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

**Non-Clinical Form**

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Goal \_\_of \_\_****Registration Year:** Mar. 1, 20 \_ \_toFeb. 28, 20\_ \_ | **Item No. From** **Non-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** |
| □ Unit A□ Unit B□ Unit C□ Unit D□ Unit E |  |  |  | □ 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:**