



# Medical Assisting Clinical Training Handbook

## Table of Contents

Page	Topic
3	Welcome
4	Medical Assisting Code of Ethics and Creed
5	Professional Ethics
6-7	Clinical Training Assignment Process
8	Clinical Training Orientation and Rotation Schedule
9	Student Absence During Clinical Training
10-11	Report of Missed Clinical Training Time
12	Lunch, Breaks, Holidays, Vacations
13-14	Professional Appearance and Attire
15	Evaluation Guidelines
16	Probation
17	Safety, Needlesticks
18	Physical Incident Report
19-20	Hepatitis B and HIV Exposure Incident Report
21	Confidentiality and Personal Maintenance
22-23	Succeeding at the Clinic
24-25	Recommended Objectives for Clinical Training
26-30	Clinical Training Timesheet
31-58	Internship Experience Record
59	Clinical Training Return Visit Questions
60-62	Student Evaluation of Clinical Training
63	Vital Signs and Medical History Checklist
63-65	Confidentiality Agreement
66-67	Handbook Signature

**Clinical training is part of your education.  
You cannot receive any monetary compensation  
for clinical training hours.**

## **WELCOME!**

You've finally made it to the final and most exciting portion of your Medical Assisting education: **CLINICAL TRAINING!** This is your opportunity to put all of your education and skills together and use them in a **REAL** healthcare environment on **REAL** patients.

You are ready for this! Embrace the opportunity! Every day, show genuine care and concern to the patients and the professional staff. Learn from them. Give to them. By learning and giving, you will be receiving more than you realize. Never forget you have entered a profession where you will be judged by the interpersonal skills you exhibit. Put your patient first; always respect their dignity, uniqueness, and confidentiality.

As you finish Clinical Training and start your career, enjoy your success, and continue to learn for the rest of your life!

Thank you for being a student at Northwestern Health Sciences University! Here you go!

## **AAMA CODE OF ETHICS**

The Code of Ethics of AAMA shall set forth principles of ethical and moral conduct as they relate to the medical profession and the particular practice of medical assisting.

Members of AAMA dedicated to the conscientious pursuit of their profession, and thus desiring to merit the high regard of the entire medical profession and the respect of the general public which they serve, do pledge themselves to strive always to:

- A. render service with full respect for the dignity of humanity;
- B. respect confidential information obtained through employment unless legally authorized or required by responsible performance of duty to divulge such information;
- C. uphold the honor and high principles of the profession and accept its disciplines;
- D. seek to continually improve the knowledge and skills of medical assistants for the benefit of patients and professional colleagues;
- E. participate in additional service activities aimed toward improving the health and well-being of the community.

## **AAMA CREED**

I believe in the principles and purposes of the profession of medical assisting.

I endeavor to be more effective.

I aspire to render greater service.

I protect the confidence entrusted to me.

I am dedicated to the care and well-being of all people.

I am loyal to my employer.

I am true to the ethics of my profession.

.

I am strengthened by compassion, courage, and faith.

## PROFESSIONAL ETHICS

Given the essential information through class lecture and laboratory simulation relating to the practice of professional ethics, the student will:

- ❖ function as a professional healthcare worker
- ❖ develop an awareness of the rights and privileges of the patient and other individual healthcare workers by observing confidentiality and treating each with respect
- ❖ observe rules and regulations of the institution and departments concerning the care and handling of sick and injured patients
- ❖ recognize the importance and value of the ethics of the institution, physician, and personnel to inspire confidence and trust in their services
- ❖ develop qualities essential to a dedicated, professional Medical Assistant:
  - honesty
  - integrity
  - sincerity
  - unselfishness
- ❖ abide by the rules and policies set forth for performing assigned responsibilities, avoiding inconvenience and delay of patient care
- ❖ handle equipment, supplies, and other items with care
- ❖ conscientiously observe safety measures
- ❖ be aware of the legal implications which could face a health care worker for violations, infringements, or deliberate acts which could place the patient in a hazardous situation

## CLINICAL TRAINING ASSIGNMENT PROCESS

Medical Assisting students who complete all prerequisite course work and have provided the following documentation to the Clinical Coordinator will receive an appropriate clinical training placement.

- **Clinic Documentation of Current Immunizations:**
  - Varicella (Chicken Pox): Documentation of immunity required – provide one of the following:
    - 2 varicella vaccines on or after first birthday, or
    - Laboratory blood test of immunity or confirmation of disease
  - MMR: Documentation of immunity required – provide one of the following:
    - 2 MMR vaccines on or after first birthday, or
    - Laboratory evidence of immunity or disease for measles, mumps, and rubella
  - Hepatitis B: Documentation of immunity status required. Provide one of the following:
    - HepB vaccine dates – all 3 dates, **or**
    - Laboratory evidence of immunity, **or**
    - Documentation of HepB disease
    - If declining immunization, submit a signed declination – immunity status still required even if declining vaccine
  - Pertussis (Tdap): Documentation of vaccine required, provide:
    - Documentation of one adult Tdap vaccine
    - If Tdap was given over 10 years ago, provide documentation of current Tetanus toxoid immunization
  - Influenza: Vaccine required, provide
    - Documentation of vaccine for current flu season
  - COVID-19: Vaccine required, provide:
    - Documentation of completed COVID-19 vaccination series
- **Tuberculosis Testing** (results must be within 90 days of starting clinical training):
  - A negative TB symptom screen
  - Documentation of a negative Two Step TB Test (TST), **or**
  - Documentation of a negative TB blood test (T-SPOT.TB or TB QuantiFERON)
  - Students with a positive TB test must provide documentation of a negative chest x-ray
- **Healthcare Provider CPR and AED Certification**
- **Resume and Cover Letter**
- **Two Professional Letters of Recommendation**
- **Criminal Background Clearance**

The assignment process takes place during the term preceding the Clinical Training experience. Placement in a Clinical Training facility will take place as soon as possible after completion of all prerequisites but will be dependent on facility availability.

During Clinical Training, students will be evaluated based on entry-level performance in clinical and administrative areas. The specific areas are determined by the site supervisor and program director. The student will receive Northwestern Health Sciences University (NWHHSU) credits for Clinical Training. After successful completion of both NWHHSU and the Clinical Training phases of education, the student will be eligible to take the AAMA certification examination.

The Clinical Training phase is usually completed in 320 hours. Occasionally, students may be required to continue performing in a particular area to gain needed efficiency. The need for increased Clinical Training will be determined by the site supervisor and clinical coordinator. All clinical training hours are unpaid.

To ensure selection of a quality Clinical Training site, placement is made only in facilities approved by the University. All arrangements are made by NWHHSU; students may not contact facilities. Except under clinical partnership agreements, students will not be placed in a site that the student either works at or is a patient of. Under partnership agreements where a student is employed by the organization and continues employment during their clinical training, the clinical training hours must be clearly defined with all clinical training hours unpaid.

NWHHSU has many Clinical Training facilities. The appropriate Clinical Training site for each student will be chosen by NWHHSU. Every effort will be made to place students in facilities that can provide the student with the best possible experience. Students who refuse a Clinical Training placement assignment may be terminated from the University.

If a problem arises during Clinical Training, the Clinical Coordinator at NWHHSU will be notified immediately by either the student or the clinic site supervisor. A University representative will investigate and take whatever action is appropriate in the individual situation. Problem resolution is performed by the University.

## **CLINICAL TRAINING ORIENTATION**

The professional designated as the Clinical Training Supervisor at the Clinical Training affiliate is responsible for orientating the student to the facility's policies. This orientation usually includes:

- explanation of physical layout and tour of the facility
- general rules and regulations
- hours and days the student will be present
- dress code
- parking arrangements
- telephone protocol
- safety procedures
- who will be available for questions
- review of weekly internship record procedure

## **TYPICAL CLINICAL TRAINING ROTATION SCHEDULE**

The Clinical Training rotation schedule will vary with each facility. The following is a suggested rotation:

Weeks 1-2	Reception, business office, filing, administrative duties
Weeks 3-5	Nursing, clinical duties
Weeks 6-7	Lab and specialized departments
Week 8	Rotate where needed

## **ATTENDANCE**

Attendance records are kept during Clinical Training by the student, Clinical Training Supervisor, and Northwestern Health Sciences University. Whenever the student must miss time during Clinical Training, the student will:

- inform the Clinical Training Supervisor
- inform the University Clinical Coordinator
- make arrangements with the site supervisor and clinical coordinator to make up the lost time



## **Student Absence During Clinical Training**

Students are generally expected to complete clinical training on a full-time basis. This is normally forty hours per week during regular Monday through Friday clinic hours. Unless pre-approved by the clinical coordinator and clinical site supervisor, the MA Program is not obligated to secure clinical training experiences of less than forty hours per week.

**Daily attendance at your clinical training site is mandatory. Any missed clinical training hours must be reported in advance to both the site supervisor and the Clinical Training Coordinator at Northwestern Health Sciences University. Failure to report missed clinical time will result in disciplinary action to be determined by the MA Department Chair and Clinical Coordinator.**

If you are ill, you must contact both the CT Coordinator and your clinic supervisor before your shift. Time missed due to illness must be made up. Remember that dependability is an important MA trait! After notification to the site supervisor and Clinical Training Coordinator, all absences, missed time must be reported on the Report of Missed Clinical Training Time sheet, the weekly Internship Experience Record, and be accurately recorded on the time sheet.

As you are not a clinic employee, there is no time off allowed for personal needs or functions. If possible, all appointments are to be made outside of clinical training hours. If you cannot possibly arrange for your necessary appointment(s) outside of clinic hours, you must notify both the NWHSU Clinical Coordinator and your clinic supervisor in advance of the absence. Do not take an entire day off for an appointment; work at least half of the day and make arrangements to make up the missed hours.

If you have already scheduled an appointment (physical exam, surgery, etc.) that will fall during your clinical training period, you must make your clinic supervisor and the NWHSU Clinical Coordinator aware of this appointment before starting your clinical training. The best time to let the supervisor know is during your first meeting/interview with your clinic supervisor.

If you use childcare, be sure to have a back-up plan in the event your daycare provider is unable to care for your child.

Third Strike Policy – Tardiness and absences of more than two occurrences may result in disciplinary action and could result in failure of clinical training.

Funeral leave for deaths within the immediate family will be determined on an individual basis and is to be approved in advance of the absence. Time missed for funeral leave must be made up.

Some clinics offer hours on weekends, evening hours, urgent care hours, etc. Students are not required to work weekends, holidays, etc. If the student would like to work more than forty hours per week, pre-approval from the clinic supervisor and NWHSU clinical coordinator is required. Approval of over forty hours cannot be requested during the first three weeks of clinical training.

## Report of Missed Clinical Training Time

Student Name: \_\_\_\_\_

Clinical Site: \_\_\_\_\_

Date of Missed Clinical Training: \_\_\_\_\_

Time Missed Due To

\_\_\_\_\_ Absence \_\_\_\_\_ Tardy \_\_\_\_\_ Early Departure

Total Time Missed: \_\_\_\_\_

Comments:

---

---

---

---

Student Signature

Date

---

Clinical Supervisor Signature

Date

The student is to complete the top portion of this form including their signature. The clinical supervisor then signs the form, and the student returns it to the Clinical Coordinator at Northwestern Health Sciences University.

**A separate form must be completed for each occurrence. It is required that ALL late arrivals (including late arrivals from break/lunch), absences, and early departures be reported.**

The attendance and lunch/break time policy is in your clinical training. A student who fails to comply with the absence, tardy, and/or break time policy is subject to disciplinary action.

## Report of Missed Clinical Training Time

Student Name: \_\_\_\_\_

Clinical Site: \_\_\_\_\_

Date of Missed Clinical Training: \_\_\_\_\_

Time Missed Due To

\_\_\_\_\_ Absence \_\_\_\_\_ Tardy \_\_\_\_\_ Early Departure

Total Time Missed: \_\_\_\_\_

Comments:

---

---

---

---

Student Signature

Date

---

Clinical Supervisor Signature

Date

The student is to complete the top portion of this form including their signature. The clinical supervisor then signs the form, and the student returns it to the Clinical Coordinator at Northwestern Health Sciences University.

**A separate form must be completed for each occurrence. It is required that ALL late arrivals (including late arrivals from break/lunch), absences, and early departures be reported.**

The attendance and lunch/break time policy is in your clinical training handbook. A student who fails to comply with the absence, tardy, and/or break time policy is subject to disciplinary action.

## **LUNCH and BREAK TIME**

The total time allowed for student lunch and/or breaks each day shall be based on the rate of one hour per full eight-hour day.

Students assigned to an eight or eight and one-half hour day are entitled to one hour of free time in which to have lunch or take breaks. Depending on the daily schedule for the assigned site, this could mean a one-hour lunch with NO breaks, a 45-minute lunch with one 15-minute break, a 30-minute lunch with two 15-minute breaks, or any other combination that adds up to one hour in total. The actual time of day in which these breaks occur will be determined by the site supervisor. Lunch hours are not included in the calculation of Clinical Training hours.

If the workday is not eight hours in length, the amount of time allowed for student lunch or breaks is prorated. A 4-hour workday will allow a 15-minute break; a 6-hour workday will allow a 30-minute break.

Unused lunch or break time may not be applied to Clinical Training hours unless approved by the site supervisor.

## **HOLIDAYS and VACATIONS**

Students shall be entitled to all holiday time off as specified by the Clinical Training site.

Each student's individual learning plan identified the beginning and tentative ending dates of clinical training. These dates are established in accordance with the current official University calendar. Students must plan vacation trips or other events to coincide with the completion of clinical training. Communication with Clinical Training Supervisor regarding any necessary time off is essential.

## **PROFESSIONAL APPEARANCE AND ATTIRE**

The personal appearance and demeanor of Medical Assistant students at Northwestern Health Sciences University reflects both the school and program standards and are indicative of the student's interest and pride in his/her profession.

Any student reporting to the clinical site who is not dressed according to the student dress code will be sent home immediately and will be required to meet with the clinical coordinator prior to the return to clinical training.

A second occurrence will result in disciplinary action to be determined by the program director and clinical training coordinator.

**The following list is a general expectation of students. Students are expected to follow individual clinical site dress codes.**

- Shoes – clean white or mostly white leather or synthetic leather shoes. Shoes should be solid without mesh; no clogs allowed. Dirty, dingy or torn tennis-type shoes are not permitted.
- Hygiene – shower or bathe daily. Use deodorant, but do not use perfumes, colognes, etc. Many patients are sensitive or allergic to scents. Most medical facilities do not allow perfumes, colognes, scented lotions, etc. of any kind. As you will be conversing with patients and co-workers, make sure teeth and breath are clean. Do not chew gum or suck on candy while at the clinic.
- Smoking – is considered offensive and is not allowed in most medical facilities. Follow individual protocol for smoking during lunch or breaks. If you are a smoker, do not smoke on your drive to the clinic. Make sure you brush your teeth and wash your hands after smoking if you smoke during a break. Cigarette smoke clings to and penetrates clothing; this is unprofessional as well as offensive to patients and co-workers. Ill patients at the clinic are particularly vulnerable and sensitive to cigarette smell on the breath, clothing and body of the smoker.
- Hair – must be clean and neat. If hair is shoulder length or longer and/or falls forward into the face, it must be pulled back and secured away from the face. This is both a safety and professionalism concern.  
Men – clean shaven is preferred, or beards and mustaches must be neatly trimmed.

