Penn State Health, Milton S Hershey Medical Center Department of Pathology Hershey, PA 17033

Competency Form

Provider Performed Microscopy

Competency Type (circle one): Initial Training/ 6-month (Annual)

Select each applicable test:	A.	And the Control of th		
Direct Observation of patient preparation, specimen collection, handling, processing and testing. Monitoring, recording and reporting of test results. Review of patient logs for completeness. Test Performance Equipment maintenance Problem Solving Skills Provider Name: Todal Felix Manuer Manuer Indicated above and understand that I am accountable for all items in the procedure manuals applicable to the testing. Provider Signature: Date: 10 21 21 21 21 21 21 21	Select each applicable test: Wet Prep KOH Pr	ep ⊠FERN	- Urine Sediment	
Direct Observation of patient preparation, specimen collection, handling, processing and testing. Monitoring, recording and reporting of test results. Review of patient logs for completeness. Test Performance Equipment maintenance Problem Solving Skills Location: Location: Jack Location: Jack Location: Jack Provider Name: Location: Date: Location: Date: Location: Date: Date: Location: Date: Date:	This form is used for comp	etency assessmen	t and includes the following for each test method:	
Direct Observation of patient preparation, specimen collection, handling, processing and testing. Monitoring, recording and reporting of test results. Review of patient logs for completeness. Test Performance Equipment maintenance Problem Solving Skills Location: Location: Jack Location: Jack Location: Jack Provider Name: Location: Date: Location: Date: Location: Date: Date: Location: Date: Date:		Date/Initials:	Notes/Comments:	
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Test Performance Equipment maintenance Problem Solving Skills Provider Name:	Monitoring, recording and reporting of test results.			
Equipment maintenance Problem Solving Skills Provider Name: Todal Felix MD Location: Nyes I attest that I have reviewed the procedure(s) for testing indicated above and understand that I am accountable for all items in the procedure manuals applicable to the testing. Provider Signature: Date: 10/21 The above named provider has demonstrated competency to perform the laboratory test procedures indicated above. Physician/Qualified Provider Signature: Date: 10/20/21	Review of patient logs for completeness.	and the state of t		
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Provider Name:	Equipment maintenance			
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Revised 12/13/2018 RLB	I attest that I have reviewed the procedure(s) for testing indicated above and understand that I am accountable for all items in the procedure manuals applicable to the testing. Provider Signature: Date: 10 21			
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