

NJHA Registry Management Program

Attachment 6

NJHA Work Experience Check List – (required for RNs/LPNs Only)

Instructions: Please fill out completely. Range of dates must include exact dates: Month/Year through Month/Year

BURN UNIT	___ yes	___ no	_____	dates of experience
CATH LAB	___ yes	___ no	_____	dates of experience
DAILYSIS	___ yes	___ no	_____	dates of experience
ER	___ yes	___ no	_____	dates of experience
EPIDURALS	___ 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 - 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
TELE - General	___ yes	___ no	_____	dates of experience
TELE - Progressive	___ yes	___ no	_____	dates of experience

SYSTEMS & PROCEDURES

___ yes	___ no	Basic Recognition of EKG arrhythmias
___ yes	___ no	Use of emergency equipment
___ yes	___ no	Balloon Pump Balloon Pump Certified ___ yes ___ no
___ yes	___ no	Computer Charting System used _____
___ yes	___ no	Blood Glucose Monitor: Type _____
___ yes	___ no	The recognition, interpretation, and recording of signs and symptoms in critically ill patient.
___ yes	___ no	The parenteral administration of electrolytes and fluids IV Certified ___ yes ___ no
___ yes	___ no	Conscious Sedation experience: If yes, How many months/years? _____
___ yes	___ no	Annual In-service training in Universal Precautions, Fire/Electrical Safety, OSHA hazardous waste, TB Transmission, Blood-borne Pathogen exposure in the workplace, Age Specific Criteria, and Violence in the Workplace.
___ yes	___ no	The recognition of the need for psychological and social services for patients and their families.

Employee Name (Printed)

Agency Name

Name (employee signature or "via phone") and Date

Agency Representative **Signature and Date**