**Continuing Competency Program ● Professional Development Plan and Outcomes**

**Clinical Form**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date form completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Goal \_\_of \_\_**  **Registration Year:**  Mar. 1, 20 \_ \_  to  Feb. 28, 20\_ \_ | **Item No. From Clinical Self-Assessment Tool** | **Goal**  (What I want to learn, specific and measurable) | **Learning Strategies/Activities**  (What I need to do to achieve my goal) | | **Anticipated Completion Date**  (Attainable and time oriented) | **Current Status** |
| □ Item 1 point:\_\_  □ Item 2 point:\_\_  □ Item 3 point:\_\_  □ Item 4 point:\_\_  □ Item 5 point:\_\_  □ Item 6 point:\_\_  □ Item 7 point:\_\_ |  |  | |  | □ Completed Date: \_\_\_\_\_\_\_\_\_\_  □ In Progress  □ Omit (Reason)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Outcomes/ Impact On Practice**  (How this learning impacted my practice) | | | | **Evidence Supporting Goal Completion/Progression**  (Certificates, course material, books, notes, dates, etc.) | | |
| Check all that apply and provide reflection:  □ Validated my practice  □ Enhanced my practice  □ Expanded my knowledge  □ Increased my awareness of existing resources  □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Please complete the attached reflection form | | | | List evidence and location in portfolio:  If audited, evidence will be required to be submitted | | |

**Outcomes/ Impact on Practice Reflection Form**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Goal \_\_ of \_\_**

**Check all that apply and provide reflection:**

□ Validated my practice

□ Enhanced my practice

□ Expanded my knowledge

□ Increased my awareness of existing resources

□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reflection:**