Registration Form – IV Therapy or Central Lines class*

Date of Program _____

Statement of Responsibility for Competency Assessment

To be signed by a representative of the employing agency

*Registration and payment can be completed online. Signed competency acknowledgement and evaluation requirements sections must be received from an immediate supervisor prior to class if registration and payment are completed online.

Signed competency should be sent via fax or electronically to:

Fax: 843-777-5354 or Email: Beejay.Parnell@mcleodhealth.org

I acknowledge that the applicant meets the eligibility requirements for this course and that the employing agency is responsible for determining the competency of the LPN through clinically supervised return demonstration based on agency-specific policies, procedures, and standing orders.

Signature of Immediate Supervisor: _____

Date Signed: _____

Evaluation Requirements:
Pee Dee AHEC will be evaluating the degree to which this learning experience has enhanced the healthcare provider's knowledge/skills and the extent to which those skills support your healthcare organization's business needs.

Participant Name: _____

Home Address: _____ City: _____ State: ____ Zip: _____

Employer: _____ Work Phone: _____

Supervisor: _____ Supervisor Phone: _____

I certify that the above named applicant has met the pre-requisites for this educational offering. I agree the program's behavioral objectives are linked to the business challenges of our organization and to the performance expectation of the above named participant. I agree the employing institution will be responsible for input used in measuring training impacts/results as outlined under evaluation requirements on this form and as recommended by Pee Dee AHEC.

Signature of Immediate Supervisor: _____

Date Signed: _____