

Date: \_\_\_\_\_

Applicant's Name: \_\_\_\_\_  
FIRST
MIDDLE INITIAL
LAST

**ADEX Medical Staffing, LLC Healthcare Professionals:**

The purpose of the following checklist is to assist in matching your skills and interests with available assignments, thus meeting your needs and the needs of our clients as much as possible. Your employment is not dependent upon responses given in this checklist.

**\*\*Please make sure this Skills Checklist is signed and dated.**

The information I have given is true and accurate to the best of my knowledge. In addition, I hereby authorize ADEX Medical Staffing, LLC, to release this Skills Checklist to client institutions of ADEX Medical Staffing, LLC, in relation to my employment with that institution.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE MARK YOUR LEVEL OF EXPERIENCE**

- |   |   |   |  |
|---|---|---|--|
| 1 | No Experience: Observed Only                                  | 3 | Moderate Experience: Performs 1-2 Times/Month; May Need Minimal Resource |
| 2 | Limited Experience: Performs < 6 Times Per Year; Needs Review | 4 | Highly Experienced: Performs on Daily or Weekly Basis; Proficient        |

A. Phlebotomy/IV Therapy	Mark One			
	1	2	3	4
1. Draw Blood:				
a. Venous Stick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Central Line	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Arterial Line	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. IV Push	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. IV Drip:				
a. Calculations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Titration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Obtain IV Access	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Mix IV Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Regulate IV's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. IV Infusion Pumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Central Line Dressing Changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Chemotherapy Administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Blood/Blood Product Administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. TPN/PPN Administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Multi-Lumen Central Catheters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Continuous Subcutaneous Infusion Pumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. PCA Pumps (Patient Controlled Analgesia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

B. Cardiovascular	Mark One			
	1	2	3	4
1. Cardiac Monitors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Rhythm Strip Measurements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Recognize & Interpret Dysrhythmias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Obtain 12 Lead EKG's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. CPR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Cardioversion/Defibrillation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Pulse Checks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Use of Doppler	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Automatic BP Cuff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Care of the Patient with:				
a. Acute MI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. CHF	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Cardiopulmonary Arrest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Abdominal Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Pre/Post Cardiac Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Carotid Endarterectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Applicant's Name

Mark One

1 2 3 4

j. Femoral Popliteal Bypass	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Permanent Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Temporary Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. External Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Pre/Post Cardiac Cath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Pre/Post PTCA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
II. Cardiac Lab Interpretation (CPK, Iso Enzymes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I2. Cardiac Rehab/Patient Teaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I3. Use and Administration of:				
a. Atropine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Digoxin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Dopamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Dobutamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Heparin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Verapamil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Lopressor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Lidocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Nitroglycerine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Nipride	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Thrombolytic Agents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Code Cart/Emergency Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C. Respiratory

Mark One

1 2 3 4

1. O <sub>2</sub> Masks/Cannulas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Ambu Bag	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Chest PT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Incentive Spirometry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Instruction of Coughing/Deep Breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Nebulizer Set Up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Suctioning:				
a. Oral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Tracheostomy Tube	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Endotracheal Tube	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Use of Pleurevac	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Interpret ABG's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Arterial Line Maintenance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
II. Sputum Specimen Collection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE MARK YOUR LEVEL OF EXPERIENCE

- 1 No Experience: Observed Only
- 2 Limited Experience: Performs < 6 Times Per Year; Needs Review
- 3 Moderate Experience: Performs 1-2 Times/Month; May Need Minimal Resource
- 4 Highly Experienced: Performs on Daily or Weekly Basis; Proficient

Mark One

1 2 3 4

I2. Pulse Oximetry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I3. Care of the Patient with:				
a. Pulmonary Edema	<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. ARDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Ventilator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Tracheostomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Pre/Post Thoracic Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Chest Tubes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I4. Assist with Intubation/Extubation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I5. Weaning Patient off Ventilator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I6. Use and Administration of:				
a. Aminophylline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Corticosteroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Inhalers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Mark One

1 2 3 4

D. Neurological

1. Neuro Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Glasgow Coma Scale	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Seizure Precautions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Assist with Lumbar Puncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Care of the Patient with:				
a. Acute Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. CVA/TIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. DT's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Spinal Cord Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Pre/Post Neuro Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Halo Traction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Overdose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Use and Administration of:				
a. Decadron	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Dilantin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PLEASE MARK YOUR LEVEL OF EXPERIENCE**

- 1 No Experience: Observed Only
- 2 Limited Experience: Performs < 6 Times Per Year; Needs Review
- 3 Moderate Experience: Performs 1-2 Times/Month; May Need Minimal Resource
- 4 Highly Experienced: Performs on Daily or Weekly Basis; Proficient

Applicant's Name \_\_\_\_\_

Mark One

- 1  2  3  4

c. Phenobarbitol

d. Magnesium Sulfate

e. Valium

f. Ativan

**E. Gastrointestinal**

Mark One

- 1  2  3  4

1. NG Tube Care and Maintenance

2. NG Tube Insertion

3. Bowel Preparation

4. Enterostomal Care

5. Care of the Patient with:

a. Tube Feedings

b. Ileostomy

c. Colostomy

d. Pancreatitis

e. GI Bleed

f. Bowel Obstruction

g. Whipple Procedure

h. Liver Transplant

i. Abdominal Wounds/Surgeries

j. Hemovac

k. Gastrostomy Tube/Jejunostomy Tube

**F. Genitourinary/Renal**

Mark One

- 1  2  3  4

1. Urinary Catheter Insertion

2. Bladder Irrigations:

a. Continuous

b. Intermittent

3. Electrolyte Imbalance/Replacement

4. Care of the Patient with:

a. Peritoneal Dialysis

b. Hemodialysis

c. T.U.R.P.

d. Shunts & Fistulas

e. Nephrectomy

f. Supra-Pubic Catheter

g. Nephrostomy Tube

**G. Orthopedics**

Mark One

- 1  2  3  4

1. Cast Care

2. Traction:

a. Skin

b. Skeletal

3. ROM

4. Use of Assistive Devices

5. Care of the Patient with:

a. Total Joint Replacement

b. Amputation

**H. Miscellaneous**

Mark One

- 1  2  3  4

1. F.S. Glucose Monitoring

2. Dressing Changes

3. Use of Air Fluidized Beds

4. Normal Serum Lab Values

5. Universal Precautions - Isolation

6. Care of the Patient with:

a. Pressure Sores

b. Sickle Cell Anemia

c. Cancer

d. Alzheimer's Disease

e. HIV/AIDS

f. Diabetes

7. Discharge Planning

**I. Age of Patient Cared For**

Mark One

- 1  2  3  4

1. Infants and Toddlers (ages 0-3 years)

2. Young Children (ages 4-6 years)

3. Older Children (ages 7-12 years)

4. Adolescents (ages 13-20 years)

5. Young Adults (ages 21-39 years)

6. Middle Adults (ages 40-64)

7. Older Adults (ages 65-79)

8. Adults (ages >80)