

Name:

Date:

Required Surgical Skills/Experience

(Surgical Nurse and Surgical Technologist)

(✓ check as appropriate - R = REQUIRED, P =PREFERRED)

	R	P	Comments
General Surgery			
Abdominal perineal resection	<input type="checkbox"/>	<input type="checkbox"/>	
Adrenalectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Anal Fissurectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Appendectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Bowel Repairs/Resections	<input type="checkbox"/>	<input type="checkbox"/>	
Brest Biopsy	<input type="checkbox"/>	<input type="checkbox"/>	
Cholecystectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Colectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Colonscopy/Sigmoidoscopy	<input type="checkbox"/>	<input type="checkbox"/>	
Colostomy/Ileostomy	<input type="checkbox"/>	<input type="checkbox"/>	
Esophageal Resection	<input type="checkbox"/>	<input type="checkbox"/>	
Esophagoscopy	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Gastric Bypass/Stapling	<input type="checkbox"/>	<input type="checkbox"/>	
Gastroplasty	<input type="checkbox"/>	<input type="checkbox"/>	
Gastroscopy	<input type="checkbox"/>	<input type="checkbox"/>	
Hemorrhoidectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatic Resection	<input type="checkbox"/>	<input type="checkbox"/>	
Herniations (Hiatal, Diaphragm)	<input type="checkbox"/>	<input type="checkbox"/>	
Herniorrhaphy (Femoral/Inguinal/Umbilical)	<input type="checkbox"/>	<input type="checkbox"/>	
Hiatal herniorrhaphy, Transabdominal/Transthoracic	<input type="checkbox"/>	<input type="checkbox"/>	
Hickman/Groshong/Portacath insertion	<input type="checkbox"/>	<input type="checkbox"/>	
Hydrocelectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Imperforate anus reconstruction	<input type="checkbox"/>	<input type="checkbox"/>	
Laparascopy	<input type="checkbox"/>	<input type="checkbox"/>	
Laparotomy	<input type="checkbox"/>	<input type="checkbox"/>	
Lumbar sympathectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Mastectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Nephrectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Nissen Fundoplication	<input type="checkbox"/>	<input type="checkbox"/>	
Omphalocele Repair	<input type="checkbox"/>	<input type="checkbox"/>	
Pancreatectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Pilonidal cystectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Pilonidalcystectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Portal/Caval Shunt	<input type="checkbox"/>	<input type="checkbox"/>	
Pyloric Stenosis	<input type="checkbox"/>	<input type="checkbox"/>	

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Radical Mastectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Rectal Cases	<input type="checkbox"/>	<input type="checkbox"/>	
Saphenous vein ligation and stripping	<input type="checkbox"/>	<input type="checkbox"/>	
Sentinal node biopsy	<input type="checkbox"/>	<input type="checkbox"/>	
Splenectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Tenckhoff catheter placement	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroglossal duct cyst excision	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroidectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Trachestomy	<input type="checkbox"/>	<input type="checkbox"/>	
Transabdominal	<input type="checkbox"/>	<input type="checkbox"/>	
Vagotomy	<input type="checkbox"/>	<input type="checkbox"/>	
Vagotomy/Pyloroplasty	<input type="checkbox"/>	<input type="checkbox"/>	
Whipple Procedure	<input type="checkbox"/>	<input type="checkbox"/>	
Ear, Nose, Throat			
Acoustic Neuroma	<input type="checkbox"/>	<input type="checkbox"/>	
Adenoidectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Caldwell-Luc	<input type="checkbox"/>	<input type="checkbox"/>	
Cleft Lip/ Palate Repair	<input type="checkbox"/>	<input type="checkbox"/>	
Closed reduction nasal fracture	<input type="checkbox"/>	<input type="checkbox"/>	
Endoscopy Sinus Surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Ethmoidectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Excision of salivary gland tumor	<input type="checkbox"/>	<input type="checkbox"/>	
Fenestration Procedure	<input type="checkbox"/>	<input type="checkbox"/>	
Frontal flap sinus procedure	<input type="checkbox"/>	<input type="checkbox"/>	
Glossectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Laryngectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Laryngoscopy	<input type="checkbox"/>	<input type="checkbox"/>	
Mandibular Fractures	<input type="checkbox"/>	<input type="checkbox"/>	
Mandibulectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Mastoidectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Maxillary Fractures	<input type="checkbox"/>	<input type="checkbox"/>	
Maxillectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Myringoplasty	<input type="checkbox"/>	<input type="checkbox"/>	
Myringotomy/with PE tube insertion	<input type="checkbox"/>	<input type="checkbox"/>	
Nasal polypectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Nick Dissection	<input type="checkbox"/>	<input type="checkbox"/>	

