

## Nurse Aide II Tasks Performed by Nurse Aide I Personnel\*

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

List below the Nurse Aide II task(s) to be performed by Nurse Aide I personnel in your agency. For each task listed, identify the approved curriculum used in training and indicate the effective date of the written policy and procedure for the performance of this task by the Nurse Aide I.

- 1) Curriculum Name: \_\_\_\_\_  
Curriculum has been: (a) Board-developed (Module # \_\_\_\_\_)  
(b) Agency developed and Board approved on \_\_\_\_\_ (date)

Written policy and procedure effective as of \_\_\_\_\_ (date)

- 2) Curriculum Name: \_\_\_\_\_  
Curriculum has been: (a) Board-developed (Module # \_\_\_\_\_)  
(b) Agency developed and Board approved on \_\_\_\_\_ (date)

Written policy and procedure effective as of \_\_\_\_\_ (date)

- 3) Curriculum Name: \_\_\_\_\_  
Curriculum has been: (a) Board-developed (Module # \_\_\_\_\_)  
(b) Agency developed and Board approved on \_\_\_\_\_ (date)

Written policy and procedure effective as of \_\_\_\_\_ (date)

- 4) Curriculum Name: \_\_\_\_\_  
Curriculum has been: (a) Board-developed (Module # \_\_\_\_\_)  
(b) Agency developed and Board approved on \_\_\_\_\_ (date)

Written policy and procedure effective as of \_\_\_\_\_ (date)

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As the Chief Nurse Administrator, I hereby verify that the requirements set forth by the North Carolina Board of Nursing for Nurse Aide I personnel performing the above listed Nurse Aide II tasks in this clinical agency, including documentation of the clinical competency of each Nurse Aide I for each task to be performed, have been met.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

\*PLEASE NOTE THAT EACH AGENCY MAY CHOOSE NO MORE THAN FOUR NURSE AIDE II TASKS TO BE PERFORMED BY THAT AGENCY BY NURSE AIDE I PERSONNEL WHO HAVE NOT COMPLETED THE ENTIRE NURSE AIDE II TRAINING AND COMPETENCY EVALUATION PROGRAM.

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**NOTE: THE STERILE TECHNIQUE MODULE (#3) IS INCLUDED AS A REQUIRED COMPONENT OF THE FOLLOWING MODULES:**

MODULE #4 - WOUND CARE  
MODULE #5 - SUCTIONING  
MODULE #6 - TRACHEOSTOMY CARE  
MODULE #7 - PERIPHERAL IV FLUIDS  
MODULE #8 - URINARY CATHETER

**Please complete and mail  
or fax this form to:**

North Carolina Board of Nursing  
Attn: Paulette Hampton  
Administrative Secretary – Practice  
PO Box 2129  
Raleigh, NC 27602

Fax: 919/781-9461

Revised: August 14, 2002