PRINT

Certified Compounded Sterile Preparation Technician™ Competency Attestation Form

The purpose of this form is to document that Certified Compounded Sterile Preparation Technician™ (CSPT™) Program Requirements for training, skill assessment, and competency assessment have been completed. PTCB requires that this form be completed to earn initial CSPT Certification and also annually to maintain CSPT Certification. This form must be completed by a Qualified Supervisor, as defined within this form, who directly observed the training, skill assessment, and competency assessment of the CSPT candidate/certificant. The PTCB certificant/candidate should submit the completed form by logging into their PTCB Account.

Supervisor Information	
Full Name: _____	
Work Address: _____	
Work City: _____ **Work State:** _____	
Work Zip Code: _____	**Contact Phone Number:** _____
Email Address: _____	
License/Registration Number: ☐**Pharmacist:** _____ **OR** ☐**Pharmacy Technician:** _____	
If Pharmacy Technician, PTCB CPhT Certification Number: _____	

Supervisor Statement of Qualification

I _____, do hereby certify that I meet the following requirements established by PTCB and that I am thereby qualified to attest to the training, skill, and competency reported on this form.

1. I am in good standing with my employer and all regulatory bodies (e.g. state board of pharmacy) that have jurisdiction over my work site.
2. I have at least _____ years of experience working directly with, or supervising compounded sterile preparations (CSPs) production. *

_____ ____/_____/_____

Signature of Qualified Supervisor **Date**

Note: If less than five (5) years, you must attach a letter from the pharmacy director describing your qualifications to supervise CSP production.

CSPT Certificant/Candidate Information	
Full Name:	_____
PTCB Certification Number:	CPhT _____ **OR** CSPT _____

Most recent date of training: _____/_____/_____

Description of training (list learning objectives or attach outline):

_____

_____

_____

_____

Hand Hygiene, Garbing, and Gloving
Date of most recent direct observation/evaluation: _____/_____/_____
Evaluation Result: _____ _____ _____ _____

Gloved Fingertip Test
Date of most recent test: ____/_____/_____
Test Result: ☐ PASS ☐ FAIL

Aseptic Manipulation
Date of most recent direct observation/evaluation: _____/_____/_____
Evaluation Result: _____ _____ _____

Media Fill Test
Date of most recent test: ____/_____/99____
Test Result: ☐ PASS ☐ FAIL

Cleaning and Disinfecting
Date of most recent direct observation/evaluation: 99 /99 /99
Evaluation Result: _____ _____ _____ _____

I _____, do hereby certify that I have directly observed the activities recorded on this form, and that the information on this form is true and correct to the best of my knowledge. I understand that material misrepresentations in this form may affect the eligibility of the candidate for PTCB CSPT Certification, and that PTCB may refer misrepresentations on this form to state regulatory bodies for review.

_____ ____/_____/_____

Signature of Qualified Supervisor **Date**