UNION CENTER FIRE CO., INC.

Division of Emergency Medical Services

P.O. Box 8800

Endwell, NY 13762-8800

(607) 748-1321

CREW CHIEF CANDIDATE EVALUATION

CANDIDATE'S NAME:_____

CALL DATE:_____ CALL #:_____ CALL LOCATION:_____

NATURE OF CALL:_____ EVALUATOR'S NAME:_____

Under the direct supervision of the evaluator, the Basic EMT Crew Chief candidate will observe, participate and demonstrate the following skills. Please rate the candidate in each category listed, on the scale provided: 1 being poor, and 5 being outstanding. N indicates that the category is not applicable to the experience being evaluated. In the Comment section, please elaborate on both strong and weak performance areas, and include specific suggestions for continued development and improvement.

OBJECTIVE	RATING	COMMENTS
PREPARATION		
Participate in vehicle/rig check	1 2 3 4 5 N	
Receipt of dispatch information	1 2 3 4 5 N	
Pre-arrival plan/preparation	1 2 3 4 5 N	
Scene size-up/management	1 2 3 4 5 N	
Initial patient assessment	1 2 3 4 5 N	
PATIENT CONTACT		
Chief complaint	1 2 3 4 5 N	
History of present illness/injury	1 2 3 4 5 N	
Past medical history	1 2 3 4 5 N	
Medications	1 2 3 4 5 N	
Allergies	1 2 3 4 5 N	
Focused history and detail physical exam	1 2 3 4 5 N	
Ongoing / repeated assessment	1 2 3 4 5 N	
VITAL SIGNS		
Level of consciousness (AVPU)	1 2 3 4 5 N	
Pulse rate & quality	1 2 3 4 5 N	
Respiratory rate & quality	1 2 3 4 5 N	
Blood pressure by auscultation/palpation	1 2 3 4 5 N	
AIRWAY/BREATHING MANAGEMENT		
Oral suctioning	1 2 3 4 5 N	
Oral/nasal airway insertion	1 2 3 4 5 N	
Oxygen therapy (nonrebreather mask or cannula	1 2 3 4 5 N	
Ventilatory assistance (BVM)	1 2 3 4 5 N	
Assessment of breath sounds	1 2 3 4 5 N	
CIRCULATORY MANAGEMENT		
Chest compressions during CPR	1 2 3 4 5 N	
Application/operation of AED	1 2 3 4 5 N	

OBJECTIVE	RATING	COMMENTS
Bleeding control measures	1 2 3 4 5 N	
Bandaging	1 2 3 4 5 N	
MAST application	1 2 3 4 5 N	
SPLINTING – TRACTION/FIXED (Check as Appropriate)	❑ Med Team Initiated ❑ Assisted Ambulance Crew	
Assessment of painful, swollen deformed extremity	1 2 3 4 5 N	
Selection of appropriate device	1 2 3 4 5 N	
Application of device	1 2 3 4 5 N	
SPINAL IMMOBILIZATION (Check as Appropriate)	❑ Med Team Initiated ❑ Assisted Ambulance Crew	
KED (or similar) application	1 2 3 4 5 N	
Shortboard application	1 2 3 4 5 N	
Use of longboard (logroll or straddle-lift)	1 2 3 4 5 N	
Standing Takedowns	1 2 3 4 5 N	
ASSESSMENT OF MEDICAL PATIENTS		
Initial assessment	1 2 3 4 5 N	
Focused history and detailed physical exam	1 2 3 4 5 N	
Ongoing assessment	1 2 3 4 5 N	
Appropriate treatment	1 2 3 4 5 N	
Administering/Assisting patient with medications	1 2 3 4 5 N	
Oral medication (identify)_____	1 2 3 4 5 N	
Inhaled Medication (identify)_____	1 2 3 4 5 N	
Injected Medication (EpiPen)	1 2 3 4 5 N	
Sublingual Medication (Nitroglycerine)	1 2 3 4 5 N	
LIFTS, MOVES AND CARRIES (Check as Appropriate)	❑ Med Team Initiated ❑ Assisted Ambulance Crew	
Emergency/non-urgent moves	1 2 3 4 5 N	
Patient transfer	1 2 3 4 5 N	
Wheeled stretcher	1 2 3 4 5 N	
Reeves stretcher	1 2 3 4 5 N	
Stair chair	1 2 3 4 5 N	
OTHER		
Participates in run review	1 2 3 4 5 N	
Assists with cleaning/restocking vehicle & equipt.	1 2 3 4 5 N	
Prepares for next run	1 2 3 4 5 N	
OBSERVATION ONLY		
Documentation/communications with hospital	1 2 3 4 5 N	
Any and all invasive and/or advanced skills	1 2 3 4 5 N	

Additional Comments by Preceptors: _____

_____

SIGNATURE OF PRECEPTOR:_____ DATE:_____

Comments from candidate: _____

_____

SIGNATURE OF CANDIDATE:_____ DATE:_____