

**Procedure Types Count**

Procedure:	Total:	Performed:	Verified:	Certified Date:
Airway Management (endotracheal intubation)		5	5	3 --
Arterial Puncture/Arterial Line (REQUIRED)		7	7	7 --
Arthrocentesis (not required)		1	1	1 --
Central Line Insertion - FEMORAL (not required)		3	3	3
Central Line Insertion - INTERNAL JUGULAR (not required)		9	9	5
Central Venous Line Placement - INTERNAL JUGULAR - PRIOR TO JUNE 2016 (not required)		3	3	3 --
Fiberoptic bronchoscopy		27	27	18 --
Hand-Off (REQUIRED)		4	4	4 --
Mini-CEX (REQUIRED)		6	6	6 --
Paracentesis (not required)		3	3	3 --
Pelvic Exam/PAP Smear/Endocervical Culture (REQUIRED)		6	6	4 --
Peripheral IV (REQUIRED)		5	5	--
Thoracentesis		1	1	--
Transbronchial Biopsy		2	2	1 --
Venous Blood Draw (REQUIRED)		5	5	--
<b>Diagnosis/Indications Count</b>				
Diagnosis/Indication:	Total:			
(none)				