|  |
| --- |
| INSTRUCTIONS FOR THE COMPETENCY ASSESSMENT |
| Instructions for Use of Test Equipment Evaluation Form (Page 2) Each of the tasks indicated on the competency assessment has two columns. The first column is marked “EXPECT”, which indicates the expected level of competency as defined below on a scale of 1 to 3. The second column is marked “COMP/INIT” which is completed by the individual technician. “COMP” is the technician numerical assessment of acknowledged competency; “INIT” indicates the technical initials.  Competency definitions:  1 - Training has not been received; knowledge is minimal.  2 - Training has been received; knowledge is sufficient to understand and apply the required concepts.  3 - Training has been received; knowledge is sufficient to train others. Instructions for Competency Assessment Evaluation (Page 3) Each of the tasks indicated on the competency assessment has three columns. The first column is marked “EXPECT”, which indicates the expected level of competency as defined below on a scale of 1 to 5. The second column is marked “COMP/INIT” which is completed by the individual technician. “COMP” is the technician numerical assessment of acknowledged competency; “INIT” indicates the technical initials. The final column, marked “CONCURRENCE” requires a supervisory signature to concur with the self-assessment from the second column.  Competency definitions:  1 - Has no knowledge or experience for this equipment and is not qualified to perform any testing or service.  2 - Has been trained to perform electrical safety tests for this type of equipment.  3 - Understands the basic physiological operation of the equipment and can perform operational and performance tests.  4 - Can perform basic trouble shooting and repair; some vendor assistance may be required.  5 - Can perform advanced trouble shooting and repair; vendor support is not required. |

|  |  |  |  |
| --- | --- | --- | --- |
| USE OF TEST EQUIPMENT EVALUATION | | | |
| **Department:** | **Date:** | | |
| **Name:** | **Title:** | | |
| **Reports to:** | **Rank/Grade:** | | |
| I have reviewed the tasks listed below and have identified by initial my competency level for each of the indicated areas. Whenever my initialed level is below the expectation level as indicated on the evaluation, additional training may be scheduled and listed on my individual development plan as resources permit. This evaluation will be kept in my training folder and may be reviewed at any time. | | | |
| TASK | | **EXPECT** | **COMP/INIT** |
| Department-specific policies and procedures | | 2 |  |
| Laser Safety | | 2 |  |
| Radiation Safety | | 2 |  |
| Standard precautions/infection control | | 2 |  |
| Technical policies, procedures, and standards | | 2 |  |
| Use of test equipment | |  |  |
| * Standard test equipment devices | | 3 |  |
| * Patient simulators | | 3 |  |
| * Pulse oximeter analyzer | | 3 |  |
| * Ultrasound output meter | | 3 |  |
| * Electrical safety analyzer | | 3 |  |
| * Electro surgical unit tester | | 3 |  |
| * Defibrillator tester | | 3 |  |
| * Infusion devise analyzer | | 3 |  |
| * IVAC thermometer tester/calibrator | | 3 |  |
| * Radiation meter | | 3 |  |
| * Microwave safety meter | | 3 |  |
|  | |  |  |
|  | |  |  |
|  | |  |  |
|  | |  |  |
|  | |  |  |
|  | |  |  |
|  | |  |  |
|  | |  |  |
|  | |  |  |
|  | |  |  |
|  | |  |  |
|  | |  |  |
|  | |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| COMPETENCY ASSESSMENT EVALUATION | | | |
| **TASK DESCRIPTION** | **EXPECT** | **COMP/INIT** | **CONCURRENCE** |
| * General patient care equipment | 4 |  |  |
| * Defibrillators | 4 |  |  |
| * Physiological monitors | 4 |  |  |
| * Telemetry equipment | 4 |  |  |
| * External demand pacemakers | 3 |  |  |
| * Electrosurgical units | 4 |  |  |
| * Blood warmers | 4 |  |  |
| * Physiological recorders | 4 |  |  |
| * Diagnostic ultrasound | 3 |  |  |
| * Physical therapy equipment | 4 |  |  |
| * Infusion devices | 5 |  |  |
| * Obstetrics/nursery equipment | 3 |  |  |
| * Dialysis machines | 4 |  |  |
| * R/F imaging | 2 |  |  |
| * Nuclear medicine imagining | 2 |  |  |
| * Ventilators | 1 |  |  |
| * RT patient test equipment | 3 |  |  |
| * RT treatment equipment | 2 |  |  |
| * Clinical lab diag/analytical | 2 |  |  |
| * Automated lab analyzers | 1 |  |  |
| * Surgical video equipment | 4/3 |  |  |
| * Anesthesia machines/equip | 1 |  |  |
| * Surgical/opth. lasers | 3 |  |  |
| * Non-patient elec. equipment | 4 |  |  |
| **EMPLOYEE SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | **DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **SUPERVISOR SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | **DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |

PRIVACY ACT STATEMENT

Section 4103 of Title 5 to U.S. Code authorizes collection of this information. This information will be used by staff management personnel and the Personnel Office servicing your locality, to plan and/or schedule training and development activities. Collection of your Social Security Number is authorized by Executive Order 9397. Furnishing the information on this form, including your Social Security Number, is voluntary.