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Open Reduction Facial Fractures	<input type="checkbox"/>	<input type="checkbox"/>	
Open Reduction Tripod Fractures	<input type="checkbox"/>	<input type="checkbox"/>	
Orbital/Zygomatic Fractures	<input type="checkbox"/>	<input type="checkbox"/>	
Parathyroidectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Parotidectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Pharyngeal flap procedure	<input type="checkbox"/>	<input type="checkbox"/>	
Radical neck dissection	<input type="checkbox"/>	<input type="checkbox"/>	
Ranulectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Reduction Nasal Fracture	<input type="checkbox"/>	<input type="checkbox"/>	
Rhinoplasty/septoplasty	<input type="checkbox"/>	<input type="checkbox"/>	
Selective osteotomy of maxilla/mandible	<input type="checkbox"/>	<input type="checkbox"/>	
Sinus Endoscopy	<input type="checkbox"/>	<input type="checkbox"/>	
Sinustomy	<input type="checkbox"/>	<input type="checkbox"/>	
Stapedectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Submucous resection	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroidectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Tonsillectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Trachostomy	<input type="checkbox"/>	<input type="checkbox"/>	
Tympanoplasty	<input type="checkbox"/>	<input type="checkbox"/>	
Vocal Cord Stripping	<input type="checkbox"/>	<input type="checkbox"/>	
Transplant			
Bone-Harvest/Transplant	<input type="checkbox"/>	<input type="checkbox"/>	
Eye-Harvest/Transplant	<input type="checkbox"/>	<input type="checkbox"/>	
Heart-Harvest/Transplant	<input type="checkbox"/>	<input type="checkbox"/>	
Liver-Harvest/Transplant	<input type="checkbox"/>	<input type="checkbox"/>	
Lung-Harvest/Transplant	<input type="checkbox"/>	<input type="checkbox"/>	
Pancreas-Harvest/Transplant	<input type="checkbox"/>	<input type="checkbox"/>	
Renal-Harvest/Transplant	<input type="checkbox"/>	<input type="checkbox"/>	
Skin-Harvest/Transplant	<input type="checkbox"/>	<input type="checkbox"/>	
Neurology			
A-V malformation	<input type="checkbox"/>	<input type="checkbox"/>	
Acoustic Neuroma	<input type="checkbox"/>	<input type="checkbox"/>	
Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	
Anterior Laparoscopic spine procedure	<input type="checkbox"/>	<input type="checkbox"/>	
Anterior Cervical Fusion	<input type="checkbox"/>	<input type="checkbox"/>	

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Anterior Lumbar interbody fusion (ALIF)	<input type="checkbox"/>	<input type="checkbox"/>	
Burr Holes	<input type="checkbox"/>	<input type="checkbox"/>	
Carotid ligation	<input type="checkbox"/>	<input type="checkbox"/>	
Carotid ligation	<input type="checkbox"/>	<input type="checkbox"/>	
Cervical Sympathetomy	<input type="checkbox"/>	<input type="checkbox"/>	
Cervical Fusion	<input type="checkbox"/>	<input type="checkbox"/>	
Cervical Laminectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Craniectomy for decompression fracture	<input type="checkbox"/>	<input type="checkbox"/>	
Cranioplasty/craniotomy	<input type="checkbox"/>	<input type="checkbox"/>	
Cranioplasty	<input type="checkbox"/>	<input type="checkbox"/>	
Craniotomy	<input type="checkbox"/>	<input type="checkbox"/>	
Crutchfield Tong Insertion	<input type="checkbox"/>	<input type="checkbox"/>	
Discectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Halo traction Application	<input type="checkbox"/>	<input type="checkbox"/>	
Hypophysectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Laminectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Meningocele Repair	<input type="checkbox"/>	<input type="checkbox"/>	
Myelomeningocele Repair	<input type="checkbox"/>	<input type="checkbox"/>	
Pedicle Screw Insertion	<input type="checkbox"/>	<input type="checkbox"/>	
Posterior Lumbar Interbody Fusion (PLIF)	<input type="checkbox"/>	<input type="checkbox"/>	
Shunt Insertions	<input type="checkbox"/>	<input type="checkbox"/>	
Spine Fusion	<input type="checkbox"/>	<input type="checkbox"/>	
Ulnar Nerve Transfer	<input type="checkbox"/>	<input type="checkbox"/>	
Ventricular Procedures	<input type="checkbox"/>	<input type="checkbox"/>	
Ventriculostomy	<input type="checkbox"/>	<input type="checkbox"/>	

