



ALLIED HEALTH SPECIALTY SHEET

Echocardiographer

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

IDENTIFYING INFORMATION	Last Name	First name	Middle name	Previous Surname													
LIFE SUPPORT CERTIFICATIONS	<input type="checkbox"/> BLS Expiration date: _____		<input type="checkbox"/> ACLS Expiration date: _____	<input type="checkbox"/> Other: Expiration date: _____													
SPECIALTY CERTIFICATIONS	<input type="checkbox"/> RVT <input type="checkbox"/> CCI																
EXAMS AND REGISTRATION	<input type="checkbox"/> A.R.D.M.S. <input type="checkbox"/> Other: _____ Registry # _____ Exp. Date _____ (mm/dd/yy) (Please include copy of registry/ID card)																
	<input type="checkbox"/> RDMS Specialty: <input type="checkbox"/> Cardiac <input type="checkbox"/> Other: _____																
	<input type="checkbox"/> RDCS Specialty: <input type="checkbox"/> Adult echocardiography <input type="checkbox"/> Pediatric echocardiography																
POPULATIONS	<input type="checkbox"/> Adult <input type="checkbox"/> Pediatric <input type="checkbox"/> Neonatal																
CLINICAL EXPERIENCE	<p>Please check the areas below where you have clinical experience within the past 24 months and where you are currently proficient.</p> <table border="0"> <tr> <td style="vertical-align: top;"> <u>Echocardiography:</u> <input type="checkbox"/> 2-dimensional <input type="checkbox"/> M-mode <input type="checkbox"/> PW Doppler <input type="checkbox"/> CW Doppler <input type="checkbox"/> Color Doppler <input type="checkbox"/> Parasternal Long Axis View <input type="checkbox"/> Parasternal Short Axis View <input type="checkbox"/> 4 Chamber View <input type="checkbox"/> 2 Chamber View <input type="checkbox"/> Subcostal View <input type="checkbox"/> Suprasternal View <input type="checkbox"/> Cardiac Anatomy <input type="checkbox"/> Assessment of Endocardium <input type="checkbox"/> Simpson's Rule <input type="checkbox"/> PISA <input type="checkbox"/> Diastolic Dysfunction Evaluation <input type="checkbox"/> Continuity Equation </td> <td style="vertical-align: top;"> <u>Special Procedures:</u> <input type="checkbox"/> Bubble study <input type="checkbox"/> Transesophageal Echocardiogram <input type="checkbox"/> Contrast study <input type="checkbox"/> Treadmill Stress Echo <input type="checkbox"/> Other: _____ </td> <td style="vertical-align: top;"> <u>General Ultrasound</u> <input type="checkbox"/> Doppler studies <input type="checkbox"/> Carotid <input type="checkbox"/> Venous (arm/leg) <input type="checkbox"/> Arterial (arm/leg) <input type="checkbox"/> Renal <input type="checkbox"/> Abdomen / Pelvis <input type="checkbox"/> Gall bladder <input type="checkbox"/> Renal <input type="checkbox"/> Testicular </td> </tr> <tr> <td colspan="2"></td> <td style="vertical-align: top;"> <u>Other Cardiology Testing:</u> <input type="checkbox"/> Holter Monitors <input type="checkbox"/> EKG </td> <td colspan="2" style="vertical-align: top;"> <u>OB/GYN examinations</u> <input type="checkbox"/> 1st Trimester <input type="checkbox"/> Transvaginal </td> </tr> <tr> <td colspan="2"></td> <td colspan="3" style="vertical-align: top;"> <u>Ultrasound Assisted Procedures</u> <input type="checkbox"/> Biopsy <input type="checkbox"/> Aspiration <input type="checkbox"/> Drainage <input type="checkbox"/> Hysterosonography <input type="checkbox"/> Amniocentesis </td> </tr> </table> <p>Please list any additional skills or procedures you have performed: _____</p> <p>_____</p> <p>_____</p>				<u>Echocardiography:</u> <input type="checkbox"/> 2-dimensional <input type="checkbox"/> M-mode <input type="checkbox"/> PW Doppler <input type="checkbox"/> CW Doppler <input type="checkbox"/> Color Doppler <input type="checkbox"/> Parasternal Long Axis View <input type="checkbox"/> Parasternal Short Axis View <input type="checkbox"/> 4 Chamber View <input type="checkbox"/> 2 Chamber View <input type="checkbox"/> Subcostal View <input type="checkbox"/> Suprasternal View <input type="checkbox"/> Cardiac Anatomy <input type="checkbox"/> Assessment of Endocardium <input type="checkbox"/> Simpson's Rule <input type="checkbox"/> PISA <input type="checkbox"/> Diastolic Dysfunction Evaluation <input type="checkbox"/> Continuity Equation	<u>Special Procedures:</u> <input type="checkbox"/> Bubble study <input type="checkbox"/> Transesophageal Echocardiogram <input type="checkbox"/> Contrast study <input type="checkbox"/> Treadmill Stress Echo <input type="checkbox"/> Other: _____	<u>General Ultrasound</u> <input type="checkbox"/> Doppler studies <input type="checkbox"/> Carotid <input type="checkbox"/> Venous (arm/leg) <input type="checkbox"/> Arterial (arm/leg) <input type="checkbox"/> Renal <input type="checkbox"/> Abdomen / Pelvis <input type="checkbox"/> Gall bladder <input type="checkbox"/> Renal <input type="checkbox"/> Testicular			<u>Other Cardiology Testing:</u> <input type="checkbox"/> Holter Monitors <input type="checkbox"/> EKG	<u>OB/GYN examinations</u> <input type="checkbox"/> 1 st Trimester <input type="checkbox"/> Transvaginal				<u>Ultrasound Assisted Procedures</u> <input type="checkbox"/> Biopsy <input type="checkbox"/> Aspiration <input type="checkbox"/> Drainage <input type="checkbox"/> Hysterosonography <input type="checkbox"/> Amniocentesis		
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EQUIPMENT	Please check the type of work-related equipment you have used: <input type="checkbox"/> GE <input type="checkbox"/> Siemens <input type="checkbox"/> Philips <input type="checkbox"/> HP Other: _____																
COMPUTER SYSTEMS	Please check the type of work-related computer systems / PACS you have used: <input type="checkbox"/> Fuji <input type="checkbox"/> AGFA <input type="checkbox"/> Siemens <input type="checkbox"/> GE Other: _____																

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

Initials _____

Date _____

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Revised 11/1/2006 Q:\Applications-Forms\CompHealth App\Allied Specialties\Echo Tech.doc APP 379