

Now Accepting Applications For Nurse Practitioner Residency in Community Health and Primary Care

Community Health Center, Inc. (CHC) of Connecticut, one of the country's largest and oldest Federally Qualified Health Centers (FQHCs), is pleased to announce that it is accepting applications for the country's first formal Nurse Practitioner Residency Program in Family Practice and Community Health. The class of 2012-2013 will begin in September 2012.



CHC is committed to leadership, transformation, and innovation in health care.

Through its Weitzman Center for Innovation, CHC develops new model and programs designed to resolve clinical, systemic, technologic and operational barriers to ensuring full access to effective health care for all individuals.

This residency is designed for new nurse practitioners with a commitment to developing career practices in the challenging setting of the FQHC and/or special populations.

The Nurse Practitioner Residency in Family Practice and Community Health has the following three goals:

- Prepares NP to assume full responsibility for primary care of complex underserved populations across all life cycles and in multiple settings.
- Building upon the education and practice base acquired in the educational program leading to certification, the Residency will develop the clinical and operational confidence necessary for efficient, effective and productive practice as a member of the health care team in a FQHC
- Increase the number of Nurse Practitioners choosing to build long-term careers in FQHCs, and their capability for leadership positions within those organizations and within the healthcare system of the future.

Application Requirements:

1. Since all residents will be credentialed providers at CHC, all applicants are required to fill out the attached CHC Credentialing Application for Nurse Practitioners
2. Please submit responses to the following question. This is an opportunity to reflect upon and communicate to CHC your personal statement of qualifications, interest, and motivation in acceptance to this Residency.
 - A. What personal, professional, educational and clinical experiences have led you to choose nursing as a profession, and the role of a family nurse practitioner as a specialty practice? What are your aspirations for a Residency program? Please comment upon your vision and planning for your short and long-term career development.
 - B. What are the goals that you are looking to accomplish during your residency at CHC? Please identify specific areas of interest by lifecycle, age, or setting that you would like to develop increased mastery, competence, or confidence in.
 - C. The CHC Residency for Nurse Practitioners is still a newly implemented concept, and as such, will require the residency class to participate to some degree as "co-creators" of this model. Please comment on your personal qualities and strengths that you think will contribute positively to this experience. What apprehensions, concerns, and hesitations might you have? Please feel free to be straightforward!
3. As one of, or in addition to the three letters of recommendation that you will be supplying with the credentialing application, please submit at least one letter that specifically addresses your capabilities and interests related to this Residency Program.



PROVIDER CREDENTIALING APPLICATION - APRN

APPLICATION REQUIREMENTS

Type or legibly print all responses and complete the application in its entirety. **COMPLETE ADDRESS AND TELEPHONE NUMBERS ARE REQUIRED WHERE INDICATED. ALL DATES MUST BE INCLUSIVE (MONTH & YEAR).**

For applicants applying to the NP Residency Training Program, not all of the questions are applicable. (CT license, DEA etc.) If a question is not applicable note "N/A." Attach additional sheets if there is insufficient space on the application for your response. **As indicated by the ✓ below, current copies of the following documents must accompany your application. Please make sure all copies are legible.**

- ✓ CV with MONTH & YEAR for WORK & EDUCATION history sections
- ✓ CV must show a five (5) year work history **MONTH & YEAR** format
- ✓ If applicable, written & signed explanation of any gaps in work history over three (3) months
- ✓ Copies of RN & APRN licenses – website verification is not acceptable
- ✓ Copies of license(s) from any other state – website verification is not acceptable
- ✓ Connecticut controlled substances license – website verification is not acceptable
- ✓ Federal DEA certificate
- ✓ ANCC / AANP certification or evidence of eligibility for certification
- ✓ Copy of driver's license
- ✓ Three (3) professional **signed** reference letters, including at least 1 peer reference
- ✓ Professional diploma (BSN, MSN)
- ✓ If applicable, non US residents must provide a copy of their permanent resident card / VISA / proof of eligibility to work in US
- ✓ Signed statement by a medical licensed independent provider attesting to your overall health status from your last physical - free of communicable diseases, ability to perform your job functions, etc. This statement cannot be more than 12 months old. This is not infection control paperwork.

