

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

**Certified Nursing Assistant:**

| Type of Facility | Experience as a CNA<br>(month/year to month/year) |    | Per<br>Diem | Core<br>Staff            | Demonstrated Experience<br>in this Type of Facility: |                          |                          |                          |
|------------------|---|----|-------------|--------------------------|--|--------------------------|--------------------------|--------------------------|
|                  |   |    |             |                          | I&O  | Vital<br>Signs           | CPR                      | 1:1<br>only              |
| Acute Care       | /   | to | /           | <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"/> |
| Hospice          | /   | to | /           | <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"/> |

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

**Sitter:**

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

**Behavioral Health Tech:**

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

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

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