

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"/>	
<b>TOTAL</b>	*	**	***	<i>Not to exceed: *365; **52; ***12</i>					

**SYSTEMS & PROCEDURES EXPERIENCE:**

Yes <input type="checkbox"/>	No <input type="checkbox"/>	Balloon Pump. <b>If yes: Balloon Pump Certified - Yes <input type="checkbox"/>/No <input type="checkbox"/></b>
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Interpretation of Cardiac Dysrhythmias
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Blood Glucose Monitor. <b>If yes: Type - _____</b>
Yes <input type="checkbox"/>	No <input type="checkbox"/>	IV Insertion
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Moderate Sedation experience. <b>If yes: _____ years/_____ months of experience</b>
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. <b>If yes: System Used - _____</b>
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