

**Medical Assistant/Medical Receptionist/Insurance Biller/Office Manager**

Name:  Date:  Experience Since:

Are you certified?  Yes  No Certified by:

	Comfortable With	Done Occasionally	No Experience
<b>Administrative Duties</b>			
Phones/Messages	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Data Entry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Word Processing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insurance Coding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dictaphone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pegboard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Collections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Billing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PPO's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worker's Compensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Software:**

CPT       Med. Manager      Typing (WPM)   
 ICD9       WordPerfect  
 CCSI       Windows      Other(s)

Clinical Duties	Comfortable With	Done Occasionally	No Experience
Patient Prep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vital Signs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adult Injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pediatric Injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phlebotomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EKG's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flex Sigmoidoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary Functions Tests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lab Tests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinalysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy Tests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Instrument Familiarity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sterile Technique	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assist Minor Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Name:  Date:

**What types of office(s) have you worked in before?**

1.
2.
3.
4.
5.
6.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agency Representative Signature

\_\_\_\_\_  
Date