Murray State College Veterinary Nursing Program
OCCI Clinical Skills Course Application- VN 2112

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
- If you have any questions or experience issues please contact Laura Sandmann B.S., RVT at lsansmann@mscok.edu or Aubree Lively, RVT at agoodwin@mscok.edu.

Facility Name (as appears on IRS tax records):

Facility Website URL:

Mailing Address

Street Address:
City:
State:
Zip Code:

Physical Address (if different from mailing)
Street Address:
City:
State:
Zip Code:

Phone Number: **Fax Number:**

Who will be utilizing your facility?
Please list all of the MSCVN students who will be using this facility to complete their required training:

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.

The CVTEA, our accrediting body, requires that students have access to certain equipment. Additionally, each of our Clinical Skills courses will require that students have access to certain pieces of equipment to complete their hands-on tasks and skills. Below you will find what equipment is <u>required</u> per Clinical Skills course.

Veterinary Imaging Clinical Skills:

Required Species**:**

Canine	Dogs
Feline	Cats

☐	Radiation Dosimeter Badges	Radiographic Digital Machine – Dental	☐
☐	Radiographic digital Machine – Fixed	Radiographic Machine – Portable	☐
☐	Radiology Calipers	Radiology Cassette or Plate Holders	☐
☐	Radiology Directional/Positional/ID Markers	Radiology PPE Storage Rack	☐
☐	Radiology- Protective Lead Apron	Radiology- Protective Lead Eyeglasses (if required by state law*)	☐
☐	Radiology- Protective Lead Gloves	Radiology- Protective Lead Thyroid Shield	☐

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: Yes

Please add your signature below.

X

Practice Owner or Practice Manager

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.

I agree to the above statements: Yes

Please add your signature below.

X

Primary Preceptor

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Primary Preceptor Information-

Name:

First	Middle Initial	Last

Maiden or former name that nay appear on license or diploma:

Email Address (Primary Preceptor)	Phone Number	Type of Phone
		Cell

Please indicate your credentials and attach a current copy of your state credentials:

Additional comments or clarification:

Name of individual submitting this application:

X _____

Practice Owner or Practice Manager

Date: