

**ATTACHMENT 2a
WORK EXPERIENCE CHECKLIST – RN/LPN**

*Please update annually, based on date completed OR date last updated
(whichever is more recent).*

**SPECIFY LPN OR RN EXPERIENCE
IN EACH AREA**

HOSPITAL UNIT	Dates of Experience (month/year to month/year)	RN	LPN
BMT		<input type="checkbox"/>	<input type="checkbox"/>
Burn		<input type="checkbox"/>	<input type="checkbox"/>
Cath Lab		<input type="checkbox"/>	<input type="checkbox"/>
Dialysis		<input type="checkbox"/>	<input type="checkbox"/>
Endoscopy/GI Lab		<input type="checkbox"/>	<input type="checkbox"/>
ER		<input type="checkbox"/>	<input type="checkbox"/>
ER-Pediatrics		<input type="checkbox"/>	<input type="checkbox"/>
ICU		<input type="checkbox"/>	<input type="checkbox"/>
ICU-CV (CVICU)		<input type="checkbox"/>	<input type="checkbox"/>
ICU-Neuro		<input type="checkbox"/>	<input type="checkbox"/>
ICU-Pediatric (PICU)		<input type="checkbox"/>	<input type="checkbox"/>
ICU-Trauma		<input type="checkbox"/>	<input type="checkbox"/>
L&D		<input type="checkbox"/>	<input type="checkbox"/>
LTC		<input type="checkbox"/>	<input type="checkbox"/>
MED SURG		<input type="checkbox"/>	<input type="checkbox"/>
NICU-Level 2		<input type="checkbox"/>	<input type="checkbox"/>
NICU-Level 3		<input type="checkbox"/>	<input type="checkbox"/>
Nursery		<input type="checkbox"/>	<input type="checkbox"/>
Nursery-Level 2		<input type="checkbox"/>	<input type="checkbox"/>
OB		<input type="checkbox"/>	<input type="checkbox"/>
Oncology		<input type="checkbox"/>	<input type="checkbox"/>
OR		<input type="checkbox"/>	<input type="checkbox"/>
OR-CV (CVOR)		<input type="checkbox"/>	<input type="checkbox"/>
ORTHO		<input type="checkbox"/>	<input type="checkbox"/>
PACU		<input type="checkbox"/>	<input type="checkbox"/>
Pediatrics		<input type="checkbox"/>	<input type="checkbox"/>
PSYCH-Adult		<input type="checkbox"/>	<input type="checkbox"/>
PSYCH-Geriatric		<input type="checkbox"/>	<input type="checkbox"/>
PSYCH-Pediatrics		<input type="checkbox"/>	<input type="checkbox"/>
Radiology		<input type="checkbox"/>	<input type="checkbox"/>
REHAB-Medical		<input type="checkbox"/>	<input type="checkbox"/>
Renal/Transplant		<input type="checkbox"/>	<input type="checkbox"/>
TELE		<input type="checkbox"/>	<input type="checkbox"/>
TELE-Progressive		<input type="checkbox"/>	<input type="checkbox"/>
Other:		<input type="checkbox"/>	<input type="checkbox"/>

SYSTEMS & PROCEDURES EXPERIENCE (Specify “yes” or “no” based on employee’s ability to perform/administer system or procedure independently and/or with minimal supervision, unless otherwise specified):

Yes <input type="checkbox"/>	No <input type="checkbox"/>	Balloon Pump. If yes: Balloon Pump Certified - Yes <input type="checkbox"/>/No <input type="checkbox"/> # of years ___ What Brand? _____
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Basic recognition of EKG arrhythmias EKG 12 lead class? Yes <input type="checkbox"/>/No <input type="checkbox"/> Date _____
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Blood Glucose Monitor. If yes: Type - _____
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Continuous Venous-Hemofiltration (CVVHD).
Yes <input type="checkbox"/>	No <input type="checkbox"/>	CRRT Experience? Yes <input type="checkbox"/>/No <input type="checkbox"/> What device? _____
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Rotoprone experience?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Conscious 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"/>	Infant Fetal Monitoring.
Yes <input type="checkbox"/>	No <input type="checkbox"/>	P/C Charting. 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"/>	Recognition of the need for psychological and social services for patients and their families.
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Recognition, interpretation, and recording of signs and symptoms in critically ill patients.
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Reviewed JCAHO National Patient Safety Goals
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Use of Emergency Equipment: Type: _____

Employee Name (printed)	Employee Signature/“VIA TELEPHONE” or “VIA EMAIL” (updates only)	Date
Agency Name	Reviewed By	Date