REQUIRED

MAP Recertification Competency Evaluation Form

Name of Staff: _____ Date of Birth: _____

Service Provider: _____

Date of Recertification Training: _____

Date of Skills Evaluation: _____

To receive a passing score on this Skills Evaluation, staff must receive a 'Yes' on every item.

MAP Trainer Recertification Skills Evaluation Checklist: (To be completed by Approved MAP Trainer only.)			Comments: (Continue on reverse side if necessary.)
1. Staff identifies the correct Medication Administration Record:	☐ Yes	☐ No	
2. Staff identifies the correct medication(s):	☐ Yes	☐ No	
3. Staff confirms the correct Health Care Provider (HCP) Order(s):	☐ Yes	☐ No	
4. Staff compares the Pharmacy Label to the Medication Administration Record:	☐ Yes	☐ No	
5. Staff prepares the correct dose(s):	☐ Yes	☐ No	
6. Staff compares the Pharmacy Label to the Medication Administration Record:	☐ Yes	☐ No	
7. Staff correctly administers the medication(s):	☐ Yes	☐ No	
8. Staff completes a 'look back', and then correctly documents the administration:	☐ Yes	☐ No	
9. Staff stores and manages medication(s) in a secure manner:	☐ Yes	☐ No	

Based on this Skills Evaluation, the above-named staff is: ☐ Eligible ☐ Not Eligible for Recertification.

Approved MAP Trainer (Print Name) _____ Approved MAP Trainer (Signature)

For Supervisory Staff Sign-Off Only
I verify that I have reviewed this form and (check one box only)

☐ recommend the above-named staff. ☐ do not recommend the above-named staff.

OR

☐ acknowledge that the above-named staff is not eligible to administer medication under the MAP as a result of this evaluation.

Signature _____ Title _____ Date _____