Plastics

Abdominoplasty	<input type="checkbox"/>	<input type="checkbox"/>	
Blepharoplasty	<input type="checkbox"/>	<input type="checkbox"/>	
Demabrasion	<input type="checkbox"/>	<input type="checkbox"/>	
Facelifts	<input type="checkbox"/>	<input type="checkbox"/>	
Mammoplasty-Augmentation	<input type="checkbox"/>	<input type="checkbox"/>	
Mammoplasty-Reduction	<input type="checkbox"/>	<input type="checkbox"/>	
Mammoplasty	<input type="checkbox"/>	<input type="checkbox"/>	
Mentoplasty	<input type="checkbox"/>	<input type="checkbox"/>	
Muscle Flaps	<input type="checkbox"/>	<input type="checkbox"/>	
Otoplasty	<input type="checkbox"/>	<input type="checkbox"/>	

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Pedicile Grafts	<input type="checkbox"/>	<input type="checkbox"/>	
Rhionplasty	<input type="checkbox"/>	<input type="checkbox"/>	
Scar Revisions	<input type="checkbox"/>	<input type="checkbox"/>	
Septoplasty	<input type="checkbox"/>	<input type="checkbox"/>	
Skin Grafts/ Split Thickness	<input type="checkbox"/>	<input type="checkbox"/>	
Vein Stripping	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiovascular			
Angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	
Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	
Aortic Balloon Insertion	<input type="checkbox"/>	<input type="checkbox"/>	
Aortic Valve Replacement	<input type="checkbox"/>	<input type="checkbox"/>	
Artial Septal Defect Repair	<input type="checkbox"/>	<input type="checkbox"/>	
A-V Fistula/Shunt	<input type="checkbox"/>	<input type="checkbox"/>	
Carotid Endarterectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Central Venous Access Placements	<input type="checkbox"/>	<input type="checkbox"/>	
Coarctation of Aorta-Resection	<input type="checkbox"/>	<input type="checkbox"/>	
Coronary Artery Bypass Graft	<input type="checkbox"/>	<input type="checkbox"/>	
Fem-Popliteal Bypass Graft	<input type="checkbox"/>	<input type="checkbox"/>	
Mitral Valve Replacement	<input type="checkbox"/>	<input type="checkbox"/>	
Pacemaker Implantation	<input type="checkbox"/>	<input type="checkbox"/>	
Pacemaker Insertion	<input type="checkbox"/>	<input type="checkbox"/>	
Patent Ductus Arteriosus	<input type="checkbox"/>	<input type="checkbox"/>	
Pericardial Procedures	<input type="checkbox"/>	<input type="checkbox"/>	
Port-A-Cath Insertion	<input type="checkbox"/>	<input type="checkbox"/>	
Tetralogy of Fallot	<input type="checkbox"/>	<input type="checkbox"/>	
Vein Harvest	<input type="checkbox"/>	<input type="checkbox"/>	
Ventral Septal Defects-Repair	<input type="checkbox"/>	<input type="checkbox"/>	
Ventricular Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	
Ophthalmological			
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	
Corneal Transplant	<input type="checkbox"/>	<input type="checkbox"/>	
Dacryocystectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Dacryocystorhinostomy	<input type="checkbox"/>	<input type="checkbox"/>	
Detached Retina	<input type="checkbox"/>	<input type="checkbox"/>	
Iridectomy	<input type="checkbox"/>	<input type="checkbox"/>	

