



Continuing Competency Program • Professional Development Plan and Outcomes Non-Clinical Form

Name: _____ Date form completed: _____

Goal __ of __	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
Registration Year: Mar. 1, 20__ __ to Feb. 28, 20__ __	<input type="checkbox"/> Unit A <input type="checkbox"/> Unit B <input type="checkbox"/> Unit C <input type="checkbox"/> Unit D <input type="checkbox"/> Unit E				<input type="checkbox"/> Completed Date: _____ <input type="checkbox"/> In Progress <input type="checkbox"/> 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: <input type="checkbox"/> Validated my practice <input type="checkbox"/> Enhanced my practice <input type="checkbox"/> Expanded my knowledge <input type="checkbox"/> Increased my awareness of existing resources <input type="checkbox"/> 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: