Parkland	Laboratory Name:	CLIA #:
	Competency Assessment for:	***New employees:*** *During the 1st year, assess competency prior to patient testing, at 6 months (non-waived testing only) & no later than 12 months. Annually thereafter.*

☐ Initial ☐ 6 month	☐ 12 month ☐ Annual ☐ Re-Training	Hire Date:	Position:

Name of test and/or instrument with manufacturer name		Direct observation of routine test performance ***AND*** Monitor test result recording & reporting	Review of worksheets, QC, PT, and maintenance records. *Check all that apply.*	Direct observation of instrument maintenance. *Check all that apply.*	Assessment of test performance (PT / Blind Samples) records. *Attach copies of original & blind sample results to competency form.*	Evaluation of problem-solving skills. *Attach document or write what was used below. Check all that apply.*
☐ Hct ☐ Hgb ☐ Hgb A1c ☐ FluVid ☐ Glucose ☐ Strep A Ag ☐ Ur Dip ☐ Ur hCG ☐ BV ☐ Trich	☐ epoc ☐ Wet Prep ☐ Fern Test ☐ PT/INR ☐ Other:	Patient ID: ______________ *Check all that apply.* ☐ Patient preparation ☐ Specimen handling ☐ Processing & Testing ☐ Recording/reporting results (incl. criticals) Date: ________________	☐ Quality Control records ☐ Proficiency test results ☐ Preventative maintenance ☐ Documents remedial action Date: ________________	☐ Daily ☐ Monthly ☐ 3 months (quarterly) ☐ 6 months (bi-annual) ☐ ________________ Date Observed: ________________	PT Event: ____________ ☐ Pass ☐ Fail Score: ____________ *Or* Blind Sample comparison ☐ Pass ☐ Fail	☐ Review of instrument ☐ Problem logs ☐ Review of QC issues ☐ Review of QA ☐ Quiz or scenario Date: ______________
☐ Hct ☐ Hgb ☐ Hgb A1c ☐ FluVid ☐ Glucose ☐ Strep A Ag ☐ Ur Dip ☐ Ur hCG ☐ BV ☐ Trich	☐ epoc ☐ Wet Prep ☐ Fern Test ☐ PT/INR ☐ Other:	Patient ID: ______________ *Check all that apply.* ☐ Patient preparation ☐ Specimen handling ☐ Processing & Testing ☐ Recording/reporting results (incl. criticals) Date: ________________	☐ Quality Control records ☐ Proficiency test results ☐ Preventative maintenance ☐ Documents remedial action Date: ________________	☐ Daily ☐ Monthly ☐ 3 months (quarterly) ☐ 6 months (bi-annual) ☐ ________________ Date Observed: ________________	PT Event: ____________ ☐ Pass ☐ Fail Score: ____________ *Or* Blind Sample comparison ☐ Pass ☐ Fail	☐ Review of instrument ☐ Problem logs ☐ Review of QC issues ☐ Review of QA ☐ Quiz or scenario Date: ______________
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Competency satisfactorily demonstrated: ☐ Yes ☐ No	Comments:			
Corrective Actions:				
Employee's Signature*:		Date:		**Next Review due by:**
Technical Consultant/Supervisor Signature		Date Reviewed:		

*Employee's signature indicates the following: employee can produce appropriate education credentials as required/requested by laboratory inspection agency; employee has read and understands the procedure; employee feels comfortable and confident performing all necessary procedures prior to performing patient tests.