- Attire – cleaned and pressed uniforms or site approved scrubs. Wrinkled and dirty uniforms are unprofessional and not acceptable.
- Pants – uniform pants or scrubs only; pant legs will not be cuffed or rolled up above socks or shoes. Pant legs will not be tucked in socks above shoe. No denim, stretch or sweat type pants or any type of street clothes.
- Socks/stockings – must be worn. Wear only plain, unpatterned white socks.
- Underwear – no underwear visible – no t-shirts hanging below uniform sleeves. No bra straps visible underneath scrub tops. Midriff area must not be visible or exposed.
- Lab coat – clean lab coat must be worn as required by clinical site.
- Nametag – student nametag must be worn daily on the outside of uniform or lab coat.
- Fingernails – must be trimmed short enough to be flush with the tip of the fingerpad when viewed from the palm side. Nails must be clean and without polish. The possibility of infection is a concern in patient care situations. Long fingernails harbor bacteria and germs!
- Tattoos – all tattoos are to be covered with clothing
- Jewelry – may be worn in moderation. If student has body piercings, jewelry for only two ear piercings may be visible during clinical training. Absolutely no facial or tongue piercings, seen or unseen, are to be in place. Jewelry is strongly discouraged as it presents safety concerns for both patient and student. Medicine is a conservative business and body piercings are not perceived as medically professional. If you are assisting with a sterile field procedure, remove all jewelry before scrubbing hands and wrists.

## EVALUATION

Evaluation of performance during Clinical Training is critical to the student's success. Evaluation is accomplished in a variety of ways.

- Weekly Internship Experience Record
  - must be filled out completely by student
  - must be signed and reviewed by the Site Supervisor or appointed staff member
  - must be uploaded to Moodle by screenshot promptly by the student
  - reviewed by Clinical Coordinator
  
- Progress Evaluation
  - formal evaluation done at least once during CT
  - accomplished during site visit by Clinical Coordinator
  - discussed and signed by Site Supervisor and student on the eval day
  
- Recommended Objectives for Clinical Training
  - reviewed by student periodically during CT
  - signed by Site Supervisor or appointed staff as objectives are accomplished
  - brought to the student/Clinical Coordinator exit meeting
  
- Final Evaluation
  - formal evaluation done at end of CT
  - discussed and signed by the Site Supervisor and student
  - mailed/emailed to NWHSU at the end of the student's CT
  - reviewed by NWHSU staff so credit may be received for CT
  
- Evaluation of Clinical Training Affiliate (site)
  - formal evaluation done by student at end of CT
  - provides valuable feedback on the CT experience from student's perspective
  - mailed to NWHSU at the end of the student's CT
  - reviewed by university staff

## **PROBATION**

If a student is not performing appropriately or satisfactorily during Clinical Training, this should be reflected in the Weekly Internship Record. If a problem occurs, the Site Supervisor or the student will communicate with the NWHSU Clinical Coordinator by phone as soon as possible.

The NWHSU Clinical Coordinator or University representative will investigate and take appropriate action. This action may be in the form of counseling by the student via telephone, visiting the Clinical Training site to counsel the student, formal probation, or dismissal from NWHSU.

The student will be notified in writing regarding probation and the improvements required. This written notification must be signed by the NWHSU representative and the student. The length of the probation must be presented in writing.

Probation during Clinical Training is a very serious matter. At the end of the agreed probationary period, the student must have made satisfactory improvement in the areas outlined by the probation notice. If this has not occurred, termination will be immediate.



## **SAFETY**

Each Clinical Training facility should orient the student to hazards present in the facility. This orientation should include:

- fire safety and evacuation routes
- biohazard handling and disposal
- location of safety equipment and fire extinguisher
- instruction in safety procedures
- precautions to follow for staff and patients during severe weather warnings

Students are required to adhere to all applicable safety regulations and procedures. Failure to do so may be grounds for dismissal from NWHSU.

## **ACCIDENTAL NEEDLE STICK**

If an accidental needle stick occurs, students will:

- take immediate first aid steps to thoroughly clean wound
- notify site supervisor and follow clinic protocol as instructed
- notify NWHSU Clinical Coordinator
- complete following incident report
- notify family physician and follow advice of physician
- physician must complete and sign incident report
- send copy of signed incident report and chosen course of action to NWHSU
- send copy of results of Hepatitis titer six weeks post-exposure

As outlined in student handbook, students are responsible for their own medical bills.

When enrolling at NWHSU, the student accepts full financial responsibility for all medical treatment and care and/or disability costs for any illness and/or injury incurred while on campus or at a university-affiliated Clinical Training site.

The student understands that neither NWHSU nor the affiliated Clinical Training sites carry medical insurance or Workers Compensation coverage on students of NWHSU and will not accept responsibility for medical or other costs incurred by sick or injured patients while on the University's campus or on Clinical Training.

## PHYSICAL INCIDENT REPORT

Northwestern Health Sciences University  
Robin Galloway, Clinical Coordinator  
2501 W. 84<sup>th</sup> Street  
Bloomington, MN 55431  
Ph: 952-885-5475  
[rgalloway@nwhealth.edu](mailto:rgalloway@nwhealth.edu)

Student / Employee Name \_\_\_\_\_

Date / Time of Incident \_\_\_\_\_ Type of Incident \_\_\_\_\_

Name of any other person involved \_\_\_\_\_

Name of witness present (if applicable) \_\_\_\_\_

Description of incident:

Action taken at time of incident

Signature of injured party \_\_\_\_\_ Date \_\_\_\_\_

Follow up – Date Completed \_\_\_\_\_

Signature of injured party \_\_\_\_\_ Date \_\_\_\_\_

**To be submitted to Clinical Coordinator at NWHSU within 24 hours of incident** (use other side if additional space is needed)

**Northwestern Health Sciences University  
Hepatitis – HIV Exposure Incident Report**

**Student / Employee to Complete**

Report date \_\_\_\_\_

Name \_\_\_\_\_

Date of birth \_\_\_\_\_

Date of Exposure \_\_\_\_\_

Time of Exposure \_\_\_\_\_

Where exposure occurred (room#, clinic, lab, etc. – be specific) \_\_\_\_\_

Witness(es) to the exposure \_\_\_\_\_

Details of exposure incident: \_\_\_\_\_

Were you wearing PPE? (personal protective equipment) \_\_\_\_\_ yes \_\_\_\_\_ no

If yes, list specific equipment \_\_\_\_\_

Did the PPE fail? \_\_\_\_\_ If yes, explain how \_\_\_\_\_

What body fluid(s) were you exposed to? \_\_\_\_\_

What part(s) of your body became exposed? \_\_\_\_\_

Estimate the size of the exposure area on your body \_\_\_\_\_ for how long? \_\_\_\_\_

Did a foreign body (needle, glass, scalpel, etc.) enter your body? \_\_\_\_\_

If yes, what was the object? \_\_\_\_\_

Where did it penetrate? \_\_\_\_\_

Was any fluid injected into your body? \_\_\_\_\_

If yes, what fluid? \_\_\_\_\_ How much? \_\_\_\_\_

If source is known, name of source \_\_\_\_\_

**IMMUNIZATION HISTORY:**

- 1. Do you have a history of Hepatitis B?                   yes \_\_\_\_\_ no \_\_\_\_\_
- 2. Have you ever received Hepatitis B vaccine?       yes \_\_\_\_\_ no \_\_\_\_\_
- 3. Did you complete the series of three?               yes \_\_\_\_\_ no \_\_\_\_\_  
    If not, how many did you receive? \_\_\_\_\_
- 4. Do you have a history of Hepatitis A?               yes \_\_\_\_\_ no \_\_\_\_\_
- 5. Do you have a history of Hepatitis C?               yes \_\_\_\_\_ no \_\_\_\_\_

**TO BE COMPLETED BY PHYSICIAN**

**REGARDING EXPOSURE INDIVIDUAL:**

- 1. Hepatitis B Antibody Test?       yes \_\_\_\_\_ no \_\_\_\_\_ refused \_\_\_\_\_
- 2. Hepatitis B Vaccine Given?       yes \_\_\_\_\_ # 1, # 2, # 3 of Series (circle number)
- 3. Hepatitis B immunoglobulin given? yes \_\_\_\_\_ no \_\_\_\_\_
- 4. HIV: (check all that apply)  
    \_\_\_\_\_ Counseling       \_\_\_\_\_ HIV Consent       \_\_\_\_\_ HIV Test  
    \_\_\_\_\_ Refused           \_\_\_\_\_ Signed consent / refusal form
- 5. \_\_\_\_\_ Discharge instructions given       \_\_\_\_\_ Information packet given
- 6. Referred to \_\_\_\_\_

**REGARDING SOURCE INDIVIDUAL:**

- 1. Obtain consent of source individual to be tested for Hepatitis B surface antigen / antibody.
- 2. HIV: (check all that apply)  
    \_\_\_\_\_ Counseling       \_\_\_\_\_ HIV Consent       \_\_\_\_\_ HIV Test  
    \_\_\_\_\_ Refused           \_\_\_\_\_ Signed consent / refusal form
- 3. \_\_\_\_\_ Discharge instructions given

**Clinical Training Supervisor** (if incident occurred at clinic site)

**Program Chair or Clinical Coordinator** (if incident occurred at university site)

- 1. Verify that student /employee completed their section before going to physician’s office.
- 2. Verify that physician completed physician section.
- 3. Verify that student / employee returns this form to the University’s Clinical Coordinator after seeing physician.
- 4. a. Clinical Coordinator: Verify all documents regarding this incident are placed in the student file.  
    b. Clinical Training Supervisor: Verify all documents regarding this incident are mailed to Northwestern Health Sciences University Clinical Coordinator, Robin Galloway, 2501 W 84<sup>th</sup> St, Bloomington, MN 55431

**ADDITIONAL COMMENTS:**

## **CONFIDENTIALITY**

All student records shall be maintained in accordance with the provisions of the “Federal Family Education Rights and Privacy Act of 1974.”

All student records accumulated during the program are considered confidential. The contents of a student’s file are not revealed to any unauthorized person without the student’s knowledge and consent. Students may review any records which pertain to them in the Program Director’s office during regular office hours.

## **PERSONAL MAINTENANCE**

The student is responsible for his / her own expenses during Clinical Training. These may include, but are not limited to:

- parking
- uniforms
- equipment
- health insurance
- medical bills
- meals

## Succeeding at the Clinic

### Remember to:

- take notes – keep a pocket notebook
- communicate with clinical coordinator when you have a question or problem
- remain flexible
- continue to review all your material
- remember to learn something new each day – use your time wisely
- take responsibility for your actions
- fit in to your CT environment – adapt to their way of doing things
- accept criticism – this is how you learn from your mistakes
- keep personal feelings out of CT situations
- treat CT as the most vital part of your education
- remember that the CT Supervisor is your most valuable reference when job hunting
- express a desire to learn – always ask “what else would you like me to do?”
- remember your manners
- use professional, courteous language
- send in Weekly Internship Record every week
- be aware of and practice patient confidentiality
- be aware of your status as a student within the CT facility organization
- ask questions
- volunteer to help whenever possible
- send a thank-you note to the CT site and supervisor at the end of your education

### **Things to Avoid:**

- expressing negative attitudes (about anything!) to CT staff
- being confrontational with CT staff
- being late for work
- being late to arrive back from lunch and breaks
- using phone for personal use
- getting involved in conflicts between CT staff members
- taking things personally
- reporting results you are unsure of – ask for help!!
- performing tasks or procedures you are unsure of – ask for help!!
- sitting around with nothing to do – find something!
- discussing your personal problems with the staff
- asking for time off
- acting like you know everything ... you are there to learn ...remember, there is always more than one way to do something

**Northwestern Health Sciences University  
Medical Assisting Program  
Recommended Objectives for Clinical Training**

**These objectives can be performed or observed as appropriate.** Please have supervisor or mentor initial as objectives as they are accomplished. If an objective cannot be performed or observed at the site, the supervisor or mentor should document N/A and include initials.

**Clinical**

1. Prepare patients to see provider:

- \_\_\_\_\_ a. Establish rapport with patient and family
- \_\_\_\_\_ b. Obtain patient history, meds prescribed, allergies, etc.
- \_\_\_\_\_ c. Take vitals – T, P, R, BP, Ht, Wt
- \_\_\_\_\_ d. Prepare, position, drape patient for exam

2. Assisting provider and patient with exam and treatment:

- \_\_\_\_\_ a. Use proper technique when assisting
- \_\_\_\_\_ b. Observe and assist with minor surgery / procedures
- \_\_\_\_\_ c. Practice aseptic technique

3. Administer medications ordered by provider:

- \_\_\_\_\_ a. Obtain proper medication
- \_\_\_\_\_ b. Administer medication safely / correctly
- \_\_\_\_\_ c. Record in patient chart

4. Practice laboratory skills:

- \_\_\_\_\_ a. Obtain specimens - blood, urine, etc., using correct technique
- \_\_\_\_\_ b. Perform routine lab procedures
- \_\_\_\_\_ c. Operate selected instruments and equipment
- \_\_\_\_\_ d. Perform
  - \_\_\_\_\_ Electrocardiogram
  - \_\_\_\_\_ Audiogram
  - \_\_\_\_\_ Spirometry
  - \_\_\_\_\_ Vision Screening
  - \_\_\_\_\_ Tympanometry
  - \_\_\_\_\_ Bandaging
  - \_\_\_\_\_ Pulse Oximetry
- \_\_\_\_\_ e. Scrub, wrap and sterilize instruments / equipment

**Administrative**

1. Perform receptionist duties:

- \_\_\_\_\_ a. Establish rapport and communicate effectively with patients
- \_\_\_\_\_ b. Telephone use
- \_\_\_\_\_ c. Schedule appointments
- \_\_\_\_\_ d. Registration duties – various

2. Processing of paperwork (hard copy and/or EMR)

- \_\_\_\_\_ a. Scanning
- \_\_\_\_\_ b. Referrals
- \_\_\_\_\_ c. Other: \_\_\_\_\_



3. Operate computer:  
\_\_\_\_\_ a. Observe, discuss, operate office computer system
4. Perform bookkeeping / accounting duties:  
\_\_\_\_\_ a. Observe, discuss, participate in office bookkeeping / accounting
5. Practice processing insurance claims:  
\_\_\_\_\_ a. Obtain/understand correct CPT codes for procedures  
\_\_\_\_\_ b. Obtain/understand correct ICD-10 codes for diagnosis  
\_\_\_\_\_ c. Observe or complete insurance forms to be submitted  
\_\_\_\_\_ d. Observe insurance payments, credits, adjustments

**General**

1. Emergency first aid and evaluation procedure:  
\_\_\_\_\_ a. Observe, discuss, participate in an emergency medical situation  
\_\_\_\_\_ b. Familiarize yourself with fire, tornado, and/or severe weather protocol
2. Universal precautions:  
\_\_\_\_\_ a. Dispose of biohazard correctly  
\_\_\_\_\_ b. Use precaution barriers as instructed  
\_\_\_\_\_ c. Familiarize yourself with office protocol for responding to and  
reporting accidents (needle sticks, blood/chemical splashes, etc.)
3. Professionalism:  
\_\_\_\_\_ a. Adhere to established attendance policy  
\_\_\_\_\_ b. Adhere to established dress code  
\_\_\_\_\_ c. Practice meticulous personal hygiene  
\_\_\_\_\_ d. Respect patient confidentiality at all times  
\_\_\_\_\_ e. Treat all staff with respect  
\_\_\_\_\_ f. Accept suggestions and constructive criticism willingly  
\_\_\_\_\_ g. Demonstrate initiative  
\_\_\_\_\_ i. Offer assistance  
\_\_\_\_\_ j. Stay busy  
\_\_\_\_\_ k. Demonstrate entry level performance in medical assisting tasks  
\_\_\_\_\_ l. Have fun

