



CLINICAL CAPABILITIES

Pediatrics

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

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|--|--|--|--|---|
| IDENTIFYING INFORMATION | Last Name | First name | Middle name | Previous Surname |
| | | | Date of Birth | |
| CERTIFICATIONS | <input type="checkbox"/> BLS expires: _____ | <input type="checkbox"/> PALS/APLS expires: _____ | <input type="checkbox"/> NALS expires: _____ | <input type="checkbox"/> NRP expires: _____ |
| | | | <input type="checkbox"/> ATLS expires: _____ | <input type="checkbox"/> ABLS expires: _____ |
| AREAS OF INTEREST: | <input type="checkbox"/> Inpatient medicine | <input type="checkbox"/> Hospitalist | <input type="checkbox"/> ICU | |
| | <input type="checkbox"/> Outpatient medicine | <input type="checkbox"/> Acute ambulatory care (urgent) | <input type="checkbox"/> Rural medicine | |
| SCOPE OF PRACTICE <i>Please be aware that this form constitutes your application to be credentialed for specific areas and procedures while on assignments through CompHealth.</i> <i>The Credentialing Committee may not consider for approval clinical capabilities where a box is not checked, or where indicated, a number is not provided.</i> | <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>Clinical Areas</u> | | | |
| | <input type="checkbox"/> | Outpatient settings* | | |
| | <input type="checkbox"/> | Inpatient settings* | | |
| | | <input type="checkbox"/> w/out ICU (or equivalent) coverage | | |
| | | <input type="checkbox"/> w/ICU (or equivalent) coverage – diagnosis and management of patients with serious or critical illnesses | | |
| | <u>Nursery Services</u> | | | |
| | <input type="checkbox"/> | Attends C-sections/high-risk deliveries (must be NRP certified) | | |
| | <input type="checkbox"/> | Nursery Level I – Routine newborn care | | |
| | <input type="checkbox"/> | Nursery Level II/NICU (or equivalent) - <i>Diagnosis and management of newborns with serious or critical illnesses; ventilator assistance may or may not be needed; ability to transfer to higher level of care if indicated</i> | | |
| | <u>Procedures</u> | | | |
| | <input type="checkbox"/> | Ventilation management – <i>establishing and maintaining an airway; various modes of ventilation for up to 24 hours without pulmonary consultation</i> | | |
| | | <input type="checkbox"/> Invasive (ETT/NT/Tracheostomy) | | |
| | | <input type="checkbox"/> Non-invasive (BiPAP/CPAP) | | |
| | <input type="checkbox"/> | Evaluation and management of acute volume / BP issues | <input type="checkbox"/> | Diagnostic/therapeutic taps (including those specified below) # |
| | Insertion of: | | <input type="checkbox"/> Bladder taps | |
| | <input type="checkbox"/> Central Line # | | <input type="checkbox"/> Lumbar puncture | |
| | <input type="checkbox"/> Arterial Line # | | <input type="checkbox"/> Paracentesis # | |
| | <input type="checkbox"/> PA Catheter # | | <input type="checkbox"/> Thoracentesis # | |
| <input type="checkbox"/> | Chest tube insertion | <input type="checkbox"/> | Circumcision # | |

*Definition: Inpatient and Outpatient settings may include evaluation and treatment of orthopedic, surgical procedures, minor gynecologic, and uncomplicated psychiatric issues; stabilization for transport of patients with potentially life-threatening emergencies of a medical, surgical, traumatic, or thermal nature

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

Initials _____ Date _____