



## CLINICAL FACILITY APPROVAL APPLICATION

**INSTRUCTIONS:** Please complete both front and back of this form to demonstrate compliance with Title 16, California Code of Regulations (CCR) §§ 2534 and 2584. Submit separate forms for multiple campuses or if use of the facility is proposed for both Vocational Nurse (VN) and Psychiatric Technician (PT) programs. **ALL REQUESTED INFORMATION IS MANDATORY. FAILURE TO PROVIDE ALL INFORMATION WILL RESULT IN THE APPLICATION BEING REJECTED AS INCOMPLETE.**

*FOR BOARD USE ONLY*

Approved By: \_\_\_\_\_

Date Approved: \_\_\_\_\_

*PRINT LEGIBLY IN INK*

SCHOOL NAME AND CAMPUS: \_\_\_\_\_ VN  PT

1. NAME OF CLINICAL FACILITY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE:  ZIP:

TELEPHONE #: ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

2. NAME OF FACILITY ADMINISTRATOR: \_\_\_\_\_

3. NAME OF FACILITY DIRECTOR: \_\_\_\_\_

4. CONTACT PERSON: \_\_\_\_\_ TELEPHONE #: ( ) \_\_\_\_\_ EMAIL: \_\_\_\_\_

5. TYPE OF FACILITY: \_\_\_\_\_

6. LICENSE STATUS (Check One):  
 Licensed  Certified  Other

7. CLIENT POPULATION: *Check All That Apply*  
 Adults  Peds  Geriatrics  Other

8. AVERAGE DAILY CENSUS FOR FACILITY: \_\_\_\_\_

9. **FACILITY DIRECTOR: PLEASE INDICATE THE UNITS/SERVICES (OB, MED/SURG, PEDS, ETC.) AVAILABLE FOR STUDENT ASSIGNMENT FROM THIS PROGRAM, THE AVERAGE DAILY CENSUS FOR EACH AND THE MAXIMUM NUMBER OF STUDENTS FROM THIS PROGRAM THAT EACH UNIT CAN ACCOMMODATE.**

UNITS/SERVICES					
Average Daily Census for Unit/Services					
# Students Possible Per Unit/Services					

10. **FACILITY DIRECTOR: PLEASE ANSWER THE FOLLOWING QUESTIONS.**

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| A. Were the student's clinical objectives given to you for review?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| B. Are the students' clinical objectives achievable in your facility?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| C. Does your facility limit the ratio of instructors to students? # ____ instructors to # ____ students.   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| D. Will the instructor(s) have an orientation to your facility?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| E. Are students' required to complete a special facility orientation?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| F. Is the instructor free to make assignments which correlate with current theory classes, including administration of medications, treatments, use of equipment and charting? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| G. Is the instructor free to move students to areas where immediate, pertinent learning is available, even with short notice?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| H. Is adequate space available for classes and conferences?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| I. Is this space available for uninterrupted use by students and faculty? If not, what other arrangements have been made?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

See page 2 for Facility Signature.

*OVER*

11. THE FOLLOWING INFORMATION MUST BE COMPLETED FOR EACH STUDENT LEVEL. IF THE CLINICAL EXPERIENCE WILL BE ACHIEVED AT A SATELLITE SITE, CHECK THIS BOX.

HOW MANY WEEKS WILL EACH STUDENT SPEND AT THIS FACILITY? (i.e. # weeks/student at facility) \_\_\_\_\_

A. Level of Student				
B. Starting Calendar Date				
C. Unit / Services				
D. Number of Students				
E. Days of Week				
F. Start & End Times of Day				
G. Total Hours Per Week *				
H. Pre-Conference Days & Times				
I. Post-Conference Days & Times				
J. Instructor on Site (List Days & Times)				

\*# Days Per Week times # Hours Per Day must equal Total Hours per Week

12. Copies of the following documents must be attached.

- CLINICAL OBJECTIVES FOR EACH STUDENT LEVEL TO BE ACHIEVED AT THIS FACILITY
- PLAN FOR FACULTY ORIENTATION TO FACILITY

13. PROGRAM DIRECTOR: PLEASE ANSWER THE FOLLOWING QUESTIONS.

Did you discuss with the facility:

- A. Course description and student clinical objectives?  Yes  No
- B. Specific nursing care and procedures required for student achievement of clinical objectives?  Yes  No
- C. The facility's policies and procedures regarding student placement?  Yes  No
- D. The facility's documentation and charting methodologies?  Yes  No
- E. Location of facility emergency and non-emergency equipment?  Yes  No
- F. Facility emergency and non-emergency procedures?  Yes  No
- G. Scheduling of facility conference rooms?  Yes  No

14. *THIS SIGNATURE CONFIRMS THAT I HAVE REVIEWED AND AGREE WITH THE CONTENTS OF THIS FORM AND ALL ATTACHMENTS.*

FACILITY Director's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

FACILITY Director's Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

15. *I HEREBY CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE AND CORRECT.*

PROGRAM Director's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PROGRAM Director's Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

FOR BOARD USE ONLY

NAME OF FACILITY REPRESENTATIVE SPOKEN WITH: \_\_\_\_\_  Approved  Denied

COMMENTS:

BOARD CONSULTANT'S SIGNATURE: