

Name _____

**Our Lady of the Lake College
School of Nursing
Master of Science in Nurse Anesthesia Program**

Record of Critical Care Experience

List in chronological order your Critical Care Experience:

Facility	Location	Specialty Area	Date

Critical Care Skills

Please indicate your skill level in the following areas:

Critical Care Skills	Independent	With Assistance	Limited	None
Physical Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EKG Interpretation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codes (ACLS / ATLS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Invasive Monitoring (CVP, CO, CV Pressures)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arterial Lines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ventilators	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vasoactive Infusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intra-aortic Balloon Pump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I certify that the statements I have made on this Application are complete. (Signature of applicant authorizes the Program to make inquiries of all former schools/employers). I understand that withholding information requested on this form may make me ineligible for admission to Our Lady of the Lake College or subject to dismissal.

Signature of Applicant: _____ Date: _____