**Suffolk County EMS – EMT Student Clinical Rotation Form [Ambulance / Hospital Rotation]**

Student Name: _____ NYS EMT-B Course #: _____

Certified Instructor Coordinator: _____ Course Location: _____

## Emergency Medical Technician Course – Clinical Requirements:

To meet the requirements of a NYS Original EMT course, students will be required to complete and document ten (10) direct patient contacts. Direct patient contact is defined as a patient who is being evaluated for an acute medical emergency or injury.

OBJECTIVES FOR PATIENT CONTACTS:

- Student must be able to directly interact with the patient.
- Student must be able to complete a patient assessment, history taking and vital signs. Student must be able to communicate and document each patient contact and report on interventions performed or observed and must be able to follow the patient through disposition.
    - Disposition is defined as the final EMS outcome: Transported to Hosp. or RMA (no other disposition is acceptable)
    - If patient contacts are done in a hospital rotation then no "Disposition" is required.
- RMA's are acceptable as a direct patient contact, as long as the above criteria are met.

The preceptor and student must sign <u>each</u> clinical observation. By signing, both parties are attesting that the student was present and participated during their patient encounter.

All patient contacts summarized below:

| DATE | AGE | AGENCY / HOSPITAL | CHIEF COMPLAINT | TREATMENTS/INTERVENTIONS | DISPOSITION |
|---|---|---|---|---|---|
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**Suffolk County EMS – EMT Student Clinical Rotation Form [Ambulance / Hospital Rotation]**

Gender: ☐ Male ☐ Female Age: _____ Chief Complaint: _____ Date: _____

Past/Present History: _____ Agency: _____

Medications: _____ Run#: _____

Vital Signs:

| Blood Pressure | Pulse | Rate/Quality | Resp | Rate/Quality | Skin Color/Condition | L.O.C. |
|---|---|---|---|---|---|---|
| / | | | | | | A V P U |

Subjective Assessment: _____

Treatments/Interventions: _____ Dispo: TXP RMA

Preceptor Name (PRINT): _____ Preceptor Signature: _____

Student Name (PRINT): _____ Student Signature: _____

Gender: ☐ Male ☐ Female Age: _____ Chief Complaint: _____ Date: _____

Past/Present History: _____ Agency: _____

Medications: _____ Run#: _____

Vital Signs:

| Blood Pressure | Pulse | Rate/Quality | Resp | Rate/Quality | Skin Color/Condition | L.O.C. |
|---|---|---|---|---|---|---|
| / | | | | | | A V P U |

Subjective Assessment: _____

Treatments/Interventions: _____ Dispo: TXP RMA

Preceptor Name (PRINT): _____ Preceptor Signature: _____

Student Name (PRINT): _____ Student Signature: _____

By signing this form the preceptor & student are verifying that the student was present and participated during their clinical rotation.

**Suffolk County EMS – EMT Student Clinical Rotation Form [Ambulance / Hospital Rotation]**

Gender: ☐ Male ☐ Female Age: _____ Chief Complaint: _____ Date: _____

Past/Present History: _____ Agency: _____

Medications: _____ Run#: _____

Vital Signs:

| Blood Pressure | Pulse | Rate/Quality | Resp | Rate/Quality | Skin Color/Condition | L.O.C. |
|---|---|---|---|---|---|---|
| / | | | | | | A V P U |

Subjective Assessment: _____

Treatments/Interventions: _____ Dispo: TXP RMA

Preceptor Name (PRINT): _____ Preceptor Signature: _____

Student Name (PRINT): _____ Student Signature: _____

Gender: ☐ Male ☐ Female Age: _____ Chief Complaint: _____ Date: _____

Past/Present History: _____ Agency: _____

Medications: _____ Run#: _____

Vital Signs:

| Blood Pressure | Pulse | Rate/Quality | Resp | Rate/Quality | Skin Color/Condition | L.O.C. |
|---|---|---|---|---|---|---|
| / | | | | | | A V P U |

Subjective Assessment: _____

Treatments/Interventions: _____ Dispo: TXP RMA

Preceptor Name (PRINT): _____ Preceptor Signature: _____

Student Name (PRINT): _____ Student Signature: _____

By signing this form the preceptor & student are verifying that the student was present and participated during their clinical rotation.

