



CLINICAL CAPABILITIES

Neurology

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 BLS expires: _____ ACLS expires: _____ PALS expires: _____

POPULATIONS WORKED WITH Adults Pediatrics Trauma

AREAS OF INTEREST Stroke Traumatic brain injury Spinal cord injury Neuromuscular disorders Sleep disorders

SCOPE OF PRACTICE ***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.***

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.

Neurology: *Diagnosis and management of neurological disorders, including headaches, seizures, strokes, dementia, etc.,*

Outpatient

Inpatient

Rehabilitation

Procedures:

Radiologic exam interpretation (unofficial)

Diagnostic/therapeutic taps (# to include those specified below) #

Lumbar puncture

Subdural taps #

Thrombolytic therapy

Biopsy #

Nerve

Muscle

EEG (Electroencephalogram)

Brain death exam #

EMG (Electromyogram)

NCV (Nerve Conduction Velocity tests)

Evoked potentials

Pain management procedures #

Peripheral nerve blocks

Spinal/paraspinal/epidural blocks

Botulinum toxin administration (Botox)

Sleep studies

Disability evaluation

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

Initials _____ Date _____