msg group medical staffing

AMBULATORY NURSING SKILLS CHECKLIST

Date: ______________________

Full Name: ____

INSTRUCTIONS

Please provide accurate answers so we can correctly match your abilities to our client job requirements. Please check the level of experience and expertise you have in each skill category, using the following scale:

#1 = Familiar with procedure but will usually or almost always require some assistance.

#2 = Competent and familiar with procedure: I can perform this procedure with excellence, usually without assistance.

#3 = Very competent: I have at least 12 months experience and can perform this procedure with excellence and without assistance.

NOTE: ***Leave blank*** any procedures which you have **no experience, training or low competence**.

SKILLS	*1*	*2*	*3*
Primary Care			
Team Nursing			
Modular Nursing			
Complete Patient Care			
Functional Care			
Modified Care			
Catherization			
Gastric Feedings			
Nasogastric Feeding			
K-Pad			
IM Injections			
Intradermal Injections			
Subcutaneous Injection			
Sterile Dressing Change			
Isolation Techniques			
Phlebotomy			
EKG			
Respiratory Care			
IV Therapy			
U/A			
Blood Pressure			
TPR			
Recording Vital Signs			
Other (Please State)			
1. Age Specific Practice Criteria			
Newborn/Neonate (birth - 30 days)			
Infant (30 days - 1 yr)			
Toddler (1 - 3 yrs)			
Preschooler (3 - 5 yrs)			

SKILLS	*1*	*2*	*3*
School age children (5 - 12 yrs)			
Adolescents (12 -18 yrs)			
Young Adults (18-39 yrs)			
Middle Adults (39 - 64 yrs)			
2. Care of patient with:			
Older Adults (64+ yrs)			
Able to adapt care to incorporate normal growth and development.			
Able to adapt method and terminology of patient instructions to their age, comprehension and maturity level.			
Can ensure a safe environment reflecting specific needs of various groups.			
SPECIALTIES			
Medical			
Surgical			
Pediatrics			
Psychiatry			
OB			
Oncology			
Orthopedics			
Outpatient			
Geriatrics			
Doctors Office			
Private Duty			
Family Practice			
Internal Medicine			
Other (Please State)			

Certification:

Please check the boxes below and indicate the expiration date for each certificate that you hold. If you do not know the exact date, please use the last date of the specific month (e.g., 05/31/2003).

CERTIFICATION	***Expiration Date/ or Date of:***
☐ BCLS	
☐ MAB	
☐ Other (type):	
☐ Computerized charting system:	
☐ Medication administration system:	

I hereby certify all statements and claims as true and that any misrepresentation of the facts on this skills checklist is sufficient cause for dismissal at any time without prior notice even if I have been already employed.

Full Name (Print): ____

Signature: ____

Retyped name acts as signature, if submitting form by email

Reviewed by______________________: Date: ________________

51 Union St, Suite 105, Worcester, MA 01608. (T): 1-888-MSG-RNRN (674-7676), 508-799-7674 (F): 1-888-201-6674, 1-508-799-6674