**Skills Training and Evaluation**

(At the completion of training session, the operator should be able to complete these tasks and successfully conduct Fecal Occult Testing)

|  |  |  |
| --- | --- | --- |
|  | Met\* | Unmet |
| 1. Reviews procedure, “Hemoccult”.
 | □ | □ |
| 1. Describes purpose of test.
 | □ | □ |
| 1. Demonstrates compliance with Standard Precautions; wears gloves
 | □ | □ |
| 1. Describes proper sample collection and application procedure.
 | □ | □ |
| 1. Waits 3-5 minutes before applying developer directly over each smear.
 | □ | □ |
| 1. Reads test results within 60 seconds
 | □ | □ |
| 1. Develop the “On Slide Performance Monitor” by applying one drop of developer between the positive and the negative Performance Monitor areas on the back of the slide.
 | □ | □ |
| 1. Reads the slide within 10 seconds
 | □ | □ |
| 1. Interprets On Slide Performance Monitor correctly (should be blue in the (+) area, no blue in the (-) area).
 | □ | □ |
| 1. Takes appropriate action based on results on the “On Slide Performance Monitor.
 | □ | □ |
| 1. If Performance monitor results are as expected, records results in appropriate log or record
 | □ | □ |
| 1. If Performance Monitor results are not as expected, takes appropriate action (repeats using new card, or card from new box, and/or developer; knows whom to notify)
 | □ | □ |

\*All skills parameters must be “met” in order to become an authorized user of this product.

**Individual Information**

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| \*Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*Employee ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*Department/Cost Center:□ RN: □ LPN:□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*Date of Training: \_\_\_ / \_\_\_ / \_\_\_Training Status:□ New/initial□ Recertification\*Required Fields |

The trainer’s signature attests that the trainee has (a) successfully completed the program and scored 80% or better on the quiz, and (b) demonstrated successful skill in performing this procedure.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ / \_\_\_ / \_\_\_

Trainer Signature Date

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

Trainer Position/Dept

Please send a copy of this form to the laboratory, attention Point of Care Coordinator.