Annual/As Necessary Re-Evaluation/Authorization
(for Medication Administration) of Direct Care Staff

(Note: This form can to be used for those unlicensed staff who did not successfully complete the initial Competency Based Training Assessment (CBTA) for Authorization or for an annual or as necessary Re-evaluation.)

1. Most Recent Evaluation Date: _____/______/ 20 _____ Present Evaluation Date: _____/______/ 20 _____

2. Reason for Evaluation/Re-Evaluation

   a. ☐ Annual Re-Evaluation

   b. ☐ Staff member unable to successfully complete initial CBTA successfully

   c. ☐ Staff member had his/her Medication Administration Authorization revoked

3. Evaluation Method Description: (i.e. written test, one-on-one discussion, demonstration/return-demonstration, review/repeat of OJT demonstration etc. Use reverse side of sheet for more explanation as necessary.)

SAMPLE

4. By signing this document, I am stating that I have participated in an evaluation for medication administration authorization on the date above to demonstrate my competence to administer medications to those individuals for whom I have been authorized by training from a state approved nurse-trainer.

____ _____ / ________/20_________
(staff signature) (Date)

5. Approval/Disapproval of authorization

   a. ☐ The staff, _________________________________ on the evaluation stated above **HAS** demonstrated
   (Name of staff being evaluated)

   competence in the safe administration of medications to selected individuals. She/he will retain her/his authorization to administer medication.

   b. ☐ The staff, _____________________________ on the evaluation stated above **HAS NOT** demonstrated
   (Name of staff being evaluated)

   competence in the safe administration of medications to selected individuals. She/he IS NOT authorized to administer medications. Retraining is scheduled for _____/______ / 20_____.at ______
   (date and time of retraining)

6. Reason for de-authorization of the above named staff (Describe deficiencies. Use reverse side of sheet if necessary.)

Nurse-Trainer Signature: _______________________________________ Date: _____ / ________/20________