**Suffolk County EMS – EMT Student Clinical Rotation Form [Ambulance / Hospital Rotation]**

Gender: ☐ Male ☐ Female Age: _____ Chief Complaint: _____ Date: _____

Past/Present History: _____ Agency: _____

Medications: _____ Run#: _____

Vital Signs:

| Blood Pressure | Pulse | Rate/Quality | Resp | Rate/Quality | Skin Color/Condition | L.O.C. |
|---|---|---|---|---|---|---|
| / | | | | | | A V P U |

Subjective Assessment: _____

Treatments/Interventions: _____ Dispo: TXP RMA

Preceptor Name (PRINT): _____ Preceptor Signature: _____

Student Name (PRINT): _____ Student Signature: _____

Gender: ☐ Male ☐ Female Age: _____ Chief Complaint: _____ Date: _____

Past/Present History: _____ Agency: _____

Medications: _____ Run#: _____

Vital Signs:

| Blood Pressure | Pulse | Rate/Quality | Resp | Rate/Quality | Skin Color/Condition | L.O.C. |
|---|---|---|---|---|---|---|
| / | | | | | | A V P U |

Subjective Assessment: _____

Treatments/Interventions: _____ Dispo: TXP RMA

Preceptor Name (PRINT): _____ Preceptor Signature: _____

Student Name (PRINT): _____ Student Signature: _____

By signing this form the preceptor & student are verifying that the student was present and participated during their clinical rotation.

**Suffolk County EMS – EMT Student Clinical Rotation Form [Ambulance / Hospital Rotation]**

Gender: ☐ Male ☐ Female Age: _____ Chief Complaint: _____ Date: _____

Past/Present History: _____ Agency: _____

Medications: _____ Run#: _____

Vital Signs:

| Blood Pressure | Pulse | Rate/Quality | Resp | Rate/Quality | Skin Color/Condition | L.O.C. |
|---|---|---|---|---|---|---|
| / | | | | | | A V P U |

Subjective Assessment: _____

Treatments/Interventions: _____ Dispo: TXP RMA

Preceptor Name (PRINT): _____ Preceptor Signature: _____

Student Name (PRINT): _____ Student Signature: _____

Gender: ☐ Male ☐ Female Age: _____ Chief Complaint: _____ Date: _____

Past/Present History: _____ Agency: _____

Medications: _____ Run#: _____

Vital Signs:

| Blood Pressure | Pulse | Rate/Quality | Resp | Rate/Quality | Skin Color/Condition | L.O.C. |
|---|---|---|---|---|---|---|
| / | | | | | | A V P U |

Subjective Assessment: _____

Treatments/Interventions: _____ Dispo: TXP RMA

Preceptor Name (PRINT): _____ Preceptor Signature: _____

Student Name (PRINT): _____ Student Signature: _____

By signing this form the preceptor & student are verifying that the student was present and participated during their clinical rotation.

**Suffolk County EMS – EMT Student Clinical Rotation Form [Ambulance / Hospital Rotation]**

Gender: ☐ Male ☐ Female Age: _____ Chief Complaint: _____ Date: _____

Past/Present History: _____ Agency: _____

Medications: _____ Run#: _____

Vital Signs:

| Blood Pressure | Pulse | Rate/Quality | Resp | Rate/Quality | Skin Color/Condition | L.O.C. |
|---|---|---|---|---|---|---|
| / | | | | | | A V P U |

Subjective Assessment: _____

Treatments/Interventions: _____ Dispo: TXP RMA

Preceptor Name (PRINT): _____ Preceptor Signature: _____

Student Name (PRINT): _____ Student Signature: _____

Gender: ☐ Male ☐ Female Age: _____ Chief Complaint: _____ Date: _____

Past/Present History: _____ Agency: _____

Medications: _____ Run#: _____

Vital Signs:

| Blood Pressure | Pulse | Rate/Quality | Resp | Rate/Quality | Skin Color/Condition | L.O.C. |
|---|---|---|---|---|---|---|
| / | | | | | | A V P U |

Subjective Assessment: _____

Treatments/Interventions: _____ Dispo: TXP RMA

Preceptor Name (PRINT): _____ Preceptor Signature: _____

Student Name (PRINT): _____ Student Signature: _____

By signing this form the preceptor & student are verifying that the student was present and participated during their clinical rotation.