

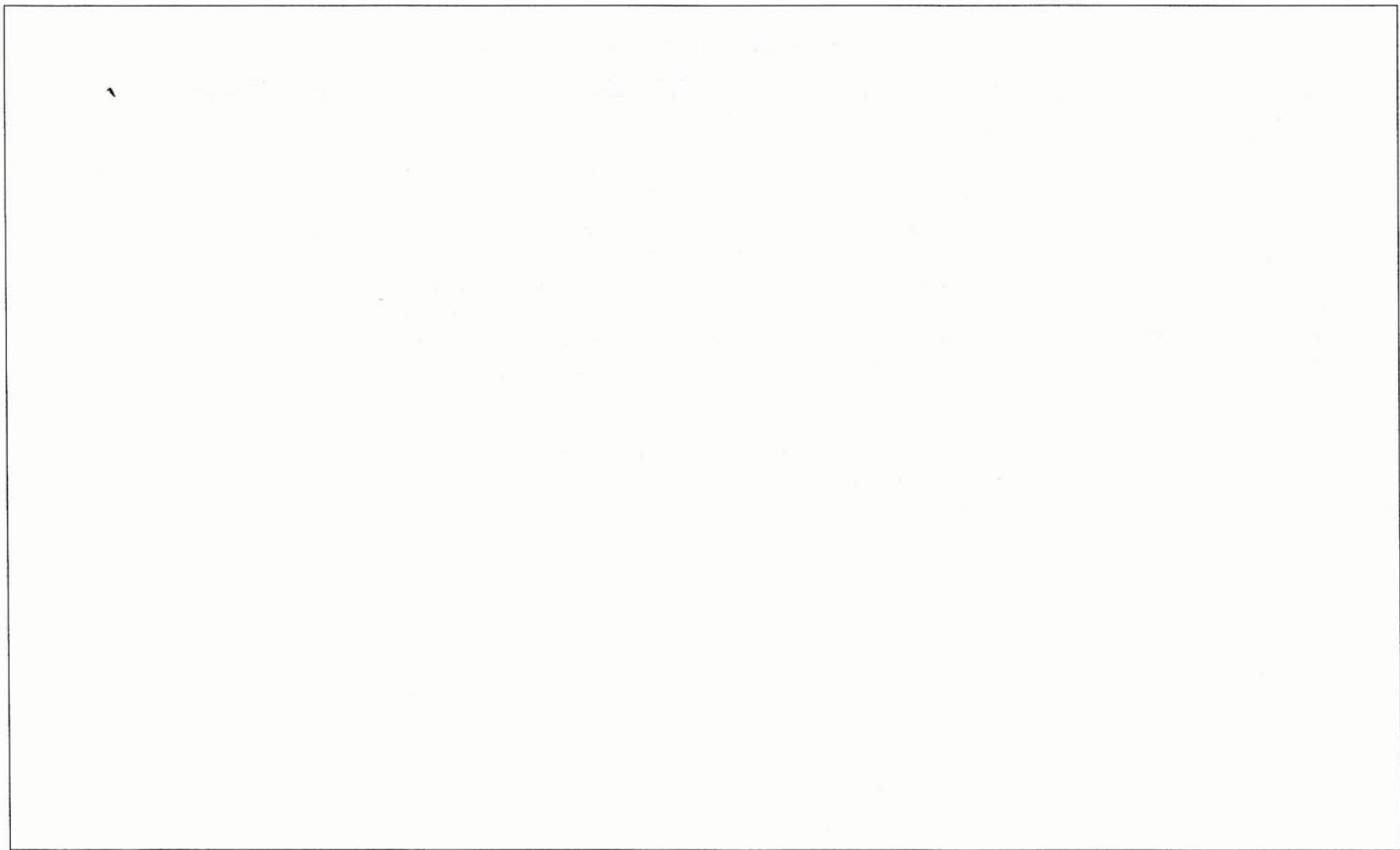
CLINICAL / INTERNSHIP DOCUMENTATION FORM

