# Certified Medication Tech Skills Checklist

**CMT :** _____

| CMT Self-Rating | Competency Assessment Method |
|---|---|
| A = I can perform well | D = Direct Observation and/or Demonstration |
| B = I need to review | O = Oral Question and Answer |
| C = I have no experience | (Circle the appropriate method below) |

| Skills | Self Rating | Supervisor Assessment Method | Supervisor Evaluation | |
|---|---|---|---|---|
| | | | Competency | Supervisor Initials & Date |
| Communication | A, B, or C | D or O | ☐Met ☐Not Met | |
| Observation, reporting and documentation of patient status and the care of services provided | A, B, or C | D or O | ☐Met ☐Not Met | |
| Basic elements of body functions and changes in condition that must be reported | A, B, or C | D or O | ☐Met ☐Not Met | |
| Maintaining a clean, safe and health environment | A, B, or C | D or O | ☐Met ☐Not Met | |
| Ability to recognize emergency situations | A, B, or C | D or O | ☐Met ☐Not Met | |
| ALL medication administration routes permitted for CMT as individual skills: | | | | |
| Oral | A, B, or C | D or O | ☐Met ☐Not Met | |
| Topical | A, B, or C | D or O | ☐Met ☐Not Met | |
| Ear | A, B, or C | D or O | ☐Met ☐Not Met | |
| Nose | A, B, or C | D or O | ☐Met ☐Not Met | |
| **Suppositories:** | | | | |
| rectally | A, B, or C | D or O | ☐Met ☐Not Met | |
| vaginally | A, B, or C | D or O | ☐Met ☐Not Met | |
| subcutaneous, | A, B, or C | D or O | ☐Met ☐Not Met | |
| finger sticks | A, B, or C | D or O | ☐Met ☐Not Met | |
| Documentation of medication administration; | A, B, or C | D or O | ☐Met ☐Not Met | |
| Infection control: - hand washing, - use of gloves, - use of sanitizer | A, B, or C | D or O | ☐Met ☐Not Met | |
| Response to medication allergies; | A, B, or C | D or O | ☐Met ☐Not Met | |
| Reporting and documentation of medication errors | A, B, or C | D or O | ☐Met ☐Not Met | |
| Vital signs: - temperature, - heart rate, - respirations | A, B, or C | D or O | ☐Met ☐Not Met | |
| Blood pressure; | A, B, or | D or O | ☐Met ☐Not | |

| | | | | |
|---|---|---|---|---|
| | C | | Met | |
| Other<br>( Describe):_____<br>_____ | A, B, or C | D or O | ☐Met ☐Not Met | |
| Equipment Use/Maintenance/Cleaning<br>(Describe:_____ | A, B, or C | D or O | ☐Met ☐Not Met | |

_____

CMT Signature /Date

_____/_____/_____

RN Evaluator Name/Signature Initials//Date