



The Respiratory Agency

10502 Johanna Avenue • Riverview • FL 33578
 813-677-1247 • 800-955-7377 • Fax 813-677-1778
 sandrad@therespiratoryagency.com

RESPIRATORY THERAPIST SELF-EVALUATION SKILLS LIST

Please enter your full legal name as it appears on your Respiratory License

Name _____

Date _____

Your level of experience: 1= No Experience 2= Limited Experience 3= Experienced 4= Highly Skilled

How often do you perform this skill or work in this Unit: N=Never R=Rarely S=Sometimes O=Often

HOSPITAL SETTINGS

	1	2	3	4	NR		1	2	3	4	NR
					SO						SO
PATIENT CARE SETTINGS						RESPIRATORY PROCEDURES					
Adult Floors Level 1						Airway Assessment and Care					
Floor Care Tx's, BiPAP, CPAP						Aerosolized Medication Delivery					
Floor Care Ventilators						Arterial Blood Gas Puncture					
General Emergency Room						Arterial Blood Gas Analysis					
Adult Intensive Care Level 2						Arterial Blood Line Sampling					
Medical ICU						Arterial Line Insertion					
Surgical ICU						CPAP/BIPAP Setup/Delivery					
Coronary Care CCU						Ventilator Assessment/Management					
Cardiac Surgical CVICU						Nasal Suctioning					
Neuro ICU						Suction(NT/Deep Tracheal)					
Burn Unit						Tracheal Suction					
Emergency Dept. Level 3						Trach Care					
Trauma ER						Trach Change Proficient					
Pediatric ER						Intubation Assistance					
Pediatric Floors Level 4						Intubation Performance					
Pediatric ICU Level 5						Chest Therapy Vest					
Pediatric Cardiac ICU Level 6						Oxygen Saturation Checks					
Labor & Delivery Level 7						Heated High Flow Nasal Canula					
Neonatal ICU Level 8						Heliox Therapy					
Transport Level 9						Nitrogen Delivery					
Home Care Level 10						Capillary Gases					

Your level of experience: 1= No Experience 2= Limited Experience 3= Experienced 4= Highly Skilled

How often do you perform this skill or work in this Unit: N=Never R=Rarely S=Sometimes O=Often

	1	2	3	4	NR SO		1	2	3	4	NR SO
PULMONARY CONDITIONS						<i>Experience with the following ventilators:</i>					
Acute/chronic Bronchitis						VENTILATOR MODEL					
ALS (Amyotrophic Lateral Sclerosis)						Airlife NCPAP Driver					
ARDS (Adult Resp Distress Syndrome)						Aladdin CPAP System					
Aspiration Pneumonia						Bear Cub					
Asthma						Biomed Devices-Cross Vent 2/3					
BPD (Bronchopulmonary dysplasia)						Bipap/Auto					
Bronchiectasis						Bird					
Cardiac Surgery						Bird IPPB					
Chest Trauma						Bunell Jet Vent					
Congestive Heart Failure						Drager Adult					
Chronic Obstructive Pulm. Disease						Drager Infant					
Congenital Heart Anomalies						Hamilton Amadeus, Veolar					
Croup						Healthdyne CPAP					
Cystic Fibrosis						LTV 950, 1000, 1200, 1250					
Epiglottitis						pNeuton					
Fresh Tracheostomy						Newport					
Gullian Barre						PLV Portable Ventilator					
Hemopneumothorax						Puritan Bennett 740, 840, 7200					
Infant Resp. Distress Syndrome						Resmed APAP, VPAP					
Laryngospasm						Respironics S/T, Vision					
Meconium Aspiration						Respironics V-60 Bipap					
Myasthenia						Sechrist					
Near Drowning						SensorMedics					
Neurological Disorders						3100A,3100B(Oscillator)					
Persistent Fetal Circulation						Siemens Servo I, S, 300					
Pneumonia						Siemens Servo 900c					
Primary Pulm.Hypertension Newborn						SIPAP					
Pulmonary Edema						T-Bird					
Pulmonary Embolism						Trilogy					
PIE (Pulmonary Interstitial Emphysema)						Versamed I Vent					
RDS (Respiratory Distress Syndrome)						COUGH ASSIST DEVICES					
RSV (Respiratory Syncytial Virus)						Emerson					
Restrictive Pulmonary Diseases						Respironics T-70					
Smoke Inhalation						OTHER VENTILATORS OR EQUIPMENT:					
Spinal Cord Injuries											
Status Asthmaticus											
Tension Pneumothorax											
Thoracotomy											
Tracheo-esophageal Fistula											
Tracheomalacia											
Tuberculosis											
Transient Tachypnea of the Newborn											

Your level of experience: 1= No Experience 2= Limited Experience 3= Experienced 4= Highly Skilled

How often do you perform this skill or work in this Unit: N=Never R=Rarely S=Sometimes O=Often