Printed name and credentials of mentors initialing the above objectives:

/	/
/	/
/	/

\_\_\_\_\_  
Student Signature/Date

\_\_\_\_\_  
Supervisor Signature/Date

## Northwestern Health Sciences University

### Clinical Training Time Sheet

Student Name \_\_\_\_\_ Clinical Training Site \_\_\_\_\_

**Example: Week 1 Dates:** \_\_\_\_\_ 5/1/21 – 5/7/21 \_\_\_\_\_

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total Hrs
<b>Time In</b>	8:00	8:30	8:00	8:15	7:30		
<b>Lunch (minutes)</b>	30	45	30	60	60		
<b>Time Out</b>	4:30	5:00	5:00	5:30	4:30		
<b>Total Hrs</b>	8	7.75	8.5	8.25	8		40.5
Supervisor/Mentor Approval (printed name/credentials):							

**Week 1 Dates:** \_\_\_\_\_

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total Hrs
<b>Time In</b>							
<b>Lunch (minutes)</b>							
<b>Time Out</b>							
<b>Total Hrs</b>							
Supervisor/Mentor Approval (printed name/credentials):							

**Week 2 Dates:** \_\_\_\_\_

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total Hrs
<b>Time In</b>							
<b>Lunch (minutes)</b>							
<b>Time Out</b>							
<b>Total Hrs</b>							
Supervisor/Mentor Approval (printed name/credentials):							

Student Name: \_\_\_\_\_

Week 3 Dates: \_\_\_\_\_

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total Hrs
<b>Time In</b>							
<b>Lunch</b> (minutes)							
<b>Time Out</b>							
<b>Total Hrs</b>							
Supervisor/Mentor Approval (printed name/credentials):							

Week 4 Dates: \_\_\_\_\_

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total Hrs
<b>Time In</b>							
<b>Lunch</b> (minutes)							
<b>Time Out</b>							
<b>Total Hrs</b>							
Supervisor/Mentor Approval (printed name/credentials):							

Week 5 Dates: \_\_\_\_\_

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total Hrs
<b>Time In</b>							
<b>Lunch</b> (minutes)							
<b>Time Out</b>							
<b>Total Hrs</b>							
Supervisor/Mentor Approval (printed name/credentials):							

Student Name: \_\_\_\_\_

Week 6 Dates: \_\_\_\_\_

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total Hrs
<b>Time In</b>							
<b>Lunch</b> (minutes)							
<b>Time Out</b>							
<b>Total Hrs</b>							
Supervisor/Mentor Approval (printed name/credentials):							

Week 7 Dates: \_\_\_\_\_

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total Hrs
<b>Time In</b>							
<b>Lunch</b> (minutes)							
<b>Time Out</b>							
<b>Total Hrs</b>							
Supervisor/Mentor Approval (printed name/credentials):							

Week 8 Dates: \_\_\_\_\_

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total Hrs
<b>Time In</b>							
<b>Lunch</b> (minutes)							
<b>Time Out</b>							
<b>Total Hrs</b>							
Supervisor/Mentor Approval (printed name/credentials):							

Student Name: \_\_\_\_\_

Week 9 Dates: \_\_\_\_\_

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total Hrs
<b>Time In</b>							
<b>Lunch</b> (minutes)							
<b>Time Out</b>							
<b>Total Hrs</b>							
Supervisor/Mentor Approval (printed name/credentials):							

Week 10 Dates: \_\_\_\_\_

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total Hrs
<b>Time In</b>							
<b>Lunch</b> (minutes)							
<b>Time Out</b>							
<b>Total Hrs</b>							
Supervisor/Mentor Approval (printed name/credentials):							

Week 11 Dates: \_\_\_\_\_

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total Hrs
<b>Time In</b>							
<b>Lunch</b> (minutes)							
<b>Time Out</b>							
<b>Total Hrs</b>							
Supervisor/Mentor Approval (printed name/credentials):							

Student Name: \_\_\_\_\_

Week 12 Dates: \_\_\_\_\_

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total Hrs
<b>Time In</b>							
<b>Lunch</b> (minutes)							
<b>Time Out</b>							
<b>Total Hrs</b>							
Supervisor/Mentor Approval (printed name/credentials):							

Week 13 Dates: \_\_\_\_\_

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total Hrs
<b>Time In</b>							
<b>Lunch</b> (minutes)							
<b>Time Out</b>							
<b>Total Hrs</b>							
Supervisor/Mentor Approval (printed name/credentials):							

Week 14 Dates: \_\_\_\_\_

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total Hrs
<b>Time In</b>							
<b>Lunch</b> (minutes)							
<b>Time Out</b>							
<b>Total Hrs</b>							
Supervisor/Mentor Approval (printed name/credentials):							

**Northwestern Health Sciences University  
2501 W. 84<sup>th</sup> Street, Bloomington, MN 55431**

**Internship Experience Record Week 1**

Student \_\_\_\_\_ Date: \_\_\_\_\_

Clinical Training Site \_\_\_\_\_

Notes for Week of \_\_\_\_\_

Number of Hours Worked \_\_\_\_\_ Hours Absent \_\_\_\_\_

Day                      Assignments, Tasks, Procedures Performed

**Monday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Tuesday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Wednesday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Thursday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Friday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Saturday / Sunday** \_\_\_\_\_  
\_\_\_\_\_

See next page for supervisor comments and signature.

**Supervisor/Mentor Notes or Comments:**

Please provide your feedback regarding the student's performance for the week identified on page 1.

Weekly Progress:    Excellent \_\_\_\_\_ Good \_\_\_\_\_ Average \_\_\_\_\_ Poor \_\_\_\_\_

Task(s) needing improvement

---

---

---

If tasks listed were to be improved from previous report(s), were the improvements achieved this week?

Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

Please provide additional information if improvements were not achieved.

Other Comments:

\_\_\_\_\_  
Supervisor/Mentor Name and Credentials (please print)

\_\_\_\_\_  
Date

**Student: Upload a screenshot of both page to Moodle each week or fax both pages to:**

**Attn: Robin Galloway  
Fax: 952-886-7579**



**Northwestern Health Sciences University  
2501 W. 84<sup>th</sup> Street, Bloomington, MN 55431**

**Internship Experience Record Week 2**

Student \_\_\_\_\_ Date: \_\_\_\_\_

Clinical Training Site \_\_\_\_\_

Notes for Week of \_\_\_\_\_

Number of Hours Worked \_\_\_\_\_ Hours Absent \_\_\_\_\_

Day                      Assignments, Tasks, Procedures Performed

**Monday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Tuesday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Wednesday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Thursday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Friday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Saturday / Sunday** \_\_\_\_\_  
\_\_\_\_\_

See next page for supervisor comments and signature.

**Supervisor/Mentor Notes or Comments:**

Please provide your feedback regarding the student's performance for the week identified on page 1.

Weekly Progress:    Excellent \_\_\_\_\_ Good \_\_\_\_\_ Average \_\_\_\_\_ Poor \_\_\_\_\_

Task(s) needing improvement

---

---

---

If tasks listed were to be improved from previous report(s), were the improvements achieved this week?

Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

Please provide additional information if improvements were not achieved.

Other Comments:

\_\_\_\_\_  
Supervisor/Mentor Name and Credentials (please print)

\_\_\_\_\_  
Date

**Student: Upload a screenshot of both page to Moodle each week or fax both pages to:**

**Attn: Robin Galloway  
Fax: 952-886-7579**

**Northwestern Health Sciences University  
2501 W. 84<sup>th</sup> Street, Bloomington, MN 55431**

**Internship Experience Record Week 3**

Student \_\_\_\_\_ Date: \_\_\_\_\_

Clinical Training Site \_\_\_\_\_

Notes for Week of \_\_\_\_\_

Number of Hours Worked \_\_\_\_\_ Hours Absent \_\_\_\_\_

Day                      Assignments, Tasks, Procedures Performed

**Monday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Tuesday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Wednesday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Thursday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Friday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Saturday / Sunday** \_\_\_\_\_  
\_\_\_\_\_

See next page for supervisor comments and signature.

