

Specialty areas worked \_\_\_\_\_  
 (Name) \_\_\_\_\_ Years experience in this specialty(s) \_\_\_\_\_

**Please check the appropriate box that best describes your work experience level for each knowledge competency and skill. Evaluate yourself based on experiences within the last one to two years.**

0 = No Experience                      1 = Limited Experience                      2 = Experienced

**PATIENT CARE**

- Bed Bath  0  1  2
- Tub Bath  0  1  2
- Shower  0  1  2
- Skin Care: Back Rub, Apply Lotion  0  1  2
- Decubitus Care  0  1  2
- Shampoo  0  1  2
- Nail Care  0  1  2
- Oral Hygiene  0  1  2
- Shaving: Safety/Electric Razor  0  1  2
- Dressing - Assisting  0  1  2
- Supine/Prone  0  1  2
- Dressing - Complete  0  1  2
- Perineal Care - Male  0  1  2
- Perineal Care - Female  0  1  2
- Care of Confused Patient  0  1  2
- Care of Suicidal Patient  0  1  2
- Care of Combative Patient  0  1  2
- Post Mortem Care  0  1  2

**ENVIRONMENT**

- Linen Change - Unoccupied Bed  0  1  2
- Linen Change - Occupied Bed  0  1  2
- Light Housekeeping  0  1  2
- Meal/Snack Preparation  0  1  2

**OSHA/JCAHO**

- Handwashing  0  1  2
- Standard Precautions  0  1  2
- Isolation Techniques  0  1  2
- Patient's Bill of Rights  0  1  2

**TRANSFER/AMBULATION TECHNIQUES**

- Gait Belt  0  1  2
- Weight Bearing  0  1  2
- Hoyer Lift  0  1  2
- 2-Person Transfer  0  1  2
- Slide Board  0  1  2
- Wheelchair  0  1  2
- Cain  0  1  2
- Walker/Crutches  0  1  2

**POSITIONING/TURNING**

- Fowler's (Sitting)  0  1  2
- Lateral (Side Lying)  0  1  2
- Use of Draw Sheet  0  1  2
- Range of Motion (ROM)**  0  1  2
- Up In Chair  0  1  2
- Supine/Prone  0  1  2

**TAKE AND RECORD VITAL SIGNS**

- Temperature - Axillary  0  1  2
- Temperature - Oral  0  1  2
- Temperature - Rectal  0  1  2
- Pulse - Radial  0  1  2
- Pulse - Apical  0  1  2
- Pulse - Brachial  0  1  2
- Respirations  0  1  2
- Blood Pressure  0  1  2
- Height and Weight  0  1  2

I affirm that all information given on this page is true and accurate. Initials _____ Date _____	Page 1 of 2
--	-------------

(Name) \_\_\_\_\_ Specialty areas worked \_\_\_\_\_  
 Years experience in this specialty(s) \_\_\_\_\_

**Please check the appropriate box that best describes your work experience level for each knowledge competency and skill. Evaluate yourself based on experiences within the last one to two years.**

0 = No Experience                      1 = Limited Experience                      2 = Experienced

**NUTRITION/HYDRATION**

- Encourage Fluids                       0  1  2
- Assist in Feeding                       0  1  2
- Feeding Techniques                       0  1  2
- Measure and Record Input                       0  1  2
- Measure and Record Output                       0  1  2

**BOWEL & BLADDER (ELIMINATION)**

- Bed Pan/Urinal & Fracture Pan                       0  1  2
- Bedside Commode                       0  1  2
- Measure and Record Output                       0  1  2
- Foley Catheter Care                       0  1  2
- External Catheter Care                       0  1  2
- Enemas: Tap, H2O, Fleets, Soap Suds                       0  1  2
- Colostomy Care                       0  1  2

**MISCELLANEOUS**

- Admitting Patients                       0  1  2
- Discharging Patients                       0  1  2
- CPR                       0  1  2
- Choking                       0  1  2
- Resuscitation                       0  1  2
- Blood Glucose Monitor                       0  1  2

**SPECIMEN COLLECTION**

- Urine                       0  1  2
- Stool                       0  1  2
- Sputum                       0  1  2

**OXYGEN**

- Flow Rate                       0  1  2
- Water to Humidifier                       0  1  2
- Cannula/Mask Placement                       0  1  2

**OBSERVATION/REPORTING/DOCUMENTATION**

- Change in Body Function                       0  1  2
- Change in Behavior                       0  1  2
- Change in Routines                       0  1  2
- Charting on Graphics Sheets                       0  1  2
- Charting on Nurse Notes                       0  1  2

**SAFETY DEVICES/EQUIPMENT**

- Padded Side Rails                       0  1  2
- Use of Restraints                       0  1  2
- Ace Bandage                       0  1  2
- Cast Care                       0  1  2
- Hot / Cold Packs                       0  1  2
- Bed Scale                       0  1  2
- CPM / Ortho                       0  1  2
- Traction                       0  1  2

**Age Specific Practice Criteria**

*Please check the boxes below for each group for which you have expertise in providing age-appropriate care.*

**A = Newborn/Infant**  
**(Birth - 1 Year)**

**B= Pediatric/Adolescent**  
**(1-18 Yrs)**

**C=Adult**  
**(19-64 Yrs)**

**D=Geriatric**  
**(65+ Yrs)**

	A	B	C	D
Able to adapt care to incorporate normal growth and development.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to adapt method and terminology of patient instructions to their age, comprehension and maturity level.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to ensure a safe environment to reflect needs and alter environment accordingly.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to administer treatments and care appropriately and understand different methods of patient care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I affirm that all information given on this page is true and accurate. Signature \_\_\_\_\_ Date \_\_\_\_\_ Page 2 of 2