OSU-CHS Procedure/Skill Card

Office Use:
Entry Date: _____
Entry Initial: _____

CWID:_____

Student's Name:_____

Rotation Month/Year:_____ **Site:** _____

Supervising Preceptor: _____

Preceptor Instructions: Initial box next to procedure or skill, enter the date, the appropriate level of performance using the legend below and complete the physician information.

O = Observed only
A1 = Assisted with basic knowledge, required significant coaching
P1 = Performed with basic knowledge, required significant coaching
A2 = Assisted with adequate knowledge, some hesitation, minimal coaching
P2 = Performed with adequate knowledge, some hesitation, minimal coaching
A3 = Assisted with in depth knowledge, no hesitation and no coaching
P3 = Performed with in depth knowledge, no hesitation and no coaching

Procedures/Skills	Initial	Date	Level
Example One			
Autism Screening			
Alzheimer's Screening			
ADHD Screening			
Breast Exam			
Digital Rectal Exam			
Male Genitalia Exam			
Mental Status Exam			
Pelvic Exam			
Pap Smear			
Vaginal Delivery			
Casting/Splinting Extremity			
Wound/Laceration Suture			
Suture Removal			
Skin Lesion Removal			
Cerumen Removal			
IM Injections			
IV Insertion			
Sub-Q Injections			
Venipuncture/Phlebotomy			
Male Catherization (Urinary)			
Female Catherization (Urinary)			
Supra Pubic Urinary Cath			
Central Line Placement			
Chest Tube Placement			
Paracentisis			
Perifineal Lovage			
C-Section			
Lumbar Puncture			

Student's Name:_____

Student Instructions: Turn in completed Skills Card at the end of each rotation. Use as many cards as needed. These cards are required and a part of your grade for Rural Health required rotations (Community Clinic, Rural Clinic, Community Hospital, and Emergency Medicine) Although optional, it is highly recommended that you use the Skills Card for other rotations and electives. You will be given a Skills Summary just before graduation. If you have question contact Vicky Pace (vicky.pace@okstate.edu).

Procedures/Skills	Initial	Date	Level

_____ _____ MD DO
Physician's Name *Initials* *(circle one)*

AOA# or FEI# *Office/Work Phone* *Office/Work Fax* *Specialty*

_____ _____ MD DO
Physician's Name *Initials* *(circle one)*

AOA# or FEI# *Office/Work Phone* *Office/Work Fax* *Specialty*

_____ _____ MD DO
Physician's Name *Initials* *(circle one)*

AOA# or FEI# *Office/Work Phone* *Office/Work Fax* *Specialty*

_____ _____ MD DO
Physician's Name *Initials* *(circle one)*

AOA# or FEI# *Office/Work Phone* *Office/Work Fax* *Specialty*

Student Comments and Notes:

_____

_____

_____