



Please Complete and Fax to: 800-807-1963

Or mail to:

Medical Staffers, LLC
910 Brooks St.
Missoula, MT 59801

Questions? 800-393-1559

Last Name _____ First Name _____ MI _____

ONCOLOGY SKILLS CHECKLIST

The following checklist is used to assess your experience and skills and help us place you in the proper assignment. Please provide an accurate self-assessment of your skills using the following guidelines:

1. No experience
2. Limited Experience
3. Experienced
4. Highly Skilled
5. Able to teach and supervise

| MEDICATIONS / IV THERAPY | 1 | 2 | 3 | 4 | 5 |
|--------------------------------|---|---|---|---|---|
| Administer Po Medications | | | | | |
| Administer Topical Medications | | | | | |
| Administer Im / Sq Medications | | | | | |
| Administer Iv Medications | | | | | |
| Needle-Less Systems | | | | | |
| Infusion Pumps | | | | | |
| Establish Peripheral Ivs | | | | | |
| Discontinue Peripheral Ivs | | | | | |
| Pain Assessment / Management | | | | | |
| Draw Blood For Lab Studies | | | | | |
| Admin Blood / Blood Products | | | | | |
| Central Venous Lines (Cvl) | | | | | |
| Hickman / Broviac Catheters | | | | | |
| Pca / Cadd | | | | | |
| Port-A-Cath | | | | | |
| Infusaid | | | | | |
| Infuse-A-Port | | | | | |

| CARE OF ONCOLOGICAL PATIENTS | 1 | 2 | 3 | 4 | 5 |
|---------------------------------|---|---|---|---|---|
| Head, Neck, Chest | | | | | |
| Hematologic System | | | | | |
| Gastrointestinal Tract | | | | | |
| Reproductive System | | | | | |
| Skin (Melanomas / Nonmelanomas) | | | | | |
| Urinary Tract | | | | | |

| Emergencies | | | | | |
|--|--|--|--|--|--|
| Cardiac Tamponade | | | | | |
| Disseminated Intravascular Coagulation | | | | | |
| Hypercalcemia | | | | | |
| Organ Obstruction | | | | | |
| Sepsis | | | | | |
| Spinal Cord Compression | | | | | |
| Superior Vena Cavae Syndrome | | | | | |
| Tumor Lysis Syndrome | | | | | |

| FAMILY / PSYCHOSOCIAL NEEDS | | | | | |
|--------------------------------|--|--|--|--|--|
| Patient / Family Education | | | | | |
| Advance Directives | | | | | |
| Acute Phase | | | | | |
| Chronic Phase | | | | | |
| Terminal Phase | | | | | |
| Bereavement Phase | | | | | |
| After Treatment (Survivorship) | | | | | |

| CANCER THERAPY | 1 | 2 | 3 | 4 | 5 |
|--|---|---|---|---|---|
| RADIATION THERAPY (RT) | | | | | |
| Electromagnetic (Xrays, Gamma Rays) | | | | | |
| Particulate (Alpha, Beta) | | | | | |
| External Beam Therapy | | | | | |
| Knowledge of Early Effects of RT | | | | | |
| Knowledge of Interm. Effects of RT | | | | | |
| Knowledge of Late Effects of RT | | | | | |
| BRACHYTHERAPY (SEALED SOURCES) | | | | | |
| Interstitial Radiation Therapy | | | | | |
| Intracavitary Radiation Therapy | | | | | |
| Intraluminal Radiation Therapy | | | | | |
| RAIDOPHARMACEUTICAL (UNSEALED SOURES) | | | | | |
| Tracer Dose | | | | | |
| Therapeutic Dose | | | | | |
| SURGICAL INTERVENTION | | | | | |
| Curative Surgery | | | | | |
| Diagnostic Surgery | | | | | |
| Mechanical Device Insertion | | | | | |
| Palliative Surgery | | | | | |
| Prophylactic Surgery | | | | | |
| Reconstructive Surgery | | | | | |
| Rehabilitative Surgery | | | | | |
| Bone Marrow Transplant - Allogenic | | | | | |
| Bone Marrow Transplant - Syngenic | | | | | |

| ONCOLOGY HEALTH CARE SETTING | 1 | 2 | 3 | 4 | 5 |
|--|---|---|---|---|---|
| Adult | | | | | |
| Pediatrics | | | | | |
| Cancer Center | | | | | |
| Radiation Oncology | | | | | |
| Surgical Oncology | | | | | |
| Bone Marrow Unit | | | | | |
| Research / Clinical Trials | | | | | |
| Subacute / Skilled Nursing | | | | | |
| Home Health Care | | | | | |
| Hospice | | | | | |
| Clinic - Risk Assess / Screening / Diagnosis | | | | | |
| Clinic - Surgery / Gyn | | | | | |
| Clinic - Medical / Hematology | | | | | |
| Clinic - Immunology / Infectious | | | | | |

