B&H EMERGENCY MEDICAL TRAINING INC.

EMT-B Student Clinical Rotation Evaluation

Student: _____ **Date:** _____

Rotation: _____ **Preceptor:** _____

Rotation Times: Start _____ **Completed** _____

INSTRUCTIONS

Please instruct the student in what will be expected of them during their rotation. At the completion of the rotation, please fill in the front and back of this evaluation as completely as possible. For the back of this page, please follow the instructions for completing this section. Fully completing this form is extremely important as it will allow us to correct any problems or shortcomings that exist. If you wish, you may seal this evaluation in an envelope (which the student will have) and give it back to the student. If there are any problems please contact Ben. Fogel at 845-220-7797 *Please make sure that your Name is clearly printed on the front of this form, and that you have signed the back.* *Students will not receive credit for the rotation if you do not put your name and signature.* Thank you for your help and cooperation.

Clinical Skill	Evaluations 1 = Poor 2 = Fair 3 = Good	Comments
History Taking: Was it complete, appropriate, In correct order with a logical Presentation?	1 ☐ 2 ☐ 3 ☐	
Physical Assessment: Was it complete, appropriate, in correct order with a logical presentation?	1 ☐ 2 ☐ 3 ☐	
Skills Performance: How was the students ability to Perform the practical skill?	1 ☐ 2 ☐ 3 ☐	
Medication Administration: (Epi Auto Injector, Aspirin, Glucose, Nebulizer.) Did the student verify the Medication order, correctly administer the medication, and have knowledge of the medication?	1 ☐ 2 ☐ 3 ☐	
Students General Attitude:	1 ☐ 2 ☐ 3 ☐	
Students Aptitude:	1 ☐ 2 ☐ 3 ☐	
Decision Making Abilities:	1 ☐ 2 ☐ 3 ☐	
Students Overall Performance:	1 ☐ 2 ☐ 3 ☐	
Willingness to Help and Learn:	1 ☐ 2 ☐ 3 ☐	

INSTRUCTIONS: **Please indicate the skills which the student correctly performed by placing an "A" in the box(es) next to the skill(s) performed on an Adult patient, or a "P" in the box(es) next to the skill(s) performed on a Pediatric patient. Please fill in a box for EACH time the student correctly performs the skill.**

	Number of Times Performed Correctly																
Skills Performed:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**
AED Usage																	
Aspirin Administration																	
Auto-Injector Med Admin.																	
Bag Valve Mask Usage																	
Bleeding Control/Bandaging																	
Breath Sounds																	
Cervical Collar-Applied																	
Childbirth-Assisted in																	
CPR																	
Glucose Administration																	
KEDS/Short Board																	
Long Board																	
Nebulizer Med. Admin.																	
O_2 Administration																	
O_2 Tank Setup																	
OPA/NPA-Inserted																	
Pt. Assessment-Adult Medical																	
Pt. Assessment-Adult Trauma																	
Patient Assessment-Pediatric																	
Patient History Taken																	
Physical Exam																	
Presumptive Dx																	
Splinting-Extremity																	
Splinting-Traction																	
Sub-Lingual Med. Admin.																	
Suctioning																	
Vital Signs (B/P, Pulse, Resp.)																	
Other: _____																	
Other: _____																	

COMMENTS: (*Please make comments here*.)

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Preceptors Signature

FOR OFFICE ONLY: Student Total Sheets _____ Computer Entry _____