**Nursing Competency Evaluation Form** **Under Direct Supervision of Medical Director**

**Nurse's Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Evaluator's Name (Medical Director):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Facility Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Department:** \_\_\_\_\_\_\_\_\_\_

**Competency Evaluation Criteria**

**1. Patient Assessment & Clinical Judgment**

**Comments:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Infection Control & Safety Practices**

**Comments:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Medication Administration**

**Comments:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. Technical Skills & Procedures**

**Comments:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. Documentation & Communication**

**Comments:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. Emergency Response & Critical Thinking**

**Comments:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7. Professionalism & Ethical Conduct**

**Comments:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Final Evaluation & Recommendations**

**Overall Competency Rating:** ☐ Meets Expectations  
☐ Needs Improvement  
☐ Does Not Meet Expectations

**Medical Director’s Comments:**

☐ Nurse is competent to perform duties independently.  
☐ Nurse requires additional training and supervision in the following areas:

**Medical Director Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nurse Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Instructions:**

* The Medical Director must observe the nurse performing tasks and document their findings.
* Areas marked as “Needs Improvement” require follow-up training.
* Completed forms should be maintained in the nurse’s personnel file.

To comply with the requirement of performing a test on a **blind specimen**, an individual or organization should follow these steps:

1. **Use a Third Party for Sample Preparation**
   * A designated individual or an external entity should prepare and distribute the blind specimens to prevent the tester from knowing their origin.
2. **Randomization of Samples**
   * Blind specimens should be mixed with routine patient samples to prevent testers from recognizing them as test samples.
3. **Standard Testing Procedures**
   * The tester should follow the same standard operating procedures (SOPs) and protocols used for regular patient specimens.
4. **Confidentiality and Anonymization**
   * Specimens should be labeled in a way that does not reveal their true identity, ensuring the tester does not have prior knowledge of their status.
5. **Performance Monitoring and Documentation**
   * The test results should be recorded and analyzed independently to evaluate the tester’s accuracy and adherence to protocols.
6. **Quality Control Measures**
   * Implement internal quality control and external proficiency testing programs to verify the reliability of results.
7. **Regulatory Compliance**
   * Ensure that the testing process aligns with industry regulations such as CLIA, CAP, or other accreditation standards for proficiency testing.
8. **Corrective Actions**
   * If errors are detected, conduct a root cause analysis, retrain staff if necessary, and implement corrective measures to prevent future issues.

By following these steps, an individual can effectively comply with the requirement of testing blind specimens and ensure unbiased, accurate results.

**Competency Assessment**

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|  |  | DO  1 | TR  2 | ID  3 | PM  4 | TP  5 | PS  6 |
| **WAIVED Test** |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Waived Test – Equipment/Device used** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **i.e. glucometer/dip stick/ etc.** |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Quality Control Establishment** |  |  |  |  |  |  |  |  |  |  |  |  |  |
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\*\*= Describe component requiring further action (attach corrective action documentation and use a new checklist for re assesment )

(Testing personnel) : I feel competent in the tests/ test systems/ task evaluated above : **YES NO**

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

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

Medical Director: I have reviewed this employee’s competency in the above functions and determined that the employee in competent to perform the tests measured above.

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Employee’s Full signature Medical Director’s Full Signature\*\* Date

**\*\*-The person signing this document must be the person listed on the certificate of wavier issued by CLIA, as per the standards of the Joint Commission dictate.**