

Employee Training for Suprapubic Catheter Care

EMPLOYEE NAME John Gebhardt

DATE 7-23-21 LENGTH OF TRAINING .25 hrs.

THE EMPLOYEE HAS RECEIVED THE FOLLOWING INFORMATION:

Yes No N/A

- | | | | |
|-------------------------------------|--------------------------|-------------------------------------|---|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Purpose and effects of procedure |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. Equipment necessary for procedure |
| <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | 3. Specific protocol |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Consequences if procedure is not performed correctly |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5. Symptoms and signs requiring physician notification |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 6. Information about contacting nurse or doctor |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 7. Procedure for cleaning/replacing equipment |
| <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | 8. Location of written procedure and protocol |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 9. Other <u>draining bag</u> |

**THE EMPLOYEE HAS SUCCESSFULLY
DEMONSTRATED THEIR SKILL IN PERFORMING THIS
PROCEDURE.**

1. I fully understand the above information and am willing to assume the responsibility for performing the procedure.
2. I will perform the procedure according to the written instructions.
3. I will notify the nurse or physician of problems or questions.

John Gebhardt
Employee Signature

[Signature]
Nurse Signature

Employee Training for Suprapubic Catheter Care

EMPLOYEE NAME ANDREA GREEN

DATE 7/27/2021 LENGTH OF TRAINING .25

THE EMPLOYEE HAS RECEIVED THE FOLLOWING INFORMATION:

Yes No N/A

- | | | | |
|-------------------------------------|--------------------------|-------------------------------------|---|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Purpose and effects of procedure |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. Equipment necessary for procedure |
| <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | 3. Specific protocol |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Consequences if procedure is not performed correctly |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5. Symptoms and signs requiring physician notification |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 6. Information about contacting nurse or doctor |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 7. Procedure for cleaning/replacing equipment |
| <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | 8. Location of written procedure and protocol |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 9. Other <u>draining bag</u> |

THE EMPLOYEE HAS SUCCESSFULLY DEMONSTRATED THEIR SKILL IN PERFORMING THIS PROCEDURE.

1. I fully understand the above information and am willing to assume the responsibility for performing the procedure.
2. I will perform the procedure according to the written instructions.
3. I will notify the nurse or physician of problems or questions.

Andrea Green
Employee Signature

J. Anderson
Nurse Signature

7-27-21

Employee Training for Suprapubic Catheter Care

EMPLOYEE NAME Jessica Gunderson

DATE 7-23-21 LENGTH OF TRAINING .25 hrs

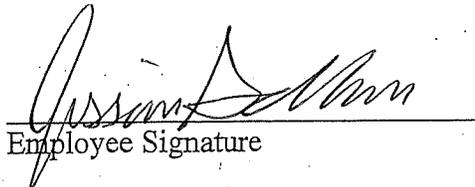
THE EMPLOYEE HAS RECEIVED THE FOLLOWING INFORMATION:

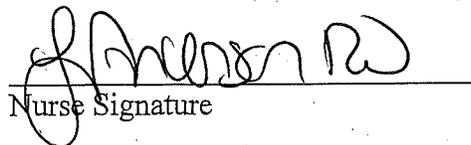
Yes No N/A

- | | | | |
|-------------------------------------|--------------------------|-------------------------------------|---|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Purpose and effects of procedure |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. Equipment necessary for procedure |
| <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | 3. Specific protocol |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Consequences if procedure is not performed correctly |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5. Symptoms and signs requiring physician notification |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 6. Information about contacting nurse or doctor |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 7. Procedure for cleaning/replacing equipment |
| <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | 8. Location of written procedure and protocol |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 9. Other <u>draining bag</u> |

**THE EMPLOYEE HAS SUCCESSFULLY
DEMONSTRATED THEIR SKILL IN PERFORMING THIS
PROCEDURE.**

1. I fully understand the above information and am willing to assume the responsibility for performing the procedure.
2. I will perform the procedure according to the written instructions.
3. I will notify the nurse or physician of problems or questions.


Employee Signature


Nurse Signature

Employee Training for Colostomy Care

EMPLOYEE Renee Schmidt

DATE 7-28-21 LENGTH OF TRAINING .25 hrs

TYPE OF PROCEDURE Changing an Ostomy Bag & Emptying

THE EMPLOYEE HAS RECEIVED THE FOLLOWING INFORMATION:

Yes No N/A

- | | | | |
|-------------------------------------|--------------------------|--------------------------|---|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Purpose and effects of procedure |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. Equipment necessary for procedure |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3. Specific protocol |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Consequences if procedure is not performed correctly |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5. Symptoms and signs requiring physician notification |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 6. Information about contacting nurse or doctor |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 7. Procedure for cleaning/replacing equipment |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 8. Location of written procedure and protocol |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 9. Other _____ |

THE EMPLOYEE HAS SUCCESSFULLY Verbalized DEMONSTRATED THEIR SKILL IN PERFORMING THIS PROCEDURE.

1. I fully understand the above information and am willing to assume the responsibility for performing the procedure.
2. I will perform the procedure according to the written instructions.
3. I will notify the nurse or physician of problems or questions.

