

Surgical Technologists Skills Checklist

First Name

Last Name

Social Security number

Date

Email

Please indicate your level of experience (0, 1, 2, or 3)

0 = Theory, no practice 1 = Limited 2 = Confident 3 = Very Confident

A. EAR, NOSE & THROAT

Caldwell – Luc	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Laryngectomy	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Cleft lip/palate repair	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Radical neck dissection	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

B. GENERAL SURGERY

Bronchoscopy	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Appendectomy	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Laparoscopic Appendectomy	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Cholecystectomy	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Laparoscopic Cholecystectomy	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Hernia Repair	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Laparoscopic Hernia Repair	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Colon Resection	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Rectal Surgery	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Splenectomy	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Thyroidectomy	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Whipple Procedure	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Abdominal Perineal Resection	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

C. GYNECOLOGY

Hysterectomy, abdominal	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Hysterectomy, vaginal	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Tuba ligation	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Tuboplasty	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Anterior posterior repair	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

D. NEUROLOGY

Craniotomy for Tumor	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Craniotomy for Aneurysm	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Ventricular Peritoneal Shunt	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Lumbar Laminectomy	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Cervical Laminectomy	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Posterior Sitting Laminectomy	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Transsphenoidal Hypophysectomy	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

Ulnar Nerve Transposition 0 1 2 3

E. OPHTHALMOLOGY

Cataract extraction with IOL 0 1 2 3

Corneal transplant 0 1 2 3

Scleral Buckling 0 1 2 3

F. ORTHOPEDICS

Ankle Surgery 0 1 2 3

Hand Surgery 0 1 2 3

Micro Hand Surgery 0 1 2 3

Hip Prosthesis 0 1 2 3

Knowles Pinning 0 1 2 3

Knee Surgery 0 1 2 3

Shoulder Surgery 0 1 2 3

Total Knee Surgery 0 1 2 3

Total Shoulder Replacement 0 1 2 3

Richards Hip 0 1 2 3

G. PLASTICS

Augmentation Mammoplasty 0 1 2 3

Rhinoplasty 0 1 2 3

Face Lift 0 1 2 3

Skin Graft 0 1 2 3

Breast Reconstruction 0 1 2 3

Breast Reduction 0 1 2 3

H. THORACIC & OPEN HEART

Open Heart By-Pass 0 1 2 3

Open heart Valve Replacement 0 1 2 3

Aortic Aneurism Repair 0 1 2 3

Thoracotomy 0 1 2 3

Lung Resection 0 1 2 3

Pneumonectomy 0 1 2 3

I. UROLOGY

Open Heart By-Pass 0 1 2 3

Open heart Valve Replacement 0 1 2 3

Aortic Anurisym Repair 0 1 2 3

Thoracotomy 0 1 2 3

Lung Resection 0 1 2 3

Pneumonectomy 0 1 2 3

Open Heart By-Pass 0 1 2 3

Open heart Valve Replacement 0 1 2 3

Aortic Anurisym Repair 0 1 2 3

J.VASCULAR

A-V access graft 0 1 2 3

Carotid Endarterectomy 0 1 2 3

Peripheral vascular bypass procedures 0 1 2 3

Thrombectomy/embolectomy 0 1 2 3

Vena cava filter/umbrella 0 1 2 3

K.EQUIPMENT

Argon beam coagulator	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>
Bair Hugger	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>
Blood/fluid warmer	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>
Cell saver	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>
Use of Cavitron machine	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>
Lasers	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>
Pleur-evac disposable chest drainage	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>
Steri-vac aeration cabinet, 3-M, portable	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>
Steris unit	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>
Suction unit, disposable	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>
Washer sanitizer – AMSCO	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>
Washer sterilizer – AMSCO	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>

AGE SPECIFIC CRITERIA

Please check the box corresponding to each age group for which you have expertise in providing age-appropriate nursing care.

- Pediatric (1-12years)
- Adolescents (12 - 18 years)
- Adult (18-65 years)
- Older Adult (Older than 65years)

EXPERIENCE WITH AGE GROUPS

1. Calculate body weight to verify correct dosing of medication	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>
2. Assess immunization status for pediatric, and adolescent	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>
3. Set age-appropriate short-term and long-term goals in care planning	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>
4. Provide age-appropriate education, considering possible vision and hearing impairment for Older than 65years.	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>

Certification: (mo/day/yr)

-
- BCLS Completion Date: _____
 - ACLS Completion Date: _____
 - Other (type): _____ Completion Date: _____
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The information I have given is true and accurate to the best of my knowledge. I hereby authorize Professional Nursing, Inc. to release this Surgical Technologist Skills Checklist to Client facilities of Professional Nursing, Inc. in consideration of my assignment to work at those facilities.

Signature

Date