

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"/> NALS expires: _____ <input type="checkbox"/> NRP expires: _____ <input type="checkbox"/> PALS expires: _____			
SCOPE OF PRACTICE Please be aware that this form constitutes your application to be credentialed for specific areas and procedures while on assignments through CompHealth. The Credentialing Committee may not consider for approval clinical capabilities where a box is not checked, or where indicated, a number is not provided.	<u>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.</u>			
	<u>Practice Setting</u>			
	<input type="checkbox"/>	Nursery Level II/NICU (or equivalent) – Evaluation and management of sick newborns; ventilator assistance may or may not be needed; ability to transfer to higher level of care if indicated		
	<input type="checkbox"/>	Nursery Level III/NICU (or equivalent) - Evaluation and management of sick newborns; ventilator assistance frequently required; consultation with multiple specialties available; no ability to transfer to higher level of care, lateral transfer possible for technical requirements.		
	<input type="checkbox"/>	Willing to transport newborns		
	<u>Procedures</u>			
	<input type="checkbox"/>	Ventilation management - Establishing and maintaining an airway; various modes of ventilation		
		<input type="checkbox"/> Invasive (ETT)		
		<input type="checkbox"/> Non-invasive (BiPAP/CPAP)		
		<input type="checkbox"/> Familiarity with use of nitric oxide (iNO)		
		<input type="checkbox"/> ECMO #		
	<input type="checkbox"/>	Chest tube insertion		
	<input type="checkbox"/>	Evaluation and management of acute volume / BP issues		
		Insertion of:		
		<input type="checkbox"/> Central Line #		
		<input type="checkbox"/> Arterial Line #		
		<input type="checkbox"/> PA Catheter #		
	<input type="checkbox"/>	Exchange transfusions		
	<input type="checkbox"/>	Hemodialysis catheter placement #		
	<input type="checkbox"/>	Diagnostic/therapeutic taps (including those specified below) #		
	<input type="checkbox"/> Lumbar puncture			
	<input type="checkbox"/> Paracentesis			
	<input type="checkbox"/> Thoracentesis			
<input type="checkbox"/>	Circumcision #			

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

Initials _____ Date _____