



12000 Findley Road  
 Suite 100  
 John's Creek, GA 30097  
 Phone: 678-417-8100  
 Fax: 678-417-8135  
 Email: specialtycaq@nccpa.net

## PHYSICIAN ATTESTATION OF PA'S KNOWLEDGE AND SKILLS

I certify that physician assistant \_\_\_\_\_, NCCPA ID #: \_\_\_\_\_ is able to apply the appropriate knowledge and skills needed for practice in **Cardiovascular/Thoracic Surgery** and has performed the following procedures and patient management relevant to the practice setting and/or understands how and when the procedures should be performed.

### Anesthesia

- Local anesthesia
- Procedural anesthesia, Conscious sedation
- Endotracheal intubation

### Advanced Wound Management

- Wound debridement, incision and drainage
- Superficial/deep wound closure

### Diagnostic/Therapeutic Procedures

- Arterial line placement
- Swan-Ganz placement
- CVP line placement
- Chest tube placement/removal
- Thoracentesis
- Pleurodesis
- Transvenous pacer wire placement/removal
- Epicardial wire removal
- Transcutaneous pacing
- PIC/PICC line insertion
- Intravenous line placement
- Intra-aortic balloon (IABP) pump placement/removal
- Nasogastric tube/feeding tube placement
- Bronchoscopy and bronchoalveolar lavage
- Pericardiocentesis
- Epicardial pacemaker management

### Diagnostic Radiographic/Other Modalities

- Chest x-ray, CT Scans, MRI interpretation
- Diagnostic ultrasonography
- Diagnostic echocardiography
- Diagnostic electrocardiography

### Operative/Perioperative Care

- Preoperative consultation, evaluation
- Active bedside patient care management
- First/Second surgical assist
- Conduit vessel harvesting
- Sternal closure/thoracotomy closure
- Sternotomy/Sternal re-entry
- Decannulation and/or separation from cardiopulmonary bypass
- Organ procurement for transplantation
- Postoperative care, management

### Resuscitation

- Cardiopulmonary

I further certify that I am a physician working in **Cardiovascular/Thoracic Surgery** and am familiar with the physician assistant's practice and experience in this specialty area.

Printed Physician Name: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I can be reached by NCCPA via the following for additional information or follow up:

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

PLEASE RETURN THIS FORM TO NCCPA VIA FAX (678-417-8135), EMAIL OR MAIL