# Clinical Site Checklist Date:

This form must be completed no earlier than 5 weeks prior to clinical placement of students.

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| Clinical Site INFORMATION |
| Facility name:  |  |
| Telephone number:  |  |
|  Contact Person: |  |
| Title: |  |
| Start date for clinical rotation: |  |

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| --- |
| facility CHECKLIST  |
| YES | NO | N/A | QUESTIONS | Details if needed |
| [ ]  | [ ]  | [ ]  | Has the facility received a decertification letter from Medicaid? |  |
| [ ]  | [ ]  | [ ]  | Is the facility under any type of extended survey? |  |
| [ ]  | [ ]  | [ ]  | Has the facility had a sub-standard survey or in the process of working to remove a sub-standard survey? |  |
| Student Special Requirements  |
| YES | NO | N/A | REQUIREMENT | Date Completed |
| [ ]  | [ ]  | [ ]  | Flu Shots |  |
| [ ]  | [ ]  | [ ]  | Background Checks |  |
| [ ]  | [ ]  | [ ]  | Drug Screens |  |
| [ ]  | [ ]  | [ ]  | CPR |  |
| [ ]  | [ ]  | [ ]  | 2-Step TB test |  |
| [ ]  | [ ]  | [ ]  | Fingerprint Check |  |
| [ ]  | [ ]  | [ ]  | Other (specify) |  |
| are the above special requirements applicable to instructors |
| YES | NO | N/A | FREQUENCY OF UPDATED DOCUMENTS REQUIRED | Date of last compliance |
| [ ]  | [ ]  | [ ]  |  |  |
| student/instructor documentation of special requirements delivered to facility  |
| YES | N/A | METHOD OF DELIVERY | Date Completed |
| [ ]  | [ ]  |  |  |
| aRE sTUDENT/INSTRUCTOR DOCUMENTATION REQUIRED TO BE BROUGHT TO CLINICALS? |
| YES | NO | N/A |  |  |
| [ ]  | [ ]  | [ ]  |  |  |