Friendship Clinic **Nurse Skills Checklist**

DATE:
NAME:

Current License # and State:
Copy of current CPR:
Copy of current TB:

In the **last year,** have you performed:

__Yes __No Vital Signs

__Yes __No Blood glucose w/ glucometer

__Yes __No Oxygen sat

__Yes __ No Venipuncture

__Yes __ No Urine dip

__Yes __ No Hemocult

__Yes __ No Quick Strept test

__Yes __No SubQ Injections

__Yes __ No IM injections

__Yes __ No Steri strip application

__Yes __ No Sterile technique

__Yes __ No Staple removal

__Yes __ No Wound care/ apply dressings

__Yes __No Assist with & prepare supplies for suturing

__Yes __No Nebulizer

Are you CPR certified? __Yes __No

AED trained? __Yes __No

If so, when and where____

Do you have experience in a clinic setting? __Yes __No

If so, when and where ____