**KENTUCKY BOARD OF NURSING**
**DT Credentialing Program**
**312 Whittington Parkway Suite 300**
**Louisville, KY 40222**
**Phone: (502) 429-3300 or (800) 305-2042**
**Fax: (502) 429-3311**
**Website: kbn.ky.gov**

# CHECKLIST FOR DIALYSIS TECHNICIAN COMPETENCY VALIDATION

This form must be completed by your immediate supervisor, signed and submitted with your application for Dialysis Technician Credentialing. Print clearly using capital letters and black ink.

## SECTION 1: Biographical Data

Last Name: _____ First Name: _____ MI: _____

DT's Social Security #: _____ DT Applicant Credential #: _____

Date of DT Training Program Completion: _____

Date of Clinical Internship Completion: _____

Immediate Supervisor's Name and Credentials: _____

License #: _____ Email: _____

Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

## SECTION 2: Immediate Supervisor's Certification

As the Immediate supervisor of the above-named dialysis technician, I certify that the following Information is true and accurate. I also certify that:

(Name of Dialysis Technician)_____ completed the Clinical Internship and performs dialysis care in a safe manner, under the direct on-site supervision of a registered nurse or physician, including the competent performance of each of the following acts (as indicated by my initials):

_____ Prepare and cannulate peripheral access sites (arterial-venous fistula and arterial venous graft)
_____ Initiate, deliver, and discontinue dialysis care.
_____ Assist the registered nurse in data collection.
_____ Obtain a blood specimen via dialysis lines or peripheral access sites.
_____ Respond to complications that arise in conjunction with dialysis care.

Administer the following medications:

_____ Heparin

_____ Intradermal Lidocaine

_____ Normal Saline

If this dialysis technician (DT) does not administer these medications, please indicate "N/A" (non-applicable).

If this DT administers these medications in the future, the DT must be educationally prepared and clinically competent to do so in a safe manner.

**SECTION 3: Return Completed Form to KBN Office if you are applying for the following:**

A. Initial DT Credential and you have completed a DT Training Program in Kentucky and the Clinical Internship.

B. Initial DT Credential and you have completed an out of state DT Training Program and you do not hold national DT certification. Additionally your DT Training Program curriculum has been reviewed and approved by KBN staff and you have completed the Clinical Internship.

C. Reinstatement of DT Credential that has lapsed for more than twelve (12) months and you have not worked in another state as a DT. Furthermore, you have completed a DT Training Program in Kentucky and have met all of the requirements in 201 KAR 20:476, Section 1.

**SECTION 4: Immediate Supervisor's Signature**

Immediate Supervisor _____

Signature of Immediate Supervisor _____

Date: _____

4/2021