



Work Experience Checklist

I am a(n):

- RN CNA
 LVN

Preferred Shifts:

- Day 7:00 a.m. – 3:00 p.m. Night 11:00 p.m. – 7:00 a.m.
 Day 7:00 a.m. – 7:00 p.m. Night 7:00 p.m. – 7:00 a.m.
 Evening 3:00 p.m. – 11:00 p.m. Other: _____

Please indicate number of years experience in the following areas:

Specialty Area	Number of Years	Dates of Experience
Adult ICU		
Neuro ICU		
CVICU		
NICU		
PICU		
ER		
OB		
OR		
Burn Unit		
Postpartum		
L&D		
Skilled Unit		
Oncology		
Tele Med		
Tele Cardiac		
Pediatrics		
Psych Peds		
Level II Nursery		
Nursery		
Ventilators		
Renal		
Ortho		
Dialysis		
H/H Infusion		
Psych		
Epidurals		
Balloon Pumps		
Hospice		
Home Health		
Computer Charting		
Private Duty		
LTC		
Intermittent Skilled Visit		
Blood Glucose Monitor		
Use of Emergency Equipment		
Basic recognition of EKG Arrhythmias		

OSHA TB Fit Test Mask Type: _____

For nurses assigned to special care units, proficiency in intensive or cardiac care and competency in:

- The recognition, interpretation, and recording of signs and symptoms in critically ill patients: ____yes ____no
 The parental administration of electrolytes and fluids: ____yes ____no
 The prevention of contamination and cross-infection as covered in the Universal Precautions annual in-service: ____yes ____no
 The exercise of appropriate safety precautions in the use of electrical and electronic equipment as covered in fire/electrical safety annual in-service: ____yes ____no
 The recognition of the need for psychological and social services for patients and their families: ____yes ____no

Employee Signature **Date**

INS Representative Signature **Date**