



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: ____/____/____

Test Result: PASS FAIL

Cleaning and Disinfecting

Date of most recent direct observation/evaluation: ____/____/____

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

