FREE GUIDE · CARDIAC CODEX

Thinking about the cath lab or the EP lab?

An honest guide from a manager who hires for both: what the work is really like, the pros and cons nobody puts in the job posting, how people get in, what pays, and the questions to ask before you say yes.



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1 · THE TWO LABS

Pipes or wiring: cath lab vs. EP lab at a glance

The cath lab works on the heart's **pipes**: the arteries and valves. The EP (electrophysiology) lab works on the heart's **wiring**: why it beats too fast or too slow, and how to fix it. Both are procedural suites with a small team around a sterile table, and both use X-ray.

	Cath lab	EP lab
What it fixes	Blocked arteries, heart attacks, structural heart problems	Fast or slow heart rhythms
Typical cases	Coronary angiograms, stents, structural heart work, emergency treatment for heart attacks (STEMI)	EP studies, ablations (heat, freezing or pulsed field), pacemakers, ICDs, CRT devices, loop recorders
Team roles	Scrub, monitor (hemodynamics), circulator. Roles often rotate.	Scrub, circulator/nurse, recording and stimulator person; mapping specialist and device rep are often from the company
What you'll learn hardest	Hemodynamics: pressures, waveforms, cardiac output	Reading intracardiac signals, intervals and pacing
Radiation	Lead apron for hours at a time	Lead too; 3D mapping systems cut X-ray time a lot during ablations
Credential	RCIS (Registered Cardiovascular Invasive Specialist)	RCES (Registered Cardiac Electrophysiology Specialist)

What a shift actually looks like

Cath lab. The team is usually three to four people around the table. On a given shift you might be:

- **Scrubbing:** sterile at the table with the physician, preparing and handing wires, catheters, balloons and stents, anticipating what comes next.
- **Monitoring:** running the hemodynamic system, recording pressures, watching waveforms and rhythm, and being the person who says out loud that something has changed.
- **Circulating:** managing the room, medications, supplies, documentation, and the patient's comfort and safety.

EP lab. The electrophysiologist leads the case. The scrub sets up and hands up sheaths, catheters and devices. The circulator gives medications and sedation as ordered. The recording and stimulator person labels signals, measures intervals and delivers pacing. Fast rhythms are sometimes started on purpose to study them, so being ready to shock is routine, not a sign of panic.

2 · PROS AND CONS

The honest version

Job postings undersell the hard parts. Here they are, next to the reasons people stay for decades.

Why people love it

- **The feedback loop is immediate.** You open an artery, the ST elevation resolves on the monitor, and the patient who was gray twenty minutes ago is talking to you. Very little of healthcare is that direct.
- **Small, tight teams.** Three or four people who rely on each other, case after case.
- **You never stop learning.** New devices, new energy sources and new procedures keep arriving, in both labs.
- **EP is a puzzle.** Working out where a rhythm starts, from signals inside the heart, appeals to people who like problem-solving.
- **A clear ladder.** The RCIS or RCES credential is often tied to pay steps, clinical ladder advancement and charge roles.

What ends careers

- **Call.** Heart attacks don't keep business hours. Most cath lab staff carry call (nights, weekends, holidays) with a required response time. For many people this matters more than pay.
- **Lead.** You wear a lead apron for hours, and the toll on your back and joints over a career is real. Modern labs reduce it, but it's a physical job.
- **A steep learning curve.** Hemodynamics in the cath lab, and intracardiac signals in EP, are hard to pick up on the fly.
- **Long cases.** Complex ablations can run long, and some are done under general anesthesia.
- **High stakes.** When a case goes badly, it goes badly fast, and you need to stay functional while it happens.

> **The two things to be honest with yourself about:** call and lead. Both are knowable before you commit, and they are the two factors that most often end cath lab careers.

3 · HOW PEOPLE GET IN

Your starting point decides your route

Into the cath lab: three common routes

Starting point	Route	Time to first day
RT, RRT or paramedic	Cross over. Rad techs are the most common crossover: you already know radiation, imaging and sterile technique.	Months: when a job opens, plus a 3–6 month orientation
Registered nurse	Transfer in. ICU, CCU and ED backgrounds are strongest: managing unstable patients, drips and codes.	Months if you're already an RN; 2–4 years if starting nursing school
Outside healthcare	An accredited invasive cardiovascular technology program, usually about two years, with clinical rotations.	About 2 years of school, then hired

Into the EP lab

EP labs hire the same backgrounds: RNs, rad techs, paramedics and EP program graduates. Most EP RNs become eligible for the RCES after a single year in the lab, because nursing counts as a health-science program.

