

Wintergreen Fire & Rescue Medic Check Sheet Intermediate and Paramedic

Name: _____

Certification Date: ___/___/___

Preceptor: _____

The Medic Preceptor Program gives the student the ability to practice under the leadership and guidance of approved ALS providers. This is intended to strengthen the skills of the Medic and will last **60 logged** hours from the certification date. The Medic may log the 60 hours in any configuration he / she desires. To be considered for release the medic must have 60 hours logged and the following check sheet completed by an approved medic preceptor.

The following procedures, SOPs, and Protocols must be performed, as well as reviewed by the EMT with the preceptor. If at the end of the 60 logged hours these skills have not been performed on a call then they may be reviewed or simulated under the supervision of a preceptor.

Skills	Date(s)	Initials and Comments
Specific Skills		
IV / INT Initiation (1)		
ET Intubation (1)		
CO2 Detector		
Gumboogie		
Capnography		
Exchange of CT Box		
Medic Medication Review		
IV Med Administration		
IM Med Administration		
SQ Med Administration		
PR Med Administration		
IV Drip Medications		
Specific Calls		
Anaphylaxis Protocol		
Asthmatic / COPD Protocol		
Burn Protocol		
Combative Patient Protocol		
Chest Pain / Cardiac Call		
CHF Protocol		
Diabetic Emergency / Altered LOC		
Eclampsia Protocol		
Overdose / Poisoning		
Seizure Protocol		
Shock Protocol		

More Skills		
CPAP		
EZ - I.O		
Needle Cricothyrotomy		
Needle Decompression		
External Jugular Cannulation		
Endotracheal Suctioning		
Orogastric Tube		
Cardiac Monitor Proficiency		
Defibrillation		
External Pacing		
Synchronized Cardioversion		
Helicopter Protocols		
PPCR Documentation		
Adult Cardiac Protocols		
Asystole		
PEA		
V-Fib / Pulseless V-Tach		
Bradycardia		
Narrow Complex Tachycardia		
Wide Complex Tachycardia		
Pediatric Cardiac Protocols		
Asystole		
PEA		
V-Fib / Pulseless V-Tach		
Bradycardia		
Narrow Complex Tachycardia		
Wide Complex Tachycardia		
Paramedics Only		
Surgical Cricothyrotomy		
Nasal / Tracheal Intubation (Review)		
RSI Protocol (OMD Approval)		

Additional Preceptor Comments:

Preceptor Signature: _____ **Date:** ___/___/___

Preceptor Signature: _____ **Date:** ___/___/___

Preceptor Signature: _____ **Date:** ___/___/___

Preceptor Signature: _____ **Date:** ___/___/___

Approved By
Chief Of EMS Operations: _____ **Date:** ___/___/___

Preceptor Time Sheet

Name: _____ **Certification Date:** ___/___/___

Level: _____

Date	Facility	Preceptor	Time	# Hours

When complete and signed by appropriate persons turn into the Chief of EMS Operations for review. The OMD and EMS Chief must clear you before practicing solo.

Date Completed: ___/___/___

Preceptor: _____ **Date:** ___/___/___

EMS Chief: _____ **Date:** ___/___/___

OMD: _____ **Date:** ___/___/___

Approved: **Disapproved:**

Reason: _____

