

Nurse, Nancy Great

Registered Nurse

OR-CVOR General Surgery

Fields marked with a red asterisk (\*) are required.

Personal Information: Personal Information

317226

Candidate #

Nancy

\*First Name

Great

Middle Name

Nurse

\*Last Name

Registered Nurse

\*Discipline / Professional License / Certification

OR-CVOR General Surgery

\*Specialty - Primary

Specialty - Secondary (Optional)

YourName@Sample.com

\*Email Address

(123) 456-7890

\*Phone Number

Either

\*Preferred Contact Method

01/08/1975

\*Birthdate (MMDDYYYY)

123-45-7896

Social Security Number

Upload

UPLOAD YOUR RESUME (Optional) Click the "Upload" button to browse and upload your resume - .pdf, .doc, or .docx files only.

Yes

\*Experienced Healthcare Traveler?

Banner Ad

\*How did you hear about us?

7 - 10 Years

\*How long have you had your License/Certification?

1234 Any Street

\*Present Address - Street

Any City

Apt #

\*City

Arizona

\*State

12345

\*Zip Code

No

\*Is this a Travel Assignment Address?

Yes

Permanent Address same as above?

Permanent Address - Street

Apt #

City

State

Zip Code

Personal Information: Additional Information

No

\*Has your license / certification ever been investigated, suspended or revoked?

If yes, please explain

No

\*In the last 7 years, convicted of a felony?

If yes, please explain

Yes

\*Can you provide proof of eligibility to work in the United States?

Yes

\*Are you a United States Citizen?

If NO, please provide Visa type

If NOT a US Citizen have you passed US Certification or NCLEX?

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Personal Information: Work Preferences

Travel

Either Shift

ALL STATES

\*What type of assignments are you interested in?

\*Preferred Shifts?

\*I am interested in learning about opportunities in

Check "State(s)" that you are interested in [checked] AL [checked] AK [checked] AZ [checked] AR [checked] CA [checked] CO [checked] CT [checked] DE [checked] DC [checked] FL [checked] GA [checked] HI [checked] ID [checked] IL [checked] IN [checked] IA [checked] KS [checked] KY [checked] LA [checked] ME [checked] MD [checked] MA [checked] MI [checked] MN [checked] MS [checked] MO [checked] MT [checked] NE [checked] NV [checked] NH [checked] NJ [checked] NM [checked] NY [checked] NC [checked] ND [checked] OH [checked] OK [checked] OR [checked] PA [checked] RI [checked] SC [checked] SD [checked] TN [checked] TX [checked] UT [checked] VT [checked] VA [checked] WA [checked] WV [checked] WI [checked] WY

I would also be interested in opportunities [checked] Caribbean Assignments [unchecked] International Assignments

No

\*Are you presently on a Travel Assignment?

Which Facility?

State?

Assignment Completion Date

ASAP

\*When are you interested in starting an assignment?

Yes

\*Do you take a vehicle on assignment?

No

Do you travel with family / friends on assignment?

Yes

Do you travel with pet(s) on assignment?

English Bull Dog

If so, please specify pet type / breed

50 lbs

If so, please specify pet's weight

Personal Information: Emergency Contacts

Significant Other

\*Emergency Contact Name

(123) 456-7890

\*Emergency Contact Phone

Emergency Contact Relationship

License and Certifications: Professional License

Arizona

\*My Primary Professional License is

I also have an "Active" license / certification in [unchecked] AL [unchecked] AK [unchecked] AZ [unchecked] AR [unchecked] CA [unchecked] CO [unchecked] CT [unchecked] DE [unchecked] DC [checked] FL [checked] GA [unchecked] HI [unchecked] ID [unchecked] IL [unchecked] IN [unchecked] IA [unchecked] KS [unchecked] KY [unchecked] LA [unchecked] ME [unchecked] MD [unchecked] MA [unchecked] MI [unchecked] MN [unchecked] MS [unchecked] MO [unchecked] MT [unchecked] NE [unchecked] NV [unchecked] NH [unchecked] NJ [unchecked] NM [unchecked] NY [unchecked] NC [unchecked] ND [unchecked] OH [unchecked] OK [unchecked] OR [unchecked] PA [unchecked] RI [unchecked] SC [unchecked] SD [unchecked] TN [unchecked] TX [unchecked] UT [unchecked] VT [unchecked] VA [checked] WA [unchecked] WV [unchecked] WI [unchecked] WY

License and Certifications: CPR Certifications

Yes

\*I presently have a valid active CPR Certification?

