STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

Board of Vocational Nursing and Psychiatric Technicians
2535 Capitol Oaks Drive Suite 205, Sacramento, CA 95833-2945
Phone 916-263-7800 Fax 916-263-7866 Web www.bvnpt.ca.gov

CLINICAL FACILITY APPROVAL APPLICATION INSTRUCTIONS

INSTRUCTIONS TO SCHOOL PROGRAM DIRECTOR:

Please complete SECTIONS I and III of this form to demonstrate compliance with California Code of Regulations (CCR), Title 16, sections 2534 and 2588.

To assure successful submissions:

- Complete all sections of the form legibly with no information crossed/whited out and replaced with different information. This form is an official document; therefore, forms with alterations will not be accepted.
- Submit separate forms for each program (PT or VN) or school campus if the facility will be used by more than one program or campus of a school.
- Check the form before submission to assure that all requested information has been included, all required signatures are present, and the required facility-specific clinical objectives are attached.
- Attach only clinical objectives from the Board-approved Instructional Plan that will be able to be accomplished **at this facility.**
- Complete Sections I and III, and attach applicable clinical objectives ***before*** giving the form to the facility contact person for review. The facility contact person should then be directed to complete Section II.
- Upon completion the application should be submitted via email to the program's assigned Nursing Education Consultant.

Check list for Program Directors before giving form to facility to complete:

- ☐ Form is completed legibly in ink with no crossed-out or whited-out information.
- ☐ Separate form has been used for each campus or program (if school offers VN and PT programs).
- ☐ All required information is included in Sections I and III.
- ☐ Clinical Objectives from the Board-approved Instructional Plan specific to this facility are attached.
- ☐ The Program Director signed and dated the form.

Check list for Program Directors after Section II has been completed by Facility Administrator/Director:

- ☐ All required information is included.
- ☐ The Facility Administrator/Director signed and dated the form.

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CLINICAL FACILITY APPROVAL APPLICATION FORM

THIS SECTION IS TO BE COMPLETED BY SCHOOL PROGRAM DIRECTOR

SCHOOL NAME AND CAMPUS: ☐VN ☐PT

1. **NAME OF CLINICAL FACILITY:**

ADDRESS OF LOCATION WHERE CLINICAL EXPERIENCE WILL TAKE PLACE:

STREET:

CITY: **STATE:** **ZIP:**

FACILITY TELEPHONE #: _____

FACILITY FAX # _____

2. **NAME OF FACILITY ADMINISTRATOR/DIRECTOR:**

3. **NAME/TITLE OF PERSON RESPONSIBLE FOR STUDENT PLACEMENT (CONTACT PERSON):**

4. **FOR FACILITY CONTACT PERSON:**

TELEPHONE #:_____

EMAIL ADDRESS: _____

THIS SECTION IS TO BE COMPLETED BY THE FACILITY DIRECTOR

FACILITY ADMINISTRATOR/DIRECTOR: Please complete the following information for your facility. Be as descriptive as possible regarding your client population and the type of care offered at your location. After completion return the form to the Program Representative.

1. **TYPE OF FACILITY (type of care designation, e.g. acute care, skilled nursing facility, long term care, clinic, private practice office, etc.)**

2. **CLIENT POPULATION:** *Check All That Apply*	3. **AVERAGE DAILY CENSUS FOR FACILITY:**
☐Med/Surg ☐OB ☐Peds ☐Mental Health ☐DD (for PT programs) ☐Other (describe):	

4. **Please complete the following table:**

Units/Services available for student assignment					
Average Daily Census for Unit/Services					
# Students Possible Per Unit/Services Per Shift					
Days of week Available for Student Assignment					
Shifts Available for Student Assignment					

5. **PLEASE ANSWER THE FOLLOWING QUESTIONS.**

A. Were the student's clinical objectives given to you for review? ☐ Yes ☐ No

B. Are the students' clinical objectives achievable in your facility? ☐ Yes ☐ No

C. Does your facility limit the ratio of instructors to students? # ____ instructors to # ____ students. ☐ Yes ☐ No

D. Can the instructor assign students to multiple units and be responsible for students on all assigned units? ☐ Yes ☐ No

E. Does your facility require facility orientation for students and/or faculty? ☐ Yes ☐ No

F. Are students required to complete a special facility orientation? ☐ Yes ☐ No

G. Is the instructor free to make assignments which correlate with current theory classes, including administration of medications, treatments, use of equipment and charting? ☐ Yes ☐ No

H. Did you discuss the following with the program representative?

- **Policies and procedures regarding student placement?** ☐ Yes ☐ No
- **Documentation and charting methodologies?** ☐ Yes ☐ No
- **Are students allowed to access the patient/resident electronic records?** ☐ Yes ☐ No
- **Facility emergency and non-emergency procedures?** ☐ Yes ☐ No

Name/Title of Program Representative with whom you discussed this application: _____

6. ***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: _____

THIS SECTION IS TO BE REVIEWED AND COMPLETED BY THE SCHOOL PROGRAM DIRECTOR

1. The following information regarding your program's use of the facility must be completed for <u>each</u> applicable term/level.

A. Term/Level of Student &Content				
B. Weeks/Term Each Student will be at this facility				
C. Unit / Services Used Each Term				
D. Number of Students/Unit				
E. Total Hours Per Week/student				

2. What is the maximum number of weeks during the program that a student would be at this facility?

REMINDER: Copies of the students' clinical objectives from the Board-approved Instructional Plan that are <u>expected to be achieved at this facility</u> must be attached to this application <u>before</u> giving the application to the facility.

3. PROGRAM DIRECTOR: PLEASE ANSWER THE FOLLOWING QUESTIONS.

Did you discuss the following topics 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

4. *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:** _____

NAME OF FACILITY REPRESENTATIVE SPOKEN WITH: _____ ☐ **Approved** ☐ **Denied**

COMMENTS:

BOARD CONSULTANT'S SIGNATURE: _____

APPROVAL DATE: _____