

**NURSE PRACTITIONER/ PHYSICIAN ASSISTANT
COMPETENCY VERIFICATION**

Regarding: _____
(Applicant Name)

Select one: Nurse Practitioner Physician Assistant

Please complete the following information, if applicable:

License #: _____ License expiration date: _____
 Certification #: _____ Certification expiration date: _____

Physician supervisor(s):

COMPETENCY CHECKLIST - To be completed by the supervising physician.

Please indicate whether the practitioner listed above demonstrates competence in each skill by initialing under the “Yes,” “No,” or “N/A” column.

<u>Basic Skills:</u>	<u>Date:</u>	<u>Yes</u>	<u>No</u>	<u>N/A</u>
Obtains complete medical history and physical data on patients	_____	_____	_____	_____
Reviews patient records and interprets integrates data to determine appropriate diagnostic and therapeutic procedures needed	_____	_____	_____	_____
Performs complete physical exam and records all findings; establishes presumptive diagnosis	_____	_____	_____	_____
Orders appropriate laboratory and diagnostic procedures; records all findings and synthesizes data to determine preliminary diagnosis and therapeutic plan using principles of prevention	_____	_____	_____	_____

<u>Basic Skills (continued):</u>	<u>Date:</u>	<u>Yes</u>	<u>No</u>	<u>N/A</u>
Administers injections, immunizations, and oral medications; sutures wounds; prepares written prescription orders for drugs and controlled substances	_____	_____	_____	_____
Interviews and advises patients regarding health and illness prevention; instructs patient and family regarding medications and treatment instructions	_____	_____	_____	_____
Assists physician by recording patient progress notes, issuing diagnostic orders, and transcribing physician orders	_____	_____	_____	_____
Provides monitoring and continuity of care between physician visits	_____	_____	_____	_____

<u>Special skills (please list):</u>	<u>Date:</u>	<u>Yes</u>	<u>No</u>	<u>N/A</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Additional comments: _____

Physician reviewer signature: _____ Date: _____

Printed Name: _____