**Supervisor/Mentor Notes or Comments:**

Please provide your feedback regarding the student's performance for the week identified on page 1.

Weekly Progress:    Excellent \_\_\_\_\_ Good \_\_\_\_\_ Average \_\_\_\_\_ Poor \_\_\_\_\_

Task(s) needing improvement

---

---

---

If tasks listed were to be improved from previous report(s), were the improvements achieved this week?

Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

Please provide additional information if improvements were not achieved.

Other Comments:

\_\_\_\_\_  
Supervisor/Mentor Name and Credentials (please print)

\_\_\_\_\_  
Date

**Student: Upload a screenshot of both page to Moodle each week or fax both pages to:**

**Attn: Robin Galloway  
Fax: 952-886-7579**

**Northwestern Health Sciences University  
2501 W. 84<sup>th</sup> Street, Bloomington, MN 55431**

**Internship Experience Record Week 4**

Student \_\_\_\_\_ Date: \_\_\_\_\_

Clinical Training Site \_\_\_\_\_

Notes for Week of \_\_\_\_\_

Number of Hours Worked \_\_\_\_\_ Hours Absent \_\_\_\_\_

Day                      Assignments, Tasks, Procedures Performed

**Monday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Tuesday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Wednesday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Thursday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Friday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Saturday / Sunday** \_\_\_\_\_  
\_\_\_\_\_

See next page for supervisor comments and signature.

**Supervisor/Mentor Notes or Comments:**

Please provide your feedback regarding the student's performance for the week identified on page 1.

Weekly Progress:    Excellent \_\_\_\_\_ Good \_\_\_\_\_ Average \_\_\_\_\_ Poor \_\_\_\_\_

Task(s) needing improvement

---

---

---

If tasks listed were to be improved from previous report(s), were the improvements achieved this week?

Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

Please provide additional information if improvements were not achieved.

Other Comments:

\_\_\_\_\_  
Supervisor/Mentor Name and Credentials (please print)

\_\_\_\_\_  
Date

**Student: Upload a screenshot of both page to Moodle each week or fax both pages to:**

**Attn: Robin Galloway  
Fax: 952-886-7579**

**Northwestern Health Sciences University  
2501 W. 84<sup>th</sup> Street, Bloomington, MN 55431**

**Internship Experience Record Week 5**

Student \_\_\_\_\_ Date: \_\_\_\_\_

Clinical Training Site \_\_\_\_\_

Notes for Week of \_\_\_\_\_

Number of Hours Worked \_\_\_\_\_ Hours Absent \_\_\_\_\_

Day                      Assignments, Tasks, Procedures Performed

**Monday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Tuesday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Wednesday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Thursday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Friday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Saturday / Sunday** \_\_\_\_\_  
\_\_\_\_\_

See next page for supervisor comments and signature.

**Supervisor/Mentor Notes or Comments:**

Please provide your feedback regarding the student’s performance for the week identified on page 1.

Weekly Progress:    Excellent \_\_\_\_\_ Good \_\_\_\_\_ Average \_\_\_\_\_ Poor \_\_\_\_\_

Task(s) needing improvement

---

---

---

If tasks listed were to be improved from previous report(s), were the improvements achieved this week?

Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

Please provide additional information if improvements were not achieved.

Other Comments:

---

Supervisor/Mentor Name and Credentials (please print)

---

Date

**Student: Upload a screenshot of both page to Moodle each week or fax both pages to:**

**Attn: Robin Galloway  
Fax: 952-886-7579**



**Northwestern Health Sciences University  
2501 W. 84<sup>th</sup> Street, Bloomington, MN 55431**

**Internship Experience Record Week 6**

Student \_\_\_\_\_ Date: \_\_\_\_\_

Clinical Training Site \_\_\_\_\_

Notes for Week of \_\_\_\_\_

Number of Hours Worked \_\_\_\_\_ Hours Absent \_\_\_\_\_

Day                      Assignments, Tasks, Procedures Performed

**Monday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Tuesday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Wednesday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Thursday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Friday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Saturday / Sunday** \_\_\_\_\_  
\_\_\_\_\_

See next page for supervisor comments and signature.



**Northwestern Health Sciences University  
2501 W. 84<sup>th</sup> Street, Bloomington, MN 55431**

**Internship Experience Record Week 7**

Student \_\_\_\_\_ Date: \_\_\_\_\_

Clinical Training Site \_\_\_\_\_

Notes for Week of \_\_\_\_\_

Number of Hours Worked \_\_\_\_\_ Hours Absent \_\_\_\_\_

Day                      Assignments, Tasks, Procedures Performed

**Monday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Tuesday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Wednesday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Thursday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Friday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Saturday / Sunday** \_\_\_\_\_  
\_\_\_\_\_

See next page for supervisor comments and signature.

**Supervisor/Mentor Notes or Comments:**

Please provide your feedback regarding the student's performance for the week identified on page 1.

Weekly Progress:    Excellent \_\_\_\_\_ Good \_\_\_\_\_ Average \_\_\_\_\_ Poor \_\_\_\_\_

Task(s) needing improvement

---

---

---

If tasks listed were to be improved from previous report(s), were the improvements achieved this week?

Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

Please provide additional information if improvements were not achieved.

Other Comments:

\_\_\_\_\_  
Supervisor/Mentor Name and Credentials (please print)

\_\_\_\_\_  
Date

**Student: Upload a screenshot of both page to Moodle each week or fax both pages to:**

**Attn: Robin Galloway  
Fax: 952-886-7579**

**Northwestern Health Sciences University  
2501 W. 84<sup>th</sup> Street, Bloomington, MN 55431**

**Internship Experience Record Week 8**

Student \_\_\_\_\_ Date: \_\_\_\_\_

Clinical Training Site \_\_\_\_\_

Notes for Week of \_\_\_\_\_

Number of Hours Worked \_\_\_\_\_ Hours Absent \_\_\_\_\_

Day                      Assignments, Tasks, Procedures Performed

**Monday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Tuesday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Wednesday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Thursday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Friday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Saturday / Sunday** \_\_\_\_\_  
\_\_\_\_\_

See next page for supervisor comments and signature.

**Supervisor/Mentor Notes or Comments:**

Please provide your feedback regarding the student's performance for the week identified on page 1.

Weekly Progress:    Excellent \_\_\_\_\_ Good \_\_\_\_\_ Average \_\_\_\_\_ Poor \_\_\_\_\_

Task(s) needing improvement

---

---

---

If tasks listed were to be improved from previous report(s), were the improvements achieved this week?

Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

Please provide additional information if improvements were not achieved.

Other Comments:

\_\_\_\_\_  
Supervisor/Mentor Name and Credentials (please print)

\_\_\_\_\_  
Date

**Student: Upload a screenshot of both page to Moodle each week or fax both pages to:**

**Attn: Robin Galloway**  
**Fax: 952-886-7579**

**Northwestern Health Sciences University  
2501 W. 84<sup>th</sup> Street, Bloomington, MN 55431**

**Internship Experience Record Week 9**

Student \_\_\_\_\_ Date: \_\_\_\_\_

Clinical Training Site \_\_\_\_\_

Notes for Week of \_\_\_\_\_

Number of Hours Worked \_\_\_\_\_ Hours Absent \_\_\_\_\_

Day                      Assignments, Tasks, Procedures Performed

**Monday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Tuesday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Wednesday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Thursday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Friday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Saturday / Sunday** \_\_\_\_\_  
\_\_\_\_\_

See next page for supervisor comments and signature.

**Supervisor/Mentor Notes or Comments:**

Please provide your feedback regarding the student's performance for the week identified on page 1.

