

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**HOW FREQUENTLY DO YOU PERFORM THE FOLLOWING SKILLS?** Check the appropriate box.

Skill	Never	Daily	Weekly	Monthly
IV line insertion large bore catheters (≥18ga)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arterial line setup/monitoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Central venous pressure line setup/monitoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac output, SVR & PVR calculations/monitoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac arrhythmia monitoring/interpretation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Code Blue leader	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Monitor during conscious sedation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**HOW FREQUENTLY DO YOU ADMINISTER THE FOLLOWING PHARMACOLOGIC AGENTS?** Check the appropriate box.

Agent	Never	Daily	Weekly	Monthly
Dopamine infusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dobutamine infusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nitroglycerine infusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nitroprusside infusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Levaphed infusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epinephrine infusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heparin infusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Propofol infusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neuromuscular blocking agents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sedative infusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**TELL US ABOUT YOUR WORK EXPERIENCE.** Circle the appropriate response.

How many beds are in the unit where you currently work?	1 – 5 beds	5 – 10 beds	11 or more beds			
Approximately how many hours per week are you working in your current critical care unit?	Less than 32 hours	33 – 40 hours	More than 40 hours			
How many beds are in the hospital where you currently work?	1 – 50 beds	51 – 100 beds	101 – 150 beds	151 – 200 beds	201 – 250 beds	More than 250 beds
Characterize your hospital.	Rural	Suburban	Urban			
Please specify the type of unit where you currently work:	_____					
How long have you worked in this unit? Circle the most appropriate time frame.	Less than 12 months	12 – 18 months	18 – 24 months	24 – 36 months	More than 36 months	
How many years have you worked in a critical care setting? Circle the most appropriate timeframe.	Less than 1 year	1 – 2 years	2 – 5 years	5 – 10 years	More than 10 years	

What have you done within the past year to make you a stronger applicant for our Nurse Anesthesia program? \_\_\_\_\_

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