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 this form to be completed to earn initial CSPT Certification and on an annual basis 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 candidate/certificant is required to submit the form by logging into their PTCB Account.

CSPT Candidate/Certificant Information
Full Name: _____
PTCB Account ID: _____

Gloved Fingertip and Thumb (GFT) Sample
Date of most recent evaluation: _____/_____/_____
Evaluation Result: ☐ PASS ☐ FAIL

Media Fill Test
Date of most recent evaluation: _____/_____/_____
Evaluation Result: ☐ PASS ☐ FAIL

Candidate/Certificant Full Name: _____

PTCB Certification Number: _____

The following three sections must be completed by a **qualified supervisor**. A qualified supervisor meets the requirements described below.

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 skills and competencies 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 five (5) years of experience supervising the production of compounded sterile preparations (CSPs).* **If you, the qualified supervisor, have less than five (5) years of experience, you must attach a letter from the pharmacy director describing your qualifications to supervise CSP production. If this form is submitted without accompanying documentation, it will be returned to the candidate/certificant for correction.* **Signature of Qualified Supervisor** _____ **Date**: _____/_____/_____

Supervisor Information
Full Name: _____
Employer address: _____ **City**: _____ **State**: _____ **Zip Code**: _____
Employer Phone #: _____
Email Address: _____
License/Registration Number: _____ **License/Registration State:** _____ ☐ Pharmacist ☐ Pharmacy Technician

Candidate/Certificant Full Name: _____

PTCB Certification Number: _____

Qualified Supervisor Attestation
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 on this form may affect the eligibility of the candidate/certificant for PTCB CSPT Certification, and that PTCB may refer misrepresentations on this form to state regulatory bodies for review. **Signature of Qualified Supervisor** _____ **Date:** _____/_____/_____