



EQUIPMENT CHECKLIST

NAME: _____ TITLE: _____ DATE: _____

Please check the appropriate letter of proficiency for the following types of clinical situations and equipment.

LEVEL OF PROFICIENCY

- A = Able to teach & supervise
- B = 1 year constant experience
- C = Intermittent experience
- D = No experience

	A	B	C	D
BEDS				
Bari Kare				
Bio DyneII				
Fluid Air Plus				
Kin Air III				
Kin Air/TC				
Hill Rom Advance 2000				
BLOOD PRESSURE MONITOR				
Colin				
COOLING BLANKET				
Medi-therm hyper/hypothermia				
COMPRESSION STOCKINGS				
Kendall				
C.P.M.				
Danni Flex				
Kine Tec				
EAGLE MONITOR				
EMERGENCY CART SUPPLY CHECKLIST				
FALL SAFE MONITOR				
GAYMAR SOFCARE BED CUSHION				
HEMOCRON/ACT TESTING				
HOYER LIFT				
IV PUMPS				
Bard PCA				
Baxter FloGard				
CADD PCA				



Equipment Checklist

	A	B	C	D
RIK Overlay				
Q2 Overlay				
FOOT EXTENSION				
SCALES				
DOPPLER				
EKG				
O2 CYLINDER				
DEFIBRILLATOR/PACEMAKER				
SUCTION				

The information I have given is true and accurate to the best of my knowledge. I hereby authorize Nurse Connection, Inc. to release checklist to client health care facilities of Nurse Connection, Inc. relating to my contract employment with that facility.

(Signature)

(Date)