

Region VII EMS

Emergency Communications Registered Nurse (ECRN)

ALS Telemetry Preceptor Log

This form is to be utilized by the ECRN Preceptor monitoring ten ALS Telemetry calls to complete the ECRN education validation

ECRN Student Name _____ Hospital affiliation _____

ECRN Class Date _____ Site sponsoring class _____ Site code # _____

ALS Call #1 Date _____ Time of run _____ Agency _____

Chief Complaint _____ SMO followed Y N ECRN direction needed/given Y N

ER Log # _____ Transported to _____ Competent on call Y N

Preceptor Signature _____ Preceptor printed name _____

ALS Call #2 Date _____ Time of run _____ Agency _____

Chief Complaint _____ SMO followed Y N ECRN direction needed/given Y N

ER Log # _____ Transported to _____ Competent on call Y N

Preceptor Signature _____ Preceptor printed name _____

ALS Call #3 Date _____ Time of run _____ Agency _____

Chief Complaint _____ SMO followed Y N ECRN direction needed/given Y N

ER Log # _____ Transported to _____ Competent on call Y N

Preceptor Signature _____ Preceptor printed name _____

ALS Call #4 Date _____ Time of run _____ Agency _____

Chief Complaint _____ SMO followed Y N ECRN direction needed/given Y N

ER Log # _____ Transported to _____ Competent on call Y N

Preceptor Signature _____ Preceptor printed name _____

ALS Call #5 Date _____ Time of run _____ Agency _____

Chief Complaint _____ SMO followed Y N ECRN direction needed/given Y N

ER Log # _____ Transported to _____ Competent on call Y N

Preceptor Signature _____ Preceptor printed name _____

ALS Call #6 Date _____ Time of run _____ Agency _____

Chief Complaint _____ SMO followed Y N ECRN direction needed/given Y N

ER Log # _____ Transported to _____ Competent on call Y N

Preceptor Signature _____ Preceptor printed name _____

ALS Call #7 Date _____ Time of run _____ Agency _____

Chief Complaint _____ SMO followed Y N ECRN direction needed/given Y N

ER Log # _____ Transported to _____ Competent on call Y N

Preceptor Signature _____ Preceptor printed name _____

ALS Call #8 Date _____ Time of run _____ Agency _____

Chief Complaint _____ SMO followed Y N ECRN direction needed/given Y N

ER Log # _____ Transported to _____ Competent on call Y N

Preceptor Signature _____ Preceptor printed name _____

ALS Call #9 Date _____ Time of run _____ Agency _____

Chief Complaint _____ SMO followed Y N ECRN direction needed/given Y N

ER Log # _____ Transported to _____ Competent on call Y N

Preceptor Signature _____ Preceptor printed name _____

ALS Call #10 Date _____ Time of run _____ Agency _____

Chief Complaint _____ SMO followed Y N ECRN direction needed/given Y N

ER Log # _____ Transported to _____ Competent on call Y N

Preceptor Signature _____ Preceptor printed name _____

Return this completed competency form to your EMS Coordinator for submission to the Resource Hospital for processing. Completion of this form is required for initial ECRN licensure.