

Gastroenterology/Endoscopy

Skills Checklist

Please print clearly in black ink.
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independent healthcare staffing, inc.



11709 Fruehauf Dr. Ste. 117 ~ Charlotte, NC 28273
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Email: IHS@Independenthealthcarestaffing.com
www.independenthealthcarestaffing.com

Date _____

Applicant's Name: _____
Last First Middle Initial

To Independent Healthcare Staffing Professionals:

The following checklist is a profile used to assess your clinical proficiency and assist in matching your skills with available assignments. Your employment is not dependent upon responses given in this checklist. Please rate your ability as accurately as possible by checking the appropriate box.

The information I have given here is true and accurate to the best of my knowledge. In addition, I also authorize IHS to release this skills checklist to client institutions of IHS in relation to my employment with that institution.

Signature _____ Date _____

Please Mark Your Level of Experience

- 1 No Experience: Theory / Observed Only 3 Moderate Experience: > 5 Times Per Year; May Need Minimal Resource
 2 Intermittent Experience: < 5 Times Per Year; Needs Review 4 Competent: Performs on Daily or Weekly Basis; Proficient

	Mark One			
	1	2	3	4
Procedures, Assist or Knowledge of				
Anoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colonoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EGD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ERCP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flexible Sigmoidoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Proper Assessment and Documentation of Conscious Sedation Record	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rigid Proctoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sphincterotomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	1	2	3	4
Assessory Equipment				
Cytology Brushes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decompression Tubes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dilators				
Baloon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maloney	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Savory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forceps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Mark One			
	1	2	3	4
Assessory Equipment (continued)				
Polyp Snares	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Valley Lab BX	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	1	2	3	4
Bleeder Cart Equipment				
Bicap Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Code Blue Lavage Kit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endo Pump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Esophageal Banding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gold Probe/Injector Needle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sero Needles and Meds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	1	2	3	4
Gastro-Intestinal Feeding Tubes				
Jejunial Tubes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Naso-Enteric Tubes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peg Insertion Equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Replacement Gastrostomy Buttons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Replacement Gastrostomy Tubes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	1	2	3	4
ERCP				
Equipment and Stock	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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ERCP (continued)

	1	2	3	4
Papillotomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Som Procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stent Placement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specimen Collection

	1	2	3	4
Biopsies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cytology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immuno Supressed Protocol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Manometry and Diagnostic Testing

	1	2	3	4
24 Hour PH Ambulatory Study	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Esophageal Manometry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver BX	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paracentesis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Pediatric Procedures

	1	2	3	4
Pediatric Peg Cart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Proper EGD Scopes According to Age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specific Equipment for Pediatric Scopes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Cleaning

	1	2	3	4
Proper Scope Cleaning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Proper Use of Scope Washers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Storing Scopes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of Leak Tester	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Equipment Please list any equipment not previously listed.

Mark One

Age of Patient Cared For

	1	2	3	4
Infant and Toddler (Ages 0-3 yrs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Young Children (Ages 4-6 yrs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Older Children (Ages 7-12 yrs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adolescents (Ages 13-20 yrs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Young Adults (Ages 21-39 yrs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Middle Age (Ages 40-64 yrs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Older Adults (Ages 65+ yrs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Units Worked **Years**

Outpatient Department

Freestanding Clinic

Total Number of Years _____

Certifications **Exp. Date**

ACIS Yes No _____

BCIS Yes No _____

IV Certification Yes No _____

NAIS Yes No _____

NPR Yes No _____

PAIS Yes No _____

Other _____

Additional Skills

Please list any additional experience or skills not previously listed.
