Training & Competency Assessment Documentation

**[ ] Annual [ ] Semi-Annual [ ] Initial Training**

**Employee:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ID #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- |
| **Skill:**  **Anaerobe Identification** | **\*Method(s) of Assessment**  **Circle code (DO, RR, etc) and enter**  **document used / record involved** | | | **Trainer**  By signing this form, I certify that I have trained these skills as outlined below.  **Assessor**  By signing this form I certify that I have assessed this individual for competency in the skills listed. I deem this individual competent to perform this (these) skill(s). |
|  | **Assessment or Training Completion:**  **Date Initial** | | | **Assessors or Trainers Signature:** |
| **Anaerobe Identification** |  | |  |  |
| **SOP Involved: CL4019** | **DO** |  | | **UCMI0002-1 Anaerobe Identification**  **05/2013** |  |
| **RR** |  | |
| **ST** |  | |
| **PS** |  | |

By signing this form I acknowledge that I have been trained, if applicable, and my competency has been assessed for these skill(s). I have discussed my questions with a trainer, as needed, and I understand that I am now accountable for being in compliance. If I need further assistance, I am to request it. A trainer or supervisor will assist me.

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| --- |
| Employee Signature & Date: |

**Supervisor signature (or designee):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:**

**Medical Director Signature (If required):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:**

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