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**Skills Checklist - Newborn and Pediatric**

The following **checklist** is used to assess your experience and **skills**. Please provide a self-assessment of your **skills** using the following guidelines: (MARK WITH AN “**X**”)

1 - No experience

2 - Require training

3 - Have performed this task and able to perform without supervision

4 - Experienced and able to perform independently

5 - Able to teach and supervise

I understand that the information provided in this application is true to the best of my knowledge. I authorize the release of the information in this document to Master Staffing, Inc. and the facilities where I may be employed.

**Name -**

**Date -**

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| **Newborn and Pediatric Care** |
|   | **1** | **2** | **3** | **4** | **5** |
| Administration of Blood/Blood Products  |   |   |   |   |   |
| Adolescent  |   |   |   |   |   |
| Apnea Monitoring  |   |   |   |   |   |
| Assist with Lumbar Puncture  |   |   |   |   |   |
| Blood Exchange  |   |   |   |   |   |
| Calculation of Pedi Dosage  |   |   |   |   |   |
| Cardiac Arrest/CPR  |   |   |   |   |   |
| Chemotherapy  |   |   |   |   |   |
| Cord and Circumcision Care  |   |   |   |   |   |
| ECMO  |   |   |   |   |   |
| Glascow Coma Scale  |   |   |   |   |   |
| Hemodynamic Monitoring  |   |   |   |   |   |
| IMV  |   |   |   |   |   |
| Infant  |   |   |   |   |   |
| Infusion Pumps  |   |   |   |   |   |
| Interpretation of Arrhythmias  |   |   |   |   |   |
| Jet Vents  |   |   |   |   |   |
| Knowledge of Normal Serum Lab Values  |   |   |   |   |   |
| Maintenance of Heparin Locks  |   |   |   |   |   |
| Neonatal Level (Circle Level) |   |   |   |   |   |
| **Newborn** Nursery  |   |   |   |   |   |
| Obtain Specimens from UAC and UVC  |   |   |   |   |   |
| Oncology/Hematology  |   |   |   |   |   |
| **Pediatric** ICU  |   |   |   |   |   |
| Pediatrics  |   |   |   |   |   |
| Phototherapy  |   |   |   |   |   |
| PIP  |   |   |   |   |   |
| Preparation of Emergency Drugs  |   |   |   |   |   |
| Pulse Oximetry |   |   |   |   |   |
| Scalp Veins  |   |   |   |   |   |
| School Aged  |   |   |   |   |   |
| Starting IVs  |   |   |   |   |   |
| Toddler  |   |   |   |   |   |
| TPN/Hyperalimentation |   |   |   |   |   |
| Transducer Set-Up &Maint. of A-Line  |   |   |   |   |   |
| Transducer Set-Up &Maint. of Swan Ganz |   |   |   |   |   |
| Transducer Set-Up & Maintenance of UAC  |   |   |   |   |   |
| Transducer Set-Up & Maintenance of UVC  |   |   |   |   |   |
| **Care of Patient With** |
| Asthma  |   |   |   |   |   |
| Bone Marrow Transplant  |   |   |   |   |   |
| Bowel Obstruction  |   |   |   |   |   |
| Broncho-Pulmonary Dysplasia  |   |   |   |   |   |
| Drug Addiction/Withdrawal  |   |   |   |   |   |
| Endotracheal Tube Care and Suctioning  |   |   |   |   |   |
| Tracheostomy Care and Suctioning  |   |   |   |   |   |
| Pre/Post Cardiac Surgery  |   |   |   |   |   |
| Pre/Post Cardiac Cath |   |   |   |   |   |
| Pre/Post Neuro Surgery  |   |   |   |   |   |
| Pre/Post Thoracic Surgery  |   |   |   |   |   |
| CHF  |   |   |   |   |   |
| Cystic Fibrosis  |   |   |   |   |   |
| Diabetes Mellitus  |   |   |   |   |   |
| Epiglottiditis |   |   |   |   |   |
| Failure to Thrive  |   |   |   |   |   |
| Intracranial Hemorrhage  |   |   |   |   |   |
| Leukemia  |   |   |   |   |   |
| Low Birth Weight Infants  |   |   |   |   |   |
| Meconium Aspiration  |   |   |   |   |   |
| Meningitis  |   |   |   |   |   |
| Near Drowning  |   |   |   |   |   |
| N.E.C.  |   |   |   |   |   |
| Neuromuscular Disease  |   |   |   |   |   |
| NG Tube Feeding  |   |   |   |   |   |
| Overdose/Poison Ingestion  |   |   |   |   |   |
| PDA Ligation  |   |   |   |   |   |
| Pneumonia  |   |   |   |   |   |
| Post Harrington Rod Insertion  |   |   |   |   |   |
| Pulmonary Edema  |   |   |   |   |   |
| RDS  |   |   |   |   |   |
| Seizure Activity  |   |   |   |   |   |
| Sickle Cell Disease  |   |   |   |   |   |
| Spina Bifida  |   |   |   |   |   |
| Systemic Infection  |   |   |   |   |   |
| Tetralogy of Fallot |   |   |   |   |   |
| Tracheoesophogeal Fistula  |   |   |   |   |   |
| Transposition of Great Vessels  |   |   |   |   |   |

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| I certify that all of the above information is correct and that any misrepresentation or falsification of fact may be considered sufficient cause for Immediate dismissal from \_\_\_\_\_\_\_\_\_\_\_\_\_.  I have filled out this **skills checklist** to the best of my knowledge and agree that all of the information Provided is correct (please check box).NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Please Print Clearly)      DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    LICENSE NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |