**MCNESSE STATE UNIVERSITY ATHLETIC TRAINING PROGRAM**

**CLINICAL SITE EVALUATION**

**Name of the Clinical Site:**

**Preceptor Responsible for Clinical Site:**

**Date of evaluation:**

**Clinical Site Information**

Patient/Athlete gender at this Clinical Site: **Male Female**

Type of Clinical Site: **High School College Physical Therapy Clinic**

 **Physician’s Office Other:**

If this clinical site offers athletics which sports are offered?

 **Football Men’s Basketball Women’s Basketball Baseball**

**Softball Men’s Track and Field Women’s Track and Field Volleyball**

**Men’s Tennis Women’s Tennis Wrestling Men’s Golf**

**Women’s Golf Men’s Cross-country Women’s Cross-country**

 **Men’s Soccer Women’s Soccer**

**Other:**

If this clinical site is a physical therapy clinic, physician’s office, or other which patient populations are present?

**Pediatric/Adolescent Adult Geriatric**

 **(0-17 years of age) (18-65 years of age) (65+ years of age)**

Number of preceptors at this clinical site:

Estimated number of athletic training students this clinical site can appropriately host per semester:

|  |  |  |
| --- | --- | --- |
| Does this clinical site have a plan in place to orientate the athletic training student upon their initial visit? | Yes | No |
| Does this clinical site have the appropriate equipment and supplies available to allow the athletic training student to complete their assigned clinical skills? | Yes | No |
| Is this clinical site staffed properly to provide adequate learning opportunities to the athletic training student? | Yes | No |
| Does the clinical site provide a safe environment for the athletic training student? | Yes | No |
| Does the clinical site provide a safe environment for the patients/athletes that receive services at the clinical site? | Yes | No |
| Does the clinical site provide an appropriate learning environment for the athletic training student? | Yes | No |
| Does this clinical site provide an environment which allows for the proper supervision of the athletic training student assigned to it at all times? | Yes | No |
| Does this clinical site have an emergency action plan? | Yes | No |
| Is this clinical site’s emergency action plan accessible to the athletic training student? | Yes | No |
| Does this clinical site have a plan in place to explain and practice the emergency action plan with/to the athletic training student? | Yes | No |
| Does the preceptor(s) at this clinical site have current and appropriate licensure(s) and certification(s) associated with their profession?  | Yes | No |
| Does this clinical site utilize proper OSHA protocol for the handling of blood, bodily fluids, and other bio-hazardous medical wastes? | Yes | No |
| Does this clinical site provide appropriate personal protective equipment for the athletic training student? | Yes | No |
| Is this clinical site compliant with OSHA standards? | Yes | No |

**CLINICAL SITE ASSESSMENT**

**Evaluator comments:**

**Clinical rotation/skills appropriate for this clinical site:**

Clinical Education Coordinator/Program Director Date

Preceptor Date