

Respiratory Therapy Skills Checklist

Name: Date: Experience Since:

	Comfortable With	Done Occasionally	No Experience
Intensive Care Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neo-natal Intensive Care Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pediatric Intensive Care Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Care Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post Anesthesia Care Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical/Surgical Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency Room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oxygen Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arterial Blood Gases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extubate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aerosol Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest Physiotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trach Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patient Teaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metered Dose Inhalers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bedside Pulmonary Function Screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Ventilators: (Please list types proficient with)

1:

2:

3:

Signature

Date

Agency Representative Signature

Date