Connecticut Department of Developmental Services
Authorized LPN Performance Evaluation

Name:_____ Authorization #:_____
Agency:_____

Directions: Rate the LPN in the identified areas using the following scale: **S= Satisfactory U= Unsatisfactory**

The Authorized LPN shall successfully demonstrate the performance of one on-site practicum under the supervision of the delegating nurse initially and at least on an annual basis.

On-Site Practicum Checklist A Application					
	Criteria	**Date of Observation**			
1.	Explains process & expectations				
2.	Demonstrates understanding of and ability to reinforce all elements identified as agency specific				
3.	Demonstrates understanding of and ability to reinforce information regarding reporting changes to RN				
4.	Demonstrates understanding of and ability to reinforce individual and site specific considerations				
5.	Demonstrates understanding of delegation process for medication administration and other delegated tasks				
6.	Allows for staff questions and responds correctly				
7.	Documentation is accurate and complete				

On-Site Practicum Checklist B Application					
	Criteria	**Date of Observation**			
1.	Explains process & expectations				
2.	Demonstrates avoidance of prompting staff				
3.	Demonstrates ability to identify components of trial that are incorrectly performed				
4.	Demonstrates ability to question staff regarding purpose and effects of the medications to be administered				
5.	Allows for staff questions and responds correctly				
6.	Demonstrates ability to identify problems with staff 's performance and stop process				
7.	Demonstrates knowledge of responsibility to communicate results of practicum to the RN				
8.	Documentation is accurate and complete				

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 Authorized LPN: **Date of signature** **Printed name of Authorized LPN**

As the 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 of Delegating RN **Date of signature** **Printed name of RN**