

TBI-FORENSIC SERVICES DIVISION PERFORMANCE VERIFICATION FORM

Instrument/Method to Verify:

Check the appropriate box: New Validation Modification Performance Check

Laboratory: NCL KCL JCL Unit: _____

Based on training and competency, the following analyst(s) are authorized by the Technical Leader to participate in this study:

Name _____ Title _____ Initials _____

Completed:

Name _____ Title _____ Initials _____

Completed:

Name _____ Title _____ Initials _____

Completed:

Verification of final review:

Unit Supervisor:

Section Manager:

Unit Supervisor:

Section Manager:

Unit Supervisor:

Section Manager:

Regional Administrator:

Regional Administrator:

Regional Administrator:

Quality Assurance Manager:

By signing below, I have verified this study meets all requirements and I deem this procedure/instrument fit for the intended use:

Technical Leader:

All information must be submitted to the Quality Assurance Manager prior to the implementation of the procedure/instrument. If applicable, include training plan and competency testing schedule.