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| MAP Recertification Competency Evaluation Form |

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| Name of Staff: |  | | | Date of Birth: |  | |
| Service Provider: | |  | | | | |
| Date of Evaluation: | | |  | | | |
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| **To receive a passing score on this Skills Evaluation, staff must receive a ‘Yes’ on every item.** | | | | | |
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| 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 |  |

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