Clinical Education Records

Students are required to keep complete and accurate records on all activities for each clinical day. The records will be monitored by the program faculty during each semester and will be reviewed for accuracy and completeness. The clinical records will be evaluated each semester and will compose a percentage of the student's final clinical education grade in the clinical record category.

Clinical Education Records

10% Clinical Education I
05% Clinical Education II-V

The following information will be required and evaluated at the end of each term:

1. Any information which will enhance the student's clinical education.
2. All patients' measurements (cm).
3. Students will be required to formulate a detailed radiographic technique chart assigned by Clinical Coordinator for each room in which he/she has rotated.
4. Listing of all clinical competencies performed. Student must include date, room, evaluator, procedure, notes, and grade.
5. Information concerning procedures which may be valuable and may be used as a resource in the future.
6. Accurate listing of patient information concerning procedures observed, assisted, and/or individually performed.
7. Any information concerning disease processes, history, diagnosis, and prognosis.

The clinical records database is housed with the Clinical Coordinator at the end of the graduating student's last tour of the clinical practice. It will serve as a permanent and official record of the student's exposure to clinic and practice experience during two years in the Program. The clinical database is a valuable component in the Radiologic Technology Program.