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### License and Certifications: Advanced Certifications

I have Advanced Certifications in ACLS CNOR PALS NALS \_\_\_\_\_

### Education History: Add Education Record

|  |   |  |                     |
|--|---|--|---------------------|
| <u>Great High School</u><br>*School Name | <u>Diploma</u><br>Degree                  | <u>Florida</u><br>School Location            |                     |
| <u>06/03/1991</u><br>Graduation Date     | <u>General Studies</u><br>Course of Study | <a href="#">Add Another Education Record</a> | <a href="#">Del</a> |
| <u>Florida State</u><br>*School Name     | <u>BSN</u><br>Degree                      | <u>Florida</u><br>School Location            |                     |
| <u>06/14/1996</u><br>Graduation Date     | <u>Nursing</u><br>Course of Study         | <a href="#">Add Another Education Record</a> | <a href="#">Del</a> |

### Employer History: Add Employer

|   |  |  |  |
|---|--|--|--|
| <u>University Medical Center</u><br>*Employer Name  | <u>Yes</u><br>*May we contact this employer?           | <u>No</u><br>*Was this a Travel Assignment?  |  |
| <u>01/15/1992</u><br>*Start Date  | <u>01/15/2014</u><br>*End Date                         | <u>Surgery Nurse</u><br>*Position            | <u>CVOR / General Surgery</u><br>*Specialty / Unit |
| <u>123 Any Street</u><br>*Address   | <u>Any City</u><br>*City                               | <u>Arizona</u><br>*State                     |  |
| <u>Jane Doe Nurse</u><br>*Supervisor  | <u>Director Surgical Services</u><br>Supervisors Title | <u>(123) 456-7890</u><br>Supervisors Phone # |  |
| <u>Wanted to experience other places and clinical settings. Starting Travel Assignment</u><br>*Reason for Leaving |  |  |  |
| <u>Circulator &amp; Scrub Nurse on CVOR and General Surgery Cases</u><br>*Brief description of duties preformed   |  |  |  |

[Add Another Employer](#)

### Professional References: Add Professional Reference

|  |   |
|--|---|
| <u>Professional Acquaintance</u><br>Reference Name | <u>Acquaintance@Test.com</u><br>Reference Email |
|--|---|

Nurse, Nancy Great

Registered Nurse

OR-CVOR General Surgery

Friend

(123) 456-7890

Reference Title

Reference Phone

Facility

Unit

Address

City

State

Facility Phone

Facility Fax

[Add Another Reference](#)

Using the scale(s) below, please complete the following skill self assessment based upon your experience within the last 2 years.

Circulate: [1] None [2] Intermittent [3] Experienced [4] Supervise / Teach

Scrub: [1] None [2] Intermittent [3] Experienced [4] Supervise / Teach

**Cardiovascular Surgery**

|                                | Circulate                           |                                     |                          |                                     | Scrub                               |                                     |                                     |                                     |
|--------------------------------|-------------------------------------|-------------------------------------|--------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
|                                | 1                                   | 2                                   | 3                        | 4                                   | 1                                   | 2                                   | 3                                   | 4                                   |
| Adult Hearts                   | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Pediatric Hearts               | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| Chamberlin Procedure           | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Tetralogy of Fallot            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Heart Transplant               | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Heart / Lung Transplant        | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Mechanical Heart               | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Left Ventricular Assist (LVAD) | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| CABG (On-Pump)                 | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| CABG (Off-Pump)                | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Heartport CABG                 | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| de Vinci Robotic Surgery       | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| Mid-CABG                       | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Bring Back Hearts              | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Pericardial Widow              | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Septal Defects                 | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Mitral Valve Replacement       | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Aortic Valve Replacement       | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Multiple Valve Transposition   | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Aortic Valve Conduit           | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Ascending Aortic Repair        | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Descending Aortic Repair       | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Femoral Artery Cannulation     | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Intra-Aortic Balloon Insertion | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| AICD Insertion                 | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Pacemaker Insertion            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Abdominal Aortic Aneurysm      | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Femoral-Popliteal Bypass Graft | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Endoscopic Vein Harvest        | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Carotid Endarterectomy         | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Radial Artery Harvest          | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Gastric Artery Harvest         | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |

**Cardiovascular Surgery Continued**

|                               | Circulate                |                          |                          |                                     | Scrub                    |                          |                          |                                     |
|-------------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|
|                               | 1                        | 2                        | 3                        | 4                                   | 1                        | 2                        | 3                        | 4                                   |
| Saphenous Vein Harvest        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Arterial Stenting             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Insertion Vena Cava Filter    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Intra-Operative Angioplasty   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Intra-Operative Angiogram     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Insertion Portacath / Hickman | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| A/V Shunts                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

**Thoracic Surgery**

|                           |                          |                          |                          |                                     |                          |                          |                          |                                     |
|---------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|
| Thoracotomy               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Thoracoscopy              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Pneumonectomy / Lobectomy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Insertion Chest Tubes     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Mediastinoscopy           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Esophageal Repair         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Rib Resection             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Biopsies                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

**General Surgery**

|  |                          |                          |                          |                                     |                          |                          |                          |                                     |
|--|--------------------------|--------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|
| Abdominal Perineal Resection                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Adrenalectomy                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Appendectomy                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Bowel Resection                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Breast Biopsy                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Cholecystectomy - Laparoscopic                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Cholecystectomy - Open                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Colostomy / Ileostomy                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Exploratory Laparotomy                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Fissurectomy                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Gastrectomy                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Gastroplasty                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Hepatic Resection                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Herniorrhaphy - Femoral, Inguinal<br>Umbilical | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

Using the scale(s) below, please complete the following skill self assessment based upon your experience within the last 2 years.

Circulate: [1] None [2] Intermittent [3] Experienced [4] Supervise / Teach

Scrub: [1] None [2] Intermittent [3] Experienced [4] Supervise / Teach

**General Surgery Continued**

|                         | Circulate                |                          |                          |                                     | Scrub                    |                          |                          |                                     |
|-------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|
|                         | 1                        | 2                        | 3                        | 4                                   | 1                        | 2                        | 3                        | 4                                   |
| Hickman / Groshong      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Hydocelectomy           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Lumbar Sympathectomy    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Pancreatectomy          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Pilonidal Cystectomy    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Pyloric Stenosis        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Saphenous Vein Ligation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Splenectomy             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Thyroidectomy           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Triple A                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Vagotomy                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Colectomy               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Esophagoscopy           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Feeding Tube Placement  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Hemorrhoidectomy        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Mastectomy              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Nephrectomy             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Pancreatectomy          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Pilonidal Cystectomy    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Portal Cava Shunt       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Rectal Cases            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Whipple                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

**Neurology**

|                             |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |
|-----------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| A-V Malformation            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Aneurysm                    | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Anterior Cervical Fusion    | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| Anterior Laparoscopic Spine | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Burr Holes                  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Carotid Ligation            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Cerebral Hemorrhage         | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Cervical Sympathectomy      | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Clipping of Aneurysm        | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |

**Neurology Continued**

|                               | Circulate                |                                     |                                     |                                     | Scrub                    |                                     |                          |                          |
|-------------------------------|--------------------------|-------------------------------------|-------------------------------------|-------------------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|
|                               | 1                        | 2                                   | 3                                   | 4                                   | 1                        | 2                                   | 3                        | 4                        |
| Craniectomy for Decompression | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cranioplasty / Craniotomy     | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Discectomy                    | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Head Trauma                   | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hypophysectomy                | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Laminectomy                   | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pedicle Screw Insertion       | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Shunt Procedure VP, VA, LP    | <input type="checkbox"/> | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tumor Resection               | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ulnar Nerve Transfer          | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ventriculostomy               | <input type="checkbox"/> | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Orthopedic**

|                             |                          |                          |                          |                                     |                          |                          |                          |                                     |
|-----------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|
| ACL Repair                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Amputation Arm / Leg        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Arthroscopy - Ankle         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Arthroscopy - Elbow         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Arthroscopy - Knee          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Total Hip Replacement       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Total Knee Replacement      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Total Shoulder Replacement  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| External Fixation           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Foot Procedures / Fractures | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Hand Procedures / Fractures | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Harrington Rod Insertion    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| I M Rod Insertion           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Nailing Procedures          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| ORIF - Upper Extremities    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| ORIF - Upper Extremities    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

**Trauma**

|                          |                          |                          |                          |                                     |                          |                          |                          |                                     |
|--------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|
| Blunt Traumatic Injuries | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Multiple Injuries        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Penetrating Injuries     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

Using the scale(s) below, please complete the following skill self assessment based upon your experience within the last 2 years.

