

Please fill out the Preceptor portion of the evaluation and immediately turn the completed evaluation in to your department Director or Educator. Students are not to see the completed evaluations. Please be honest and complete in your assessment of the student. Envelopes have been left with designated individuals to send back to school.

**PRECEPTOR
SIGNATURE** _____

Date _____

Quarter: _____

Clinical Site: _____

Preceptor (Include last name and credentials):

Primary Areas Assigned:

Type(s) of care observed/administered:

Vital Signs _____

Oxyhood _____

Croup Tent _____

Pt. Positioning _____

O2 Analysis _____

Pulse Oximetry _____

Peak Flow _____

SVN Therapy _____

X-ray _____

MDI/Spacer _____

NC (Low Flow O2) _____

Humidity _____

Oxygen Masks _____

LVN _____

Entrainment Mask _____

IPPB _____

Aerosol Mask _____

IS _____

Trach Mask _____

T-Piece _____

CPT _____

Gas Cylinder _____

Vent _____

Aline _____

Airway _____

CPR _____

Student Comments:

Preceptor please complete below dotted line (except signature at top)

Critical Needs or comments: (Preceptor, please utilize this section when the student scores lower than a three on the Skill Assessment Score Report Sheets to detail areas of improvement needed). Also place comments about students here.

Student Rating: 0 = Not acceptable
1 = Needs Improvement
2 = Acceptable
3 = Good
4 = Very Good
5 = Excellent

- 1. Dependability _____
- 2. Appearance _____
- 3. Professionalism _____
- 4. Teamwork _____
- 5. Organization _____
- 6. Attitude _____
- 7. Competence _____

Any other comments you wish to make _____
