



SCOPE OF SERVICES
Neonatology

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

Please list any limitations on a separate sheet

Neonatology	
<input type="checkbox"/>	Attend C-Sections
<input type="checkbox"/>	ECMO
<input type="checkbox"/>	Post-Opp Cardiac
<input type="checkbox"/>	PDA Litigations
<input type="checkbox"/>	Heel Stick
<input type="checkbox"/>	Bladder Tap
<input type="checkbox"/>	Umbilical Catheters
<input type="checkbox"/>	Chest Tube
<input type="checkbox"/>	Boricardial Tube
<input type="checkbox"/>	UAC/UVC insert
<input type="checkbox"/>	Intubation
<input type="checkbox"/>	Arterial Sticks
<input type="checkbox"/>	Lumbar Punctures
<input type="checkbox"/>	Shunts
<input type="checkbox"/>	Subdural Tap
<input type="checkbox"/>	Transcutaneous Bilirubin Testing
<input type="checkbox"/>	Vessel Transillumination
<input type="checkbox"/>	Venipuncture
<input type="checkbox"/>	Suprapubic Bladder Aspiration
<input type="checkbox"/>	Typanocentesis
<input type="checkbox"/>	Tibial Bone Marrow Biopsy
<input type="checkbox"/>	Intravenous Line Placement
<input type="checkbox"/>	Tracheotomy

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

Signature

Date
