EAMC Point of Care Testing
Waived Testing Competency Assessment Documentation

Name: _____ DOD ID: _____ Date _____

Section: _____ Supervisor: _____ Competency type: Initial ☐ 6-month ☐ Annual ☐

I attest that I have read and understand the procedure manual. (Signature) _____ Date _____

Competency Assessed	Urine hCG (Kit)	Urine –Multistix 10SG Manual Dipstick	Occult Blood	Rapid Strep (Kit)	
Observation: patient test performance Date and DOD ID of patient test performed					
Accurate recording and reporting of test results Date and DOD ID of patient test performed					
Review: results, worksheets, or quality control records Date of Quality Control Testing				Date and DOD ID of patient's Strep ordered and sent to the lab for negative rapid strep	
Observation: instrument maintenance, as applicable Date of Instrument Maintenance					
Assessment of test performance through testing, PT or blind samples Date CAP survey or blind samples					
Evaluation of problem-solving skills Date and score test					
Assessor Name, Signature & Date of assessment					

I understand that of all the topics listed in this document, I will be allowed to perform only those listed for my skill level/Scope of Practice, after I have successfully demonstrated competency in those tasks.

Employee Signature: _____ Date: _____

Point of Care Coordinator: _____ Signature: _____ Date: _____

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Competency Assessed Fill in shaded information under instrument/ kit type.	**Clinitek Status Connect (urine)**	**Clinitek Clinitest (urine hCG)**	**Accu-Chek Inform II (glucose)**	**HemoCue (hgb)**	**Sofia- Rapid Strep/Flu**
Observation: patient test performance-Date and DOD ID of patient test performed					
Accurate recording and reporting of test results Date and DOD ID of patient test performed					
Review: test results (QC) Date of Quality Control Testing					Date and DOD ID of patient's Strep ordered and sent to the lab for negative rapid strep or flu
Observation: instrument maintenance Date of Instrument Maintenance					
Assessment of test performance: blind samples Date CAP survey performed					
Evaluation of problem-solving skills Date and score					
Assessor Name, Signature & Date of assessment					

I understand that of all the topics listed in this document, I will be allowed to perform only those listed for my skill level/Scope of Practice, after I have successfully demonstrated competency in those tasks.

Employee Signature: _____ Date: _____

Point of Care Coordinator: _____ Signature: _____ Date: _____