



OPERATING ROOM SKILLS CHECKLIST

- 1 = No Experience
- 2 = Perform infrequently (would require some supervision)
- 3 = Able to perform without any supervision

Name: _____

Date: _____

	1	2	3
1. GYNECOLOGICAL			
a. D & C			
b. Laparoscopy			
c. TAH/BSO			
d. Vag. Hyst			
e. Tubal Reanastomosis			
2. GENERAL SURGERY			
a. Br. Bx/Mastectomy			
b. Herniorraphy			
c. Cholecystectomy			
d. Bowel Resection			
e. A & P Resection			
f. Pediatric			
g. Auto Staples			
3. UROLOGICAL			
a. Cystoscopy/TURP			
b. Prostatectomy			
c. Cystectomy			
d. Penile Prosthesis			
4. CARDIO-THORACIC			
a. Thoracotomy			
b. Pacemaker Implant			
5. PLASTIC/RECONSTRUCTIVE			
a. Blepharoplasty			
b. Rytidectomy			
c. Skin Graft			
d. Mammoplasty			
e. Rhinoplasty			
f. Cleft Lip/Palate			

	1	2	3
6. ARTERIO-VASCULAR			
a. Carotid Endarterectomy			
b. A-V Fistula			
c. Porto-Caval Shunts			
d. Vein Ligation/Stripping			
e. Aorta Femoral			
f. Fem. Pop.			
g. Amputation			
7. NEUROSURGICAL			
a. Laminectomy			
1. Lumbar			
2. Thoracic			
3. Ant. Cervical			
b. Shunts: VP, VA, LP			
c. Burr Holes			
d. Craniotomy			
e. Carpal Tunnel			
f. Micro-Surgery			
8. ORTHOPEDICS			
a. Ofb.			
b. Podiatry			
c. Total Joint Replacement			
1. Hip			
2. Knee			
d. Plating & Rod			
e. Hand Surgery			
f. Arthroscopy			
1. Knee			
2. Shoulder			

OPERATING ROOM SKILLS CHECKLIST

	1	2	3
3. Wrist			
g. External Fixation			
9. EAR/NOSE/THROAT			
a. T & A			
b. SMR			
c. Radical Neck			
d. TMU			
e. Sinus Endoscopy			
f. Maxillofacial			
10. OPHTHALMOLOGY			
a. Retinal Detachment			
b. Scleral Buckle			
c. Cataract with IOL			
11. ENDOSCOPIC			
a. Bronchi/Esophogoscopy			
b. Gastroscopy			
12. MISCELLANEOUS			
a. Cell Saver			
13. EMERGENCY PROCEDURES			
a. CPR			
b. Defibrillation			
c. Ambu Bag			

NUMBER OF YEARS EXPERIENCE:

OR _____

CERTIFICATIONS:

CPR _____ EXP DATE: _____

ACLS _____ EXP DATE: _____

OTHERS _____ EXP DATE: _____

The information I have given is true and accurate to the best of my knowledge. I hereby authorize Premier Nursing Service to release this list to its client health care facilities.

Signature Date

Authentication By Agency:

DON Signature Date