

**Competency Form**

**Provider Performed Microscopy**

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

Select each applicable test:  Wet Prep  KOH Prep  FERN  ~~Urine Sediment~~

*not applicable  
SLM 4/6/21*

This form is used for competency assessment and includes the following for each test method:

	Date/Initials:	Notes/Comments:
Direct Observation of patient preparation, specimen collection, handling, processing and testing.	SLM 4/6/21	Name of physician/qualified provider performing direct observation Stacey Milunz, MS
Monitoring, recording and reporting of test results.	↓	↓
Review of patient logs for completeness.		
Test Performance		
Equipment maintenance		
Problem Solving Skills	↓	↓

Provider Name: Carl Clebak

Location: N-25A

*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: [Signature]

Date: 4/6/21

The above named provider has demonstrated competency to perform the laboratory test procedures indicated above.

Physician/Qualified Provider Signature: Stacey Milunz, MS

Date: 4/6/21