STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

Board of Vocational Nursing and Psychiatric Technicians
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Phone 916-263-7800 Fax 916-263-7866 Web www.bvnpt.ca.gov

CLINICAL FACILITY APPROVAL APPLICATION

INSTRUCTIONS: Please complete both front and back of this form to demonstrate compliance with Title 16, California Code of Regulations (CCR) §§ 2534 and 2584. Submit separate forms for multiple campuses or if use of the facility is proposed for both Vocational Nurse (VN) and Psychiatric Technician (PT) programs. **ALL REQUESTED INFORMATION IS MANDATORY. FAILURE TO PROVIDE ALL INFORMATION WILL RESULT IN THE APPLICATION BEING REJECTED AS INCOMPLETE**.

FOR BOARD USE ONLY

Approved By:

Date Approved:

PRINT LEGIBLY IN INK

SCHOOL NAME AND CAMPUS: _____ *VN* ☐ **PT** ☐

1. NAME OF CLINICAL FACILITY: _____

ADDRESS: _____

CITY: _____ **STATE:** ☐ **ZIP:** ☐☐☐☐☐

TELEPHONE #: ( ) _____ **FAX #:** ( ) _____

2. NAME OF FACILITY ADMINISTRATOR:	**3. NAME OF FACILITY DIRECTOR:**
4. CONTACT PERSON: _____ **TELEPHONE #: ( )**_____ **EMAIL:** _____	
5. TYPE OF FACILITY:	**6. LICENSE STATUS (Check One):** ☐ **Licensed** ☐ **Certified** ☐ **Other**
7. CLIENT POPULATION: *Check All That Apply* ☐ **Adults** ☐ **Peds** ☐ **Geriatrics** ☐ **Other**	**8. AVERAGE DAILY CENSUS FOR FACILITY:**

9. FACILITY DIRECTOR: PLEASE INDICATE THE UNITS/SERVICES (OB, MED/SURG, PEDS, ETC.) AVAILABLE FOR STUDENT ASSIGNMENT FROM THIS PROGRAM, THE AVERAGE DAILY CENSUS FOR EACH AND THE MAXIMUM NUMBER OF STUDENTS FROM THIS PROGRAM THAT EACH UNIT CAN ACCOMMODATE.

UNITS/SERVICES					
Average Daily Census for Unit/Services					
# Students Possible Per Unit/Services					

10. FACILITY DIRECTOR: PLEASE ANSWER THE FOLLOWING QUESTIONS.

A. Were the student's clinical objectives given to you for review?	☐ **Yes**	☐ **No**
B. Are the students' clinical objectives achievable in your facility?	☐ **Yes**	☐ **No**
C. Does your facility limit the ratio of instructors to sudents? # ____ instructors to # ____ students.	☐ **Yes**	☐ **No**
D. Will the instructor(s) have an orientation to your facility?	☐ **Yes**	☐ **No**
E. Are students' required to complete a special facility orientation?	☐ **Yes**	☐ **No**
F. Is the instructor free to make assignments which correlate with current theory classes, including administration of medications, treatments, use of equipment and charting?	☐ **Yes**	☐ **No**
G. Is the instructor free to move students to areas where immediate, pertinent learning is available, even with short notice?	☐ **Yes**	☐ **No**
H. Is adequate space available for classes and conferences?	☐ **Yes**	☐ **No**
I. Is this space available for uninterrupted use by students and faculty? If not, what other arrangements have been made?	☐ **Yes**	☐ **No**

See page 2 for Facility Signature. *OVER*

11. THE FOLLOWING INFORMATION MUST BE COMPLETED FOR EACH STUDENT LEVEL. IF THE CLINICAL EXPERIENCE WILL BE ACHIEVED AT A SATELLITE SITE, CHECK THIS BOX. ☐

HOW MANY WEEKS WILL <u>EACH</u> STUDENT SPEND AT THIS FACILITY? (i.e. # weeks/student at facility) _____

A. Level of Student				
B. Starting Calendar Date				
C. Unit / Services				
D. Number of Students				
E. Days of Week				
F. Start & End Times of Day				
G. Total Hours Per Week *				
H. Pre-Conference Days & Times				
I. Post-Conference Days & Times				
J. Instructor on Site *(List Days & Times)*				

***# Days Per Week** *times* **# Hours Per Day** *must equal* **Total Hours per Week**

12. Copies of the following documents must be attached.

☐ **CLINICAL OBJECTIVES FOR EACH STUDENT LEVEL <u>TO BE ACHIEVED AT THIS FACILITY</u>**

☐ **PLAN FOR FACULTY ORIENTATION TO FACILITY**

13. PROGRAM DIRECTOR: PLEASE ANSWER THE FOLLOWING QUESTIONS.

Did you discuss with the facility:

A. Course description and student clinical objectives? ☐ **Yes** ☐ **No**

B. Specific nursing care and procedures required for student achievement of clinical objectives? ☐ **Yes** ☐ **No**

C. The facility's policies and procedures regarding student placement? ☐ **Yes** ☐ **No**

D. The facility's documentation and charting methodologies? ☐ **Yes** ☐ **No**

E. Location of facility emergency and non-emergency equipment? ☐ **Yes** ☐ **No**

F. Facility emergency and non-emergency procedures? ☐ **Yes** ☐ **No**

G. Scheduling of facilty conference rooms? ☐ **Yes** ☐ **No**

14. ***THIS SIGNATURE CONFIRMS THAT I HAVE REVIEWED AND AGREE WITH THE CONTENTS OF THIS FORM AND ALL ATTACHMENTS.***

FACILITY Director's Signature: _____ Date: _____

FACILITY Director's Printed Name: _____ Date: _____

15. ***I HEREBY CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE AND CORRECT.***

PROGRAM Director's Signature: _____ Date: _____

PROGRAM Director's Printed Name: _____ Date: _____

FOR BOARD USE ONLY

NAME OF FACILITY REPRESENTATIVE SPOKEN WITH: _____ ☐ **Approved** ☐ **Denied**

COMMENTS:

BOARD CONSULTANT'S SIGNATURE: