

Employee Training for Blood Glucose Testing

EMPLOYEE NAME Pamela Davis

DATE 6/12/23 LENGTH OF TRAINING .25

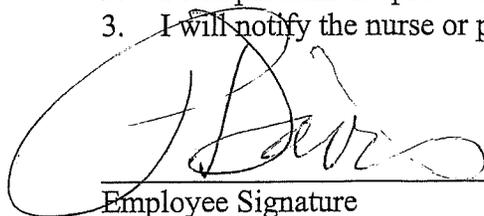
THE EMPLOYEE HAS RECEIVED THE FOLLOWING INFORMATION:

Yes No N/A

- | | | | |
|-------------------------------------|--------------------------|--------------------------|---|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Overview of diabetes and diabetic medication |
| <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. Procedure for 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 checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 9. Purpose and effects of procedure |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 10. Other _____ |

**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

OBSERVED SKILL ASSESSMENT

Name of staff member Pam Davis

The staff member has successfully demonstrated the ability to administer medications by the following routes, according to facility procedures:

Route	Date	Nurse Signature
Oral	_____	_____
Skin/topical	_____	_____
Ear drops	_____	_____
Eye drops	_____	_____
Buccal	_____	_____
Sublingual	_____	_____
Transdermal	_____	_____
Rectal	_____	_____
Vaginal	_____	_____
Inhaler	_____	_____
Nasal Spray	_____	_____
Gastrostomy	_____	_____
Subcutaneous Injection	<u>6/12/23</u>	<u>[Signature]</u>
Other	_____	_____
Other	_____	_____
Other	_____	_____

File in staff member's personnel file.

6/12/23

Date:

NOTE: INFORMATION IN GRAY SHADED AREAS MUST BE TYPED IN

Training Time	Trainer Name	Training ID	Area	Content/Description
.5	Toni Anderson RN			Diabetes/Insulin Training/Demo

Make up Date	Initial	EE ID	Name
	pd		Pamela Davis

Make up Date	Initial	EE ID	Name

Make Up Date	Initial	Manager/Admin
		Courtney Kelly
		Smith, Kennedy
		Gunderson, Jessica

Other Attendees

6/12/23

Date:

NOTE: INFORMATION IN GRAY SHADED AREAS MUST BE TYPED IN

Training Time	Trainer Name	Training ID	Area	Content/Description
.5	Toni Anderson RN			Enteral Tubes/Meds/Nutrition

Make up Date	Initial	EE ID	Name
	KS		Dolly Stein

Make up Date	Initial	EE ID	Name

Make Up Date	Initial	EE ID	Manager/Admin
			Courtney Kelly
			Smith, Kennedy
			Gunderson, Jessica

Make Up Date	Initial	EE ID	Other Attendees