



Elite Medical Group Staffing

EXCEEDING EXPECTATIONS DAILY

ULTRASONOGRAPHER

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 # _____ _____ (mm/dd/yyyy) (Please include a copy of registry & ID card) Exp date: _____		
	Ultrasonography Credentials <input type="checkbox"/> RDMS Specialty: <input type="checkbox"/> Abdomen <input type="checkbox"/> Neurosonology <input type="checkbox"/> OB/GYN <input type="checkbox"/> Ophthalmology		
	<input type="checkbox"/> RDCS Specialty: <input type="checkbox"/> Adult echo-cardiography <input type="checkbox"/> Pediatric echo-cardiography		
	<input type="checkbox"/> RVT Specialty: <input type="checkbox"/> Vascular Technology		
	<input type="checkbox"/> ROUB Specialty: <input type="checkbox"/> Registered ophthalmic ultrasound biometrist		
CLINICAL SKILLS	Please check the areas below where you clinical experience within the past 24 months and where you are currently proficient.		
	General Procedures:	Special Procedures:	Please list any additional skills or procedures you have performed. _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
	<input type="checkbox"/> Abdomen <input type="checkbox"/> Aorta <input type="checkbox"/> Biliary Tree <input type="checkbox"/> Breast <input type="checkbox"/> Doppler Studies <input type="checkbox"/> Carotid <input type="checkbox"/> Venous (arm/leg) <input type="checkbox"/> Arterial (arm/leg) <input type="checkbox"/> Arterial graft duplex <input type="checkbox"/> Renal Doppler <input type="checkbox"/> Transcranial Doppler <input type="checkbox"/> Segmental pressures <input type="checkbox"/> Gall Bladder <input type="checkbox"/> Heart <input type="checkbox"/> Liver <input type="checkbox"/> Transvaginal procedures <input type="checkbox"/> Obstetrical Exam <input type="checkbox"/> Neonatal abdomen <input type="checkbox"/> Neonatal head <input type="checkbox"/> Pancreas <input type="checkbox"/> Renal <input type="checkbox"/> Small parts <input type="checkbox"/> Thyroid <input type="checkbox"/> Transrectal procedures	<input type="checkbox"/> Biopsy procedures <input type="checkbox"/> Cyst aspiration <input type="checkbox"/> Paracentesis <input type="checkbox"/> Thoracentesis <input type="checkbox"/> Hysterosonography Please list any additional skills or procedures you have performed. _____ _____ _____ _____ _____ _____ _____ _____ _____	

I hereby certify that all of the information provided by me in this application or any other required documents is correct, accurate and complete to the best of my knowledge. I understand that the falsification, misrepresentation or omission of any facts in said documents will be cause for denial of assignment or immediate termination regardless of timing or circumstances of discovery.

Signature: _____ Date: _____

Please print complete and fax or mail to: EMG Staffing 12705 Century Dr Suite 105 Alpharetta, Ga 30004 Office #: (678) 893-0921 Fax #: (866) 899-8967.