PLEASE NOTE:

Our JCAHO accreditation requires that copies of all licenses (CT, CT Rx & Federal DEA etc) be authenticated. You may submit a license to CHC in one of two formats: (1) the original employer license card or (2) write on your photocopy **I certify this photocopy from the original license** and **sign**. Or you may use the enclosed label(s) for your photocopy and sign where indicated.

EDUCATION

List education in chronological order – include **month/year** of attendance and graduation and **full mailing** address of institution.

Undergraduate:

Institution _____ Dates _____ to _____

Complete
Address: _____

Degree Awarded _____ Date of Degree _____

Medical:

Institution _____ Dates _____ to _____

Complete
Address: _____

Degree Awarded _____ Date of Degree _____

Other Graduate/Professional (PhD, MPH):

Complete
Address: _____

Degree Awarded _____ Date of Degree _____

Degree Awarded: _____ Date of Degree _____

ROTATIONS/FELLOWSHIPS/PRECEPTORSHIPS

List in chronological order – include **month/year** of attendance and **full mailing** address of institution.

Rotation 1:

Complete
Address: _____

Degree Awarded _____ Date of Degree _____

Specialty _____ Program Director _____

Rotation 2:

Complete
Address: _____

Degree Awarded _____ Date of Degree _____

Specialty _____ Program Director _____

Rotation 3:

Complete
Address: _____

Degree Awarded _____ Date of Degree _____

Specialty _____ Program Director _____

Rotation 4:

Complete Address: _____

Degree Awarded _____ Date of Degree _____

Specialty _____ Program Director _____

Other:

Complete Address: _____

Degree Awarded _____ Date of Degree _____

Specialty _____ Program Director _____

PRACTICING SPECIALTY

Primary Specialty _____

Secondary Specialty _____

BOARD CERTIFICATION STATUS

<u>Certificate Field/Specialty</u>	<u>Certifying Board</u>	<u>Certificate Number</u>	<u>Year Certified</u>	<u>Last Year Recertified</u>	<u>Certification Expires</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

If not certified in one or more of your practicing specialties for which board certification is available, please complete the following, indicating the specialty(ies) to which your responses apply.

Have you been accepted by the board to take the examination and are you actively in the board certification examination process? YES _____ NO _____

If yes, indicate the year by which you must complete the process according to the board's requirement _____

Have you ever taken and failed a certification examination? YES _____ NO _____

If yes, indicate the portion(s) failed and the year. Written _____ Oral _____

OTHER CERTIFICATIONS/MEMBERSHIPS

Indicate type or field in which certified (examples: use of specific laser, BLS, ACLS, ATLS, etc.), date acquired, date expires, if applicable and organization issuing the certificate. Also include memberships to IPAs, medical societies, AMA, etc.

<u>Certification</u>	<u>Certifying Organization</u>	<u>Date Received</u>	<u>Date Expires</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PROFESSIONAL CAREER

PRIOR WORK HISTORY: include month/year of employment

<u>Name & Nature of Practice</u>	<u>Full Address</u>	<u>Inclusive Dates (mm/yy)</u>
1. _____	_____	____/____ to ____/____

2. _____	_____	____/____ to ____/____

3. _____	_____	____/____ to ____/____

4. _____	_____	____/____ to ____/____

ACADEMIC APPOINTMENTS:

<u>School Name & Full Address</u>	<u>Rank</u>	<u>Department</u>	<u>Inclusive Dates (mm/yy)</u>
1. _____	_____	_____	____/____ to ____/____

2. _____	_____	_____	____/____ to ____/____

OTHER INSTITUTIONAL AFFILIATIONS: (industrial, military service, etc.)

<u>Name</u>	<u>Full Address</u>	<u>Inclusive Dates</u>
_____	_____	____/____ to ____/____
_____	_____	____/____ to ____/____

PROFESSIONAL REFERENCES

Provide three (3) professional references, at least one of which must be a peer reference:

<u>Name</u>	<u>Full Address</u>	<u>Telephone</u>
1. _____	_____	_____

2. _____	_____	_____

3. _____	_____	_____

PROFESSIONAL LIABILITY INSURANCE

Include a copy of the malpractice insurance facesheet.

Current Company _____ Policy # _____

Full Address _____

Effective Date _____ Expiration Date _____ Amount of Coverage _____

If the above policy is less than five (5) years old OR if you are employed less than five (5) years at your current job, provide your previous malpractice information:

Previous Company _____ Policy # _____

Full Address _____

Effective Date _____ Expiration Date _____ Amount of Coverage _____

Have you ever been denied coverage (either initial or renewal) by any professional liability insurance carrier or had an individual surcharge placed on you based on your individual experience? YES ___ NO ___

If yes, please explain: _____

Have you ever had any malpractice actions brought against you or judgments or settlements made, or do you have any cases pending? YES ___ NO ___

If yes, please explain: _____

DISCIPLINARY/OTHER ACTIONS

Have any of the following ever been or are any currently in the process of being denied, revoked, suspended, reduced, limited, made subject to probationary terms, or not renewed? Or have you relinquished or withdrawn or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional conduct? If yes, please provide a full explanation on a separate sheet.

	YES	NO
License/registration to practice in any state	___	___
DEA/controlled substance registration	___	___
Membership on any hospital staff	___	___
Clinical privileges at any hospital	___	___
Participation in Medicare, Medicaid or other payor programs	___	___
Non-hospital practice affiliation or authorization to provide services	___	___
Board certification	___	___
Have you been convicted of or pleaded no contest to any criminal charges (other than motor vehicle violations) brought against you?	___	___
Have you been convicted of or pleaded no contest to a drug or alcohol related offense?	___	___
Have you been sanctioned by a PPO or similar federal or state agency?	___	___

HEALTH STATUS

If any of the following questions are answered in the affirmative, please provide full explanation on a separate sheet.

Do you presently have a physical or mental health condition, including alcohol or drug abuse, that affects or that may reasonably be expected to progress within the next two years to the point of affecting your ability to practice your profession or place your patients at increased risk? YES ___ NO ___

Are you currently taking medication/under other therapy for a condition that could affect your ability to perform professional duties if the medication/therapy were discontinued today? YES ___ NO ___

Have you at any time during the past ten years been hospitalized or received any other type of institutional care for any such condition/problem? YES ___ NO ___

Are you free of communicable diseases? YES ___ NO ___

Are you able to perform the functions of your job? YES ___ NO ___

Most recent physical examination: Date ___/___/___

Performed by _____

Significant findings _____

Provide Community Health Center Inc. with a statement signed by a medical licensed independent provider attesting to your overall health status - free of communicable diseases, ability to perform your job functions, etc. This statement cannot be more than 12 months old. This is not infection control paperwork.



STATEMENT OF APPLICATION AND RELEASE FORM
(Please read carefully before signing.)

I understand that Community Health Center, Inc. is required to credential and recredential providers every two years and therefore, I agree to make available to Community Health Center, Inc. any documents or records, either in my possession or in the possession of another, which may have a material and reasonable bearing on my suitability as a contracted provider.

I hereby authorize any and all persons, institutions and organizations, including those specifically identified in this Application, with information pertaining to my professional standing or qualifications as a provider to furnish upon request, all such information to Community Health Center, Inc. its employees and agents. In consideration for the furnishing by a person, institution or organization of information, I release the person, institution, or organization from and against any and all liability, loss, damage, claim or expense of any kind arising from or in connection with, disclosure of information to Community Health Center, Inc. made in good faith and without malice in conformance with this authorization.

I certify that the information provided herein, including attachments, represents full and truthful disclosures of the matters to which they pertain.

A copy of this document shall be considered as valid as the original.

Print Name _____

Signature _____

Date _____



**NOTICE OF BACKGROUND CHECK AND
FAIR CREDIT REPORTING ACT DISCLOSURE**

As part of the interview process, Community Health Center, Inc. may conduct a background check. If you are hired, Community Health Center, Inc. may also conduct a background check in deciding whether to continue your employment and when making other employment-related decisions directly affecting you. As part of the background check, Community Health Center, Inc. may obtain a “consumer report” from a “consumer reporting agency.” These terms are defined in the Fair Credit Reporting Act (“FCRA”), which applies to you. A consumer report includes information regarding such issues as your credit standing, criminal record, motor vehicle record, character and reputation. If Community Health Center, Inc. obtains a “consumer report” about you, and considers any information in the “consumer report” when making an employment-related decision that directly and adversely affects you, you will be provided with a copy of the report before the decision is finalized.

