

RHC Waived Test Competency Record

Employee Name: \_\_\_\_\_ Employee ID: \_\_\_\_\_ Location: \_\_\_\_\_

Initial Training     Annual Competency Assessment

List of tests and/or instruments	Assess competency using at least TWO of the following methods:			
	Performance of a test on a blind specimen <i>(Specific test(s) / records reviewed-Reviewer date &amp; initial when completed)</i>	Observation of routine work by the supervisor or qualified designee <i>(Reviewer date &amp; initial when completed)</i>	Monitor quality control performance <i>(Specific test(s) / records reviewed-Reviewer date &amp; initial when completed)</i>	Successful completion of written test specific to the method performed <i>(Attach completed test)</i>
Culture transmittal				
Glucose				
Hemoglobin/Hematocrit				
Stool occult				
Urinalysis				
Pregnancy HCG				
Competency has been satisfactorily demonstrated <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If No, document corrective action or additional training below)</i>				
Reviewer Comments:				
Corrective Actions:				
Employee Signature:			Date:	
Reviewer Signature:			Date:	
Medical Director Signature:			Date:	