

UNIVERSITY OF WASHINGTON SCHOOL OF NURSING
INFORMATION FOR EMPLOYERS OF STUDENT NURSES
 NCLIN 306, NCLIN 402, & NCLIN 406 CLINICAL SKILLS CHECKLIST

STUDENT _____

PROJECTED GRADUATION YEAR _____

To the employer: The above-named student has completed the clinical courses below, as signed by the instructor.

To the Instructor: SECTION I: Provide the quarter and year the student enrolled in your course. Circle the descriptor that best portrays the student's skills as demonstrated in the course. Write in the name of the clinical site. SECTION II: Check each skill the student has performed in the context of your course. SECTION III: Rate the student overall using a 1 (below average) to 4 (excellent) scale. Make additional comments in the space provided. Sign and date your review. Obtain the signature and date of the student. **SEND/BRING A COPY TO ACADEMIC SERVICES, BOX 357260, HEALTH SCIENCES BUILDING ROOM T310**, for the student file.

To the Student: Review the responses of your instructor. Sign and date your review. Your signature constitutes permission to share this form with employers, including as a reference regarding courses and skills completed. **RETAIN A COPY FOR YOUR RECORDS.**

SECTION I

Quarter _____ Year _____ NCLIN 306: Basic Skills of Nursing Practice <i>Health Status:</i> <input type="checkbox"/> well <input type="checkbox"/> acutely ill <input type="checkbox"/> chronically ill <i>Developmental Level:</i> <input type="checkbox"/> child <input type="checkbox"/> adult <input type="checkbox"/> elder <i>Primary Response:</i> <input type="checkbox"/> physiological <input type="checkbox"/> psychosocial <i>Setting:</i> <input type="checkbox"/> Community <input type="checkbox"/> Hospital <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient Site: _____	Quarter _____ Year _____ NCLIN 402: Care in Illness I <i>Health Status:</i> <input type="checkbox"/> well <input type="checkbox"/> acutely ill <input type="checkbox"/> chronically ill <i>Developmental Level:</i> <input type="checkbox"/> child <input type="checkbox"/> adult <input type="checkbox"/> elder <i>Primary Response:</i> <input type="checkbox"/> physiological <input type="checkbox"/> psychosocial <i>Setting:</i> <input type="checkbox"/> Community <input type="checkbox"/> Hospital <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient Site: _____	Quarter _____ Year _____ NCLIN 406: Care in Illness II <i>Health Status:</i> <input type="checkbox"/> well <input type="checkbox"/> acutely ill <input type="checkbox"/> chronically ill <i>Developmental Level:</i> <input type="checkbox"/> child <input type="checkbox"/> adult <input type="checkbox"/> elder <i>Primary Response:</i> <input type="checkbox"/> physiological <input type="checkbox"/> psychosocial <i>Setting:</i> <input type="checkbox"/> Community <input type="checkbox"/> Hospital <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient Site: _____
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SECTION II

<input type="checkbox"/> Bath: <input type="checkbox"/> Bed <input type="checkbox"/> Tub <input type="checkbox"/> Shower <input type="checkbox"/> Blood glucose monitoring <input type="checkbox"/> Care maps/treatment plans <input type="checkbox"/> Chest tubes <input type="checkbox"/> Discharge teaching <input type="checkbox"/> Infusion pumps <input type="checkbox"/> Intake & output	Medications: <input type="checkbox"/> PO <input type="checkbox"/> SQ <input type="checkbox"/> IM <input type="checkbox"/> ID <input type="checkbox"/> NG <input type="checkbox"/> SL <input type="checkbox"/> IV <input type="checkbox"/> IVPB <input type="checkbox"/> Monitoring/Regulating IV Therapy NG tube: <input type="checkbox"/> Insert <input type="checkbox"/> Monitor <input type="checkbox"/> Feeding Oxygen therapy: <input type="checkbox"/> Masks <input type="checkbox"/> Cannula <input type="checkbox"/> Aerosol Rx <input type="checkbox"/> Perinatal Care <input type="checkbox"/> Peri-operative care	<input type="checkbox"/> Restraint application <input type="checkbox"/> Sterile dressing: <input type="checkbox"/> wet <input type="checkbox"/> dry <input type="checkbox"/> Support stocking application <input type="checkbox"/> Anti-embolism device application <input type="checkbox"/> Tracheostomy care and suctioning <input type="checkbox"/> Urinary catheterization: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Vital signs (T, P, R, BP) <input type="checkbox"/> Weight: <input type="checkbox"/> bed <input type="checkbox"/> chair <input type="checkbox"/> standing
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SECTION III

EVALUATION 1=below average 2=average 3=very good 4= excellent <input type="checkbox"/> Quality of work <input type="checkbox"/> Dependability <input type="checkbox"/> Professional Conduct <input type="checkbox"/> Communication <input type="checkbox"/> Use of Supervision COMMENTS: <hr/> Instructor name (<i>please print</i>) <hr/> Signature of Instructor _____ Date _____ <hr/> Signature of Student _____ Date _____	EVALUATION 1=below average 2=average 3=very good 4= excellent <input type="checkbox"/> Quality of work <input type="checkbox"/> Dependability <input type="checkbox"/> Professional Conduct <input type="checkbox"/> Communication <input type="checkbox"/> Use of Supervision COMMENTS: <hr/> Instructor name (<i>please print</i>) <hr/> Signature of Instructor _____ Date _____ <hr/> Signature of Student _____ Date _____	EVALUATION 1=below average 2=average 3=very good 4= excellent <input type="checkbox"/> Quality of work <input type="checkbox"/> Dependability <input type="checkbox"/> Professional Conduct <input type="checkbox"/> Communication <input type="checkbox"/> Use of Supervision COMMENTS: <hr/> Instructor name (<i>please print</i>) <hr/> Signature of Instructor _____ Date _____ <hr/> Signature of Student _____ Date _____
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