



Radiology Skills Assessment Checklist

Name: _____

Date: _____

Please indicate your level of experience

A. Theory, no practice	C. One - two years experience
B. Intermittent experience	D. Two plus years experience

1. Radiography

a. Head/Skull					
i. Orbits	A	B	C	D	
ii. Mandible	A	B	C	D	
iii. Facial Bones	A	B	C	D	
iv. Nasal Bones	A	B	C	D	
b. Spine/Pelvis					
i. Cervical Spine	A	B	C	D	
ii. Thoracic Spine	A	B	C	D	
iii. Lumbar Spine	A	B	C	D	
iv. SI Joints	A	B	C	D	
v. Scoliosis Studies	A	B	C	D	
c. Abdomen					
i. Abdominal Series	A	B	C	D	
ii. Erect/Decubitus Film	A	B	C	D	
d. Thorax					
i. PA/Lat Chest	A	B	C	D	
ii. Decubitus Chest	A	B	C	D	
iii. Ribs	A	B	C	D	
iv. Sternum	A	B	C	D	
e. Extremities					
i. Small Extremities	A	B	C	D	
ii. Large Extremities	A	B	C	D	
f. Pediatric					
i. Head Work	A	B	C	D	
ii. Chest/Abdomen	A	B	C	D	
iii. Spine	A	B	C	D	
iv. Extremities	A	B	C	D	
g. Equipment					
i. R & F Rooms	A	B	C	D	



ii. C-Arm	A	B	C	D
iii. Portable Exams	A	B	C	D
iv. Automatic Processing/Darkroom	A	B	C	D
v. Daylight System	A	B	C	D
vi. Panoramix	A	B	C	D
h. Flourosocopy/Special Exams				
i. GI Tract (Upper & Lower)	A	B	C	D
ii. Swallowing Functions	A	B	C	D
iii. Hysterosalpingogram	A	B	C	D
iv. Myelogram	A	B	C	D
v. IVP/Tomograms	A	B	C	D
vi. Trauma Cases	A	B	C	D
vii. Surgery (C-arm/Portable)	A	B	C	D

2. Mammography

a. Screening Mammograms	A	B	C	D
b. Diagnostic Mammograms	A	B	C	D
c. Magnification Views	A	B	C	D
d. Implants	A	B	C	D
e. Stereotactic Biopsy	A	B	C	D
f. Digital	A	B	C	D
g. Needle Localizations	A	B	C	D

3. Radiation Therapy

a. Linear Accelerator	A	B	C	D
b. Linear Accelerator with Electrons	A	B	C	D
c. Superficial Treatment	A	B	C	D
d. Ortho Voltage	A	B	C	D
e. Hyperthermia Treatment	A	B	C	D
f. Cobalt 60 Therapy	A	B	C	D
g. Dosimetry	A	B	C	D
h. Treatment Planning	A	B	C	D

4. Interventional/Specials/Cardio

a. Angiography/Arteriography	A	B	C	D
b. Venography	A	B	C	D
c. Aorteriography	A	B	C	D
d. Cardiography	A	B	C	D
e. Cardiac Catheterizations	A	B	C	D
f. Digital Angiography (DSA)	A	B	C	D
g. Lymphangiography	A	B	C	D



5. Sonography/Ultrasound

a. General Chest Procedures	A	B	C	D
b. General Abdominal Procedures	A	B	C	D
c. Paracentesis	A	B	C	D
d. Thoracentesis	A	B	C	D
e. Breast	A	B	C	D
f. Biopsies	A	B	C	D
g. Amniocentesis	A	B	C	D
h. Upper Extremities (Venous/Arterial)	A	B	C	D
i. Lower Extremities (Venous/Arterial)	A	B	C	D
j. Female Pelvis	A	B	C	D
k. Male Pelvis	A	B	C	D
l. Transvaginal	A	B	C	D
m. Doppler Studies	A	B	C	D
n. Color Doppler Studies	A	B	C	D
o. 2D and M-Mode	A	B	C	D
p. Stress Testing	A	B	C	D
q. Portable Studies	A	B	C	D
r. Carotids	A	B	C	D

6. CT

a. Chest	A	B	C	D
b. Brain with Contrast	A	B	C	D
c. Brain without Contrast	A	B	C	D
d. Cervical Spine	A	B	C	D
e. Thoracic Spine	A	B	C	D
f. Lumbar Spine	A	B	C	D
g. Abdomen Studies	A	B	C	D
h. PET Scan	A	B	C	D
i. 3-D or Multidimensional	A	B	C	D
j. Skull/Facial/Orbits/Sinuses	A	B	C	D
k. Biopsy/Angio Procedures	A	B	C	D

7. MRI

a. Angio	A	B	C	D
b. Multiplanar Reconstruction	A	B	C	D
c. Contrast Studies	A	B	C	D
d. Spin Echo Imaging	A	B	C	D
e. Partial Saturation Imaging	A	B	C	D
f. Surface Coils	A	B	C	D



g. T1 Weighted Imaging	A	B	C	D
h. T2 Weighted Imaging	A	B	C	D
i. Gradient Echo Imaging	A	B	C	D

8. Nuclear Medicine

a. I-123 Uptake	A	B	C	D
b. I-131 Therapy	A	B	C	D
c. Bone Scan	A	B	C	D
d. Brachytherapy	A	B	C	D
e. Brain Scan	A	B	C	D
f. Cerebral Blood Flow	A	B	C	D
g. Gallium Scan	A	B	C	D
h. HIDA Scan	A	B	C	D
i. Hot Lab	A	B	C	D
j. Aerosol Lung Scan	A	B	C	D
k. Indium I-111 WBC	A	B	C	D
l. Liver Scan	A	B	C	D
m. Muga Scan	A	B	C	D
n. Persantine Thallium	A	B	C	D
o. Radio Pharmaceutical Prep	A	B	C	D
p. Stress Holter Monitoring	A	B	C	D
q. Thallium Stress Test	A	B	C	D
r. Thyroid Uptake	A	B	C	D
s. Thyroid Therapy	A	B	C	D
t. Thyroid Scan	A	B	C	D
u. RIA (Radio Immuno Assay)	A	B	C	D
v. VP Lung Scan	A	B	C	D
w. Spect Scan	A	B	C	D
x. NVG Rest	A	B	C	D
y. NVG Stress	A	B	C	D
z. GI Bleeding Study	A	B	C	D
aa. Radionuclide Arteriogram	A	B	C	D
bb. Renagrams	A	B	C	D
cc. Renal Scan	A	B	C	D
dd. Shillings	A	B	C	D
ee. Spleen Scan	A	B	C	D
ff. Testicular Studies	A	B	C	D



Certification:

Please read and agree to the statements below by signing and dating the bottom of this form.

I attest that the information I have given is true and accurate to the best of my knowledge and that I am the individual completing this form. I hereby authorize RN Exclusive to release this Skills Checklist to the Client facilities in relation to consideration of employment with those facilities.

Signature: _____ Date: _____