



**Murray State College Veterinary Nursing Program- Distance Learning  
Off-Campus Clinical Institution Site Application  
Small Animal Facility**

Instructions:

- The practice owner or practice manager must complete this form.
- The primary preceptor listed must sign the Student Clinical Experience Agreement for the facility.
- Make sure to fill all applicable spaces
- When finished email document to [mscvn.mscok.edu](mailto:mscvn.mscok.edu)
- If you have any questions or experience issues please contact Laura Sandmann B.S., RVT at [lsansmann@mscok.edu](mailto:lsansmann@mscok.edu) or Aubree Goodwin, RVT at [agoodwin@mscok.edu](mailto:agoodwin@mscok.edu).

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Facility Name (as appears on IRS tax records): Click or tap here to enter text.

Facility Website URL: Click or tap here to enter text.

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**Mailing Address**

Street Address: Click or tap here to enter text.

City: Click or tap here to enter text.

State: Click or tap here to enter text.

Zip Code: Click or tap here to enter text.

**Physical Address (if different from mailing)**

Street Address: Click or tap here to enter text.

City: Click or tap here to enter text.

State: Click or tap here to enter text.

Zip Code: Click or tap here to enter text.

**Phone Number:** Click or tap here to enter text.

**Fax Number:** Click or tap here to enter text.

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**Who will be utilizing your facility?**

Please list all of the MSCVNDL students who will be using this facility to complete their required training:

Click or tap here to enter text.

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**Facility Equipment Check List-** Please check next to each item your clinic has readily available. If your clinic does not have an item, do not check the box, but highlight the item using the yellow highlight option.

**Anesthesia:**

Canine/Feline Anesthetic Machine <input type="checkbox"/>	Isoflurane Anesthetic Gas <input type="checkbox"/>
Non-Rebreathing System <input type="checkbox"/>	Functional Anesthetic Waste Gas Exhaust System <input type="checkbox"/>
Endotracheal Tubes Varying Sizes <input type="checkbox"/>	Anesthetic Masks Varying Sizes <input type="checkbox"/>
Laryngoscope <input type="checkbox"/>	

**Surgical Instruments, Relative Equipment, and Supplies:**

Autoclave <input type="checkbox"/>	Gurney/Stretcher <input type="checkbox"/>
Fluid Pump <input type="checkbox"/>	Basic Surgical Instruments <input type="checkbox"/>
Surgical Light <input type="checkbox"/>	*Specific Surgical Instruments (Orthopedic) <input type="checkbox"/>
Electric Clippers <input type="checkbox"/>	Designated Surgery Table <input type="checkbox"/>
Warming Device (e.g. circulating warm water blanket, forced warm air blanket) <input type="checkbox"/>	**Equipped & Accessible Emergency Crash Cart <input type="checkbox"/>

\*(familiarity with common orthopedic instruments – e.g. orthopedic wire, K-wire, pins, bone screws, pin cutter, wire cutting scissors, rongeur, bone holding forceps, hand chuck, osteotome, bone curette, mallet, Gigli wire saw and handles, elevator, and bone plates)

\*\* (including, but not limited to, assorted endotracheal tubes, resuscitation bag, assorted intravenous catheter sizes, epinephrine, atropine, lidocaine, face mask(s), stethoscope)

**Patient Monitoring Equipment:**

Thermometer/Temperature Monitoring Device <input type="checkbox"/>	Capnometer <input type="checkbox"/>
Pulse Oximeter <input type="checkbox"/>	Esophageal Stethoscope <input type="checkbox"/>
Cardiac Monitor <input type="checkbox"/>	Blood Pressure Monitoring Equipment <input type="checkbox"/>
Electrocardiograph (with printing capabilities as optional) <input type="checkbox"/>	Resuscitation Bag <input type="checkbox"/>

**Examination/Treatment Supplies & Equipment:**

Examination Tables <input type="checkbox"/>	*Kennels/Cages <input type="checkbox"/>	Scale <input type="checkbox"/>
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Bandage Material <input type="checkbox"/>	Casting Material <input type="checkbox"/>	Oral Speculum <input type="checkbox"/>
Ophthalmoscope <input type="checkbox"/>	Otoscope <input type="checkbox"/>	Stethoscope <input type="checkbox"/>
Tonometer <input type="checkbox"/>	Vaginal Speculum <input type="checkbox"/>	Syringes/Disposable Needles <input type="checkbox"/>
Tourniquet <input type="checkbox"/>	Feeding Tubes & Gavage <input type="checkbox"/>	**Oral Dosing Equipment <input type="checkbox"/>
Bathing Equipment <input type="checkbox"/>	***Refrigerator <input type="checkbox"/>	

\*Kennels & Cages must follow federal regulations.