Student Name: _____ _____	Date of Rotation: <i>(beginning date)</i> _____ Start Time: <i>(military time)</i> _____	Clinical Location: <input type="checkbox"/> St. Joe <input type="checkbox"/> CSMC <input type="checkbox"/> Grimes St. Joes <input type="checkbox"/> Burleson St Joes <input type="checkbox"/> St Marks <input type="checkbox"/> Trinity Medical Center <input type="checkbox"/> Tomball Regional <input type="checkbox"/> St Davids <input type="checkbox"/> Richards Memorial <input type="checkbox"/> Other (specify): _____	Department: <input type="checkbox"/> ER <input type="checkbox"/> L&D <input type="checkbox"/> Behav. <input type="checkbox"/> OR <input type="checkbox"/> ICU <input type="checkbox"/> RT <input type="checkbox"/> HS <input type="checkbox"/> NICU <input type="checkbox"/> Cath <input type="checkbox"/> Other	Internship Location: Unit #: _____ <input type="checkbox"/> College Station FD <input type="checkbox"/> Bryan FD <input type="checkbox"/> Robertson County EMS <input type="checkbox"/> Austin County EMS <input type="checkbox"/> Washington County EMS <input type="checkbox"/> Harris Co ESD 1 EMS <input type="checkbox"/> Montgomery County EMS <input type="checkbox"/> Other (specify) _____	Preceptor Crew (print names) 1. _____ 2. _____ Preceptor Signature _____
Total Hours Worked: _____	 _____	 _____	 _____	 _____	 _____
Total Patients Contacted: _____	End Time: <i>(military time)</i> _____	_____	_____	_____	_____

Use one Page for each Clinical / Internship Shift *(Use back if necessary)*

FOR OFFICE USE ONLY

Site Hours: ER ____ L&D ____ Behav ____ RT ____ OR ____ ICU ____ NICU ____ HS ____ Cath ____ EMS ____
Skills Performed: EKG Non-NS ____ EKG NS ____ VP ____ ET ____ Med Admin ____ Births ____ <> **Transports:** BLS ____ ALS ____
Patient Contacts: Adult ____ Pedi ____ Geri ____ <> Psych ____ Cardio ____ Resp ____ GI/GU ____ Trauma ____ OB/GYN ____ Medical ____



This is an accurate representation of clinical/internship time

Name:	Signature:	Date:
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PRECEPTOR EVALUATION OF STUDENT

Class Level:	Basic Intermediate Paramedic	Student Name:	Last four of SSN:
Class Dates:		Clinical Site:	Department:
		Preceptor:	

CATEGORY	RATING	IMPROVEMENT PLAN	
ASSESSMENT			
Primary Assessment	N/A 1 2 3 4 5	1. Please write a brief comment on all areas of performance where the rating is a "1" or a "2".	
Secondary Assessment	N/A 1 2 3 4 5		
Medical History	N/A 1 2 3 4 5		
SKILLS PERFORMED			
Patient Relations	N/A 1 2 3 4 5	2. List at least 2 tasks that the student can to improve performance on the item(s) listed above.	
Lifting and Moving.....	N/A 1 2 3 4 5		
Airway Maintenance	N/A 1 2 3 4 5		
Oxygen Administration.....	N/A 1 2 3 4 5		
Bag Valve Mask.....	N/A 1 2 3 4 5		
Suctioning	N/A 1 2 3 4 5		
CPR Adult / Child / Infant.....	N/A 1 2 3 4 5		
Esophageal Airway	N/A 1 2 3 4 5		
Endotracheal Intubation	N/A 1 2 3 4 5		
PASG Monitoring / Removal	N/A 1 2 3 4 5		
IV Cannulation	N/A 1 2 3 4 5		
Medication Administration	N/A 1 2 3 4 5		
ECG Recognition	N/A 1 2 3 4 5		
Defibrillation / Cardioversion ...	N/A 1 2 3 4 5		
_____	N/A 1 2 3 4 5		3. List 2 things the program instructor can do to help the student improve performance in support of the task(s) listed in number 1.
_____	N/A 1 2 3 4 5		
REPORTING			
Radio Operation	N/A 1 2 3 4 5		
Oral or Radio Reporting	N/A 1 2 3 4 5		
Documentation	N/A 1 2 3 4 5		
Log Book and Misc. Records....	N/A 1 2 3 4 5		
		<i>PLEASE WRITE COMMENTS ON THE BACK OF THIS FORM IF NEEDED</i>	
1= POOR 2=MARGINAL 3=ACCEPTABLE 4=VERY GOOD 5=EXCELLENT		Evaluator Signature: _____ Date: _____	
		Student Signature: _____ Date: _____	