SECTION 4
ADVANCED CARE PARAMEDICINE
CLINICAL DOCUMENTATION
COMPLETION REQUIREMENTS

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Introduction to ACP Clinical Documentation

During the clinical session, the student is responsible for maintaining accurate records of patient contacts as well as skills performed. The Medavie HealthEd currently tracks student competency attainment through the computer-based competency tracking system, Comptracker managed by 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.

Utilizing this computer based process for track 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 ACP 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 clinical 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 clinical and be advised that they will be required to complete more clinical 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 clinical placement. Failure to complete the clinical 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 clinical placements will require the student to re-enroll in the ACP program if they wish to successfully complete the program.

Performance Environment's

Based on the National Occupational Competency Profiles for Paramedic Practitioners, June 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 clinical setting is identified with a "C". (See table below) The clinical 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 clinical setting where the competencies for the clinical 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 Clinical Preceptorship are designed to allow the preceptor to evaluate the student during the clinical 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 clinical 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 clinical setting, the students will be evaluated based on individual skills only and not overall patient care. Therefore, the students will be evaluated on their ability to perform individual competencies based on the National Occupational Competency Profile and the Nova Scotia EHSNS Essential Competencies list.

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 give a reason for not approving that competency.

Clinical Objectives/Learning Requirements

The student will be required to enter a number of different clinical environments, each with a set number of minimum hours, to obtain their clinical competencies. If a competency is not obtained in the clinical environment, the student may be required to complete extra hours or obtain that competency in the ambulance practicum. The student is expected to attend the following clinical sites:

1) Operating Room (minimum of 3 X 8 hr shifts with 15 successful intubations)
2) ICU/CCU (minimum of 3 X12 hr shifts)
3) Emergency Room (minimum of 9 X 12 hr shifts)
4) Labour and Delivery Unit (minimum of 3 X 8 hr shifts)

The lists of competencies a student may obtain in the clinical environment are identified in the table below. All competencies identified with an "*****" must be obtained in either the clinical or practicum environment, by the time a student completes their program. Note: all competencies require a minimum of two sign offs except for intubations (require 15 approved sign offs) and IV initiation (require 20 approved sign offs).

ACP CLINICAL COMPETENCY TABLE			Performance Environment
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.j	Behave ethically.	P
	1.1.k	Function as patient advocate.	P
1.3		Possess an understanding of the medicolegal aspects of the profession.	
	1.3.a	Comply with scope of practice.	P
	1.3.b	Recognize "patient rights" and the implications on the role of the provider.	A
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	Exhibit reasonable and prudent judgment.	P
	1.6.b	Practice effective problem-solving.	P
	1.6.c	Delegate tasks appropriately.	P
2		COMMUNICATION	
2.1		Practice effective oral communication skills.	
	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 skills.	
	2.2.a	Record organized accurate and relevant patient information.	P
2.3		Practice effective non-verbal communication skills.	
	2.3.a	Employ effective non-verbal behaviour.	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 behaviours.	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.	P
	2.4.g	Employ conflict resolution skills	S
4.0		ASSESSMENT AND DIAGNOSTICS	

4.2	Obtain patient history	
4.2.a	Obtain list of patient's allergies.	P
4.2.b	Obtain patient's medication profile.	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.**	C
4.3.g	Conduct gastrointestinal system assessment and interpret findings.	P
4.3.h	Conduct genitourinary/reproductive system assessment and interpret findings.	P
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.	S
4.3.l	**Conduct neonatal assessment and interpret findings.**	C
4.3.m	Conduct psychiatric assessment and interpret findings.	S
4.3.n	**Conduct paediatric assessment and interpret findings.**	C
***4.3.o**	**Conduct geriatric assessment and interpret findings.**	P
4.3.p	Conduct bariatric assessment and interpret findings.	A
4.4	Assess vital signs.	
4.4.a	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.	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.	P
4.5	Utilize diagnostic tests.	
***4.5.a**	**Conduct oximetry testing and interpret findings.**	C
***4.5.b**	**Conduct end-tidal CO2 monitoring and interpret findings.**	C
4.5.c	Conduct glucometric testing and interpret findings.	P
*4.5.d	Conduct peripheral venipuncture.	S
4.5.e	Obtain arterial blood samples via radial artery puncture.	A
4.5.f	Obtain arterial blood samples via arterial line access.	A
4.5.g	Conduct invasive core temperature monitoring and interpret findings.	A
4.5.h	Conduct pulmonary artery catheter monitoring and interpret findings.	A
4.5.i	Conduct central venous pressure monitoring and interpret findings.	A
4.5.j	Central venous access.	A
4.5.k	Conduct arterial line monitoring and interpret findings.	A
4.5.l	Interpret laboratory data as specified in Appendix 5.	S

4.5.m	Conduct 3-leadelectrocardiogram (ECG) and interpret findings.	**P**
4.5.n	Obtain 12-lead electrocardiogram and interpret findings.	**P**
4.5.o	Interpret radiological data.	**A**
4.5.p	Interpret data from CT, ultrasound and MRI.	**A**
4.5.q	Conduct urinalysis by macroscopic method.	**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.**	**C**
***5.1.c**	**Suction beyond oropharynx.**	**C**
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.	**S**
5.1.g	Utilize airway devices not requiring visualization of vocal cords and introduced endotracheally.	**S**
***5.1.h**	**Utilize airway devices requiring visualization of vocal cords and introduced endotracheally.**	**C**
5.1.i	Remove airway foreign bodies (AFB).	**S**
5.1.j	Remove foreign body by direct techniques.	**S**
5.1.k	Conduct percutaneous cricothyroidotomy.	**S**
5.1.l	Conduct surgical cricothyroidotomy.	**S**
EHSNS	Rapid Sequence Intubation.	**X**
5.2	Prepare oxygen delivery devices.	
5.2.a	Prepare oxygen delivery devices.	**A**
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.c	Administer oxygen using controlled concentration mask.	**A**
***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 positive pressure.**	**C**
5.4.b	Recognize indications for mechanical ventilation.	A
*5.4.c	Prepare mechanical ventilation equipment.	S
5.4.d	Provide mechanical ventilation.	S
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.	**P**
***5.5.d**	**Conduct peripheral intravenous (IV) cannulation.**	**P**
5.5.e	Conduct intraosseous needle insertion.	**S**
5.5.f	Utilize direct pressure infusion devices with intravenous infusions.	**S**
5.5.g	Administer volume expanders (colloid and non-crystalloid).	**S**
5.5.h	Administer blood and /or blood products.	**A**
5.5.i	Conduct automated external defibrillation	**S**
5.5.j	Conduct manual defibrillation	**S**
5.5.k	Conduct Cardioversion.	**S**
5.5.l	Conduct transcutaneous pacing.	**S**

5.5.m	Maintain Transvenous pacing.	**A**
5.5.n	Maintain intra-aortic balloon pumps.	**A**
***5.5.o**	**Provide routine care for patient with urinary catheter.**	**C**
5.5.p	Provide routine care for patient with ostomy drainage system.	**S**
5.5.q	Provide routine care for patient with non-catheter urinary drainage system.	**A**
5.5.r	Monitor chest tubes.	**S**
5.5.s	Conduct needle thoracostomy.	**S**
5.5.t	Conduct oral and nasal gastric tube insertion.	**S**
5.5.u	Conduct urinary catheterization.	**S**
EHSNS	*Use of IV pumps.*	**A**
EHSNS	*Access portacaths.*	**A**
EHSNS	*Maintain and initiate central IV infusions with or without additives.*	**A**
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.	**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**
5.7.c	*Reduce fractures and dislocations.*	**A**
5.8	Administer medications.	
5.8.b	Follow safe process for responsible medication administration.	**P**
*5.8.c	Administer medication via subcutaneous route.	S
***5.8.d**	**Administer medication via intramuscular route.**	**C**
5.8.e	Administer medication via intravenous route.	**P**
5.8.f	Administer medication via intraosseous route.	**S**
5.8.g	Administer medication via endotracheal route.	**S**
***5.8.h**	**Administer medication via sublingual route.**	**C**
5.8.i	Administer medication via buccal route.	**C**
*5.8.j	Administer medication via topical route.	S
5.8.k	**Administer medication via oral route.**	**C**
***5.8.l**	**Administer medication via rectal route.**	**A**
5.8.m	**Administer medication via inhalation.**	**C**
5.8.n	Administer medication via intranasal route.	S
5.8.o	Provide patient assist according to provincial list of medications.	A
6.0	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 toxicologic syndromes.	**P**
6.1.l	Provide care to patient experiencing non-urgent medical problem.	**S**
6.1.m	Provide care to palliative patient.	**S**
6.1.n	Provide care to patient experiencing signs and symptoms due to exposure to adverse environments.	**S**
6.1.o	Provide care to trauma patient.	**P**
6.1.p	Provide care for psychiatric patient.	**P**
***6.1.q**	**Provide care to obstertical patient.**	**C**
EHSNS	*Perform conscious sedation*	**N**
6.2	Provide care to meet the needs of unique patient groups.	
***6.2.a**	**Provide care for neonatal patient.**	**C**
***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**

