

Reference Material 6-9  
**Work Experience Checklist - RN/LPN**

**Instructions:** check Hospital Unit box as applicable and insert date Month/Year to Month/Year.  
DO NOT USE "Present" or "Current".

**HEALTH CARE PROVIDER'S NAME:** \_\_\_\_\_

**HOSPITAL UNIT**

<input type="checkbox"/> Burn	/	to	/	<input type="checkbox"/> MED SURG	/	to	/
<input type="checkbox"/> Cath Lab	/	to	/	<input type="checkbox"/> Nursery	/	to	/
<input type="checkbox"/> Dialysis - Hemo	/	to	/	<input type="checkbox"/> Nursery Level 2	/	to	/
<input type="checkbox"/> Dialysis Peritoneal	/	to	/	<input type="checkbox"/> OB	/	to	/
<input type="checkbox"/> Dialysis - Renal	/	to	/	<input type="checkbox"/> Oncology	/	to	/
<input type="checkbox"/> ER	/	to	/	<input type="checkbox"/> OR	/	to	/
<input type="checkbox"/> ER-Pediatrics	/	to	/	<input type="checkbox"/> OR CV (CVOR)	/	to	/
<input type="checkbox"/> Epidurals	/	to	/	<input type="checkbox"/> ORTHO	/	to	/
<input type="checkbox"/> Geriatrics	/	to	/	<input type="checkbox"/> PACU	/	to	/
<input type="checkbox"/> Home Health	/	to	/	<input type="checkbox"/> Pediatrics	/	to	/
<input type="checkbox"/> H/H Infusion	/	to	/	<input type="checkbox"/> Private Duty	/	to	/
<input type="checkbox"/> Hospice	/	to	/	<input type="checkbox"/> Psych Adult	/	to	/
<input type="checkbox"/> ICU-Adult	/	to	/	<input type="checkbox"/> Psych Geriatric	/	to	/
<input type="checkbox"/> ICU - CV	/	to	/	<input type="checkbox"/> Psych Peds	/	to	/
<input type="checkbox"/> ICU - Neuro	/	to	/	<input type="checkbox"/> Rehab Medical	/	to	/
<input type="checkbox"/> ICU - Pediatric	/	to	/	<input type="checkbox"/> Skilled Visit	/	to	/
<input type="checkbox"/> L&D	/	to	/	<input type="checkbox"/> Trauma	/	to	/
<input type="checkbox"/> LTC	/	to	/	<input type="checkbox"/> Telemetry	/	to	/

**SYSTEMS & PROCEDURES (Answer all questions):**

- Yes**    **No** Epidurals
- Yes**    **No** Fetal Monitoring
- Yes**    **No** Interpretation of Cardiac Dysrhythmias
- Yes\***    **No** Balloon Pump   \* \_\_\_\_\_ dates of experience
- Yes\***    **No** Online Charting: System used \* \_\_\_\_\_
- Yes\***    **No** Blood Glucose Monitor: Type \* \_\_\_\_\_
- Yes**    **No** The parenteral administration of electrolytes and fluids
- Yes\***    **No** Moderate sedation experience? If yes, How many months/years? \* \_\_\_\_\_
- Yes**    **No** IV insertion
- Yes**    **No** Phlebotomy
- Yes**    **No** Recognition of the need for psychological & social services for patients and their families

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

Employee signature (or "via phone") and Date \_\_\_\_\_

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

Agency Representative Signature and Date \_\_\_\_\_