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LASIK	<input type="checkbox"/>	<input type="checkbox"/>	
Lid and Muscle Procedures	<input type="checkbox"/>	<input type="checkbox"/>	
Orbit/Globe Fractures	<input type="checkbox"/>	<input type="checkbox"/>	
Orbital Implant	<input type="checkbox"/>	<input type="checkbox"/>	
Phaco Emulsification	<input type="checkbox"/>	<input type="checkbox"/>	
Pterygium Repair	<input type="checkbox"/>	<input type="checkbox"/>	
Recession Rescetion	<input type="checkbox"/>	<input type="checkbox"/>	
Scleral Buckle	<input type="checkbox"/>	<input type="checkbox"/>	
Vitrectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Oral			
Closed Reduction Facial Fractures/Wiring	<input type="checkbox"/>	<input type="checkbox"/>	
Excision Odontoma	<input type="checkbox"/>	<input type="checkbox"/>	
Extraction fd Deciduous Teeth	<input type="checkbox"/>	<input type="checkbox"/>	
Extraction of Impacted Molars	<input type="checkbox"/>	<input type="checkbox"/>	
Fractures Jaw, Mandible, Zygoma	<input type="checkbox"/>	<input type="checkbox"/>	
LeFort Osteotomies	<input type="checkbox"/>	<input type="checkbox"/>	
Maxillary Procedure with Graft	<input type="checkbox"/>	<input type="checkbox"/>	
TMJ with Exploration/Arthroplasty	<input type="checkbox"/>	<input type="checkbox"/>	
Urology			
Circumcision	<input type="checkbox"/>	<input type="checkbox"/>	
Cystectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Cystoscopy	<input type="checkbox"/>	<input type="checkbox"/>	
Hydrocelectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Hypospadias Repair	<input type="checkbox"/>	<input type="checkbox"/>	
Implants-Penile/Testicular	<input type="checkbox"/>	<input type="checkbox"/>	
Incontinence Device Placement	<input type="checkbox"/>	<input type="checkbox"/>	
Lithotripsy	<input type="checkbox"/>	<input type="checkbox"/>	
Nephrectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Nephrolithotomy	<input type="checkbox"/>	<input type="checkbox"/>	
Orchioplexy	<input type="checkbox"/>	<input type="checkbox"/>	
Penile Prothesis	<input type="checkbox"/>	<input type="checkbox"/>	
Prostatectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Pyeloplasty	<input type="checkbox"/>	<input type="checkbox"/>	
Radical Node Dissection	<input type="checkbox"/>	<input type="checkbox"/>	
TURP	<input type="checkbox"/>	<input type="checkbox"/>	

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Ureterolithotomy	<input type="checkbox"/>	<input type="checkbox"/>	
Vasectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Vasovasostomy	<input type="checkbox"/>	<input type="checkbox"/>	
Waterhouse Procedure	<input type="checkbox"/>	<input type="checkbox"/>	
Gynecology - OB/GYN			
Abdominal Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Cesarean Section	<input type="checkbox"/>	<input type="checkbox"/>	
Colposcopy	<input type="checkbox"/>	<input type="checkbox"/>	
Dilation & Curettage	<input type="checkbox"/>	<input type="checkbox"/>	
Hysterectomy, vaginal	<input type="checkbox"/>	<input type="checkbox"/>	
Hysterectomy, abdominal	<input type="checkbox"/>	<input type="checkbox"/>	
Laparoscopy	<input type="checkbox"/>	<input type="checkbox"/>	
Marshall Marchetti	<input type="checkbox"/>	<input type="checkbox"/>	
Marsupialization Bartholin Cyst	<input type="checkbox"/>	<input type="checkbox"/>	
Ovarian Cystectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Radium Insertion	<input type="checkbox"/>	<input type="checkbox"/>	
Salpingoplasty	<input type="checkbox"/>	<input type="checkbox"/>	
Shirodkar Procedure	<input type="checkbox"/>	<input type="checkbox"/>	
Suction Currettage	<input type="checkbox"/>	<input type="checkbox"/>	
Tubal Ligation	<input type="checkbox"/>	<input type="checkbox"/>	
Vaginal Reconstruction	<input type="checkbox"/>	<input type="checkbox"/>	
Vulvectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Thoracic & Open Heart			
Bronchoscopy	<input type="checkbox"/>	<input type="checkbox"/>	
Chamberlain Procedure	<input type="checkbox"/>	<input type="checkbox"/>	
Chest Tubes	<input type="checkbox"/>	<input type="checkbox"/>	
Closed Thoractomy	<input type="checkbox"/>	<input type="checkbox"/>	
Correction Pectus Excavatum	<input type="checkbox"/>	<input type="checkbox"/>	
Esophageal Repair	<input type="checkbox"/>	<input type="checkbox"/>	
Heller Procedure	<input type="checkbox"/>	<input type="checkbox"/>	
Mediastionscopy	<input type="checkbox"/>	<input type="checkbox"/>	
Mitral Commissurotomy	<input type="checkbox"/>	<input type="checkbox"/>	
Pacemaker Implantation-Endocardial	<input type="checkbox"/>	<input type="checkbox"/>	
Pacemaker Implantation-Myocardial	<input type="checkbox"/>	<input type="checkbox"/>	
Pericardiectomy	<input type="checkbox"/>	<input type="checkbox"/>	

