Student Name:  
Course #:  
Ambulance Designation:  

Date:  
Total Hours Completed:  

Start Time:  
End Time:  

(To be completed by student)

Description of Clinical Experience
List patient encounters, skills performed, pertinent negatives/positives
(i.e. Vital Signs, Splinting, CPR, AED, etc.)

________________________________________________________________________
________________________________________________________________________
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________________________________________________________________________

VERIFICATION BY CLINICAL PRECEPTOR

The above named student has successfully completed the requirements of this Ambulance Rotation in accordance with the objectives set forth.

Preceptor Signature:  
Date:  
Preceptor Name (Print):  
Title:  
Work Phone:
Please utilize the following rating scale (1 representing worst, 5 representing best) by circling the number which best corresponds to your evaluation of the designated area of your ambulance experience. Use additional forms to accentuate positive or negative comments (if necessary).

1. Appropriate Orientation by your Instructor Coordinator
   Comments: 
   Rating: 1 2 3 4 5

2. Responsibilities clearly defined by your Instructor Coordinator
   Comments: 
   Rating: 1 2 3 4 5

3. Adequate Supervision on Ambulance
   Comments: 
   Rating: 1 2 3 4 5

4. Availability of preceptor(s) during session
   Comments: 
   Rating: 1 2 3 4 5

5. Responsiveness to clinical questions by staff
   Comments: 
   Rating: 1 2 3 4 5

6. Incorporation as member of crew
   Comments: 
   Rating: 1 2 3 4 5

7. Educational objectives accomplished
   Comments: 
   Rating: 1 2 3 4 5

8. Overall educational experience
   Comments: 
   Rating: 1 2 3 4 5

Please comment on Individual Preceptors for which you have had educational interactions

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<th>Clinical Teachings</th>
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