Renee Schmidt
Employee Signature

J. Anderson
Nurse Signature

7-28-21

GENERAL PAI SITE TRAINING (60DAY)

EMPLOYEE Nancy Snyder DATE 7-27-21
LENGTH OF TRAINING 1hr

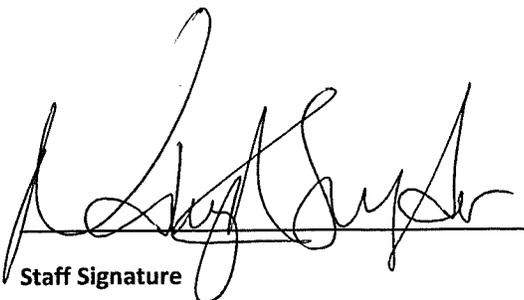
THE STAFF MEMBER HAS RECEIVED THE FOLLOWING INFORMATION:

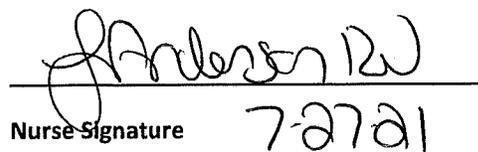
Yes No N/A

1. Epilepsy/Seizures – VNS, protocols, first aid, report forms, rescue meds
2. Epi-pen – purpose and use
3. DNR/DNI – POLST
4. Diabetes – general overview, diet, meds
5. Other _____

The staff member has received information on all topics presented and has successfully verbalized/demonstrated any skills.

1. I fully understand the above information and am willing to assume responsibility for performing the any of the above training/procedures.
2. I will perform any procedure according to the instructions provided.
3. I will notify the nurse or healthcare provider of problems or questions.


Staff Signature


Nurse Signature 7-27-21

Employee Training for Suprapubic Catheter Care

EMPLOYEE NAME Kathryn (Dolly) Stein

DATE 7/23/21 LENGTH OF TRAINING 25 hrs

THE EMPLOYEE HAS RECEIVED THE FOLLOWING INFORMATION:

Yes No N/A

- | | | | |
|-------------------------------------|--------------------------|-------------------------------------|---|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Purpose and effects of procedure |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. Equipment necessary for procedure |
| <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | 3. Specific protocol |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Consequences if procedure is not performed correctly |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5. Symptoms and signs requiring physician notification |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 6. Information about contacting nurse or doctor |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 7. Procedure for cleaning/replacing equipment |
| <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | 8. Location of written procedure and protocol |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 9. Other <u>draining bag</u> |

**THE EMPLOYEE HAS SUCCESSFULLY
DEMONSTRATED THEIR SKILL IN PERFORMING THIS
PROCEDURE.**

1. I fully understand the above information and am willing to assume the responsibility for performing the procedure.
2. I will perform the procedure according to the written instructions.
3. I will notify the nurse or physician of problems or questions.

Kathryn Stein
Employee Signature

J. Johnson RN
Nurse Signature

Employee Training for Colostomy Care

EMPLOYEE Dave Turner

DATE 7-28-21 LENGTH OF TRAINING 20 hrs

TYPE OF PROCEDURE Changing an Ostomy Bag + Emptying

THE EMPLOYEE HAS RECEIVED THE FOLLOWING INFORMATION:

Yes No N/A

- | | | | |
|-------------------------------------|--------------------------|--------------------------|---|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Purpose and effects of procedure |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. Equipment necessary for procedure |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3. Specific protocol |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Consequences if procedure is not performed correctly |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5. Symptoms and signs requiring physician notification |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 6. Information about contacting nurse or doctor |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 7. Procedure for cleaning/replacing equipment |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 8. Location of written procedure and protocol |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 9. Other _____ |

THE EMPLOYEE HAS SUCCESSFULLY Verbalized DEMONSTRATED THEIR SKILL IN PERFORMING THIS PROCEDURE.

1. I fully understand the above information and am willing to assume the responsibility for performing the procedure.
2. I will perform the procedure according to the written instructions.
3. I will notify the nurse or physician of problems or questions.

Dave Turner
Employee Signature

J. Anderson RN
Nurse Signature 7-28-21

Employee Training for Suprapubic Catheter Care

EMPLOYEE NAME Zach Weimann

DATE July 23 2021 LENGTH OF TRAINING 0.25 hrs

THE EMPLOYEE HAS RECEIVED THE FOLLOWING INFORMATION:

Yes No N/A

- | | | | |
|-------------------------------------|--------------------------|-------------------------------------|---|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Purpose and effects of procedure |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. Equipment necessary for procedure |
| <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | 3. Specific protocol |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Consequences if procedure is not performed correctly |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5. Symptoms and signs requiring physician notification |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 6. Information about contacting nurse or doctor |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 7. Procedure for cleaning/replacing equipment |
| <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | 8. Location of written procedure and protocol |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 9. Other <u>drainage bag</u> |

**THE EMPLOYEE HAS SUCCESSFULLY
DEMONSTRATED THEIR SKILL IN PERFORMING THIS
PROCEDURE.**

1. I fully understand the above information and am willing to assume the responsibility for performing the procedure.
2. I will perform the procedure according to the written instructions.
3. I will notify the nurse or physician of problems or questions.


Employee Signature

Nurse Signature