



Hudson Staffing

* Denotes required field

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

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

First name*

Last name*

Email

Please indicate your level of experience

A. Theory, no practice

C. One - two years experience

B. Intermittent experience

D. Two plus years experience

A. TREATMENTS/PROCEDURES

1. Assessment

a. Breath sounds

A B C D

b. Peak flow rate

A B C D

c. Pulmonary function testing

A B C D

d. Rate and work of breathing

A B C D

e. Transcutaneous monitoring

A B C D

2. Interpretation of lab results

a. Arterial blood gases

A B C D

b. Basic EKG

A B C D

c. Blood chemistry

A B C D

d. Chest x-ray

A B C D

3. Equipment & procedures

a. Airway management devices/suctioning

- (1) Check intracuff pressure A B C D
- (2) Endotracheal tube/suctioning A B C D
- (3) Nasal airway placement A B C D
- (4) Nasal airway/suctioning A B C D
- (5) Oral airway placement A B C D
- (6) Oropharyngeal/suctioning A B C D
- (7) Sputum specimen collection A B C D
- (8) Tracheostomy/suctioning A B C D
- b. Analyze oxygen A B C D
- c. Arterial line insertion A B C D
- d. Care of the patient with a chest tube
 - (1) Assessment of function/proper operation A B C D
 - (2) Placement assistance A B C D
- e. Chest physiotherapy A B C D
- f. Drawing arterial blood gases
 - (1) Arterial line A B C D
 - (2) Brachial artery A B C D
 - (3) Femoral artery A B C D
 - (4) Radial artery/Allen tests A B C D
- g. Extubate A B C D
- h. Extubation assistance A B C D
- i. Hemodynamic monitoring A B C D
- j. Incentive spirometry A B C D
- k. Infection control practices A B C D
- A B C D

- l. Intubate
- m. Intubation assistance A B C D
- n. Medication delivery systems
- (1) Aerosol heated/cool A B C D
- (2) Aerosol set up-mask A B C D
- (3) Aerosol set up-trach A B C D
- (4) IPPB A B C D
- (5) Medihaler A B C D
- (6) Metered dose inhalers A B C D
- o. O₂
- (1) Bag and mask A B C D
- (2) ET tube A B C D
- (3) External CPAP A B C D
- (4) Face masks A B C D
- (5) Nasal cannula A B C D
- (6) Nebulizer
- a. Cold A B C D
- b. Hand held A B C D
- c. Heated A B C D
- d. Ultrasonic A B C D
- (7) O₂ A B C D
- (8) T-piece A B C D
- (9) Trach collar A B C D
- p. Thoracentesis assistance A B C D
- q. Ventilator set up and care
- (1) Assist/control A B C D

- (2) CPAP A B C D
- (3) Flow-by A B C D
- (4) High frequency jet ventilator A B C D
- (5) High frequency oscillator A B C D
- (6) IMV A B C D
- (7) Inverse ratio ventilator A B C D
- (8) Pressure support A B C D
- (9) Pressure vents A B C D
- (10) SIMV A B C D
- (11) Trouble shooting high pressure alarms A B C D
- (12) Trouble shooting low pressure alarms A B C D
- (13) Volume vents A B C D
- (14) Weaning A B C D

B. CARE OF THE PATIENT WITH:

- a. Acute/chronic bronchitis A B C D
- b. ARDS (adult respiratory distress syndrome) A B C D
- c. Aspiration A B C D
- d. Asthma A B C D
- e. Bronchoscopy A B C D
- f. Cardiac surgery A B C D
- g. CHF A B C D
- h. COPD A B C D
- i. Cystic fibrosis A B C D
- j. Epiglottitis A B C D
- k. Fresh tracheostomy A B C D
- l. Gullian Barre A B C D
- m. Hemopneumothorax A B C D
- n. Laryngospasm A B C D
- o. Myasthenia A B C D
- p. Pneumonia A B C D
- q. Pulmonary edema A B C D
- r. Pulmonary embolism A B C D

- s. Smoke inhalation A B C D
- t. Status asthmaticus A B C D
- u. Tension pneumothorax A B C D
- v. Thoracotomy A B C D
- w. Tracheo-esophageal fistula A B C D
- x. Tuberculosis A B C D

