**Common Standards Second Edition, Training and Competency Form**

This form is provided as a tool for documenting training and competency required of Clinical Program Directors, attending physicians, physicians-in-training, and advanced practice providers/professionals (as applicable). Confirmation that training was provided and competency was assessed during the current accreditation cycle in each of the following areas must be provided to FACT prior to an on-site inspection. Equivalent documentation is acceptable if all information below is included.

|  |  |
| --- | --- |
| **Name:** |  |
| **Position:** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Topic** | **Yes** | **No** | **N/A** | **Comment** |
| ***Specific training and competency in each of the following:*** | | | | |
| B3.2.4.1 Indications for cellular therapy. |  |  |  |  |
| B3.2.4.2 Selection of suitable recipients and appropriate cellular therapy products. |  |  |  |  |
| B3.2.4.3 Product characteristics including donor eligibility determination. |  |  |  |  |
| B3.2.4.4 Informed consent of the patient consistent with institutional policy and Applicable Law. |  |  |  |  |
| B3.2.4.5 Cellular therapy product administration and patient management. |  |  |  |  |
| B3.2.4.6 Adverse events associated with cellular therapy. |  |  |  |  |
| B3.2.4.7 Management of anticipated complications of cellular therapy. |  |  |  |  |
| B3.2.4.8 Evaluation of post-treatment cellular therapy outcomes. |  |  |  |  |
| B3.2.4.9 Evaluation of late effects of cellular therapy. |  |  |  |  |
| B3.2.4.10 Documentation and reporting for patients on investigational protocols. |  |  |  |  |
| ***Specific clinical training and competency in each of the following for allogeneic cellular therapy:*** | | | | |
| B3.2.5.1 Identification, evaluation, and selection of cell source, including use of donor registries. |  |  |  |  |
| B3.2.5.2 Donor eligibility determination. |  |  |  |  |
| B3.2.5.3 Methodology and implications of HLA typing. |  |  |  |  |
| B3.2.5.4 Management of patients receiving ABO incompatible cellular therapy products. |  |  |  |  |
| ***Knowledgeable in the following:*** | | | | |
| B3.2.6.1 Cellular therapy product collection. |  |  |  |  |
| B3. 2.6.2 Cellular therapy product processing. |  |  |  |  |
| B3.2.6.3 Cellular therapy product cryopreservation. |  |  |  |  |

**Reviewer Signature and Date (must be signed by someone other than personnel being assessed):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**