You may also contact the Federal Trade Commission in Washington, D.C., about your rights under the FCRA as a consumer with regard to “consumer reports” and the “consumer reporting agencies” that prepare these reports. Your signature below authorizes Community Health Center, Inc. to obtain consumer reports regarding you from consumer reporting agencies in connection with your application and during the course of your employment.

To perform the background check, please provide the following information:

Social Security No.: _____ - _____ - _____ Date of Birth: _____

Driver’s License No: _____ State: _____

Signature: _____ Print Name: _____

Print Former Name: _____ Date: _____



AUTHORIZATION TO COLLECT BACKGROUND INFORMATION

I have applied for employment at Community Health Center, Inc. I authorize investigation of all statements contained on my resume and in this application for employment as may be necessary in arriving at an employment decision. I authorize representatives of Community Health Center, Inc. to obtain pertinent information from my previous employers, references, and other persons with knowledge of my work history and background, financial history, education, regulatory or police records, driving records, licensing status or professional designation, and character or reputation, and to consider the information provided by the background check when making decisions regarding my employment at Community Health Center, Inc..

I authorize all previous employers, references or other persons having knowledge of my record or myself to release such information to Community Health Center, Inc., and hereby release all persons from liability for any damage that may result from furnishing such information to Community Health Center, Inc.

A photocopy of this authorization may be accepted in lieu of the original.

Signature: _____ Print Name: _____

Print Former Name: _____ Date: _____

During the past 7 years I have lived at the following addresses and under the name of:

_____	_____	_____
name	address	city, state, country
_____	_____	_____
name	address	city, state, country
_____	_____	_____
name	address	city, state, country
_____	_____	_____
name	address	city, state, country
_____	_____	_____
name	address	city, state, country



APPLICANT'S AGREEMENT AND CERTIFICATION

I certify that the answers given in this application are true to the best of my knowledge.

I understand that the use of this application form does not indicate that there are any positions open and does not in any way obligate Community Health Center, Inc.

I understand that should I be granted an interview, no representations that may be made at the interview are to be construed as creating any obligation, promise or contract on behalf of Community Health Center, Inc. I understand that the lack of truthfulness, misleading information or material omissions given in my application, resumes, interview(s) or during the course of my employment are grounds to terminate the hiring process or employment whenever they are discovered.

I understand that acceptance for employment shall depend on satisfactory replies from my references and other background checks.

I have read, understood and agree to the foregoing.

Print Name _____

Signature _____

Date _____



CRIMINAL BACKGROUND

NOTE: THIS PORTION OF THE APPLICATION WILL ONLY BE REVIEWED BY MEMBERS OF THE HUMAN RESOURCES DEPARTMENT (OR THE PERSON(S) IN CHARGE OF EMPLOYMENT) AND ANYONE INVOLVED IN INTERVIEWING THE APPLICANT

Have you ever been convicted of or pleaded guilty or nolo contendere (no contest) to, a violation of any state, federal, county or municipal law? (Do not include minor traffic violations)

Yes _____ No _____

If yes, please give information regarding the nature of the charge, the date and location of conviction and the final disposition of the case:

Applicants are not required to disclose the existence of an arrest, criminal charge or conviction for which records have been “erased.” The types of records subject to erasure under Connecticut law are as follows: (a) a finding of delinquency or that a child was a member of a family with service needs; (b) a sentence as a youthful offender; (c) a criminal charge that was dismissed or “nolled”; (d) a criminal charge for which the person was found not guilty; and (e) a conviction for which the person received an absolute pardon.

Any applicant whose criminal records were erased will be considered to have never been arrested and may so swear under oath.

I understand that the information provided above will not necessarily result in the rejection of my application, but that the nature of the information will be considered as it relates to the performance of the job duties in question and in light of the requirements of state and federal law.

Print Name _____

Signature _____

Date _____



PRESCRIPTIVE PRIVILEGES FOR ADVANCED PRACTICE REGISTERED NURSES

Community Health Center, Inc., a non-profit corporation licensed by the State of Connecticut Department of Public Health as an outpatient facility, provides a practice setting in which Advanced Practice Registered Nurses (APRN) may fully execute the privileges of their licensure, including the prescribing of medications. The APRN may prescribe, dispense and administer medical therapeutics in this setting or in any other setting described under Section 20-87a of the public health code.

The following policies have been proposed by CHC's Credentialing Committee and approved by its President and CEO, Medical Director, and Clinical Director.

