

**MEDICAL ONCOLOGY
CLINICAL CAPABILITIES**

IDENTIFYING INFORMATION

Last Name	First Name	Middle Initial	Previous Name(s)
Social Security Number			Date of Birth

CERTIFICATIONS

<input type="checkbox"/> BLS expires: _____	<input type="checkbox"/> ACLS expires: _____
---	--

SCOPE OF PRACTICE

<p><u>General Internal Medicine</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Diagnosis and management of common outpatient medical problems <input type="checkbox"/> Independent care of all uncomplicated inpatient medical problems <input type="checkbox"/> Care of seriously ill patients with multi-symptom disease, usually requiring ICU/CCU care (ICU/CCU privileges required) <p><u>Medical Oncology</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> General outpatient oncology <input type="checkbox"/> General outpatient hematology <input type="checkbox"/> Malignant <input type="checkbox"/> Non-malignant <input type="checkbox"/> General inpatient oncology <input type="checkbox"/> General inpatient hematology <p><u>Procedures</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Fine needle aspiration biopsy <input type="checkbox"/> Bone marrow biopsy and aspiration <input type="checkbox"/> Intrathecal chemotherapy <input type="checkbox"/> Intrapleural or peritoneal chemotherapy <input type="checkbox"/> Special catheter management/insertion <input type="checkbox"/> Solid tumor experience <input type="checkbox"/> Other: _____ <p><u>Additional</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Member of hospital tumor board <input type="checkbox"/> Blood bank supervisor <input type="checkbox"/> Blood bank advisor 	<p><u>EM</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Management and treatment of medical emergencies including: cardiac arrest, acute CHF, respiratory failure, acute GI bleeding, DKA <p><u>Other</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Pediatric Oncology <input type="checkbox"/> Surgical Oncology <input type="checkbox"/> Gynecological Oncology <input type="checkbox"/> Head and Neck Oncology <input type="checkbox"/> GI Oncology <input type="checkbox"/> GU Oncology <input type="checkbox"/> Thoracic Oncology <input type="checkbox"/> Bone marrow transplant <input type="checkbox"/> Other _____ <p><u>Administration of chemotherapy preferred</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Self <input type="checkbox"/> Nurse oncologist <input type="checkbox"/> Other: _____
---	---

Please list any limitations or comments you may have on a separate sheet.

I affirm that all information given on this page is true and accurate. Initials _____ Date _____