicine	<input type="checkbox"/> ICU
<input type="checkbox"/> Outpatient	<input type="checkbox"/> Hospitalist	<input type="checkbox"/> Rural Medicine	<input type="checkbox"/> HMO

Medicine

<input type="checkbox"/> Adult Outpatient	<input type="checkbox"/> Adult Inpatient	<input type="checkbox"/> without ICU/CCU	<input type="checkbox"/> with ICU/CCU
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Pediatric

<input type="checkbox"/> Newborn (> 2000 grams)	<input type="checkbox"/> General Inpatient	<input type="checkbox"/> General Outpatient	<input type="checkbox"/> Newborn resuscitation
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GYN

<input type="checkbox"/> Pelvic exam / pap smear	<input type="checkbox"/> Colposcopy	<input type="checkbox"/> Endometrial biopsy	<input type="checkbox"/> IUD insertion and removal
<input type="checkbox"/> D&C			

Orthopedic

<input type="checkbox"/> Non-displaced fractures	<input type="checkbox"/> Trigger Point / Joint injections
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Surgery

<input type="checkbox"/> Surgical assisting	<input type="checkbox"/> Skin/tissue biopsy	<input type="checkbox"/> Suturing of minor lacerations	<input type="checkbox"/> I & D (Incision and Drainage)
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Psychiatric

<input type="checkbox"/> Uncomplicated adult	<input type="checkbox"/> Uncomplicated child/adolescent	<input type="checkbox"/> Uncomplicated geriatric
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OB	Number performed within last:	12 months	12-24 months	24-36 months*
<input type="checkbox"/> Prenatal Care				
<input type="checkbox"/> Date of last delivery: ____/____/____				
	Vaginal Deliveries			
	C-sections			
	VBAC			
	Instrument assisted deliveries (forceps, vacuum, etc.)			
	Ultrasounds			

* Physicians who recently completed residency must provide numbers for the last 36 months

Occupational Medicine

- Employment Physicals Disability Exams Diagnosis and management of common industrial-related medical problems

Procedures

- Ventilation Management**
performed in the last 2 years _____
- Evaluation and management of acute volume/BP issues

** Ventilation management - establishing and maintaining an airway; various modes of ventilation for up to 24 hours without pulmonary consultation

Insertion of:

- Central Line # performed in the last 2 years _____ PA Catheter # performed in the last 2 years _____
- Arterial Line # performed in the last 2 years _____ EKG Interpretation (Unofficial) # performed in the last 2 years _____

Diagnostic/therapeutic taps:

- Lumbar puncture
- Paracentesis # performed in the last 2 years _____ Thoracentesis # performed in the last 2 years _____

Please list any procedures customary to your specialty training that you are not comfortable performing:

DISCLAIMER

The information I have given is true and accurate to the best of my knowledge. By signing below I hereby authorize Advantage Locums, LLC to release this Primary Care Clinical Capabilities Checklist to facilities of Advantage Locums, LLC in relation to consideration of my employment.

Signature

Print Name

Date Completed