1. All Advanced Practice Nurses hired by CHC for the positions of nurse practitioner or nurse midwife shall:
 - A. Hold a minimum of a master's degree in nursing.
 - B. Be currently certified by ANA, ANCC, AANP, ACNM, ACOG, or other recognized certification body as defined in Section 20-94a of the Public Health Code.
 - C. Hold current and active Registered Nurse and Advanced Practice Registered Nurse licenses in Connecticut
2. As part of the credentialing process, CHC will verify that newly hired APRNs have a current, valid and unrestricted APRN license in Connecticut. Newly graduated nurse practitioners who have not yet become certified, or nurse practitioners new to practice in Connecticut who have not yet been granted an APRN license, may not prescribe until such time as an active license has been granted.
3. The on-site medical director of each CHC site, or any other CHC physician mutually agreeable to the physician and the APRN shall be the designated "collaborating physician". A written and signed collaborative agreement shall be in place at all times between each APRN and a collaborating physician.
4. The APRN practices within both the legal guidelines established in the public health code and within the guidelines of competent, safe clinical practice. Effective October 1, 1999, APRNs practicing in Connecticut have the prescribing authority for Schedule II-V medications in addition to the general prescribing authority that has been enjoyed since 1987.

It is expected that the APRN will follow all generally accepted medical standards for competent and clinically indicated prescriptive privilege activity, seeking consultation from the on-site directing physician, other on-site physicians and other APRNs as needed and indicated.
5. The prescriptive authority for APRNs extends to the ordering of diagnostic laboratory and radiologic testing, as well as ordering of ancillary services and referrals such as home care and physical therapy. Test requisitions and provider signatures are completed in accordance with the regulations and policies of the institution at which the testing is performed.
6. At the time of the annual performance evaluation, all APRNs shall submit no less than ten charts to the collaborative physician or to the on-site medical director for review of the clinical appropriateness of the prescriptive regimen in terms of the clinical history, symptoms and diagnosis. In addition, APRNs shall participate in the regular clinical peer review activities conducted at each site. It is suggested but not required that the APRN's chart peer review be conducted by that APRN's collaborating physician.
7. All APRNs accept professional responsibility for maintaining their licensure as both RNs and as APRNs in good standing, including fulfilling the continuing education requirements required to maintain active certification.
8. APRNs at CHC communicate information concerning their collaboration with physicians and arrangement for care in the in the absence of the APRN through the brochures designed specifically for new patients, through the prescription pads that list all prescribers at each site and through direct communication between the APRN and his/her patients.
9. All APRNs hired at CHC on or after March 1, 1999 are subject to the guidelines entitled "Prescriptive Privileges for Newly Hired APRNs at Community Health Center, Inc." These guidelines are intended to allow newly hired APRNs to gradually increase their independence in the prescribing of medications and diagnostic testing consistent with their increasing level of clinical experience and their increasing level of experience within CHC system and with its patients. At the same time, it allows CHC a vehicle for ensuring that the APRN is demonstrating appropriate clinical judgment consistent with safe patient care.

10. In the setting of CHC it is critical that the APRN be able to give directions and “orders” to the RN/LPN staff and that these staff members be able to carry out those directives while practicing within the scope of RN/LPN license. However, current statutory language does not name APRNs as one of the professional groups that RNs can take directives/orders from. Therefore, check if this has been changed CHC has invested its positions of Medical Director and on-site Medical Directors with the authority to assume the “directing” authority over the APRNs in giving orders/directives to RN/LPN staff. In effect, the RNs/LPNs carrying out the orders of the APRN are acting under the “direction” of a physician.

Schedule of Advancing Privileges for APRNs

As part of orientation to CHC and practice site, the APRN and his/her supervisor will review proper use of CHC prescriptions and laboratory requisitions, safe storage and handling of prescription pads, protocols for calling in prescriptions and/or refills to pharmacies and protocols for documentation of medication in the patient clinical record. The orientation will include a review of CHC policies on accepted and disallowed abbreviations in prescribing, CHC’s patient safety standards with regard to medication administration, prescribing, and dispensing, and specific review of CHC policies concerning high risk medication, in particular anticoagulants and opioids.

Schedule of Advancing Privileges for APRNs hired after 3/1/99.

