

Annual Skills Checklist

INSTRUCTIONS: ONLY Directors/Managers/Coordinators or person otherwise designated by nursing may complete this form. Check only those skills you have watched staff correctly perform per DODD Curriculum Skills Checklists. See nursing with any issues. Return to nursing no more than 6 months prior to staff Med Admin expiration date.

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| <input type="checkbox"/> Oral | <input type="checkbox"/> Vitals |
| <input type="checkbox"/> Sublingual | <input type="checkbox"/> Apply Clean Dressing |
| <input type="checkbox"/> Diastat | <input type="checkbox"/> Measuring Bodily I/O |
| <input type="checkbox"/> Ear | <input type="checkbox"/> External Urinary Catheter Care |
| <input type="checkbox"/> Eye | <input type="checkbox"/> Empty Urinary Collection Bag |
| <input type="checkbox"/> Nasal | <input type="checkbox"/> Collection of Clean Catch Urine |
| <input type="checkbox"/> Transdermal | <input type="checkbox"/> Oral Suction |
| <input type="checkbox"/> Rectal | <input type="checkbox"/> Glucometer |
| <input type="checkbox"/> Vaginal | <input type="checkbox"/> Empty/Replace Colostomy Bag |
| <input type="checkbox"/> Topical OTC Musculoskeletal | <input type="checkbox"/> Bi/CPap |
| <input type="checkbox"/> Skin Medications | <input type="checkbox"/> Prescription Compression Hose |
| <input type="checkbox"/> Inhalers | <input type="checkbox"/> Pulse Oximetry |
| <input type="checkbox"/> Nebulizer | <input type="checkbox"/> Cough Assist Insufflator |
| <input type="checkbox"/> Oxygen | <input type="checkbox"/> Apply Compression Vest |

Staff Printed Name	Staff Signature	Date
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Authorized Person Printed Name/Title	Authorized Person Signature	Date
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