**STUDENT CLINICAL ORIENTATION CHECKLIST**

\*\*This checklist must be submitted within 1 week after the clinical start date\*\*

Name of School: Click here to enter text. Semester/Year: Click here to enter text.

Name of Instructor: Click here to enter text.

Dates of Experience (m/d/yy – m/d/yy): Click here to enter text. Campus: Click here to enter text. Unit: Click here to enter text.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Student’s Full Name**  **Print:**  **First and Last name** | **UNIT** | **EQUIPMENT** | | | | | | **DOCUMENTATION** | | **POLICIES** |
| **Oriented to unit** | **IV Pump** | **Syringe Pump** | **Feeding Pump** | **PCA Pump** | **Scales** | **Other: \_\_\_\_\_\_\_\_\_\_\_\_** | **Charting** | **EPIC** | **Access to policies via intranet** |
| Validation | Validation | Validation | Validation | Validation | Validation | Validation | Validation | Validation | Validation |
| 1. Click here to enter text. |  |  |  |  |  |  |  |  |  |  |
| 2. Click here to enter text. |  |  |  |  |  |  |  |  |  |  |
| 3. Click here to enter text. |  |  |  |  |  |  |  |  |  |  |
| 4. Click here to enter text. |  |  |  |  |  |  |  |  |  |  |
| 5. Click here to enter text. |  |  |  |  |  |  |  |  |  |  |
| 6. Click here to enter text. |  |  |  |  |  |  |  |  |  |  |
| 7. Click here to enter text. |  |  |  |  |  |  |  |  |  |  |
| 8. Click here to enter text. |  |  |  |  |  |  |  |  |  |  |

# Validation Methods – Key

O=Observation of student performance D=Demonstration through simulation or verbalization in skills lab NA=Not Applicable

**Instructor Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Submit form to [StudentPlacement@choa.org](mailto:StudentPlacement@choa.org?subject=Submitting%20Student%20Clinical%20Orientation%20Checklist) or Fax to (404) 785-7817