

NAME: _____

	1	2	3	4
A. ALCOHOL DEPENDENCY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. DRUG DEPENDENCY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. ELECTROCONVULSIVE THERAPY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. HALLUCINATIONS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. MANIC BEHAVIOR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. MED-PSYCH PATIENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. ORGANIC DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. PARTIAL HOSPITAL/INTENSIVE OUTPATIENT PROGRAM PATIENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. SECLUSION AND RESTRAINTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. SEIZURE DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. SUICIDAL BEHAVIOR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. TRACHEOSTOMY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. MEDICATIONS:				
A. ADMINISTRATION OF ORAL PSYCHOTROPIC MEDICATIONS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. HEPARIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. INTRAMUSCULAR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. MANAGEMENT OF EXTRAPYRAMIDAL SYMPTOMS (EPS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	1	2	3	4
E. ORAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. RECTAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. SUB-Q	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. UNIT DOSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Z-TECHNIQUE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. PHLEBOTOMY/IV THERAPY				
1. EQUIPMENT & PROCEDURES:				
A. ADMINISTRATION OF BLOOD/BLOOD PRODUCTS:				
1) PACKED RED BLOOD CELLS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) WHOLE BLOOD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. DRAWING BLOOD FROM CENTRAL LINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. DRAWING VENOUS BLOOD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. MANAGEMENT OF PATIENT WITH HYPERALIMENTATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. MANAGEMENT OF PATIENT WITH IV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. STARTING IVS:				
1) ANGIOCATH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) BUTTERFLY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) HEPARIN LOCK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

AGE SPECIFIC PRACTICE CRITERIA:

PLEASE CHECK THE BOXES BELOW FOR EACH AGE GROUP FOR WHICH YOU HAVE EXPERTISE IN PROVIDING AGE-APPROPRIATE NURSING CARE.

A. NEWBORN/NEONATE (BIRTH - 30 DAYS)	D. PRESCHOOLER (3 - 5 YEARS)	G. YOUNG ADULTS (18 - 39 YEARS)
B. INFANT (30 DAYS - 1 YEAR)	E. SCHOOL AGE CHILDREN (5 - 12 YEARS)	H. MIDDLE ADULTS (39 - 64 YEARS)
C. TODDLER (1 - 3 YEARS)	F. ADOLESCENTS (12 - 18 YEARS)	I. OLDER ADULTS (64+)

	A	B	C	D	E	F	G	H	I
ABLE TO ADAPT CARE TO INCORPORATE NORMAL GROWTH AND DEVELOPMENT.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CAN ENSURE A SAFE ENVIRONMENT REFLECTING SPECIFIC NEEDS OF VARIOUS AGE GROUPS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<p>MY EXPERIENCE IS PRIMARILY IN: (PLEASE INDICATE NUMBER OF YEARS.) ADOLESCENT _____ YEAR(S) ADULT _____ YEAR(S) CHEMICAL DEPENDENCY/DETOX YEAR(S)</p>

CERTIFICATION:	EXP DATE:	CERTIFICATION:	EXP DATE:
<input type="checkbox"/> BCLS		<input type="checkbox"/> OTHER	
<input type="checkbox"/> CEN		<input type="checkbox"/> OTHER	
<input type="checkbox"/> TNCC		<input type="checkbox"/> OTHER	
<input type="checkbox"/> ACLS		<input type="checkbox"/> OTHER	

THE INFORMATION I HAVE GIVEN IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE AS NEEDED STAFFING TO RELEASE THIS PSYCHIATRIC NURSING SKILLS CHECKLIST TO CLIENT FACILITIES OF AS NEEDED STAFFING IN RELATION TO CONSIDERATION OF MY EMPLOYMENT WITH THOSE FACILITIES.

SIGNATURE

DATE