ConTemporary
HEALTHCARE SOLUTIONS

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Attachment 6

Chesapeake Registry Program WORK EXPERIENCE CHECKLIST- RN/LPN

Instructions: Fill out Completely. Range of dates must include exact dates: Month/Year – Month/Year.

BURN UNIT	___ yes	___ no	_____ dates of experience
CATH LAB	___ yes	___ no	_____ dates of experience
DIALYSIS - Hemo	___ yes	___ no	_____ dates of experience
DIALYSIS - Peritoneal	___ yes	___ no	_____ dates of experience
DIALYSIS - Renal	___ yes	___ no	_____ dates of experience
ER	___ yes	___ no	_____ dates of experience
ER – Pediatrics	___ yes	___ no	_____ dates of experience
EPIDURALS	___ yes	___ no	_____ dates of experience
GERIATRICS	___ yes	___ no	_____ dates of experience
HOME HEALTH:	___ yes	___ no	_____ dates of experience
H/H INFUSION	___ yes	___ no	_____ dates of experience
HOSPICE:	___ yes	___ no	_____ dates of experience
ICU - Adult	___ yes	___ no	_____ dates of experience
ICU - CV	___ yes	___ no	_____ dates of experience
ICU - Neuro	___ yes	___ no	_____ dates of experience
ICU - Pediatric	___ yes	___ no	_____ dates of experience
L & D	___ yes	___ no	_____ dates of experience
LTC:	___ yes	___ no	_____ dates of experience
MED SURG	___ yes	___ no	_____ dates of experience
NICU	___ yes	___ no	_____ dates of experience
NURSERY	___ yes	___ no	_____ dates of experience
NURSERY – level 2	___ yes	___ no	_____ dates of experience
OB	___ yes	___ no	_____ dates of experience
ONCOLOGY	___ yes	___ no	_____ dates of experience
OR	___ yes	___ no	_____ dates of experience
OR – CV	___ yes	___ no	_____ dates of experience
ORTHO	___ yes	___ no	_____ dates of experience
PACU	___ yes	___ no	_____ dates of experience
PEDIATRICS	___ yes	___ no	_____ dates of experience
PRIVATE DUTY:	___ yes	___ no	_____ dates of experience
PSYCH – Adult	___ yes	___ no	_____ dates of experience
PSYCH – Geriatric	___ yes	___ no	_____ dates of experience
PSYCH – Pediatrics	___ yes	___ no	_____ dates of experience
REHAB:	___ yes	___ no	_____ dates of experience
SKILLED VISIT:	___ yes	___ no	_____ dates of experience
TRAUMA	___ yes	___ no	_____ dates of experience
TELEMETRY	___ yes	___ no	_____ dates of experience

SYSTEMS & PROCEDURES:

___ yes ___ no Interpretation of Cardiac Dysrhythmias
___ yes ___ no Balloon Pump _____ dates of experience
___ yes ___ no Online Charting: System used _____
___ yes ___ no Blood Glucose Monitor: Type_____
___ yes ___ no The parenteral administration of electrolytes and fluids.
___ yes ___ no Moderate sedation experience? If yes, How many months/years? _____
___ yes ___ no IV insertion
___ yes ___ no Phlebotomy

_____
Employee Name (Printed) Name (employee signature or "via phone") and Date

ConTemporary Nursing Solutions, Inc
_____
Agency Name Agency Representative Signature and Date