Circulate: [1] None [2] Intermittent [3] Experienced [4] Supervise / Teach

Scrub: [1] None [2] Intermittent [3] Experienced [4] Supervise / Teach

**Genitourinary**

|                   | Circulate                |                          |                          |                                     | Scrub                    |                          |                          |                                     |
|-------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|
|                   | 1                        | 2                        | 3                        | 4                                   | 1                        | 2                        | 3                        | 4                                   |
| Cystectomy        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Cystoscopy        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Ilea loop         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Kidney Transplant | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Nephrectomy       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Nephrolithotomy   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Prostatectomy     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| T.U.R.P.          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

**OB / GYN**

|                              | Circulate                |                          |                          |                                     | Scrub                    |                          |                          |                                     |
|------------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|
|                              | 1                        | 2                        | 3                        | 4                                   | 1                        | 2                        | 3                        | 4                                   |
| A&P Reconstruction           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| C-Sentions                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| D&C                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Ectopic Pregnancy            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Laparoscopic Procedures      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Ovarian Cyst                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Total Abdominal Hysterectomy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Tubal Ligation               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Vaginal Hysterectomy         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

**Plastic / Reconstructive**

|                           | Circulate                |                          |                                     |                          | Scrub                    |                          |                          |                                     |
|---------------------------|--------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|
|                           | 1                        | 2                        | 3                                   | 4                        | 1                        | 2                        | 3                        | 4                                   |
| Abdominoplasty            | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Blepharoplasty            | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Cleft Lip / Palate Repair | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Dermabrasion              | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Face Lift                 | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Liposuction               | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Mammoplasty               | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Otoplasty                 | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Pedicle Grafts            | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Rhinoplasty               | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Scar Revisions            | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Skin Grafts               | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |

**Endoscopy**

|              | Circulate                |                          |                          |                                     | Scrub                    |                          |                          |                                     |
|--------------|--------------------------|--------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|
|              | 1                        | 2                        | 3                        | 4                                   | 1                        | 2                        | 3                        | 4                                   |
| Bronchoscopy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Colonoscopy  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Gastrosocopy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

**Oral**

|                                   | Circulate                |                          |                          |                                     | Scrub                    |                          |                          |                                     |
|-----------------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|
|                                   | 1                        | 2                        | 3                        | 4                                   | 1                        | 2                        | 3                        | 4                                   |
| Closed Reduction Facial Fractures | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Excision Odontoma                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Fractured Jaws, Mandibular        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| LeFort Osteotomies                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Sagittal Osteotomy                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| TMJ Exploration                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Temporomandibular                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

**Pediatrics**

|               | Circulate                |                          |                          |                                     | Scrub                    |                          |                          |                                     |
|---------------|--------------------------|--------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|
|               | 1                        | 2                        | 3                        | 4                                   | 1                        | 2                        | 3                        | 4                                   |
| Hernias       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Pyloromyotomy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Thoracotomy   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

**Equipment**

|                       | Circulate                |                          |                          |                                     | Scrub                    |                          |                          |                                     |
|-----------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|
|                       | 1                        | 2                        | 3                        | 4                                   | 1                        | 2                        | 3                        | 4                                   |
| Argon Beam Coagulator | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Zimmer Dermatome      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Stryker Drills        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Brown Dermatome       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Cell Saver            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Emerson Thoracic Pump | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Fracture Table        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Pneumatic Tourniquet  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Laser                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Ohio Suction Units    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Electrosurgical Unit  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |



Nurse, Nancy Great

Registered Nurse

OR-CVOR General Surgery

### Electronic Signature: Application Signature



\*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 General Application to the Client Agencies in relation to consideration of employment with those Agencies.