

**CERTIFIED NURSE ASSISTANT  
SKILLS CHECKLIST**

**NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

*Please place a check in the column that best describes your clinical experience.*

CLINICAL SKILL INVENTORY	HAVE DONE MANY TIMES	A FEW TIMES	NEVER DONE
HAVE DONE: a. Massages			
b. Enema			
c. Feed Patient			
d. Foley Catheter Care			
e. Tracheostomy			
Caring for Patient in: a. Isolation			
Restraints: a. Posey Jackets			
b. Wrist Restraints			
Post Mortem Care			
Body Mechanics			
Turning and Positioning			
Transferring patient on to a gurney			
Assist with Ambulation			
Collecting Lab Specimen: a. Urine			
b. Stool			
c. Sputum			
d. Clini-Test			
Measure & Record Vital Signs			

The information I have given is true and accurate to the best of my knowledge. I hereby authorize Be Well Nursing LLC. to release checklist to client health care facilities of Be Well Nursing LLC. relating to my contract employment with that facility.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)