



**EMERGENCY NURSING EXPERIENCE QUESTIONNAIRE**

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

BASIC EMERGENCY TRAINING: DATES: From: \_\_\_\_\_ To: \_\_\_\_\_

WHERE: \_\_\_\_\_

EMERGENCY CERTIFICATE: NO YES State Which: \_\_\_\_\_

CERTIFIED IN BCLS Dates: \_\_\_\_\_ ACLS: Dates: \_\_\_\_\_

EMERGENCY EXPERIENCE POST TRAINING:

DATES: From: \_\_\_\_\_ To: \_\_\_\_\_

WHERE: \_\_\_\_\_

NO. OF EMERGENCY BEDS: \_\_\_\_\_

SOME COMMON DIAGNOSES: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

CURRENTLY WORKING IN EMERGENCY: NO YES

IF YES, WHERE?: \_\_\_\_\_ HOW LONG? : \_\_\_\_\_

IF NO, LAST WORKED IN EMERGENCY FROM \_\_\_\_\_ TO \_\_\_\_\_

TRAINING OR EXPERIENCE	NO	YES	LENGTH OF EXPERIENCE	
			FROM	TO
CARDIAC CARE				
CLINICS OR AMBULATORY CARE				
OBSTETRICS				
ORTHOPAEDIC NURSING				
PAEDIATRIC NURSING				
PRE-HOSPITAL CARE:				
❖ Ambulance Services				
❖ Mobile Intensive Care				
❖ Trauma Team				
PSYCHIATRIC NURSING				

**SPECIAL SKILLS / EXPERIENCES / COURSES:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**COUNSELLING SKILLS: Please describe :** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PROFESSIONAL AFFILIATIONS:** \_\_\_\_\_

\_\_\_\_\_

**THIS FORM WAS COMPLETED BY:** MAIL PERSONAL INTERVIEW

**SIGNATURE OF PERSON COMPLETING THIS FORM:** \_\_\_\_\_