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Pneumonectomy/Lobectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Thoracic Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	
Thoracoplasty	<input type="checkbox"/>	<input type="checkbox"/>	
Thoractomy	<input type="checkbox"/>	<input type="checkbox"/>	
Tracheal Ressection	<input type="checkbox"/>	<input type="checkbox"/>	
Orthopedics			
Achilles Tendon Repair	<input type="checkbox"/>	<input type="checkbox"/>	
ACL Repair	<input type="checkbox"/>	<input type="checkbox"/>	
Amputation Arm/Leg	<input type="checkbox"/>	<input type="checkbox"/>	
Anterior Cruciate Ligament Repair	<input type="checkbox"/>	<input type="checkbox"/>	
Arthroscopy-Knee	<input type="checkbox"/>	<input type="checkbox"/>	
Arthroscopy-Ankle	<input type="checkbox"/>	<input type="checkbox"/>	
Arthroscopy-Elbow	<input type="checkbox"/>	<input type="checkbox"/>	
Arthroscopy-Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	
Arthrotomy	<input type="checkbox"/>	<input type="checkbox"/>	
Bipolar/Unipolar Hips	<input type="checkbox"/>	<input type="checkbox"/>	
Bunionectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Calcaneal Reconstruction	<input type="checkbox"/>	<input type="checkbox"/>	
Capsulorrhaphy	<input type="checkbox"/>	<input type="checkbox"/>	
Cast Application	<input type="checkbox"/>	<input type="checkbox"/>	
Closed Fracture Reduction	<input type="checkbox"/>	<input type="checkbox"/>	
External Fixtions	<input type="checkbox"/>	<input type="checkbox"/>	
Foot Procedure/Fractures	<input type="checkbox"/>	<input type="checkbox"/>	
Hand Surgery/Fx Repairs	<input type="checkbox"/>	<input type="checkbox"/>	
Harrington Rod Insertion	<input type="checkbox"/>	<input type="checkbox"/>	
IM Rods	<input type="checkbox"/>	<input type="checkbox"/>	
Laminectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Nailing Procedures	<input type="checkbox"/>	<input type="checkbox"/>	
ORIF-Lower Extremity	<input type="checkbox"/>	<input type="checkbox"/>	
ORIF-Upper Extermity	<input type="checkbox"/>	<input type="checkbox"/>	
Patellectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Sacro-iliac (SI) Joint Screws	<input type="checkbox"/>	<input type="checkbox"/>	
Spica Cast Application	<input type="checkbox"/>	<input type="checkbox"/>	
Spinal Fusion	<input type="checkbox"/>	<input type="checkbox"/>	
Total Hip Replacement	<input type="checkbox"/>	<input type="checkbox"/>	
Total Knee Replacement	<input type="checkbox"/>	<input type="checkbox"/>	

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Total Shoulder Replacement	<input type="checkbox"/>	<input type="checkbox"/>	_____
Equipment			
Aquamatic K Thermia Unit	<input type="checkbox"/>	<input type="checkbox"/>	_____
Argon Beam Coagular	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthroscopy Cameras	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bair Hugger	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Warmer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bovie Electrosurgical Unit	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cazrdiac Monitor-Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cell Saver	<input type="checkbox"/>	<input type="checkbox"/>	_____
Centrifuge	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cidex Sterlization	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cidex Soak	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cry-Ophthalmic Unit	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dermatone	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drills	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dual Tract Lights	<input type="checkbox"/>	<input type="checkbox"/>	_____
Electrosurgical Unit	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emerson Thoracic Pump	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ethylene Oxide Sterlizer - AMSCO	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ethylene Oxide Sterilizer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fiber Optic Lumiator	<input type="checkbox"/>	<input type="checkbox"/>	_____
Flash Autoclave-AMSCO	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fluid Pumps	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hyperthermia Unit	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kiddie Pneumatic Tourniquet	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kreiselman Resuscitator	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lasers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nerve Stimulator	<input type="checkbox"/>	<input type="checkbox"/>	_____
Operating Microscope	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pleur-e-vac Units	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shavers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stapling Equipment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Suction Unit Disposable	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vac-pac Positioner	<input type="checkbox"/>	<input type="checkbox"/>	_____

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Trauma			
Burns	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gunshot/stab wounds	<input type="checkbox"/>	<input type="checkbox"/>	_____
Motor Vehicle Accidents	<input type="checkbox"/>	<input type="checkbox"/>	_____
Traumatic Amputations	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vascular			
A -V Access Graft	<input type="checkbox"/>	<input type="checkbox"/>	_____
Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endarterectomy/Carotid-Femoral	<input type="checkbox"/>	<input type="checkbox"/>	_____
Peripheral Vascular Bypass Procedure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Resection Carotid Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thrombectomy/Embolectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vena Cava Ligation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vena Cava Filter/Umbrella	<input type="checkbox"/>	<input type="checkbox"/>	_____