BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS
EMPLOYMENT VERIFICATION – NURSING EXPERIENCE

Part I is to be completed by the applicant and submitted to employers for verification of nursing experience. The remainder of this form must be completed by the RN Director or Supervisor and returned to the applicant by the employer in a sealed business envelope. FORMS CONTAINING STRIKEOUTS OR CORRECTIONS WILL NOT BE ACCEPTED. (See Page 1 for detailed instructions on how to complete this form.)

Part I: To be completed by the Applicant (print or type - do not use pencil):

1. NAME (LAST)	(FIRST)	(MIDDLE)
2. ADDRESS	(STREET OR BOX NUMBER)	(APT. NO)
3. CITY	STATE	ZIP
4. NAME WHILE EMPLOYED AT THIS FACILITY:	5. SOCIAL SECURITY NUMBER* **NOT required, but may assist employer in locating records*	6. DAYTIME TELEPHONE NUMBER ( )_____ Area Code

Part II: To be completed by the Employer - Indicate the name and type of facility where the experience was obtained:

Name of facility where experience was obtained:

Type of facility: □ Acute or sub-acute(hospital) □ Convalescent □ Skilled Nursing/Long Term Care □ Assisted Living
□ Home Health □ Outpatient Clinic/emergency care □ Other

Part III: To be completed by the Employer - Include dates and the area of nursing being verified. Indicate if employment was full-time (40 hrs/wk) or part-time and include the total number of hours worked in each area:

Areas of Bedside Nursing Experience	Employment Period: (Month/Date/Year)	Hours Worked Per Week	Total Hours In Each Area	For Office Use Only
Medical-Surgical Nursing	From: / / To: / /			
Pediatric Nursing	From: / / To: / /			
Maternity Nursing	From: / / To: / /			
Genitourinary Nursing	From: / / To: / /			
Psychiatric Nursing	From: / / To: / /			
Office Nursing	From: / / To: / /			
Long Term Care/Convalescent	From: / / To: / /			
Private Duty (in a general acute care facility)	From: / / To: / /			
Other:	From: / / To: / /			

Part IV: To be completed by the Employer - Indicate if the applicant has satisfactorily demonstrated the following knowledge and skills with safety to the patient:

Knowledge and Skills	Demonstrated YES	Demonstrated NO	Knowledge and Skills	Demonstrated YES	Demonstrated NO
A. Basic Bedside Nursing					
1. Ambulation Techniques			9. Intake and Output		
2. Bedmaking			10. Personal Hygiene and Comfort Measures		
3. Urinary Catheter Care			11. Positioning and Transfer		
4. Collection of Specimens			12. Range of Motion		
5. Diabetic Testing			13. Skin Care		
6. Administration of a Cleansing Enema			14. Vital Signs		
7. Feeding Patient			15. Communication Skills, Both Verbal and Written, Including Communication With Patients Who Have Psychological Disorders		
8. Hot and Cold Applications					
B. Infection Control Procedures (may be demonstrated in classroom, lab, and/or patient care settings)					
1. Asepsis			2. Techniques for strict, contact, respiratory, enteric, tuberculosis, drainage, universal and immunosuppressed patient isolation.		

TO BE SIGNED BY THE RN DIRECTOR OR SUPERVISOR: I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE FOREGOING IS TRUE AND CORRECT.

Signature: _____ Print Name_____
Nursing License # _____Exp. Date:_____ Telephone Number: (_____)_ _____
Address: _____ Today's Date: _____
City/State: _____ Zip Code:_____