SECTION 3
PRIMARY CARE PARAMEDICINE
PRACTICUM DOCUMENTATION
COMPLETION REQUIREMENTS

Quick Reference	

Introduction to PCP Practicum Documentation

During the practicum session, the student is responsible for maintaining accurate records of patient contacts as well as skills performed. Medavie HealthEd has moved to a computer-based competency tracking system, through Great Big Solutions based in Edmonton Alberta. Great Big Solutions will provide technical support to all users and may be contacted via one of the following methods:

Phone: Toll free – 1-866-432-3280
E-mail: support@studentlogbook.com
Online Support: Log on to www.studentlogbook.com and log in, then click the Support link and submit the case.

Great Big Solutions indicates they will respond to requests within two business days guaranteed. The office hours for Great Big Solutions are Monday to Friday 9 am to 5 pm (Mountain Standard Time). They are three hours behind us in Atlantic Canada.

Moving to the computer based tracking of competencies provides the school with an electronic version of those competencies a student is required to obtain to graduate from their program.

The school endeavors to provide a consistent and fair evaluation process for students in the PCP program. As the student transitions into the practical, live patient care environment, we seek input from preceptors on how well our students are performing the competencies they were taught in school. To aid in this process, the school provides the preceptor with a Preceptor Manual, which can be found on our website. It contains the Essential Skills Manual used to evaluate the students in the schools lab setting, as well as excerpts from the National Occupational Competency Profile. The preceptor and student are expected to reference these documents, anytime there is a question as to how a student performed a competency; the goal is to ensure the student is being fairly evaluated based on what they were taught in the class/lab setting.

It should be noted, that these evaluation tools represent an extremely important component of student practicum experience therefore care must be taken in completing them.

Incomplete Documentation

Failure to complete the required documentation will result in the student completing further hours in the required setting.

The student is strongly encouraged to ensure their assigned preceptor completes all required documentation before the end of their shift, with that preceptor.

If the student continually fails to pass in his or her documentation on time, they will receive an incomplete mark for the practicum and be advised that they will be required to complete more practicum time. The student, after receiving an incomplete will then be placed on academic probation. A learning contract will be written which will clearly outline the completion

requirements and consequences of not completing them. Any costs that occur due to this extra time will be absorbed by the student.

Based on school policy a student will be provided an allotted timeframe to complete their practicum placement. Failure to complete the practicum rotation in the allotted time can result in an incomplete grade. The student will fail to graduate and a diploma will not be awarded. A failing mark during practicum placements will require the student to re-enroll in the PCP program if they wish to successfully complete the program.

Performance Environment's

Based on the National Occupational Competency Profiles for Paramedic Practitioners, October 2011 as developed by the Paramedic Association of Canada, "The Performance Environment specifies the setting in which the practitioner must demonstrate competence." The Performance Environment for the practicum setting is identified with a "P". (See table below) The practicum environment is a setting where the student is able to provide care to an actual patient who is seeking care in one of the following settings: hospital, health clinic, medical office, nursing home or other practicum setting where the competencies for the practicum performance environment may be obtained.

Area Key – Performance Environment

C	Must be evaluated in the Clinical setting for successful completion. On the Comptracker program an * indicates what competencies are mandatory in the clinical setting.
P	Must be evaluated in the Ambulance Practical setting for successful completion. On the Comptracker program an ***** indicates what competencies are mandatory in the practicum setting. Competencies identified as "C" that are not obtained in the clinical setting may be obtained in the ambulance practicum setting, but not vice-versa.
S	May be evaluated through a scenario based format
X	Student has awareness of but evaluation is not required
N	Does not apply to the students scope of practice

Defining and Evaluating Proficiency

The Evaluation tools under Practicum Preceptorship are designed to allow the preceptor to evaluate the student during the practicum experience based on the National Occupational Competencies Profile (NOCP) guidelines.

"The Paramedic Association of Canada Board of Directors has approved the following definition of proficiency: Proficiency involves the demonstration of skills, knowledge and abilities in accordance with the following principles:

- Consistency (the ability to repeat practice techniques and outcomes; this requires performance more than once in the appropriate Performance Environment)
- Independence (ability to practice without assistance from others)
- Timeliness(the ability to practice in a time frame that enhances patient safety)

- Accuracy (the ability to practice utilizing correct techniques and to achieve the intended outcomes)
- Appropriateness (the ability to practice in accordance with practicum standards and protocols outlined within the practice jurisdiction)

The preceptor should be familiar with the schools Proficiency Evaluation Key (See table below) before completing the evaluation forms. Individual competencies will either be approved or not approved by the preceptor. The preceptor may also reference a complete listing on Essential Competencies and their sub-competencies found in the Preceptor Manual.

In the practicum setting, the students will be evaluated based on individual skills and how they perform on the overall call. There are many aspects to an ambulance call and it is essential that a student be competent at performing all aspects of a call not just individual skills/competencies.

Individual skills/competencies will be evaluated using the Proficiency Evaluation Key (See table below).

Proficiency Evaluation Key

√	Approved – means the student was able to perform the competency on an appropriate call.
X	Not Approved – means the student was not able to perform the competency on an appropriate call.

Note: When a preceptor indicates an individual competency is not approved they will be prompted to provide a reason for not approving that competency. It is important for the student to receive feedback on skills that have not been approved, so they (the student) may improve their performance.

The overall call will be evaluated using the Overall Call – Evaluation Key (See table below). The student must show consistency in completing their overall calls with a minimum score of 3 on eighty percent (or 12 calls) of the last less than 15 calls in the practicum setting.

Overall Call – Evaluation Key

Score	Score Description
5 Excellent	The student excelled at this call. They demonstrated a high standard of Proficiency as they conducted their assessment and interpreted the findings associated with this patient's condition. Furthermore, excelled at integrating the competencies required to provide care to the patient on this call.
4 Above Average	The student showed an above average ability to conduct an assessment and interpret the findings related to this patient's condition. The student has successfully integrated the competencies required to provide care to the patient on this call.
3 Average	The student has meet the basic assessment and intervention skills required to conduct an assessment and interpret the findings related to this patient. The student has successfully integrated the competencies required to provide care to

	the patient on this call.
2 Below Average	The student has a below average level of assessment and/or treatment. The student did not perform all of the critical assessments and interventions, required for this patient. Remediation is not required at this time, as we believe the student requires more exposure to supervised live patient interaction to gain more experience.
1 Not Acceptable	The student is Unsafe. Student was unable to manage significant any aspect of this call on their own; furthermore, their performance compromised patient care and/or safety. Remediation is required as the student is unsuitable for unsupervised practice, or progression in the practicum environment.

The overall call evaluation will require a comment from the preceptor. A drop down menu is provided for this section.

Practicum Objectives/Learning Requirements

The student will be required to enter the practicum environment and complete a minimum of 13 weeks following their designated preceptor's rotation. During the 13 week preceptorship, they must complete 450 hrs. If a competency is not obtained, the student will be required to complete extra hours to obtain that competency in the ambulance practicum.

The list of competencies a student may obtain in the practicum environment are identified in the table on the following pages. All competencies identified with a "**P**" must be obtained in the practicum environment, by the time a student completes their program. Note: A student may obtain clinical "C" competencies in this environment as well.

Primary Care Paramedic Practicum Competencies

1.0 Professional Responsibilities		
1.1 Function as a professional		
1.1.a	Maintain Patient Dignity	P
1.1.b	Reflect professionalism through use of appropriate language	P
1.1.c	Dress appropriately and maintain personal hygiene	P
1.1.d	Maintain appropriate personal interaction with patients.	P
1.1.e	Maintain patient confidentiality.	P
1.1.f	Participate in quality assurance and enhancement programs.	A
1.1.g	Promote Awareness of Emergency Medical System and Profession	A
1.1.h	Participate in Professional Association	A
1.1.i	Behave ethically. 2011	P
1.1.j	Function as patient advocate. 2011	P
1.3	**Possess understanding of the medicolegal aspects of the profession**	
1.3.a	Comply with scope of practice.	P
1.3.b	Recognize the rights of the patient and the implications on the role of the provider.	A
1.3.c	Include all pertinent and required Information on reports and medical records 2011	P
1.4	**Recognize and Comply with relevant provincial and federal legislation 2011**	
1.4.a	Function within relevant Legislation policies and procedures	P
1.5	**Function effectively in a team environment.**	
1.5.a	Work collaboratively with a partner.	P
1.5.b	Accept and deliver constructive feedback.	P
1.6	**Make decisions effectively**	
1.6.a	Employ reasonable and prudent judgment	P
1.6.b	Practice effective problem-solving.	P
1.6.c	Delegate tasks appropriately.	P

2.0 Communication		
2.1 Practice effective oral communication skills		
2.1.a	Deliver an organized, accurate and relevant report utilizing telecommunication devices.	S
2.1.b	Deliver an organized, accurate and relevant verbal report 2011	P
2.1.c	Deliver an organized, accurate and relevant patient history 2011	P
2.1.d	Provide information to patient about their situation and how they will be cared for.	P
2.1.e	Interact effectively with the patient, relatives and bystanders who are in stressful situations.	P
2.1.f	Speak in language appropriate to the listener.	P
2.1.g	Use appropriate terminology.	P
2.2 Practice effective written communication 2011		

2.2.a	Record organized, accurate and relevant patient information 2011	P

2.3 Practice effective non-verbal communication skills.		
2.3.a	Exhibit effective non-verbal behaviour. 2011	S
2.3.b	Practice active listening techniques.	P
2.3.c	Establish trust and rapport with patients and colleagues.	P
2.3.d	Recognize and react appropriately to non-verbal behaviors	P
2.4 Practice effective interpersonal relations.		
2.4.a	Treat others with respect.	P
2.4.b	Employ empathy and compassion while providing care.	P
2.4.c	Recognize and react appropriately to persons exhibiting emotional reactions	P
2.4.d	Act in a confident manner.	P
2.4.e	Act assertively as required.	P
2.4.f	Employ diplomacy, tact and discretion. 2011	P
2.4.g	Employ conflict resolution skills. 2011	S

3.0 Health and Safety		
3.1 Maintain good physical and mental health		
3.1.e	Exhibit physical strength and fitness consistent with the requirements of professional practice.	P
3.2 Practice safe lifting and moving techniques		
3.2.a	Practice safe biomechanics.	P
3.2.b	Transfer patient from various positions using applicable equipment and / or techniques.	P
3.2.c	Transfer patient using emergency evacuation techniques.	S
3.2.d	Secure patient safely to applicable equipment.	P
3.3 Create and maintain a safe work environment		
3.3.a	Assess for scene safety 2011	P
3.3.b	Address potential occupational hazards	P
3.3.c	Conduct basic extrication.	S
3.3.d	Exhibit defusing and self-protection behaviours appropriate for use with patients and bystanders.	S
3.3.e	Conduct procedures and operations consistent with Workplace Hazardous Materials Information System and hazardous materials management requirements.	A
3.3.f	Practice infection control techniques	P
3.3.g	Clean and disinfect equipment 2011	P
3.3.h	Clean and disinfect work environment 2011	P

4.0 Assessment and Diagnosis		
4.2 Obtain patient history		
4.2.a	Obtain list of patient's allergies.	P
4.2.b	Obtain patients medication profile. 2011	P

4.2.c	Obtain chief complaint and / or incident history from patient, family members and / or bystanders	P
4.2.d	Obtain information regarding patient's past medical history.	P
4.2.e	Obtain information about patient's last oral intake.	P
4.2.f	Obtain information regarding incident through accurate and complete scene assessment.	P
4.3 Conduct complete physical assessment demonstrating appropriate use of inspection, palpation, percussion & auscultation, and interpret findings		
4.3.a	Conduct primary patient assessment and interpret findings.	P
4.3.b	Conduct secondary patient assessment and interpret findings.	P
4.3.c	Conduct cardiovascular system assessment and interpret findings.	P
4.3.d	Conduct neurological system assessment and interpret findings.	P
4.3.e	Conduct respiratory system assessment and interpret findings.	P
4.3.f	Conduct obstetrical assessment and interpret findings.	S
4.3.g	Conduct gastrointestinal system assessment and interpret findings.	S
4.3.h	Conduct genitourinary / reproductive system assessment and interpret findings.	S
4.3.i	Conduct integumentary system assessment and interpret findings.	S
4.3.j	Conduct musculoskeletal assessment and interpret findings.	P
4.3.k	Conduct assessment of the ears, eyes, nose and throat and interpret findings 2011	S
4.3.l	Conduct neonatal assessment and interpret findings 2011	S
4.3.m	Conduct psychiatric assessment and interpret findings 2011	S
4.3.n	Conduct pediatric assessment and interpret findings 2011	C
4.3.o	Conduct geriatric assessment and interpret findings 2011	P
4.3.p	Conduct bariatric assessment and interpret findings 2011	A
4.4 Assess Vital Signs		
4.4a	Assess pulse.	P
4.4.b	Assess respiration.	P
4.4.c	Conduct non-invasive temperature monitoring.	C
4.4.d	Measure blood pressure (BP) by auscultation.	P
4.4.e	Measure BP by palpation. 2011	S
4.4.f	Measure BP with non-invasive BP monitor.	C
4.4.g	Assess skin condition	P
4.4.h	Assess pupils.	P
4.4.i	Assess level of consciousness. 2011	P
4.5 **Utilized Diagnostic Tests**		
4.5.a	Conduct oximetry testing and interpret findings.	C
4.5.b	Conduct end-tidal carbon dioxide monitoring and interpret findings.	A
4.5.c	Conduct glucometric testing and interpret findings.	P
4.5.d	Conduct peripheral venipuncture. 2011	A
4.5.m	Conduct 3-lead ECG and interpret findings. 2011	P
4.5.n	Obtain 12-lead ECG and interpret findings. 2011	S

5.0 Therapeutics		
5.1 Maintain patency of upper airway and trachea		
5.1.a	Use manual maneuvers and positioning to maintain airway patency.	C
5.1.b	Suction oropharynx.	S

5.1.d	Utilize oropharyngeal airway.	S
5.1.e	Utilize nasopharyngeal airway	S
5.1.f	Utilize airway devices not requiring visualization of vocal cords and not introduced endotracheally. 2011	S
5.1.i	Remove airway foreign bodies (AFB).	S
5.1.j	Remove foreign body by direct techniques 2011	A
5.2 Prepare Oxygen Delivery Devices		
5.2.a	Prepare oxygen delivery devices. 2011	A
5.2.b	Utilize portable oxygen delivery system. 2011	P
5.3 Deliver Oxygen and administer manual ventilation		
5.3.a	Administer oxygen using nasal cannula	C
5.3.b	Administer oxygen using low concentration mask.	S
5.3.d	Administer oxygen using high concentration mask.	C
5.3.e	Administer oxygen using pocket mask.	S
5.4 Utilize Ventilation equipment		
5.4.a	Provide oxygenation and ventilation using manual positive pressure devices**.**	C
5.5 Implement measures to maintain hemodynamic stability		
5.5.a	Conduct Cardiopulmonary Resuscitation (CPR).	S
5.5.b	Control external hemorrhage through the use of direct pressure and patient positioning.	S
5.5.c	Maintain peripheral IV access devices and infusions of crystalloid solutions without additives**.**	C
5.5.d	Conduct peripheral intravenous (IV) cannulation.	C
5.5.f	Utilize direct pressure infusion devices with intravenous infusions.	S
5.5.i	Conduct automated external defibrillation	S
5.5.o	Provide routine care for patient with urinary catheter.	S
5.5.p	Provide routine care for patient with ostomy drainage system.	A
5.5.q	Provide routine care for patient with non-catheter urinary drainage system.	A
EHSNS	*Use of IV pumps*	N
EHSNS	*Maintain and initiate peripheral IV infusions with or without additives.*	S
5.6 Provide basic care for soft tissue injuries		
5.6.a	Treat soft tissue injuries	P
5.6.b	Treat burn.	S
5.6.c	Treat eye injury.	S
5.6.d	Treat penetration wound	S
5.6.e	Treat local cold injury.	S
5.6.f	Provide routine wound care 2011	S
5.7 Immobilize actual and suspected fractures		
5.7.a	Immobilize suspected fractures involving appendicular skeleton	S
5.7.b	Immobilize suspected fractures involving axial skeleton.	P
EHSNS	Realignment of limb threatening fractures and dislocations.	N

5.8 Administer Medications		
5.8.a	Recognize principals of pharmacology as applied to medications listed in Appendix 5 2011	A
5.8.b	Follow safe process for the responsible medication administration.	C
5.8.c	Administer medication via subcutaneous route.	S

