

Reference Material 6-11
Work Experience Checklist – RN & LPN

HOSPITAL UNIT	UNIT EXPERIENCE DURING LAST 12 MOS			<i>THIS FORM MUST BE COMPLETED ANNUALLY!</i>		
	APPROX. # SHIFTS	<u>OR</u> APPROX. WEEKS (FULL-TIME)	<u>OR</u> APPROX. MONTHS (FULL-TIME)	Experience in Career as an RN (month/year to month/year)	Per Diem	Core Staff
BMT				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
Burn				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
Cath Lab				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
Dialysis				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
Endoscopy/GI Lab				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
ER				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
ER-Pediatrics				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
ICU				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
ICU-CV (CVICU)				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
ICU-Neuro				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
ICU-Pediatric (PICU)				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
ICU-Trauma				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
L&D				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
LTC				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
MED SURG				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
NICU-Level 2				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
NICU-Level 3				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
Nursery				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
Nursery-Level 2				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
OB				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
Oncology				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
OR				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
OR-CV (CVOR)				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
ORTHO				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
PACU				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
Pediatrics				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
PSYCH-Adult				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
PSYCH-Geriatric				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
PSYCH-Pediatrics				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
Radiology				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
REHAB-Medical				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
Renal/Transplant				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
TELE				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
TELE-Progressive				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
Other:				/ to /	<input type="checkbox"/>	<input type="checkbox"/>
TOTAL	*	**	***	<i>Not to exceed: *365; **52; ***12</i>		

SYSTEMS & PROCEDURES EXPERIENCE:

Yes <input type="checkbox"/>	No <input type="checkbox"/>	Balloon Pump. If yes: Balloon Pump Certified - Yes <input type="checkbox"/>/No <input type="checkbox"/>
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Interpretation of Cardiac Dysrhythmias
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Blood Glucose Monitor. If yes: Type - _____
Yes <input type="checkbox"/>	No <input type="checkbox"/>	IV Insertion
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Moderate Sedation experience. If yes: _____ years/ _____ months of experience
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Epidurals
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Fetal Monitoring
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Computerized Documentation. If yes: System Used - _____
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Parenteral administration of electrolytes and fluids
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Phlebotomy
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Recognition of the need for psychological and social services for patients and their families

Employee Name (printed)	Employee Signature/“VIA TELEPHONE” (updates only)	Date / <input type="checkbox"/> Update
Agency	Reviewed by (Signature & Credentials [i.e., RN])	Date