# Log Sheet

**Intravenous Quality Assurance**
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## Low-Risk Media Fill Test Kit

**Employee Name:** _____ **Date Test Performed:** _____

**Media Fill Test Kit Number:** _____ **Kit Expiration Date:** _____

| Vial Number | Hood Number | Incubation Temp. | Length of Incubation* | Result: Growth/No Growth | Interpretation: Pass/Fail | Notes/Corrective Action: (Attach additional pages if necessary) |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |

*Recommended length of incubation is 14 days for negative cultures.

**Supervisor Signature:** _____ **Date:** _____