Log Sheet

Intravenous Quality Assurance
P.O. Box 5194, Hacienda Heights, CA 91745
Phone: 626-629-0418
Fax: 760-406-6299

High-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:** ___________________________