Weekly Progress:    Excellent \_\_\_\_\_ Good \_\_\_\_\_ Average \_\_\_\_\_ Poor \_\_\_\_\_

Task(s) needing improvement

---

---

---

If tasks listed were to be improved from previous report(s), were the improvements achieved this week?

Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

Please provide additional information if improvements were not achieved.

Other Comments:

\_\_\_\_\_  
Supervisor/Mentor Name and Credentials (please print)

\_\_\_\_\_  
Date

**Student: Upload a screenshot of both page to Moodle each week or fax both pages to:**

**Attn: Robin Galloway  
Fax: 952-886-7579**



**Northwestern Health Sciences University  
2501 W. 84<sup>th</sup> Street, Bloomington, MN 55431**

**Internship Experience Record Week 10**

Student \_\_\_\_\_ Date: \_\_\_\_\_

Clinical Training Site \_\_\_\_\_

Notes for Week of \_\_\_\_\_

Number of Hours Worked \_\_\_\_\_ Hours Absent \_\_\_\_\_

Day                      Assignments, Tasks, Procedures Performed

**Monday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Tuesday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Wednesday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Thursday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Friday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Saturday / Sunday** \_\_\_\_\_  
\_\_\_\_\_

See next page for supervisor comments and signature.

**Supervisor/Mentor Notes or Comments:**

Please provide your feedback regarding the student's performance for the week identified on page 1.

Weekly Progress:    Excellent \_\_\_\_\_ Good \_\_\_\_\_ Average \_\_\_\_\_ Poor \_\_\_\_\_

Task(s) needing improvement

---

---

---

If tasks listed were to be improved from previous report(s), were the improvements achieved this week?

Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

Please provide additional information if improvements were not achieved.

Other Comments:

\_\_\_\_\_  
Supervisor/Mentor Name and Credentials (please print)

\_\_\_\_\_  
Date

**Student: Upload a screenshot of both page to Moodle each week or fax both pages to:**

**Attn: Robin Galloway**  
**Fax: 952-886-7579**

**Northwestern Health Sciences University  
2501 W. 84<sup>th</sup> Street, Bloomington, MN 55431**

**Internship Experience Record Week 11**

Student \_\_\_\_\_ Date: \_\_\_\_\_

Clinical Training Site \_\_\_\_\_

Notes for Week of \_\_\_\_\_

Number of Hours Worked \_\_\_\_\_ Hours Absent \_\_\_\_\_

Day                      Assignments, Tasks, Procedures Performed

**Monday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Tuesday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Wednesday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Thursday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Friday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Saturday / Sunday** \_\_\_\_\_  
\_\_\_\_\_

See next page for supervisor comments and signature.

**Supervisor/Mentor Notes or Comments:**

Please provide your feedback regarding the student's performance for the week identified on page 1.

Weekly Progress:    Excellent \_\_\_\_\_ Good \_\_\_\_\_ Average \_\_\_\_\_ Poor \_\_\_\_\_

Task(s) needing improvement

---

---

---

If tasks listed were to be improved from previous report(s), were the improvements achieved this week?

Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

Please provide additional information if improvements were not achieved.

Other Comments:

\_\_\_\_\_  
Supervisor/Mentor Name and Credentials (please print)

\_\_\_\_\_  
Date

**Student: Upload a screenshot of both page to Moodle each week or fax both pages to:**

**Attn: Robin Galloway  
Fax: 952-886-7579**

**Northwestern Health Sciences University  
2501 W. 84<sup>th</sup> Street, Bloomington, MN 55431**

**Internship Experience Record Week 12**

Student \_\_\_\_\_ Date: \_\_\_\_\_

Clinical Training Site \_\_\_\_\_

Notes for Week of \_\_\_\_\_

Number of Hours Worked \_\_\_\_\_ Hours Absent \_\_\_\_\_

Day                      Assignments, Tasks, Procedures Performed

**Monday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Tuesday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Wednesday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Thursday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Friday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Saturday / Sunday** \_\_\_\_\_  
\_\_\_\_\_

See next page for supervisor comments and signature.

**Supervisor/Mentor Notes or Comments:**

Please provide your feedback regarding the student's performance for the week identified on page 1.

Weekly Progress:    Excellent \_\_\_\_\_ Good \_\_\_\_\_ Average \_\_\_\_\_ Poor \_\_\_\_\_

Task(s) needing improvement

---

---

---

If tasks listed were to be improved from previous report(s), were the improvements achieved this week?

Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

Please provide additional information if improvements were not achieved.

Other Comments:

\_\_\_\_\_  
Supervisor/Mentor Name and Credentials (please print)

\_\_\_\_\_  
Date

**Student: Upload a screenshot of both page to Moodle each week or fax both pages to:**

**Attn: Robin Galloway  
Fax: 952-886-7579**

**Northwestern Health Sciences University  
2501 W. 84<sup>th</sup> Street, Bloomington, MN 55431**

**Internship Experience Record Week 13**

Student \_\_\_\_\_ Date: \_\_\_\_\_

Clinical Training Site \_\_\_\_\_

Notes for Week of \_\_\_\_\_

Number of Hours Worked \_\_\_\_\_ Hours Absent \_\_\_\_\_

Day                      Assignments, Tasks, Procedures Performed

**Monday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Tuesday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Wednesday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Thursday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Friday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Saturday / Sunday** \_\_\_\_\_  
\_\_\_\_\_

See next page for supervisor comments and signature.

**Supervisor/Mentor Notes or Comments:**

Please provide your feedback regarding the student's performance for the week identified on page 1.

Weekly Progress:    Excellent \_\_\_\_\_ Good \_\_\_\_\_ Average \_\_\_\_\_ Poor \_\_\_\_\_

Task(s) needing improvement

---

---

---

If tasks listed were to be improved from previous report(s), were the improvements achieved this week?

Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

Please provide additional information if improvements were not achieved.

Other Comments:

\_\_\_\_\_  
Supervisor/Mentor Name and Credentials (please print)

\_\_\_\_\_  
Date

**Student: Upload a screenshot of both page to Moodle each week or fax both pages to:**

**Attn: Robin Galloway  
Fax: 952-886-7579**



**Northwestern Health Sciences University  
2501 W. 84<sup>th</sup> Street, Bloomington, MN 55431**

**Internship Experience Record Week 14**

Student \_\_\_\_\_ Date: \_\_\_\_\_

Clinical Training Site \_\_\_\_\_

Notes for Week of \_\_\_\_\_

Number of Hours Worked \_\_\_\_\_ Hours Absent \_\_\_\_\_

Day                      Assignments, Tasks, Procedures Performed

**Monday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Tuesday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Wednesday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Thursday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Friday** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Saturday / Sunday** \_\_\_\_\_  
\_\_\_\_\_

See next page for supervisor comments and signature.

**Supervisor/Mentor Notes or Comments:**

Please provide your feedback regarding the student’s performance for the week identified on page 1.

Weekly Progress:     Excellent \_\_\_\_\_ Good \_\_\_\_\_ Average \_\_\_\_\_ Poor \_\_\_\_\_

Task(s) needing improvement

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If tasks listed were to be improved from previous report(s), were the improvements achieved this week?

Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

Please provide additional information if improvements were not achieved.

Other Comments:

\_\_\_\_\_  
Supervisor/Mentor Name and Credentials (please print)

\_\_\_\_\_  
Date

**Student: Upload a screenshot of both page to Moodle each week or fax both pages to:**

**Attn: Robin Galloway  
Fax: 952-886-7579**

## **Clinical Training Return Visit Questions**

Name \_\_\_\_\_

Date \_\_\_\_\_

List the aspects of your clinical training that you like the best.

List the aspects of your clinical training that you like the least and explain why.

List some goals that you would like to accomplish in the next few weeks of your clinical training.

What has been the biggest surprise or adjustment from school to clinical training?



5. Did the staff communicate, praise your performance, evaluate your performance? Were you given feedback in a timely manner?