ONCOLOGY SKILLS CHECKLIST

| ANTINEOPLASTIC AGENTS | 1 | 2 | 3 | 4 | 5 |
|--|---|---|---|---|---|
| ROUTES OF ADMINISTRATION | | | | | |
| Oral / SQ / IM | | | | | |
| Intravenous | | | | | |
| Intraarterial | | | | | |
| Intrathecal / Intraventricular | | | | | |
| Intraperitoneal (Tenckhoff Catheter) | | | | | |
| Intrapleural | | | | | |
| Intravesicular | | | | | |
| ALKYLATING AGENTS | | | | | |
| Bulsulfan (Myleran) | | | | | |
| Chlorambucil (Leukeran) | | | | | |
| Cisplatin (Platinol) | | | | | |
| Cyclophosphamide (Cytoxan) | | | | | |
| Mechlorethamine (Mustargen) | | | | | |
| ANTIMETABOLITES | | | | | |
| Cytarabine (Ara-C) | | | | | |
| Fluorouracil (5-FU) | | | | | |
| Mercaptopurine (6-MP) | | | | | |
| Methotrexate | | | | | |
| Leucovorin Rescue Protocol | | | | | |
| ANTINEOPLASTIC ANTIBIOTICS | | | | | |
| Bleomycin | | | | | |
| Dactinomycin (Actinomycin) | | | | | |
| Daunorubicin (Daunoxome) | | | | | |
| Doxorubicin (Adriamycin) | | | | | |
| PLANT ALKALOIDS | | | | | |
| Paclitaxel (Taxol) | | | | | |
| Vinblastine (Velban) | | | | | |
| Vincristine (Oncovin) | | | | | |
| HORMONAL ANTINEOPLASTICS | | | | | |
| Leuprolide (Lupron) | | | | | |
| Megestrol (Megace) | | | | | |
| Tamoxifen (Nolvadex) | | | | | |
| Testolactone (Teslac) | | | | | |
| STAFF MINIMIZE RISK OF EXPOSURE | | | | | |
| During Preparation | | | | | |
| During Administration | | | | | |
| During Disposal | | | | | |

| CLASSIFICATION OF NEOPLASMS | 1 | 2 | 3 | 4 | 5 |
|--------------------------------|---|---|---|---|---|
| Staging - Tnm System | | | | | |
| Tissue of Origin | | | | | |
| Biologic Behavior | | | | | |
| Degree of Cell Differentiation | | | | | |
| Anatomic Site | | | | | |

| TREATMENT SIDE EFFECTS | 1 | 2 | 3 | 4 | 5 |
|--------------------------------------|---|---|---|---|---|
| RECOGNITION AND MANAGEMENT OF | | | | | |
| Anxiety / Depression | | | | | |
| Metabolic Alterations | | | | | |
| Hypersensitivity | | | | | |
| Fatigue | | | | | |
| HEMATOPOIETIC | | | | | |
| Anemia | | | | | |
| Leukopenia | | | | | |
| Thrombocytopenia | | | | | |
| GASTROINTESTINAL | | | | | |
| Anorexia / Dehydration | | | | | |
| Nausea / Vomiting | | | | | |
| Constipation / Diarrhea | | | | | |
| Mucositis / Ulceration | | | | | |
| Hepatic Toxicity | | | | | |

| TREATMENT SIDE EFFECTS | 1 | 2 | 3 | 4 | 5 |
|--------------------------|---|---|---|---|---|
| INTEGUMENTARY | | | | | |
| Alopecia | | | | | |
| Dermatitis | | | | | |
| Hyperpigmentation | | | | | |
| GENITOURINARY | | | | | |
| Cystitis | | | | | |
| Renal Toxicity | | | | | |
| CARIOVASCULAR | | | | | |
| Cardiac Toxicity | | | | | |
| Phlebitis | | | | | |
| Extravasation | | | | | |
| NEUROLOGIC | | | | | |
| Neurotoxicity | | | | | |
| Ototoxicity | | | | | |
| Metabolic Encephalopathy | | | | | |
| Peripheral Neuropathy | | | | | |
| PULMONARY | | | | | |
| Fibrosis | | | | | |
| Pneumonitis | | | | | |
| Edema | | | | | |
| REPRODUCTIVE | | | | | |
| Infertility | | | | | |
| Changes In Libido | | | | | |
| Erectile Dysfunction | | | | | |

| NUTRITION | 1 | 2 | 3 | 4 | 5 |
|--|---|---|---|---|---|
| Assess / Manage Nutritional Impairment | | | | | |
| Interpretation of Lab Values | | | | | |
| Oral Feedings | | | | | |
| Enteral Tube Feeding | | | | | |
| Peripheral Parenteral Nutrition (Ppn) | | | | | |
| Central TPN | | | | | |

Age Appropriate Care: The ability to adapt care to incorporate normal growth and development, adapt method and terminology of client instructions as it relates to the age and comprehension level of the client, and to ensure a safe environment - reflecting specific needs of the client and various age groups.

| AGE | 1 | 2 | 3 | 4 | 5 |
|-----------------------------|---|---|---|---|---|
| Newborn (birth- 30 days) | | | | | |
| Infant (30 days-1 year) | | | | | |
| Toddler (1-3 years) | | | | | |
| Preschooler (3- 5 years) | | | | | |
| School Age (5 -12 years) | | | | | |
| Adolescents (12-18 years) | | | | | |
| Young Adults (18-39 years) | | | | | |
| Middle Adults (39-64 years) | | | | | |
| Older Adults (64+ years_ | | | | | |

ONCOLOGY SKILLS CHECKLIST

The information I have provided above is true and accurate to the best of my knowledge, and I hereby authorize Medical Staffers, LLC to release this checklist to any potential employer that is contracted with Medical Staffers, LLC.

Employee Signature _____

Name and Title (please print) _____

Date _____