**INDIVIDUAL DEVELOPMENT PLAN**

**NAME:**

**SSN:**

**PERIOD COVERED:**

**CAREER FIELD:**

**POSITION TITLE/GRADE:**

**ORGANIZATION:**

**1. DEVELOPMENTAL OBJECTIVES (Skills/Performance Enhancement, Career Accomplishments, Etc.)**

**a. Short-Term Objectives**

**b. Long-Term Objectives (3 - 5 Years)**

**1.**

**2.**

**3.**

**4.**

**5.**

**6.**

**1.**

**2.**

**3.**

**4.**

**5.**

**6.**

**2. FORMAL TRAINING (Priority 1 or 2)**

|  |
| --- |
| Course Title/Number Priority Course Provider Date Required Hours Tuition Est Trvl/PD |
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |
| 6. |
| 7. |
| 8. |

**3. ON-THE-JOB TRAINING (Priority 1 or 2)**

|  |
| --- |
| OJT Description Priority Location Proposed Dates Est Trvl/PD |
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |
| 6. |
| 7. |
| 8. |

I certify that I will support the training and/or development outlined in this IDP and will recommend approval of training costs in each FY budget. I have counseled the employee for whom this IDP has been prepared.

**Supervisor Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have been counseled regarding my career goals and training or development needed to achieve these goals. I have included only goals that I can realistically expect to achieve during the time period specified.

**Employee Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| INDIVIDUAL TRAINING RECORD | | | | | | | |
| **DEPARTMENT:** | | | **PAGE: OF** | | | | |
| **NAME:** | | | **TITLE:** | | | | |
| **REPORTS TO:** | | | **RANK/GRADE:** | | | | |
| DESCRIPTION OF TRAINING TYPE CODES | | | | | | | |
| AC – Academic Course | | | SS – Service School | | | | |
| OJ – On-the-Job Training | | | IH – In-House Training | | | | |
| IS – Informational Seminar | | | Outside Source | | | | |
| DESCRIPTION | **TYPE CODE** | **DATE** | | **CLASS LENGTH** | **SAT.**  **COMPL** | **TRAINEE INITIALS** | **SUPV.**  **INITIALS** |
|  |  |  | |  |  |  |  |
|  |  |  | |  |  |  |  |
|  |  |  | |  |  |  |  |
|  |  |  | |  |  |  |  |
|  |  |  | |  |  |  |  |
|  |  |  | |  |  |  |  |
|  |  |  | |  |  |  |  |
|  |  |  | |  |  |  |  |
|  |  |  | |  |  |  |  |
|  |  |  | |  |  |  |  |
|  |  |  | |  |  |  |  |
|  |  |  | |  |  |  |  |
|  |  |  | |  |  |  |  |
|  |  |  | |  |  |  |  |
|  |  |  | |  |  |  |  |
|  |  |  | |  |  |  |  |
|  |  |  | |  |  |  |  |
|  |  |  | |  |  |  |  |
|  |  |  | |  |  |  |  |
|  |  |  | |  |  |  |  |
|  |  |  | |  |  |  |  |
|  |  |  | |  |  |  |  |
|  |  |  | |  |  |  |  |
|  |  |  | |  |  |  |  |
|  |  |  | |  |  |  |  |
|  |  |  | |  |  |  |  |
|  |  |  | |  |  |  |  |

|  |  |
| --- | --- |
| VENDOR COMPETENCY VERIFICATION | |
| **Company Name:** | **Contact:** |
| **Address:** | **Phone:** |
|  | **FAX:** |
| **Equipment Under Contract:** | |
| 1. | |
| 2. | |
| 3. | |
| 4. | |
|  | |
| **No. Years in Business:** | **Service Personnel:** |
| **Response Time (Hours):** | **On-Site:** |
| **Primary Service Technician:** | **Secondary Service Technician:** |
| **Availability of :** | |
| Diagnostic Software Y N N/A | Service Manuals Y N N/A |
| Loaner Equipment Y N N/A | Service Hotline Y N N/A |
|  | |
| **Proof of Liability Insurance**  Initial | |
| **Proof of Service Representative Competency**  **Attached** Initial | |
| **Signature**  Company Representative | **Date** |