When does the credential come?

For most people, **you get hired first and credentialed second.**

Credential	Most common way to qualify	Exception
RCIS (cath)	1 year of full-time invasive cardiovascular experience and 600 documented procedures (CCI pathway RCIS235)	Accredited CVT program graduates qualify at graduation (RCIS4)
RCES (EP)	A health-science degree (nursing, rad tech, paramedic and similar) plus 1 year of full-time EP experience (RCES235), or 2 years of EP experience (RCES1)	Accredited EP program graduates qualify at graduation (RCES4)

Eligibility rules are CCI's and change over time. Confirm the current requirements at cci-online.org before you plan around them.

> **Already inside a hospital with a cath or EP lab?** Ask to shadow. Managers say yes far more often than people expect, and it's the most valuable hour you can spend: for deciding whether you want the work, and for becoming someone the lab already knows. Internal transfers face far less competition than outside applicants.

4 · PAY AND OUTLOOK

What the numbers actually say

Median pay (May 2025)	Range	Projected growth 2025–35	Openings per year
$74,310	Lowest 10% under $39,000; highest 10% above $121,350	4% (about average)	About 3,400

Source: U.S. Bureau of Labor Statistics, cardiovascular technologists and technicians (Occupational Outlook Handbook and OEWS May 2025). Retrieved 2026-10-05.

Read these honestly. The BLS job code covers cardiovascular technologists broadly, including echo and vascular, so it's a reference point, not a precise number for cath lab or EP work, and it doesn't cover nurses. Growth is steady, not booming, but about 3,400 openings a year includes people retiring and moving up, and those are real jobs. Pay also varies a lot by state and setting; the RCIS salary page on cardiaccodex.com breaks it down.

5 · WHAT GETS YOU HIRED

What I look for when I hire

I hire and develop cath lab, EP and interventional staff. Candidates worry most about the credential, their school and the procedure count on their résumé. In my experience, these decide it instead:

1. **Can you be taught?** I'm hiring someone I'll spend months orienting. Coachability outranks nearly everything else, and it shows up in an interview quickly.
2. **Will you tell me about a mistake?** Everyone in this field has one. The candidate who describes an error, what they did and what changed is telling me they'll speak up in my lab.
3. **Are you steady?** I don't need someone unaffected by a crashing patient. I need someone who stays functional and keeps communicating while it happens.
4. **Do you understand what call means?** Asking me hard questions about call is a green flag, not a red one.
5. **Did you learn anything about us?** Our volume, our programs, what you'd want to learn here. It takes twenty minutes and almost nobody does it.

On credentials: I don't require RCIS to hire, and most labs don't, because the common pathway makes that impossible for anyone who hasn't worked in a lab yet. I do look for evidence that you intend to earn it.

Questions to ask in the interview

A good lab will be glad you asked. Vague answers tell you something too.

☐ **Call:** How often am I on call, what's the response time, and how many cases come in on a typical call night?

☐ **Orientation:** How long is orientation, is there a written plan, and who signs me off on each role?

☐ **Preceptors:** Will I have a consistent preceptor, or a different person each day?

☐ **Case mix:** What does a typical day look like here: diagnostic, intervention, structural, ablation, devices? What's the volume?

☐ **Roles:** Which roles will I rotate through (scrub, monitor, circulate, recording), and when?

☐ **Credentialing:** Do you support the RCIS or RCES: exam fee, study resources, a pay step when I pass?

☐ **Radiation and ergonomics:** What shielding and lead options do you have? Is a personal dosimetry badge provided and reviewed?

☐ **Turnover:** How long has the current team been here? Why did the last person in this role leave?

Red flags worth noticing

- No written orientation plan, or "you'll pick it up as you go."
- Call described vaguely, or "it's not that bad" with no numbers.
- A different preceptor every day, or being counted as staff during orientation.
- Nobody can tell you how they support certification.
- High turnover that nobody wants to talk about.

> *"I would far rather someone tell me in the interview that call is a problem for their life right now than have them resign at eight months."*

Your next three steps

1. **Shadow** in a cath lab or EP lab if you can, and decide which one fits you.
2. **Get a head start** with the free "Your First 30 Days" course for the cath lab (15 short lessons) or EP lab (13 lessons): who does what, wires, catheters, pacing and more. Free with a Cardiac Codex account at app.cardiaccodex.com.
3. **Start logging cases from day one.** You'll need the count for your credential later. The free case log is at cardiaccodex.com/case-log.

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