LifeCare Medical Center
Main Laboratory
Laboratory Aide Competency Assessment

Name: _____ Year: _____ Assessment: ( ) Initial ( ) 6 months ( ) Annual ( ) Follow- up

Employee will be assessed as (**C**) – Competent (**NC**) – Non-Competent. Evaluation will be discussed with employee to establish an action plan if needed.

Department: Outpatient/ Serology/Phlebotomy	**DO 1**	**TR 2**	**ID 3**	**PM 4**	**TP 5**	**PS 6**	**C**	**NC ****	**Date**
Test / Test System									
Nova BioMedical Stat Strip Glucometer *(waived)*									
Hemocue Hb801 *(waived)*									
Roche Coagucheck XS Plus *(waived)*									
Siemens Uristix *(waived)*									
Abbott ID Now (Group A Strep, COVID-19) *(waived)*									
BD Veritor System (Rapid Influenza A/B) *(waived)*									
Sekisui Diagnostics OSOM Card Pregnancy Test *(waived)*									
Cardinal Health Mono II Rapid Test *(waived)*									

DO=Direct observation of routine patient performance; **TR**=Monitoring and recording of test results; **ID**=Review of intermediate test results/worksheets/quality control/preventive maintenance records; **PM**=Direct observation of performance of instrument maintenance and function checks; **TP**=Assessment of test performance/proficiency/blind testing samples/previously analyzed specimens; **PS**=Assessment of probem solving skills

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Non-Technical	DO 1	TR 2	ID 3	PM 4	TP 5	PS 6	C	NC **	Date
Process									
Venipuncture									
Capillary Puncture									
Blood Alcohol Collection									
Blood Culture Collection									
Isolation									

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***= Describe component requiring further action (attach corrective action documentation and use a new checklist for re-assessment)*

Laboratory Aide : I feel competent in the tests/test systems/tasks evaluated above : **YES** **NO**

If **NO**, describe test/test system/task in which you need additional training:

_____
_____

Director/Lead: I have reviewed this employee's competency in the above functions and determined that the employee is competent to perform the tests measured above.

_____	_____	_____
Employee's Full signature	Director/Lead's Full Signature**	Date

*****=Director/Lead must be a qualified individual under CLIA Subpart M std. 493.1411 for moderate complexity and std. 493.1419 for high complexity tests.***