Personnel Orientation/Training Check List

Orientation, training/ information has been provided to (name and title of employee) ______________________________ in the following areas of Member’s/Patient’s Rights and Safety on the dates documented and signed by the employee and trainer listed below.

<table>
<thead>
<tr>
<th><strong>Member Rights:</strong></th>
<th><strong>Date/ Signatures</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Confidentiality</td>
<td></td>
</tr>
<tr>
<td>Informed Consent (including Human Sterilization where applicable)</td>
<td></td>
</tr>
<tr>
<td>Prior Authorization requests</td>
<td></td>
</tr>
<tr>
<td>Grievance/Complaint Procedure</td>
<td></td>
</tr>
<tr>
<td>Sensitive Services/Minors’ Rights</td>
<td></td>
</tr>
<tr>
<td>Health Plan Referral Process/Procedures/ Resources</td>
<td></td>
</tr>
<tr>
<td>Safety:</td>
<td>Date/signatures</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Infection Control/Universal Precautions</td>
<td></td>
</tr>
<tr>
<td>Biohazardous Waste Handling</td>
<td></td>
</tr>
<tr>
<td>Child/Elder/Domestic Violence Abuse</td>
<td></td>
</tr>
<tr>
<td>*Blood Borne Pathogens Exposure Prevention</td>
<td></td>
</tr>
<tr>
<td>* Documentation of Annual Training</td>
<td></td>
</tr>
<tr>
<td>required.</td>
<td></td>
</tr>
</tbody>
</table>

**Annual Blood Borne Pathogens Exposure Prevention Training:**

(Documentation of the annual inservice/training date, employee’s signature/ title and the signature/ title of the trainer are required.)

**Date/signatures of annual inservice/training**

________________________
________________________
________________________
________________________
________________________

Additional date/signature pages to be added as needed.
Use and maintenance of medical office equipment

(Name and title of employee) __________________________ has been oriented/instructed in the proper use and maintenance of all medical office equipment used in the scope of his/her work at this facility. A qualified instructor has provided the orientation/instruction.

This employee has provided a return demonstration showing his/her knowledge, understanding and competency in the proper use and maintenance of the medical equipment listed below.

A satisfactory return demonstration has been performed/completed as documented by the date (date of completion) and signature/title of the employee and trainer documented below.

* Indicate if item is not used in the employee’s scope of work.

<table>
<thead>
<tr>
<th>Date/signatures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiometer</td>
</tr>
<tr>
<td>Autoclave</td>
</tr>
<tr>
<td>Centrifuge</td>
</tr>
<tr>
<td>Defibrillator</td>
</tr>
<tr>
<td>EKG machine (electrocardiogram)</td>
</tr>
<tr>
<td>Eye charts (literate and illiterate) and Occluder for vision testing</td>
</tr>
</tbody>
</table>
Glucometer

Hemaglobinometer

Oxygen tank/equipment

Scales
  o Adult
  o Infant

Stethoscope and Sphygmomanometer (BP Cuff)
  o Child
  o Adult
  o Obese/thigh

Stature measuring devices
  (height/length)

Thermometer (with numeric reading)
  o Oral
  o Tympanic/Temporal

Ultrasonography equipment

Other (name of equipment not listed above)