

Certified Nurse Assistant Skills Checklist

Name: Date:

Indicate the number of years of experience working as a Certified Nurse Assistant:

Please indicate your experience with the patient care areas and procedures listed below:

Skills	Comfortable With	Done Occasionally	No Experience
Applying Restraints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ambulating Patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transferring Patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making-up bed - empty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making-up bed - occupied	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Providing Backrub	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Providing Bed bath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perineal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting - apply Depend/Attend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting - urinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting - bedpan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting - bedside commode	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting - toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Measuring intake / output	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assist Patient in Dressing / Undressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Collection of Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Testing of Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of Catheters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeding Patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking Vital Signs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Providing Range of Motion Exercises - Passive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Providing Range of Motion Exercises - Active	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recording and Reporting Observations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Measuring Height / Weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature

Date

Agency Representative Signature

Date