

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 | OR APPROX. WEEKS (FULL-TIME) | OR 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 |