6. Did you adequately keep and maintain records according to established protocol?

7. Were you able to handle the normal workload efficiently? Were you able to perform procedures as specified by the facility? Please address specific procedures or areas.

8. Were you able to take initiative and seek additional tasks/activities that you could complete after you finished your assignments?

9. Has your clinical training helped you develop attitudes consistent with those of a professional Medical Assistant?

10. What were the best aspects of your Clinical Training?

11. What were the weak aspects of your clinical training?

12. Please list any areas you feel you need further experience, background.

13. Did your clinical training prepare you to accept the position and extent of responsibility of a Medical Assistant?

Student Signature \_\_\_\_\_

Date \_\_\_\_\_

## Clinical Training MEDA2290 Vital Signs and Medical History Checklist

**Student Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Clinic Mentor or Evaluator:** \_\_\_\_\_

**Task / Conditions:** In a rooming situation with a clinical patient, the CT student will accurately measure vital signs of temperature, pulse, respiration, and blood pressure as appropriate to clinical protocol for the patient's visit needs. The student will document the chief complaint or visit encounter with medical history as appropriate to patient's particular visit needs.

Performance Standards	Yes	No	Comments
Obtain and document a chief complaint with medical history			
Temperature reading and recording identical to evaluator's			
Pulse reading and recording within two beats per minute of evaluator's			
Respiration reading and recording within two breaths per minute of evaluator's			
Blood Pressure reading and recording within a total of 4mm/Hg of evaluator's results <ul style="list-style-type: none"> <li>• 4 mm/Hg error margin               <ul style="list-style-type: none"> <li>○ Error margin may be:                   <ul style="list-style-type: none"> <li>✓ Systolic difference</li> <li>✓ Diastolic difference</li> <li>✓ Combination of both results</li> </ul> </li> </ul> </li> <li>• Example: evaluator's result of 120/80 could allow for student result of 124/80, or 122/78, 120/76</li> </ul>			

**FACULTY/STAFF/STUDENT CONFIDENTIALITY AGREEMENT FOR CLINICAL TRAINING**  
**Student Copy**

Name (Print): \_\_\_\_\_

Check One:

- Student
- Staff
- Faculty

The discussions, uses, and disclosures addressed by this agreement apply to any written, verbal, or electronic communications.

I understand that I am never to discuss or review any information regarding a patient at a clinical site unless the discussion or review is part of my assignment to the site. I understand that I am obligated to know and adhere to the privacy policies and procedures of the clinical site to which I am assigned. I acknowledge that medical records, accounting information, patient information, and conversations between or among healthcare professionals about patients are confidential under law and this agreement.

I understand that, while in the clinical setting, I may not disclose any information about a patient during the clinical portion of my clinical assignment to anyone other than the medical and nursing staff of the clinical site.

I understand that I may not remove any record from the clinical site without the written authorization of the site. Additionally, I understand that, before I use or disclose patient information in a learning experience, classroom, case presentation, class assignment, or research, I must attempt to exclude as much of the following information as possible:

<ul style="list-style-type: none"><li>• Names</li><li>• Geographical subdivisions smaller than a state</li><li>• Dates of birth, admission, discharge, and death</li><li>• Telephone numbers</li><li>• Fax numbers</li><li>• E-mail addresses</li><li>• Social Security numbers</li><li>• Medical Record numbers</li><li>• Health plan beneficiary numbers</li><li>• Account numbers</li></ul>	<ul style="list-style-type: none"><li>• Certificate/license numbers</li><li>• Vehicle identifiers</li><li>• Device identifiers</li><li>• Web locators (URLs)</li><li>• Internet protocol addresses</li><li>• Biometric identifiers</li><li>• Full face photographs</li><li>• Any other unique identifying number, characteristic, or code</li><li>• All ages over 89 years</li></ul>
--	--

Additionally, I acknowledge that any patient information, whether or not it excludes some or all of those identifiers, may only be used or disclosed for health care training and educational purposes, and must otherwise remain confidential.

I understand that I must promptly report any violation of the clinical site's privacy policies and procedures, applicable by law, or this confidentiality agreement, by me, or a student or faculty member to the appropriate clinical coordinator or program director.

Finally, I understand that, if I violate the privacy policies and procedures of the clinical site, applicable law, or this agreement, I will be subject to disciplinary action.

By signing this agreement, I certify that I have read and understand its terms and will comply with them.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**FACULTY/STAFF/STUDENT CONFIDENTIALITY AGREEMENT FOR CLINICAL TRAINING  
NWHSU Copy – sign and return to Clinical Coordinator**

Name (Print): \_\_\_\_\_

Check One:

- Student
- Staff
- Faculty

The discussions, uses, and disclosures addressed by this agreement apply to any written, verbal, or electronic communications.

I understand that I am never to discuss or review any information regarding a patient at a clinical site unless the discussion or review is part of my assignment to the site. I understand that I am obligated to know and adhere to the privacy policies and procedures of the clinical site to which I am assigned. I acknowledge that medical records, accounting information, patient information, and conversations between or among healthcare professionals about patients are confidential under law and this agreement.

I understand that, while in the clinical setting, I may not disclose any information about a patient during the clinical portion of my clinical assignment to anyone other than the medical and nursing staff of the clinical site.

I understand that I may not remove any record from the clinical site without the written authorization of the site. Additionally, I understand that, before I use or disclose patient information in a learning experience, classroom, case presentation, class assignment, or research, I must attempt to exclude as much of the following information as possible:

<ul style="list-style-type: none"> <li>• Names</li> <li>• Geographical subdivisions smaller than a state</li> <li>• Dates of birth, admission, discharge, and death</li> <li>• Telephone numbers</li> <li>• Fax numbers</li> <li>• E-mail addresses</li> <li>• Social Security numbers</li> <li>• Medical Record numbers</li> <li>• Health plan beneficiary numbers</li> <li>• Account numbers</li> </ul>	<ul style="list-style-type: none"> <li>• Certificate/license numbers</li> <li>• Vehicle identifiers</li> <li>• Device identifiers</li> <li>• Web locators (URLs)</li> <li>• Internet protocol addresses</li> <li>• Biometric identifiers</li> <li>• Full face photographs</li> <li>• Any other unique identifying number, characteristic, or code</li> <li>• All ages over 89 years</li> </ul>
---	--

Additionally, I acknowledge that any patient information, whether or not it excludes some or all of those identifiers, may only be used or disclosed for health care training and educational purposes, and must otherwise remain confidential.

I understand that I must promptly report any violation of the clinical site’s privacy policies and procedures, applicable by law, or this confidentiality agreement, by me, or a student or faculty member to the appropriate clinical coordinator or program director.

Finally, I understand that, if I violate the privacy policies and procedures of the clinical site, applicable law, or this agreement, I will be subject to disciplinary action.

By signing this agreement, I certify that I have read and understand its terms and will comply with them.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Handbook Signature**

**Student Copy**

I, \_\_\_\_\_, (student's name), am in possession of the Clinical Training handbook for the Medical Assisting program. I have reviewed the handbook with a representative of the Medical Assisting staff.

I agree to abide by the information supplied in this handbook. I am aware and will abide by the consequences if policies are not followed.

I understand that all Clinical Training hours are unpaid.

Student's Signature \_\_\_\_\_

Date \_\_\_\_\_

MA Program Representative Signature \_\_\_\_\_

**Handbook Signature**

**NWHSU Copy – sign and return to Clinical Coordinator**

I, \_\_\_\_\_, (student's name), am in possession of the Clinical Training handbook for the Medical Assisting program. I have reviewed the handbook with a representative of the Medical Assisting staff.

I agree to abide by the information supplied in this handbook. I am aware and will abide by the consequences if policies are not followed.

I understand that all Clinical Training hours are unpaid.

Student's Signature \_\_\_\_\_

Date \_\_\_\_\_

MA Program Representative Signature \_\_\_\_\_