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) Attendance Record
2) Patient Record
3) Airway Management Record
5) Weekly Evaluation Report
6) Preceptor Contact Form

1) Attendance Record

Completing the Documentation:

- The students attending your clinical 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, clinical 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 the 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) Patient Record

Completing the Documentation:

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

- The student must be evaluated with an "approved", at least twice, on all the clinical competencies required for their program. The competencies that must be approved are those identified with an "*" on the student electronic information gathering device.

- 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.
    - 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 the 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.
    - 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 clinical 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: Clinical Competencies are identified as "C's" in the NOCP Documentation, all competencies identified as a "C", must be approved minimum of twice. Note – IV initiation requires 20 signs offs, while Intubation requires a minimum of 15 sign offs. If a student fails to obtain the required approval at least twice they will be required to complete more hours to obtain those competencies; or to obtain the competencies in the ambulance practicum "P" setting.

Verification of Information (MEDAVIE HEALTHED Agent):

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

    - The student has completed all the information required under Completing the Form (above).
    - No confidential patient information is contained on the form. Form is to contain patient's age and sex only.
    - The student was evaluated with a minimum score of approved, at least 15 times, on all their ability to access peripheral veins. This information will be found on the Patient Record.
    - Designated staff will ensure they complete the date, audited by and, if required, auditors comments section of the Patient Record.

3) Airway Management Record

Completing the Documentation:

- This form serves as the primary evaluation tool for Advanced Airway Management; which will take place in an operating room setting. It is used to determine the student's ability to meet the Proficiency requirements based on the National Occupational Competency Profile. The preceptor uses the Proficiency Evaluation Key to rate the

student on their ability to perform the competencies listed on the Advanced Airway Management Form.

- The student must be evaluated with a minimum score of approved, at least 15 times during the Operating Room experience.

- The student will record the following on this form:
    - The date and Patient number (which may be obtained from the Patient Record, should the student be performing these skills in another setting other than the Operating Room).
    - Patient age, sex and chief complaint. Note the student is not permitted to gather any confidential information on the patient.
    - All other information required on the form.

- The preceptor will then record the following on this form:
    - A score based on the Proficiency Evaluation Key for each competency the student performed on that patient.
    - The preceptor then initials the block for preceptor's initials, thus indicating they have evaluated the student on those competencies.

Verification of Information (MEDAVIE HEALTHED Agent):

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

    - The preceptor has approved and signed or initialed the competencies completed by the student.
    - The student and preceptor have completed all the information required under Completing the Form (above).
    - The student was evaluated with a minimum score of approved, at least fifteen times, on all the clinical competencies required for their program.
    - No confidential patient information is contained on the form.
    - Designated staff will ensure they complete the date, audited by and, if required, auditors comments section of the Patient Record.

Note: Clinical Competencies are identified as "C's" in the NOCP Documentation, all competencies identified as a "C", must be scored at a minimum of approved at least twice. Note – IV initiation and Intubation require a minimum of 15 sign offs. If a student fails to obtain the required score at least twice they will be required to complete more hours to obtain those competencies; or to obtain the competencies in the ambulance practicum "P" setting.

5) Weekly Evaluation Report

Completing the Documentation:

- This form is to be completed by the student and then the Preceptor. This form is used to identify any areas of concern the student or preceptor may have during the student's rotation.
- It is to be completed at the end of each rotation the student is assigned to (e.g. labour and delivery 24 hrs, ER every 42 hours, etc.)
- The goal is for the preceptor and student to have an open dialogue to ensure there are no areas of concern or to identify areas of concern.
- It also provides a mechanism for either the student or the preceptor to ask for school assistance during the placement.

Verification of Information (MEDAVIE HEALTHED Agent):

- This form will be verified by staff at the Medavie HealthEd. Designated staff will ensure the follow occurs if requested.

6) 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 the Medavie HealthEd and the Affiliate Placement Coordinator.

Comptracker Quick Start Guides

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