

Med Aide On-Line Training Solutions©

Training Documentation

Students: This Form & the Clinical Skills Checklist must be maintained by your facility.

Med Aide Student Name: _____

Facility Name: _____

Submit to Facility to obtain certificate

- High School Diploma or GED
- 1:1 Clinical Skills Checklist

NOTE: Upon program registration, the Facility RN Instructor will be automatically provided a STUDENT ID login and password allowing student to access the program, AND a separate EXAM TESTING password. The EXAM TESTING password is not to be shared with the student at anytime. To view, verify and print a complete listing of the student's course grades: within the program, select grades under "This course." Also a course completion block on right-hand side of screen lists quiz status.

The above student, enrolled in the Avera Med Aide On-line Training Solutions program, has completed the following:

| <u>Unit 1</u> | Score | Date | <u>Unit 1 Exam</u> | Score | Date | Proctor |
|---------------|-------|-------|--------------------------------|-------|-------|---------|
| Module 1 | _____ | _____ | 1st Attempt: | _____ | _____ | _____ |
| Module 2 | _____ | _____ | 2nd Attempt: | _____ | _____ | _____ |
| Module 3 | _____ | _____ | (if needed) | | | |

| <u>Unit 2</u> | Score | Date | <u>Unit 2</u> | Score | Date |
|---------------|-------|-------|--------------------------------|-------|-------|
| Module 4 | _____ | _____ | On-Line Lab Quiz | _____ | _____ |
| Module 5 | _____ | _____ | Unit 2 Exam | Score | Date |
| Module 6 | _____ | _____ | 1st Attempt: | _____ | _____ |
| Module 7 | _____ | _____ | 2nd Attempt: | _____ | _____ |
| Module 8 | _____ | _____ | (if needed) | | |
| Module 9 | _____ | _____ | Final Exam | Score | Date |
| Module 10 | _____ | _____ | 1st Attempt: | _____ | _____ |
| Module 11 | _____ | _____ | 2nd Attempt: | _____ | _____ |
| Module 12 | _____ | _____ | (if needed) | | |

***Practical Application & Lab Requirements:** *(minimum of 3 hours) lab & one to one skills evaluation*

Your employer will communicate with you regarding the **additional requirements** for completing your training program. It will consist of a minimum of 3 hours in a lab/clinical environment with your facility's approved RN or LPN instructor and a skills evaluation by your approved RN instructor using the **BON skills checklist**. Your facility may have additional training requirements. Attach additional training requirements and completion status to this form/student's training records.

3 HR (minimum) Lab & 1:1 Skills Performance Evaluation w/BON Skills Checklist

RECORD DATE(S) COMPLETED: _____

*You may not pass medications until you successfully complete this full 20 hour approved program, receive a certificate of completion from your employer, and pass the state registry exam if required and placed on the SD Med Aide registry if required. The state registry exam & registry status is required for those employed in skilled nursing facilities (SNF/nursing homes), assisted living centers (ALC), and hospitals.

I attest that all quiz and Exam scores are accurate, and all Exams were proctored:

Facility RN Instructor Signature: _____

Student Signature: _____