



COMPETENCY CHECKLIST

THIS RESOURCE IS INTENDED TO SUPPLEMENT YOUR ORGANIZATIONAL POLICY, PROCEDURE OR STANDARDS, NOT TO REPLACE IT.

THIS DOCUMENT CAN BE REVISED TO SUIT THE NEEDS OF YOUR ORGANIZATION OR FACILITY

Date: _____

Name: _____ Designation: _____

Department of person being evaluated: _____

	ASSESSMENT OF KNOWLEDGE	MET	COMMENTS
<input type="checkbox"/>	Examples:		
	• indication for PIV		
	• vein identification		
	• promotes vessel preservation		
	• selects device that is least invasive for duration and type of therapy		
<input type="checkbox"/>			
<input type="checkbox"/>			
<input type="checkbox"/>			
	ASSESSMENT OF SKILL		
<input type="checkbox"/>	(List supplies)		
<input type="checkbox"/>	Detail procedure. Examples:		
	• appropriate tourniquet application		
	• antiseptic application		
	• drying of antiseptic		
	• vein stabilization		
	• adherence to aseptic technique		
	• documentation of procedure		
<input type="checkbox"/>			

Signature: _____

Name of Evaluator: _____

Signature indicates that the skill has been performed accurately under direct supervision by a competent peer. The healthcare professional acknowledges responsibility, accountability, and the associated requirements from their governing body.

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