NAVAL MEDICAL CENTER PORTSMOUTH
POINT OF CARE TESTING
COMPETENCY ASSESSMENT DOCUMENTATION FORM
PROVIDER PERFORMED MICROSCOPY

Name (Last, First, MI)	**Hospital Badge ID**	**Circle One** **MD CNM NP PA**
Ward/Clinic (Include all)	**Work Email**	

Competency type: **Initial ☐** **6-month ☐** **Annual ☐**

Tests performed: **Fern ☐** **KOH ☐** **Vaginal Wet Prep ☐**

Assessment Performed	Date assessed	Employee (initial)	Comments/ Score/ Remedial action if needed.
1. Problem-solving skills as appropriate to the job. • Written or online quiz through medtraining.org			Quiz Score:
2. Direct observation of instrument function. • Direct observation of performance of microscope maintenance.			
3. Direct observation of routine patient test performance. • Direct observation of patient identification, sample collection, handling, processing, & testing.			
4. Review of proficiency testing or preventative maintenance performance. • Review of test results, patient logs, quality control, proficiency testing, and microscope maintenance logs.			
5. Test performance: • Completion of MTS Competency for each test performed. • Proficiency testing (CAP), Blind Sample identification (Quiz), or Patient Test sample			MTS/Blind Sample (Quiz) Score:
6. Monitoring, recording, and reporting of test results • Transcription review- are results in Genesis?			Affix Genesis patient label here that includes the patients Name, DOB, DOD ID, and FIN.

I have been oriented to the competencies indicated on this document. I have noted any comments in the area provided. I understand that I am accountable for all items that I initialed. **I have read and understand the Point-of-Care SOP** and I am responsible to follow all policies and procedures as stated in the procedure manuals, and I am responsible for any updates that may be implemented.
FAILURE TO FOLLOW POCT POLICIES AND PROCEDURES CAN RESULT IN THE LOSS OF MY PRIVELEGES TO PERFORM TESTING AND ADMINISTRAIVE ACTION.

Employee (Signature): _____ Date: _____

I have assessed this employee in the above-named area and determined that the employee has _____ has not _____ demonstrated competence in this procedure (s) or process(es)

PPM Direct Observational Provider: (print name): _____

SIGNATURE: _____ Date: _____