\*\*Canine and Feline Specific

\*\*\*Designated Exam/Treatment use

**Radiology:**

Protective Apron <input type="checkbox"/>	Protective Thyroid Shield <input type="checkbox"/>	Protective Gloves <input type="checkbox"/>
Storage Rack for PPE <input type="checkbox"/>	Radiation Dosimeter Badges <input type="checkbox"/>	Calipers <input type="checkbox"/>
Fixed Radiology Machine <input type="checkbox"/>	Portable Radiology Machine <input type="checkbox"/>	Dental Radiology Unit <input type="checkbox"/>
Cassette or Plate Holders <input type="checkbox"/>	High Speed/Rare Earth Screens <input type="checkbox"/>	Directional/Positional Markers <input type="checkbox"/>
Protective Lead Eyeglasses (if required by state law*) <input type="checkbox"/>		

**Laboratory:**

Clinical Chemistry Analyzer <input type="checkbox"/>	Electronic Blood Cell Counter <input type="checkbox"/>
Differential Blood Cell Counter (manual or electronic smartphone apps) <input type="checkbox"/>	Microscope <input type="checkbox"/>
Incubator <input type="checkbox"/>	Refrigerator (designated lab use) <input type="checkbox"/>
Hand Tally Cell Counter <input type="checkbox"/>	Centrifuge <input type="checkbox"/>
Microhematocrit Centrifuge <input type="checkbox"/>	Refractometer <input type="checkbox"/>

**Dentistry:**

Ultrasonic Scaler <input type="checkbox"/>	Dental Polisher <input type="checkbox"/>
Appropriate Hand Dental Instruments <input type="checkbox"/>	*PPE- Mouth/Nose/Eye Covering <input type="checkbox"/>

\*Personal Protective Equipment

**Restraint:**

Muzzles (Canine and Feline) <input type="checkbox"/>	Restraint Pole <input type="checkbox"/>
Elizabethan Collars <input type="checkbox"/>	

**Other Necessary Supplies & Equipment:**

*Controlled Drug Cabinet <input type="checkbox"/>	Nail Trimmers <input type="checkbox"/>
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Microchip Scanner <input type="checkbox"/>	Laboratory Animal Restraint Equipment <input type="checkbox"/>
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\*Must be following state and federal laws.

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**Facility Standard Agreement**

We want to make sure our students to have adequate exposure to quality veterinary medical practices and equipment. Therefore, in order to be approved as an OCCI site for the Murray State College Veterinary Nursing Distance Learning Program your veterinary care facility(s) must meet certain minimum criteria in regard to equipment, practice quality, and hospital staff. Each individual OCCI site must agree to follow the minimum standards in order to receive approval.

I have thoroughly reviewed the MSCVNDL OCCI Clinical Requirements Information document and agree to make sure my facility and staff uphold these standards.

I agree to the above statements: Choose an item.

Please add your signature below.

X

Practice Owner or Practice Manager

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**Primary Preceptor Agreement-**

By completing and submitting this application, I am in agreeance to act as the listed student(s) primary preceptor for this facility (the facility listed in the above document). I acknowledge that I have read and reviewed this application entirely and will verify that to the best of my knowledge the information we provided is accurate. I have reviewed information provided over the MSCVNDL program and agree to act as the primary preceptor for this student in this facility.

As the primary preceptor of this OCCI site I agree that I will notify the program chair and/or required staff if there are significant changes within the facility including, but not limited to, structural integrity and physical structure. Additionally, I know it is my responsibility to notify the chair of the program or required staff if my credentials change, association or employment with the facility changes, or if I no longer want to be listed as a primary preceptor.

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I agree to the above statements: Choose an item.

Please add your signature below.

X

Primary Preceptor

**Primary Preceptor Information-  
Name:**

First	Middle Initial	Last
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

Maiden or former name that may appear on license or diploma: Click or tap here to enter text.

Email Address (Primary Preceptor)	Phone Number	Type of Phone
Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.

Please indicate your credentials and attach a current copy of your state credentials: Choose an item.

Additional comments or clarification:  
Click or tap here to enter text.

Name of individual submitting this application: Click or tap here to enter text.

X

Practice Owner or Practice Manager

Date: Click or tap to enter a date.