	1	2	3	4	NR SO		1	2	3	4	NR SO
MEDICATIONS						SURFACTANTS					
Antibiotics						Beractant (Survanta)					
Amikin (Amikacin Sulfate)						Direct instillation through ET Tube					
Gentamicin						EQUIPMENT AND PROCEDURES					
Pentamidine						Oxygen Concentrator Set Up					
Tobramycin (TOBI)						Bedside Pulm. Func. Testing					
Vancomycin						Bilevel Ventilation					
Aztreanam (CAYSTON)						Bronchoscopy Assistance					
Bronchodilators						Capnography					
Advair Diskus						Cardiac Stress Testing					
Albuterol/Atrovent (Duoneb)						Complete Pulm. Func. Testing					
Albuterol Sulfate(Proventil)						ECMO Assistance					
Albuterol/Ipratropium Bromide(Combivent)						ECMO Operation					
Cromolyn Sodium (Intal)						EKG					
Formoterol Fumarate (Foradil)						EKG Interpretation					
Ipratropium Bromide (Atrovent)						IPPB					
Levalbuterol HCL (Xopenex)						Hyperbaric Therapy					
Pirbuterol Acetate(Maxair)						Infant Ventilator Management					
Racemic Epinephrine(Vaponephrine)						Inverse Ratio Ventilation					
Salmeterol Xinafoate(Serevent)						Lung Expansion Therapy					
Serevent/Flovent Combo						Neonatal High Freq. Ventilation					
Symbicort (Budesonide/Formoterol)						Neonatal Ventilator Management					
Terbutaline (BRETHINE)						Pediatric Ventilator Management					
Tiotropium (SPIRIVA) DISKUS						Pressure Controlled Ventilators					
Corticosteroids						PRVC Ventilation					
Asthmanex						Sleep Apnea Studies					
Beclomethasone						Do you have or have you acquired any new skills that are not on this list? Please explain.					
Budesonide (Pulmicort Respules)											
FLOVENT											
Flunisolide (AEROBID)											
Mometasone Furoate (DULERA)											
Triamcinolone (AZMACORT)											
Local Anesthetics											
Lidocaine (XYLOCAINE)											
Morphine Sulphate											
Mucokinetic Agents											
Acetylcysteine (Mucomyst)											
Normal Saline (0.9%) (NS)											
Pulmozyme (Dornase alpha)											
Relenza (ZANAMIVIR)											
Sodium Bicarbonate (2%)											



AGE SPECIFIC PRACTICE CRITERIA

Please check the boxes below for each age group you have expertise in providing respiratory care.

A-Newborn/Neonate (birth-30 days)
B-Infant (30 days-1 year)
C-Toddler (1-3 years)
D-Preschooler (3-5 years)
E-School Age (5-12 years)

F-Adolescents (12-18 years)
G-Young Adults (18-39 years)
H-Middle Adults (39-64 years)
I-Older Adults (64+ years)

EXPERIENCE WITH AGE GROUPS

	A	B	C	D	E	F	G	H	I
Able to adapt care to incorporate normal growth and development	<input type="checkbox"/>								
Able to adapt method and terminology of patient instructions to their age, comprehension, and maturity level	<input type="checkbox"/>								
Can ensure a safe environment reflecting specific needs of various age groups	<input type="checkbox"/>								

PRIMARY EXPERIENCE

Please indicate your primary experience and indicate how many years in the boxes provided.

<input type="checkbox"/> General Adult Inpatient	<input type="text"/>	year(s)	<input type="checkbox"/> Pediatrics	<input type="text"/>	year(s)
<input type="checkbox"/> Home Care	<input type="text"/>	year(s)	<input type="checkbox"/> Pulmonary Rehab	<input type="text"/>	year(s)
<input type="checkbox"/> Intensive Care Unit	<input type="text"/>	year(s)	<input type="checkbox"/> Sleep Lab	<input type="text"/>	year(s)
<input type="checkbox"/> Long Term Care	<input type="text"/>	year(s)	<input type="checkbox"/> Subacute	<input type="text"/>	year(s)
<input type="checkbox"/> Neonatal ICU	<input type="text"/>	year(s)	Level	<input type="text"/>	

CERTIFICATIONS

Please check below and indicate the expiration date for each certificate that you have.

If you do not know the exact date, please use the last date of the specific month (e.g, 03/31/2003).

<input type="checkbox"/> CRT	Exp Date _____ (mm/dd/yyyy)	<input type="checkbox"/> ACLS	Exp Date _____ (mm/dd/yyyy)
<input type="checkbox"/> RRT	Exp Date _____ (mm/dd/yyyy)	<input type="checkbox"/> PALS	Exp Date _____ (mm/dd/yyyy)
<input type="checkbox"/> NPS	Exp Date _____ (mm/dd/yyyy)	<input type="checkbox"/> NRP	Exp Date _____ (mm/dd/yyyy)
<input type="checkbox"/> CPFT	Exp Date _____ (mm/dd/yyyy)	<input type="checkbox"/> EKG Tech	Exp Date _____ (mm/dd/yyyy)
<input type="checkbox"/> RPFT	Exp Date _____ (mm/dd/yyyy)	<input type="checkbox"/> EEG Tech	Exp Date _____ (mm/dd/yyyy)
<input type="checkbox"/> SDS	Exp Date _____ (mm/dd/yyyy)	<input type="checkbox"/> Passport	Exp Date _____ (mm/dd/yyyy)
<input type="checkbox"/> BCLS	Exp Date _____ (mm/dd/yyyy)	<input type="checkbox"/> Other (fill in below with exp dates)	_____
<input type="checkbox"/> Computerized Charting System (fill in below)	_____		_____
	_____		_____

Please read and agree to the statements below by marking the checkbox.

I attest that the information I have given is true and accurate to the best of my knowledge and that I am the individual completing this form. I hereby authorize TRA to release this Respiratory Therapy Checklist to the Client facilities in relation to consideration of employment with TRA with those facilities.

Name/Signature

Date

By checking this box, I certify that this document has been electronically signed by me and the information I have provided above is true.

