

HEALTH CAREER INSTITUTE
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Hospital/Field EMS Program Verification Form

**THE PRECEPTOR OR INSTRUCTOR WILL NOT SIGN THIS FORM UNLESS
 THEY AGREE WITH WHAT THE STUDENT HAS FILLED IN SEE BELOW.**

This form is to be signed by the Clinical Instructor or EMS Preceptor for verification of:

1. The time the student attended.
2. The Skills the student performed or observed are correct.

STUDENT NAME _____ DATE OF ATTENDANCE _____

NAME OF LOCATION _____ HOURS OF ROTATION _____

Attach to patient contact reports completed for the date above.

BLS Care	Observed	Performed by student
Communication with patient		
Bandaging/Wound Management		
Traction Splint(ex: Traction etc.)		
Suction		
Airway Type(NC, NRB etc)		
Immobilization Type(Spine Board, C collar)		
Movement of Patient		
Chest Compressions		
Set up IV materials		
ALS CARE		
Blood Glucose monitor		
Capnometry		
2-Lead Placement		
12-Lead		
Pulseoximetry		
Capnography		
Intravenous Access		
Intubations		
Electrical Therapy (cardioversion, defibrillation)		
Medication Administration (Epi, Nitro, Atropine)Dose		

Please verify the above before signing, thank you for your assistance.

Signature of preceptor/Instructor _____ Date _____