Southern Healthcare Agency, Inc.

C N A

EMPLOYEE INTAKE

NAME:_____ **DATE:**_____

***Please note years of experience (1 year min. required). DOES NOT INCLUDE CLINICAL ROTATIONS**

SKILLS	YRS EXP		SKILLS	YRS EXP
Access Devices			Neuro	
Ports			NICU	
PICC Lines			Nursing Home	
Cardiac Cath			OB	
Case Manager			Occupational	
Cat Scans			Oncology	
Charge			OR	
Chem. Dependency			Ortho	
Adult			Peds	
Child			PICU	
Clinic			Private Duty	
Correctional			Psych	
Dialysis			Adult	
ER			Child	
Geriatrics			Quads	
Hemodialysis			Recovery	
Home Health			Rehab	
Home Infusion			Respite	
Hospice			Step-Down	
ICU/CCU			Telemetry	
Industrial			Trach Care	
L & D			Ventilator Care	
IV Certified			Wound Care	
Med Surg				
Mental Retardation			Other: Please List	
Adult				
Child				

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CNA Skills Evaluation - Self Assessment

Levels of Proficiency

A = Expert. You have performed this task frequently and you would feel comfortable with no Supervision.

B = Experienced In. You have performed task before, but would feel comfortable with a resource person nearby.

C = Familiar With. You are familiar with the task, but you feel you need more skill or practice.

D = Never Performed. I have never performed this task.

Please mark an **"X"** in the column that best describes your level of proficiency.

Certified Nursing Assistant		**A**	**B**	**C**	**D**
Documentation:					
Clinical Note					
Personal Care					
Total Bed Bath					
Tub Bath					
Shower					
Sponge Bath					
Sitz Bath					
Hair Care					
Shampoo					
Nail and Foot Care					
Skin Care					
Perineal Care					
Oral Care					
Denture Care					
Shave					
Assist with Dressing					
Other: (LIST)					
Elimination:					
Monitor Bowel Movements					
Measure Output					
Bedpan					
Bedside Commode					
Assist to Bathroom					
Assist with Bowel Program					
Empty Catheter Bag					
Empty Drainage Bag					
Other: (LIST)					

Certified Nursing Assistant		A	B	C	D
Activity:					
Repositioning					
Walk with Assistance					
Walk with Supervision					
Up in Chair					
Dangle					
Walker					
Passive Range of Motion					
Active Range of Motion					
Transfer					
Hoyer Lift					
Assist with Exercise Program					
Other: (LIST)					
Observation:					
Temperature					
Oral					
Axillary					
Respiration:					
Blood Pressure					
Weight					
Nutrition:					
Serve Meal					
Assist with Feeding					
Encourage Fluids					
Fluid Restriction					
Other: (LIST)					
Care of Patient:					
Linen Change					
Complete Bed Change					
Cleaning					
Infection Control:					
Universal Precautions					
TB Precautions					
Blood Borne Pathogens					
Disposal of Hazardous Waste					

Certified Nursing Assistant		A	B	C	D
Age-Appropriate Care:					
Newborn (birth-30 days)					
Infant (30 days-1 year)					
Toddler (1-3 years)					
Preschooler (3-5 years)					
School Age (5-12 years)					
Adolescents (12-18 years)					
Young Adults (18-39 years)					
Middle Adults (39-64 years)					
Olders Adults (64 + years)					

The information I have given is true and accurate to the best of my knowledge, and I hereby authorize Southern Healthcare Agency, Inc. to release this Skills Checklist to staffing clients of Southern Healthcare. Submit this self evaluation checklist with your initial application. To be Updated annually.

_____

Applicant Signature Date

_____

Applicant Name & Title (please print)

_____

SHA Representative Signature Date