



**ARIZONA STATE BOARD OF NURSING**

4747 N. 7th Street, Suite 200  
Phoenix, AZ 85014-3655  
E-Mail: arizona@azbn.gov Home Page: www.azbn.gov

**FOR OFFICE USE ONLY**

**Practice Hours Requirement Evaluation**

LNAs or CNAs who are Caregivers whose practice hours are worked in a facility or setting that does not require you to be a LNA/CNA. **Family care does not qualify as meeting practice requirements.**

**Practice Hour Requirement**

CNAs - 8 hours past 2 years  
LNAs - 160 hours past 2 years

**Employer must complete all the information below. Return completed form with your renewal application to AZBN.**

\_\_\_\_\_ provided the following nursing assistant duties at  
CNA Caregiver's Name (print)

\_\_\_\_\_  
Employer's Name or Facility Name (print)

8 hours for CNA       160 hours for LNA

Check all duties CNA/Caregiver provided

- |  |   |
|--|---|
| <input type="checkbox"/> Vital Signs                         | <input type="checkbox"/> Transfers - bed to wheelchair              |
| <input type="checkbox"/> Ambulation                          | <input type="checkbox"/> Intake & Output                            |
| <input type="checkbox"/> Denture/Oral care                   | <input type="checkbox"/> Weight                                     |
| <input type="checkbox"/> Range of motion                     | <input type="checkbox"/> Specimen collection                        |
| <input type="checkbox"/> Feeding and hydration               | <input type="checkbox"/> Observe & report pain                      |
| <input type="checkbox"/> Bathing                             | <input type="checkbox"/> Apply clean bandages                       |
| <input type="checkbox"/> Skin care                           | <input type="checkbox"/> Change soiled briefs                       |
| <input type="checkbox"/> Turning & repositioning in bed      | <input type="checkbox"/> Hair care                                  |
| <input type="checkbox"/> Nail care                           | <input type="checkbox"/> Dressing the patient                       |
| <input type="checkbox"/> Toileting                           | <input type="checkbox"/> Perineal care                              |
| <input type="checkbox"/> Maintaining a patient's environment | <input type="checkbox"/> Recognizing and reporting abnormal changes |

Dates of care: from \_\_\_\_ / \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\_\_\_\_\_  
Employer Signature and Title

\_\_\_\_\_  
Date

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

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

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