During the first three months of employment, APRN shall review no less than ten charts each week with the collaborating physician with the exception of psychiatric APRNs, who shall be required to review five charts per week with the collaborating psychiatrist. This review shall be focused on the appropriateness of the prescriptive/diagnostic regimen relative to the individual patient and shall include a broad sampling of patients for whom medication has been prescribed.

Effective October 1, 2005, a log sheet recording the patient ID/chart number of each record reviewed shall be maintained in the APRN’s credentialing folder at CHC as documentation of this review.

All new APRNs are encouraged and supported to seek consultation and guidance from more senior clinical colleagues during the initial months of practice. In particular, all APRNs shall be strongly encouraged to seek consultation from either the collaborative physician or a senior clinical colleague prior to prescribing a Schedule II controlled medication or any other medication with a known abuse potential.

APRN Signature

APRN Name (print)

Physician’s Signature

Physician’s Name (print)

Date of Hire

Effective date

09.28.05

CREDENTIALS PRIVILEGE LIST

PRINCIPAL PURPOSES: To evaluate each provider's formal education, training, experience, and evidence of physical, moral, and ethical capabilities and to assist the Credentials Committee in making recommendations with regard to the provider's competence to treat certain conditions and perform certain procedures. The Credentials Privilege List is not meant to be all-inclusive, but to reflect the most common procedures that a provider would have been expected to have gained competency through formal training. The provider is expected to document training and capability in those areas for which they are requesting privileges that, in general, would not fall within their specialty category that require informed consent.

USE(S): Information may be released to government boards or agencies of professional societies if needed to license or monitor professional standards of dental practitioners. It may also be released to other institutions or organizations where the provider is applying for staff.

Indicate (✓) privilege in the requested column:

Office Procedures

Requested	Approved	Procedure	Requested	Approved	Procedure
_____	_____	Abscess, incision/drain	_____	_____	Injection, tendon
_____	_____	Adults, 21+ primary care	_____	_____	IUD insertion
_____	_____	Arthrocentesis	_____	_____	IUD removal
_____	_____	Bartholin cyst, drainage	_____	_____	Lipoma, removal
_____	_____	Bladder aspir/suprapubic	_____	_____	Lumbar puncture
_____	_____	Burn care, ambulatory	_____	_____	Mgt foot ulcers, diabetic
_____	_____	Colposcopy	_____	_____	Nail removal w/digital block
_____	_____	Corneal abrasion mgt	_____	_____	Nail removal w/o digital block
_____	_____	Cryotherapy	_____	_____	Paronychia, drainage
_____	_____	Debrid/wounds no rpr	_____	_____	Pediatric primary care 0-21
_____	_____	Diaphragm fitting	_____	_____	Perianal abscess, drainage
_____	_____	Dislocation, fingers	_____	_____	Pilonidal cyst, drainage
_____	_____	Electrocardiogram interp	_____	_____	prenatal care, routine
_____	_____	Epistaxis control, anterior	_____	_____	Pulmonary function test
_____	_____	Foreign body removed, ear	_____	_____	Sebaceous cyst, removal
_____	_____	Foreign body removed, eye/smpl	_____	_____	Skin biopsy
_____	_____	Foreign body removed, nose	_____	_____	Skin biopsy, excisional
_____	_____	Hepatitis C medical management	_____	_____	Skin biopsy, punch
_____	_____	HIV/AIDS medical management	_____	_____	Skin biopsy, shave
_____	_____	Injection, bursa	_____	_____	Spirometry
_____	_____	Injection, intramuscular	_____	_____	Suboxone management
_____	_____	Injection, subcutaneous	_____	_____	Urinary cath place

Non Office Procedures

Requested	Approved	Procedure	Requested	Approved	Procedure
_____	_____	Amniocentesis	_____	_____	Hyperalimentation
_____	_____	Amnioinfusion	_____	_____	Inguinal hernia repair
_____	_____	Arterial line placement	_____	_____	Intrauterine cath place
_____	_____	Arterial puncture	_____	_____	Intubation, infant
_____	_____	Artificial rupt/membranes	_____	_____	Intubation, nasotracheal
_____	_____	Cardiac stress testing	_____	_____	Intubation, oral/endotracheal
_____	_____	Central venous line place	_____	_____	Labor, augmentation of
_____	_____	Cervical laceration repair	_____	_____	Labor, induction of

