



## AMBULATORY NURSING SKILLS CHECKLIST

First Name	MI	Last Name
E-mail	Last 4 digits SS#	Date

**Instructions:** Please check the appropriate column that best describes your experience level for each knowledge competency and skill. Please use the rating scale below to evaluate yourself based on experiences within the last two years.

### Self-Assessed Experience Rating Scale

1 = No Experience    2 = Minimal Experience    3 = Performs well/competent    4 = Supervise and Teach

Skills:	1	2	3	4
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 Injections				
Sterile Dressing Change				
Isolation Techniques				
Phlebotomy				
EKG				
Respiratory Care				
IV Therapy				
U/A				
Blood Pressure				
TPR				
Recording Vital Signs				
Other (Please Specify)				

Skills:	1	2	3	4
Medical				
Surgical				
Pediatrics				
Psychiatry				
OB				
Oncology				
Orthopedics				
Outpatients				
Geriatrics				
Doctors Office				
Private Duty				
Family Practice				
Internal Medicine				
Other (Please Specify)				

Name: \_\_\_\_\_

Ambulatory Nursing  
Skills Checklist (page 2)

**Certification:**

<b>SKILLS CONTINUED:</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>1. Age Specific Practice Criteria</b>				
Newborn/Neonate (birth – 30 days)				
Infant (30 days – 1 year)				
Toddler (1 – 3 years)				
Preschooler (3 – 5 yrs)				
School age children (5 – 12 years)				
Adolescents (12 – 18 years)				
Young Adults (18 – 39 years)				
Middle Adults (39 – 64 years)				
Older Adults (64+ years)				
<b>2. Care of Patient with:</b>				
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.				

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 (i.e. 1/31/2007).

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 checklist is sufficient cause for dismissal at any time without prior notice even if I have been already employed.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date