



Clinical Experience Form

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|--|------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Ambulance | <input type="checkbox"/> Cath Lab | <input type="checkbox"/> Labor & Delivery | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Anesthesia/OR | <input type="checkbox"/> Emergency | <input type="checkbox"/> PICU | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Burn Center | <input type="checkbox"/> ICU | <input type="checkbox"/> Psychiatric | |

EMT name and license number:	Time scheduled (military):
Date:	Total hours:
Proctor's signature <i>and</i> printed name:	Clinical area:

Instructions: Please indicate on the chart below the number of times that a particular skill was performed by the EMT during their clinical rotation. All preceptors should record any comments to the EMT's performance below and sign the form in the above designated area for the EMT to receive credit.

Paramedic Skills	# Performed	EMT Skills	# Performed
Medication administration		Patient assessment	
Endotracheal intubation		Vital signs	
Venous access (successful)		Oxygen therapy	
Ventilate patient		Ventilate patient	
Cardiac rhythm interpretation		Suctioning	
		Spinal precautions	
Age Specific		Splinting	
Assessment pediatric (<18)		Wound care	
Assessment adult (19-64)			
		Age Specific	
Assessment geriatric (65+)		Assessment pediatric (<18)	
		Assessment adult (19-64)	
		Assessment geriatric (65+)	
Pathologies/Complaints		Pathologies/Complaints	
Assessment of OB patient		Assessment of OB patient	
Assessment of trauma patient		Assessment of trauma patient	
Assessment of psychiatric patient		Assessment of psychiatric patient	
Assessment of chest pain patient		Assessment of chest pain patient	
Assessment of respiratory distress – ADULT		Assessment of respiratory distress – ADULT	
Assessment of respiratory distress – PEDIATRIC		Assessment of respiratory distress – PEDIATRIC	
Assessment of GI/GU abdominal pain patient		Assessment of GI/GU abdominal pain patient	
Assessment of altered mental status patient		Assessment of altered mental status patient	
Assessment of syncope patient		Assessment of syncope patient	
Assessment of OTHER patient		Assessment of OTHER patient	
		Assessment of OTHER patient	
		Other Skill	
		Vehicle/equipment checks	
		Radio/phone communications	
		Team Leader	
		Prehospital runs	
Preceptor/EMT comments:			
EMT signature:	Signature serves as verification that all documented hours were completed and in an off-duty capacity.		