

MERCY HOSPITAL  
IOWA CITY, IOWA

NURSING EXPERIENCE QUESTIONNAIRE

Name \_\_\_\_\_ Date \_\_\_\_\_

PLEASE ANSWER ANY OR ALL QUESTIONS RELATED TO YOUR PREVIOUS EXPERIENCE

1. What nursing areas have you worked in most exclusively? Length of time?

Ambulatory Surgery _____	Pediatrics _____
ENT _____	Psychiatric _____
General Medicine _____	Surgery _____
General Surgical _____	Urology _____
Neurology _____	Coronary Care _____
Obstetrics _____	Emergency _____
Labor and Delivery _____	MICU _____
Nursery _____	ICU _____
NICU _____	Recovery _____
Oncology _____	Other _____

2. Are you currently certified in Basic Cardiac Life Support?

Yes No Date of Expiration \_\_\_\_\_

3. Are you currently certified in Advanced Cardiac Life Support?

Yes No Date of Expiration \_\_\_\_\_

4. Are you certified in any nursing specialty areas?

Yes No Please describe \_\_\_\_\_

5. Have you had experience with the following? Comments.

a. Clinical Ladder Program	yes	no
b. Computer entry for orders, patient information, etc.	yes	no
c. CVP lines	yes	no
d. Insertion of IV's	yes	no
e. Intradermal injection technique	yes	no
f. IV PCA pumps	yes	no
g. Nursing Diagnosis and Patient Care Planning	yes	no
h. Patient Classification System	yes	no
i. Quality Improvement Program	yes	no
j. Tracheostomy Care	yes	no
k. Ventilators	yes	no

Comments

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(OVER)

6. What type of nursing care delivery system have you used?

Primary  
Team  
Total Patient  
Other \_\_\_\_\_

7. Approximately how many patients have been your direct responsibility in your previous work situation(s)? \_\_\_\_\_

8. Are you accustomed to assigning, teaching, and evaluating auxiliary personnel? Yes No

9. Have you attended a formal critical care class? Yes No  
Number of hours \_\_\_\_\_ Date attended \_\_\_\_\_

If Yes:

- a. Was clinical experience part of the class Yes No  
b. Did you have clinical experience in an intensive and/or coronary care unit immediately after completing the classes? Yes No  
If no, what length of time between classes and clinical experience? \_\_\_\_\_  
c. Have you used MCL1 monitoring lead? Yes No

10. Have you had experience with the following? Comments.

- |    |                               |     |    |
|----|-------------------------------|-----|----|
| a. | Arterial line                 | Yes | No |
| b. | Swan-Ganz                     | Yes | No |
| c. | Thermodilution Cardiac Output | Yes | No |
| d. | SV02 monitoring               | Yes | No |
| e. | Defibrillation                | Yes | No |
| f. | EKG Interpretation            | Yes | No |
| g. | Rhythm strip interpretation   | Yes | No |
| h. | Permanent Pacer               | Yes | No |
| i. | Temporary Pacer               | Yes | No |
|    | 1. AV Sequential              | Yes | No |
|    | 2. External                   | Yes | No |
| j. | Initiating Emergency Protocol | Yes | No |
| k. | Intra-Aortic Balloon Pump     | Yes | No |
| l. | Post-op Cardiac Surgery       | Yes | No |

Revised: 6/01