

Please list any limitations or comments you may have on a separate sheet

IDENTIFYING INFORMATION	Last Name	First name	Middle name	Previous Surname		
				Date of Birth		
CERTIFICATIONS	<input type="checkbox"/> BLS expires: _____	<input type="checkbox"/> ACLS expires: _____	<input type="checkbox"/> ATLS expires: _____	<input type="checkbox"/> PALS expires: _____	<input type="checkbox"/> ABLIS expires: _____	<input type="checkbox"/> NRP expires: _____
POPULATIONS WORKED WITH	<input type="checkbox"/> Adults	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Neonatal			
AREAS OF INTEREST	<input type="checkbox"/> Outpatient	<input type="checkbox"/> Inpatient	<input type="checkbox"/> Trauma			
SCOPE OF PRACTICE	<p>Please check the box indicating which clinical capabilities you are able to perform, and where indicated, list the approximate number performed within the last 24 months.</p>					
<p>Please be aware that this form constitutes your application to be credentialed for specific areas and procedures while on assignments through CompHealth.</p> <p>The Credentialing Committee may not consider for approval clinical capabilities where a box is not checked, or where indicated, a number is not provided.</p>	<input type="checkbox"/> General surgery* Adult cases# _____ Pediatric cases# _____ Neonatal cases# _____ Trauma cases# _____					
	Surgeries / Procedures					
	<input type="checkbox"/> Laparoscopic surgery (not specified below)	#	<input type="checkbox"/> Vascular surgery – Open	#		
	<input type="checkbox"/> Appendectomy	#	Endovascular	#		
	<input type="checkbox"/> Cholecystectomy	#	<input type="checkbox"/> Aneurysm repairs	#		
	<input type="checkbox"/> Hernioplasty	#	<input type="checkbox"/> Thoracic			
	<input type="checkbox"/> Nissen fundoplication	#	<input type="checkbox"/> Abdominal			
	<input type="checkbox"/> Head/neck surgery (including thyroid)	#	<input type="checkbox"/> Other			
	<input type="checkbox"/> Chest wall/pleural procedures	#	<input type="checkbox"/> Arterial bypass			
	<input type="checkbox"/> Breast surgery	#	<input type="checkbox"/> Peripheral			
	<input type="checkbox"/> Obstetric and gynecologic surgery	#	<input type="checkbox"/> Vascular access devices			
	<input type="checkbox"/> Cesarean section	#	<input type="checkbox"/> AV shunt			
	<input type="checkbox"/> D&C	#	<input type="checkbox"/> Other			
	<input type="checkbox"/> Hysterectomy	#	<input type="checkbox"/> Plastic surgery*	#		
	<input type="checkbox"/> Liver surgery	#	Additional Procedures for Physicians Trained as Pediatric Surgeons			
	<input type="checkbox"/> GI Endoscopy	#	<input type="checkbox"/> Atresias			
	<input type="checkbox"/> Upper		<input type="checkbox"/> Esophageal	#		
	<input type="checkbox"/> Lower		<input type="checkbox"/> Intestinal	#		
	<input type="checkbox"/> Sigmoidoscopy		<input type="checkbox"/> Biliary	#		
	<input type="checkbox"/> Colonoscopy		<input type="checkbox"/> Abdominal wall defects			
<input type="checkbox"/> Minor orthopedic surgery	#	<input type="checkbox"/> Gastroschisis	#			
<input type="checkbox"/> Hand surgery	#	<input type="checkbox"/> Umbilical defects	#			
Miscellaneous		<input type="checkbox"/> Hernia				
<input type="checkbox"/> Ventilation management*		<input type="checkbox"/> Omphalocele				
<input type="checkbox"/> Chest tube insertion		<input type="checkbox"/> Diaphragmatic hernia	#			
<input type="checkbox"/> Central line insertion		<input type="checkbox"/> Imperforate anus	#			
<input type="checkbox"/> PA catheter placement		<input type="checkbox"/> PDA ligation	#			
<input type="checkbox"/> Laser certification (specify type):		<input type="checkbox"/> Other: (Specify)				

***DEFINITIONS:**

General surgery – abdominal (gall bladder, stomach, spleen, colon, appendix), hernia, amputations, lymph node and other biopsies, etc.

Plastic surgery – facial laceration repairs, scar revisions, other minor skin revisions, skin grafts/flaps

Ventilation management – establishing and maintaining an airway; various modes of ventilation

I affirm that all information given on this page is true and accurate.

Initials _____ Date _____

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