5.8.d	Administer medication via intramuscular route.	S
5.8.e	Administer medication via intravenous route. 2011	A
5.8.f	Administer medication via intraosseous route. 2011	A
5.8.g	Administer medication via endotracheal route. 2011	A
5.8.h	Administer medication via sublingual route.	S
5.8.i	Administer medication via the buccal route 2011	S
5.8.j	Administer medication via topical route.	A
5.8.k	Administer medication via oral route. 2011	S
5.8.l	Administer medication via rectal route. 2011	A
5.8.m	Administer medication via inhalation. 2011	C
5.8.n	Administer medications via intranasal route 2011	S
5.8.o	Provide patient assist according to provincial list of medications 2011	A

6.1 Integration		
6.1 Utilize differential diagnosis skills, decision-making skills and psychomotor skills in providing care to patients.		
6.1.a	Provide care to patient experiencing signs and symptoms involving cardiovascular system.	P
6.1.b	Provide care to patient experiencing signs and symptoms involving neurological system.	P
6.1.c	Provide care to patient experiencing signs and symptoms involving respiratory system.	P
6.1.d	Provide care to patient experiencing signs and symptoms involving genitourinary / reproductive systems	S
6.1.e	Provide care to patient experiencing signs and symptoms involving gastrointestinal system.	P
6.1.f	Provide care to patient experiencing signs and symptoms involving integumentary system.	P
6.1.g	Provide care to patient experiencing signs and symptoms involving musculoskeletal system.	P
6.1.h	Provide care to patient experiencing signs and symptoms involving immunologic system.	S
6.1.i	Provide care to patient experiencing signs and symptoms involving endocrine system.	S
6.1.j	Provide care to patient experiencing signs and symptoms involving the eyes, ears, nose and throat.	S
6.1.k	Provide care to patient experiencing toxicological syndromes.	S
6.1.l	Provide care to patient experiencing non-urgent problem.	S
6.1.m	Provide care to a palliative patient.	S
6.1.n	Provide care to patient experiencing illness or injury due to exposure to adverse environments.	S
6.1.o	Provide care to Trauma Patient 2011	P
6.1.p	Provide care to psychiatric patient. 2011	P
6.1.q	Provide care to obstetrical patient.	S

6.2 Provide care to meet the needs of unique patient groups		
6.2.a	Provide care for neonatal patient.	S
6.2.b	Provide care for pediatric patient.	C
6.2.c	Provide care for geriatric patient.	C
6.2.d	Provide care for physically-impaired patient.	S
6.2.e	Provide care for mentally impaired patient.	S
6.2.f	Provide care to bariatric patient	A
6.3 Conduct ongoing assessments and provide care		
6.3.a	Conduct ongoing assessments based on patient presentation and interpret findings	P
6.3.b	Re-direct priorities based on assessment findings.	P

7.0 Transportation		
7.1 Prepare Ambulance for service		
7.1.a	Conduct vehicle maintenance and safety check	P
7.1.b	Recognize conditions requiring removal of vehicle from service	A
7.1.c	Utilize all vehicle equipment and vehicle devices within ambulances	S
7.3 Transfer patient to air ambulance		
7.3.a	Create a safe landing zone for rotary-wing aircraft	A
7.3.b	Safely approach stationary rotary-wing aircraft	A
7.3.c	Safely approach stationary fixed-wing aircraft	A
7.4 Transfer patient to air ambulance		
7.4.a	Prepare patient for air medical transport	S

8.0 Health Promotion and Public Safety		
8.1 Integrate professional practice into community care		
8.1.c	Work collaboratively with other members of the health care community	P
8.2 Contribute to public safety through collaboration with other emergency response agencies		
8.2.a	Work collaboratively with other emergency response agencies	P

Completing the Electronic Forms

The following pages contain information for the preceptor, student and auditors on how to complete the electronic forms. Sample documentation includes the following:

1) Practicum Attendance Record
2) Call Record
3) Weekly Evaluation
4) Preceptor Contact Form
5) Preceptor Assignment Form

1) Practicum Attendance Record

Completing the Documentation:

- The students attending your practicum site have a specific number of hours they must complete. The purpose of the attendance record is to track those hours.
- The student is to complete specific sections on this form, prior to the preceptor signing it. The student will complete the date, practicum site, preceptors name, start/finish times, and Total hours.
- The school staff may contact the student at anytime and request that this form be faxed to the school.
- The **preceptor** will then record the following on this form:
    - The preceptor signs or initials the form indicating the student has completed those hours. We ask that the preceptor ensure they sign this at the end of every shift.

