



Hudson Staffing

* Denotes required field

This profile is for use by Radiology Professionals with more than one year experience in their discipline and specialty. It will not be a determining factor in your acceptance for the Hudson Staffing program.

Please enter your full legal name as it appears on your **Social Security Card**.

First name*

Email

Last name*

Please indicate your level of experience

A. Theory, no practice

C. One - two years experience

B. Intermittent experience

D. Two plus years experience

A. RADIOGRAPHY

1. Head/Skull

- a. Orbits A B C D
- b. Mandible A B C D
- c. Facial Bones A B C D
- d. Nasal Bones A B C D

2. Spine/Pelvis

- a. Cervical Spine A B C D
- b. Thoracic Spine A B C D
- c. Lumbar Spine A B C D
- d. SI Joints A B C D
- e. Scoliosis Studies A B C D

3. Abdomen

- a. Abdominal Series A B C D
- b. Erect/Decubitus Film A B C D

4. Thorax

- a. PA/Lat Chest A B C D
- b. Decubitus Chest A B C D
- c. Ribs A B C D
- d. Sternum A B C D

5. Extremities

- a. Small Extremities A B C D
- b. Large Extremities A B C D

6. Pediatric

- a. Head Work A B C D
- b. Chest/Abdomen A B C D
- c. Spine A B C D
- d. Extremities A B C D
- 7. Equipment
 - a. R & F Rooms A B C D
 - b. C-Arm A B C D
 - c. Portable Exams A B C D
 - d. Automatic Processing/Darkroom A B C D
 - e. Daylight System A B C D
 - f. Panoramix A B C D
- 8. Fluoroscopy/Special Exams
 - a. GI Tract (Upper & Lower) A B C D
 - b. Swallowing Functions A B C D
 - c. Hysterosalpingogram A B C D
 - d. Myelogram A B C D
 - e. IVP/Tomograms A B C D
 - f. Trauma Cases A B C D
 - g. Surgery (C-arm/Portable) A B C D

B. MAMMOGRAPHY

- 1. Screening Mammograms A B C D
- 2. Diagnostic Mammograms A B C D
- 3. Magnification Views A B C D
- 4. Implants A B C D
- 5. Stereotactic Biopsy A B C D
- 6. Digital A B C D
- 7. Needle Localizations A B C D

C. RADIATION THERAPY

- 1. Linear Accelerator A B C D
- 2. Linear Accelerator with Electrons A B C D
- 3. Superficial Treatment A B C D
- 4. Ortho Voltage A B C D
- 5. Hyperthermia Treatment A B C D
- 6. Cobalt 60 Therapy A B C D
- 7. Dosimetry A B C D
- 8. Treatment Planning A B C D

D. INTERVENTIONAL/SPECIALS/CARDIO

- 1. Angiography/Arteriography A B C D
- 2. Venography A B C D
- 3. Aorteriography A B C D
- 4. Cardiography A B C D
- 5. Cardiac Catheterizations

- 7. T1 Weighted Imaging A B C D
- 8. T2 Weighted Imaging A B C D
- 9. Gradient Echo Imaging A B C D

H. NUCLEAR MEDICINE

- 1. I-123 Uptake A B C D
- 2. I-131 Therapy A B C D
- 3. Bone Scan A B C D
- 4. Brachytherapy A B C D
- 5. Brain Scan A B C D
- 6. Cerebral Blood Flow A B C D
- 7. Gallium Scan A B C D
- 8. HIDA Scan A B C D
- 9. Hot Lab A B C D
- 10. Aerosol Lung Scan A B C D
- 11. Indium I-111 WBC A B C D
- 12. Liver Scan A B C D
- 13. Muga Scan A B C D
- 14. Persantine Thallium A B C D
- 15. Radio Pharmaceutical Prep A B C D
- 16. Stress Holter Monitoring A B C D
- 17. Thallium Stress Test A B C D
- 18. Thyroid Uptake A B C D
- 19. Thyroid Therapy A B C D
- 20. Thyroid Scan A B C D
- 21. RIA (Radio Immuno Assay) A B C D
- 22. VP Lung Scan A B C D
- 23. Spect Scan A B C D
- 24. NVG Rest A B C D
- 25. NVG Stress A B C D
- 26. GI Bleeding Study A B C D
- 27. Radionuclide Arteriogram A B C D
- 28. Renagrams A B C D
- 29. Renal Scan A B C D
- 30. Shillings A B C D
- 31. Spleen Scan A B C D
- 32. Testicular Studies A B C D

AGE SPECIFIC PRACTICE CRITERIA

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

- A. Newborn/Neonate (birth - 30 days)
- B. Infant (30 days - 1 year)
- C. Toddler (1 - 3 years)
- D. Preschooler (3 - 5 years)
- F. Adolescents (12 - 18 years)
- G. Young adults (18 - 39 years)
- H. Middle adults (39 - 64 years)
- I. Older adults (64+)

E. School age children (5 - 12 years)

EXPERIENCE WITH AGE GROUPS:

A B C D E F G H I

Able to adapt care to incorporate normal growth and development.

Able to adapt method and terminology of patient instructions to their age, comprehension and maturity level.

Can ensure a safe environment reflecting specific needs of various age groups incorporating ALARA.

Please list any other exam experience not listed previously:

_____ 

Certification:

Please check the boxes 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., 08/31/2003).

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> BCLS | Exp. date: _____ | (mm/dd/yyyy) | |
| <input type="checkbox"/> ARRT | <input type="checkbox"/> Radiography | <input type="checkbox"/> Mammography | |
| <input type="checkbox"/> Fluoroscopy | <input type="checkbox"/> Interventional | <input type="checkbox"/> MRI | |
| <input type="checkbox"/> CT | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> ARDMS (Sonography) | |
| <input type="checkbox"/> NMTCB (Nuclear Medicine) | | <input type="checkbox"/> Management Experience | |
| <input type="checkbox"/> Certification eligible for any of the above: | | | |
| <input type="checkbox"/> Cross-trained in: | | | |

Years of Experience:

- | | | |
|---|-------|---------------|
| <input type="checkbox"/> Outpatient | _____ | year(s) |
| <input type="checkbox"/> Small Hospital | _____ | year(s) |
| <input type="checkbox"/> Large Hospital | _____ | year(s) |
| <input type="checkbox"/> Other | _____ | _____ year(s) |

Most Recent Experience:

- Outpatient Small Hospital Regional Larger Facility

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 the Company to release this Radiology Checklist to the Client facilities in relation to consideration of employment as a Traveler with those facilities.