Connecticut Department of Developmental Disabilities
Medication Administration Certification Program
ON-SITE PRACTICUM /CHECKLIST B

PRINT Name_____ Agency _____

CHECK ONE: ❑ Initial ❑ Recertification ❑Annual ❑Other_____-

Employee must demonstrate the ability to prepare, administer and record the administration of medication by successfully completing the following items. A trial is defined as the pour and pass of one medication. **Staff must complete 3 trials with 100% accuracy**	**INDICATE PRACTICUM SITE:**	Use the following codes to indicate performance. Do NOT use check marks or arrow lines. N/A = Non Applicable S = Satisfactory U = Unsatisfactory			
	DATE of pour and pass trial:	/ /	/ /	/ /	/ /
	ROUTE of medication passed:				
Defines desired effects of the medication					
Describes side effects of the medication					
Calmly approaches task					
Allows no distractions					
Assembles appropriate equipment					
Uses good hand washing techniques					
Compares prescriber's orders to Medication Administration Record (MAR)					
Checks drug label to MAR 3 times before administration (Rule of 3 and 5 Rights)					
Prepares medications correctly					
Identifies the correct person					
Administers medication properly					
Checks that the person has swallowed the medication					
Keeps medication storage areas locked at appropriate times					
Documents correctly					

MUST indicate one: Comments on back of this form: Comments attached to form: No Comments:

I certify that the information recorded on this checklist is true and complete to the best of my knowledge. I understand that if I knowingly make any misstatement of fact, I am subject to disqualification from participating in the program, possible disciplinary action, and revocation of certification to administer medications.

Signature of staff: Date of signature:

As the Authorized LPN or **delegating** RN, I certify that the statements made by me on this checklist are true and complete to the best of my knowledge. I understand that if I knowingly make any misstatement of fact, I am subject to possible action by DDS or other agency.

_____ _____ _____
Signature & Title of Nurse Documenting Practicum Date of signature Printed name of Nurse Documenting Practicum

***Complete the signature below if Practicum observed and documented by DDS Authorized LPN Only**
As the **delegating** RN, I certify that the statements made to me by the DDS Authorized LPN about this checklist are true and complete to the best of my knowledge. I understand that if I knowingly make any misstatement of fact, I am subject to possible action by DDS or other agency.

_____ _____ _____
***** Signature of Registered Nurse Date of signature Printed name of Registered Nurse