



SCOPE OF SERVICES  
Emergency Medicine

Last Name	First Name	Middle Name
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Check appropriate box indicating which clinical capabilities you are able to perform

**Please list any limitations on a separate sheet**

**Certifications**

BLS Expires:	ACLS Expires:
ATLS Expires:	ABLS Expires:
PALS / APLS Expires:	NBP Expires:

**Areas of Interest**

Government Assignments	
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**Management and Treatment of Medical Emergencies Including:**

Cardiac Arrest/Failure	DRA
Respiratory Arrest/Failure	Minor GI Bleeding
Sepsis	

**Stabilization and Initial Treatment of Single or Multiple Traumas Including:**

Blunt or penetrating injuries of the head, chest, abdomen	Fractures
Spinal Cord Injuries	Dislocations
Soft Tissue Injuries Including the Eye	

**Management and Treatment of Thermal Injuries Including:**

Burns	Management and treatment of pediatric emergencies Not categorized:
Electrocution	
Hypo/Hyperthermia	

**Board Standing in Emergency Medicine, If Applicable:**

	Yes	No	
ABEM Certified:			Date First Certified:
			Date First Became Qualified:
ABEM Qualified:			Date Most Recently Re-Certified:
			Expected Date of Completion:
			Written Exam:
			Oral Exam:

**Other Board Eligibility / Certifications:**

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**What Formal Emergency Training or Related CME Have you Completed?**

Description of Training	Dates (from/through)

Signing below indicates that I am qualified to perform the services chosen on the checklist

Signature
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Date
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