

Reference Material 6-10  
**Work Experience Checklist - CNA/Sitter/BHT**

**Certified Nursing Assistant:**

Type of Facility	Experience as a CNA (month/year to month/year)			Per Diem	Core Staff	Demonstrated Experience in this Type of Facility:			
						I&O	Vital Signs	CPR	1:1 only
Acute Care	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Private Duty	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospice	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nursery	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Blood Glucose Monitor Type:** \_\_\_\_\_

**Sitter:**

Type of Facility	Experience as a Sitter (month/year to month/year)			Per Diem	Core Staff
Acute Care	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
Private Duty	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
Hospice	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
Nursery	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>

**Behavioral Health Tech:**

Population	Experience as a BHT (month/year to month/year)			Per Diem	Core Staff	Demonstrated Experience with this Population:	
						Crisis Intervention	CPR
1:1	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Groups	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adults	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adolescents	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Employee Name (Printed) \_\_\_\_\_

Employee signature (updates only "via phone") and Date \_\_\_\_\_

Agency Name \_\_\_\_\_

Reviewed by (Signature & Credentials) and Date \_\_\_\_\_

**Work Experience Checklist - OR Tech/ER Tech**

**OR Tech:**

Type of Unit	Experience as an OR Tech (month/year to month/year)			Per Diem	Core Staff
General	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
Central Supply	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
ENT	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
L&D	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
Laparoscopic	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
Laser	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
Neurosurgery	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
OB/GYN	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
Open Heart	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
Ophthalmic	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
OR	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
Orthopedic	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
Plastic	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
Thoracic	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
Total Joint	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
Urology	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
Vascular	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>

**NOTES:**

**ER Tech:**

	Experience as an OR Tech (month/year to month/year)			Per Diem	Core Staff
EMT	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
Emergency Department	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
Critical Care	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
Vital Signs	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
I & O	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
Pulse Ox	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
IV Insertion	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
Phlebotomy	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
EKG (12lead)	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
CPR	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
Ambulate/transfer	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
Crutch walking	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
Splinting	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
Enemas	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
Cath insert/care	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
Urine specimen	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
Stool specimen	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
NG tube insert	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
Personal hygiene	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
Non-sterile wound dressing	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
Simple Wound Care	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
Isolation	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>
Yanker Oral Suction	/	to	/	<input type="checkbox"/>	<input type="checkbox"/>

**NOTES:**

Employee Name (Printed) \_\_\_\_\_

Employee signature (updates only "via phone") and Date \_\_\_\_\_

Agency Name \_\_\_\_\_

Reviewed by (Signature & Credentials) and Date \_\_\_\_\_