Verification of Information (MEDAVIE HEALTHED Agent):

- This form will be verified by staff at Medavie HealthEd. Designated staff will ensure the following:

    - The preceptor has signed for all the dates and hours the student has completed.
    - The student has completed all the information required under Completing the Form (above).
    - The student has completed the hours required for this component of the program. (Designated staff will check for the number of hours to be completed).

2) Call Record

Completing the Documentation:

- When numbering the patient record start at 1 and continue until you have a total number of patient contacts for the entire time you are in any clinical setting. Eg 1, 2, 3, 4, 5, 6, 7, 8 ,9 10, 11…..50, up to your total number of patient contacts.

- This form serves at the primary evaluation tool to determine if the student is meeting the Proficiency requirements based on the National Occupational Competency Profile. The preceptor uses the Proficiency Evaluation Key and Overall Call Evaluation Key to rate

the student on their ability to perform the competencies listed on the Patient Record Form.

- Individual competencies must be evaluated with an "approved", at least twice, in the practicum setting. The competencies that must be approved are those identified with an "*" on the student electronic information gathering device.

- The student must show consistency in completing their overall calls with a minimum score of 3 on eighty percent (or 12 calls) of the last less than 15 calls in the practicum setting.

- The student will record the following on this form:
    - The patient's age and sex.
    - The patient's chief complaint.
    - Other information that is pertinent to identifying the competency the student wants to obtain. (E.g. for the NOCP regarding high concentration mask the student would have to have recorded on the Patient Record that a high concentration mask was used on the patient.)
    - The competency the student wants to be signed off on.
    - Note the student is not permitted to gather any other information on the patient, due to confidentially for the patient.

- The **preceptor** will then record the following on this form:
    - Approved or not approved for each of the competencies the student performed on that patient.
    - An overall call score ranging from a low of 1 to a high of 4.
    - The preceptor then signs or initials the form, thus indicating they have evaluated the student.

Verification of Information (MEDAVIE HEALTHED Agent):

- This form will be verified by staff at Medavie HealthEd. Designated staff will ensure the following:

    - The preceptor has approved or not approved and signed or initialed the competencies completed by the student.
    - An overall call score was assigned and that the student has complete at least eighty percent (or 12 calls) of their last 15 calls at a score of 3 or higher.
    - The student has recorded all the information required for the competency to be signed off on the Patient Record.
    - The student was approved, at least twice, on all the practicum competencies required for their program.
    - No confidential patient information is contained on the form. Form is to contain patient's age and sex only.
    - Designated staff will ensure they complete the date, audited by and, if required, auditors comments section of the Patient Record

Note: Practicum Competencies are identified as "P's" in the NOCP Documentation, all competencies identified as a "P", must be approved minimum of twice. Note – A student will be required to complete extra time if one of the following occurs:

- If a student fails to obtain the required approval at least twice for the individual competencies, or
- If a student fails to obtain a score of 3, or higher, on at least 12 of their last 15 calls.

3) Weekly Evaluation

Completing the Documentation:

- This form is to be completed by the preceptor and is used to provide a general evaluation on the student's professional responsibilities, communication skills and health and safety. This form is completed at the end of each rotation.
- The preceptor must assign a score (approved or not approved) based on the Proficiency Evaluation Key) and then sign or initial the box indicating the preceptor's initials are required.
- A space is provided for a narrative of overall comments from the preceptor.

Verification of Information (MEDAVIE HEALTHED Agent):

- This form will be verified by staff at Medavie HealthEd. Designated staff will ensure the following:

    - The preceptor has completed all the information required.
    - Designated staff will ensure they complete the date, audited by and, if required, auditors comments section of the Patient Record.

4) Preceptor Contact Form

Completing the Documentation:

- The preceptor is asked to complete the preceptor information, so that we have accurate information on those professionals willing to help educate our students. This information is obtained for our records, so that we may contact the preceptor regarding the evaluation of the student.

Verification of Information (MEDAVIE HEALTHED Agent):

This form will be verified by staff at Medavie HealthEd Staff.

5) Preceptor Assignment Form

Completing the Documentation:

- The preceptor may assign a student homework based on areas where, they perceive, the student to require a stronger level of knowledge. Should homework be assigned the preceptor and student will complete a form for each occurrence.

Comptracker Quick Start Guides

The following pages contain information on using the Comptracker System's validation process.

Reference Video guides for IPAD and online site