C. MEDICATIONS

1. Administration of:
 - a. Aerobid, Vanceryl A B C D
 - b. Aminophylline (Theophylline) A B C D
 - c. Azmacort A B C D
 - d. Bicarbonate A B C D
 - e. Combivent A B C D
 - f. Cromolyn Sodium (Intal) A B C D
 - g. Decadron A B C D
 - h. Flonase A B C D
 - i. Flovent A B C D
 - j. Inhaled steroids A B C D
 - k. Ipratropium bromide (Atrovent) A B C D
 - l. Isoetharine (Bronkosol) A B C D
 - m. Isoproterenol (Isuprel) A B C D
 - n. Metaproterenol (Alupent) A B C D
 - o. Mucomyst A B C D
 - p. Nasalcort A B C D
 - q. Racemic epinephrine A B C D
 - r. Salbutamol (Albuterol, Proventil, Ventolin) A B C D
 - s. Terbutaline sulfate (Bricanyl) A B C D
2. Familiar with effects of:
 - a. Anectine A B C D
 - b. Atropine A B C D
 - c. Corticosteroids A B C D
 - d. Digitalis A B C D
 - e. Digoxin A B C D
 - f. Dopamine A B C D
 - g. Duramorph A B C D
 - h. Heli/ox therapy A B C D
 - i. Ketamine A B C D
 - j. Lidocaine A B C D
 - k. Morphine sulfate A B C D
 - l. Nipride A B C D
 - m. Nitric oxide therapy A B C D
 - n. Pavulon A B C D
 - o. Pentamidine isethionate A B C D
 - p. Propofol A B C D

Experience with the following ventilators:

<input type="checkbox"/> Bear		Series (name or number)
<input type="checkbox"/> Bird		Series (name or number)
<input type="checkbox"/> BP		Series (name or number)
<input type="checkbox"/> Hamilton Amadeus, Veolar		Series (name or number)
<input type="checkbox"/> MA		Series (name or number)
<input type="checkbox"/> Newport		Series (name or number)
<input type="checkbox"/> Sechrist		Series (name or number)
<input type="checkbox"/> Servo		Series (name or number)
<input type="checkbox"/> Drager Infant		
<input type="checkbox"/> Emerson		
<input type="checkbox"/> Engstrom		
<input type="checkbox"/> Puritian Bennett 7200		
<input type="checkbox"/> Others, List		

My experience is primarily in: (Please indicate number of years.)

<input type="checkbox"/> General adult inpatient		_____ year(s)	<input type="checkbox"/> Pediatrics		_____ year(s)
<input type="checkbox"/> Home care		_____ year(s)	<input type="checkbox"/> Pulmonary rehab		_____ year(s)
<input type="checkbox"/> Intensive care unit		_____ year(s)	<input type="checkbox"/> Sleep lab		_____ year(s)
<input type="checkbox"/> Long term care		_____ year(s)	<input type="checkbox"/> Subacute		_____ year(s)
<input type="checkbox"/> Neonatal ICU		_____ year(s)	Level _____		

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"/> PALS	Exp. date:	_____	(mm/dd/yyyy)
<input type="checkbox"/> EKG technician	Date:	_____	(mm/dd/yyyy)
<input type="checkbox"/> EEG technician	Date:	_____	(mm/dd/yyyy)
<input type="checkbox"/> ACLS	Exp. date:	_____	(mm/dd/yyyy)
<input type="checkbox"/> NRP	Exp. date:	_____	(mm/dd/yyyy)
<input type="checkbox"/> RRT	Date:	_____	(mm/dd/yyyy)
<input type="checkbox"/> CRTT	Date:	_____	(mm/dd/yyyy)
<input type="checkbox"/> Arterial blood gas technician	Exp. date:	_____	(mm/dd/yyyy)
<input type="checkbox"/> Other (type): _____	Exp. date:	_____	(mm/dd/yyyy)
<input type="checkbox"/> Computerized charting system: _____	Exp. date:	_____	(mm/dd/yyyy)

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 Respiratory Therapy Checklist to the Client facilities in relation to consideration of employment as a Traveler with those facilities.