QMAP Competency/ Skills Checklist

Name: _____ Date: _____

0= No experience, **1**= Need Direction, **2**= Minimal assistance needed, **3**= Very Competent

Please check the column that applies to your skill level:

SKILLS	**3**	**2**	**1**	**0**	**EXPERIENCE**	**# of Years**
Administer meds by route:	-	-	-	-	Assisted living facilities	
Oral					Adult foster care facilities	
Sublingual					Alternate care facilities	
Eye drops or Ointment					Residential childcare facilities	
Ear Drops					Secure resident treatment centers	
Nasal					State certified adult day programs	
Transdermal					Experience with Adults	
Inhaled					Experience with Seniors/ Geriatrics	
Rectal or Vaginal					Experience with Peds	
Maintain Proper Documentation					Experience with Infants	
Safely & Accurately fill Med Boxes						

I, _____, certify that all the information provided here is true and accurate to the best of my knowledge.

_____ _____

Applicant Signature Date