RECOMMENDATION LETTER FOR PROVIDER CERTIFICATION

Name: ……

Designation: ……

Department: ……

Work Address: ……

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Contact No: ……..

Email: ……

Supervisor: ……

Please answer the question below.

1. How long have you been practicing ultrasound in your clinical work?

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2. What is the main usage of ultrasound in your practice?

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3. What is your future plan after undergo Provider Certification?

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Applicant Signature & Date (Stamp)

4. This part is to be filled by the supervisor.

Please rate the skill level as accurately as possible by placing a check (√) in the appropriate box.

1 = No experience: Theory/observed only

2 = Limited competency: Needs supervision

3 = Acceptable competency: Able to perform basic with minimal supervision

4 = Competent:Proficient

Skill Level	**1**	**2**	**3**	**4**
Knowledge (general, knobology and physics)				
Image Acquisition				
Basic ultrasonography anatomy identification				
Ability to relate with clinical practice				
Competency in:				
i. Airway				
ii. Lung				
iii. Cardiac				
iv. Abdominal (Aorta/Liver/Renal/Spleen)				
v. Vascular				
vi. EFAST				
vii. Others (please specify)				

5. Supervisor Recommendation:

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Supervisor's Signature & Date (Stamp)