



Elite Medical Group Staffing

EXCEEDING EXPECTATIONS DAILY

Radiology Skills Checklist

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

IDENTIFYING INFORMATION	Last Name	First Name	Middle Name
	Previous Surname	Social Security number	
CERTIFICATIONS	<input type="checkbox"/> BLS: Expiration Date <input type="checkbox"/> ACLS: Expiration Date <input type="checkbox"/> Other: Expiration Date		
EXAMS AND REGISTRATION	Registered by: <input type="checkbox"/> ARRT <input type="checkbox"/> NMTCB <input type="checkbox"/> other _____ Registry # _____ Exp Date _____ (mm/dd/yyyy) (Please include a copy of registry & ID card)		
	Primary Modalities: <input type="checkbox"/> Radiology Tech <input type="checkbox"/> Nuclear Medicine <input type="checkbox"/> Radiation		
	Advance Modalities: <input type="checkbox"/> Cardiovascular Interventional <input type="checkbox"/> CT Scan <input type="checkbox"/> MRI <input type="checkbox"/> Mammography (MQSA) <input type="checkbox"/> Yes <input type="checkbox"/> No) <input type="checkbox"/> Quality Management		
LICENSES List all states in which you are or have ever been licensed, beginning with your original state license.	Original Sate License	License Number	Exp. Date
	State License	License Number	Exp. Date
	State License	License Number	Exp. Date
CLINICAL SKILS	<i>Please check the areas below where you have clinical experience within the past 24 months.</i>		
	General Radiology	Cardiovascular/Interventional	CT Studies
<input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Facial bones <input type="checkbox"/> Skull <input type="checkbox"/> Sinuses <input type="checkbox"/> Cervical spine <input type="checkbox"/> Thoracic spine <input type="checkbox"/> IVP <input type="checkbox"/> Lumbar spine <input type="checkbox"/> Hip <input type="checkbox"/> Extremities <input type="checkbox"/> Pelvis <input type="checkbox"/> Shoulder region <input type="checkbox"/> Cholangiograms <input type="checkbox"/> Myelogram <input type="checkbox"/> Arteriogram <input type="checkbox"/> Pediatric Radiology <input type="checkbox"/> Portable Radiology <input type="checkbox"/> O.R Exam <input type="checkbox"/> Trauma/ER <input type="checkbox"/> Trauma/ER Level I <input type="checkbox"/> Trauma /ER Level II <input type="checkbox"/> Trauma/ER Level III	<input type="checkbox"/> Cardiac Catheterization <input type="checkbox"/> Angioplasty <input type="checkbox"/> Artherectomy <input type="checkbox"/> Stenting <input type="checkbox"/> Thrombolysis <input type="checkbox"/> Embolization <input type="checkbox"/> Arteriography <input type="checkbox"/> Common carotid <input type="checkbox"/> Subclavian/Vertebral <input type="checkbox"/> Thoracic aorta <input type="checkbox"/> Coronary <input type="checkbox"/> Extremity <input type="checkbox"/> Abdominal aortography <input type="checkbox"/> Mesenteric <input type="checkbox"/> Renal <input type="checkbox"/> Selective visceral <input type="checkbox"/> Pulmonary <input type="checkbox"/> Venography <input type="checkbox"/> Nephrostomy/ Urethral stents	<input type="checkbox"/> Brain/Head <input type="checkbox"/> Facial Bones <input type="checkbox"/> Chest <input type="checkbox"/> CT Assisted biopsy <input type="checkbox"/> Neck/Larynx <input type="checkbox"/> IAC <input type="checkbox"/> TM Joints <input type="checkbox"/> Cervical spine <input type="checkbox"/> Thoracic spine <input type="checkbox"/> Lumbar spine <input type="checkbox"/> Abdomen <input type="checkbox"/> Liver <input type="checkbox"/> Routine abdomen <input type="checkbox"/> Pancreas <input type="checkbox"/> Renal <input type="checkbox"/> GI Tract <input type="checkbox"/> Extremities <input type="checkbox"/> Sinuses <input type="checkbox"/> Orbit <input type="checkbox"/> Contrast Agent Preparation <input type="checkbox"/> Quality Assurance <input type="checkbox"/> Image Display	

