



# Log Sheet

Intravenous Quality Assurance  
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## Medium-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: \_\_\_\_\_