RESPIRATORY CARE STUDENT TASK PROFICIENCY LIST

STUDENT'S NAME____________________________________________________

INDICATE WITH A CHECK WHICH OF THE FOLLOWING TASKS THE STUDENT HAS DEMONSTRATED PROFICIENCY IN THE LAB AND/OR CLINICAL SETTING (NOTE: A STUDENT WITH A PROVISIONAL LICENSE WILL BE ABLE TO PERFORM ONLY THOSE TASKS CHECKED BELOW.)

_____Metered dose inhaler medication administration
_____Small (or large) volume nebulizer medication administration
_____IPPB with medication administration
_____Humidity and aerosol therapy with bland solutions
_____Medical gas administration (nasal cannula, simple mask, venturi masks, partial and non-rebreathing masks)
_____Respiratory mechanics
_____Pulmonary function testing
_____Incentive spirometry
_____PEP therapy
_____Arterial/capillary blood gas analysis (may include electrolytes)
_____Arterial blood gas/capillary sampling
_____Venous sampling
_____Mechanical ventilation
   ____ CPAP
   ____ BIPAP
   ____ PS
   ____ PCV
   ____ A/C
   ____ PEEP
_____Intubation/Extubation
_____Suctioning
_____Pulse oximetry
_____Chest physiotherapy
_____Bronchoscopy assist
_____CPR
_____EKG

Name of Institution                                    City/State
Date Started                                            Date Expected to Complete
Program Director’s Name                                License Number

Signature of Program Director

(SEAL)

This institution has no seal

NOTARY PUBLIC INFORMATION

Sworn to before me on:                                Commission Number:          My Commission expires

Notary Public Signature

RCform6(09/2021)
AN EDUCATOR OF THE RESPIRATORY THERAPIST/TECHNICIAN PROGRAM IN WHICH YOU ARE CURRENTLY ENROLLED MUST COMPLETE BOTH SIDES OF THIS FORM. THE SEAL OF THE INSTITUTION MUST BE IMPRESSED ON THIS FORM FOR THE STATEMENT AT THE BOTTOM OF THIS FORM MUST BE SIGNED BY THE AUTHOR AND THE SIGNATURE NOTARIZED. ALL SIGNATURES MUST BE ORIGINAL.

I, ____________________________________________, DO HEREBY CERTIFY

Name of educator

THAT ____________________________________________ IS CURRENTLY ENROLLED

Name of applicant

AT ___________________________________________ LOCATED IN ______________________________________________.

Name of institution City, State

DATE STARTED: ________________________________DATED EXPECTED TO COMPLETE: __________________________

RECORDS OF THIS INSTITUTION INDICATE THAT THE APPLICANT HAS ________ HAS NOT _______ BEEN THE SUBJECT OF DISCIPLINARY ACTION.

If applicant has been the subject of disciplinary action (i.e., suspension, probation, etc.) please explain on a separate sheet of paper.

(SEAL)

Name of Educator
Signature
Title
Date

This institution has no seal

Signature of Educator

NOTARY PUBLIC INFORMATION

Sworn to before me on: Commission Number: My Commission expires

(SEAL)

Notary Signature

I, ____________________________________________, hereby authorize the above-named institution to report to the Oklahoma State Board of Medical Licensure and Supervision any information that refers or relates to any disciplinary action (i.e., suspension, probation, etc.) or any change in my enrollment status.

_____________________________ ____________________________
Date Signature of Applicant

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