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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.** |
|       |  |       |
| 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 |