

Student _____

Facility _____

**Iowa Western Community College
Medication Courses
Clinical Evaluator Agreement**

I, _____, agree to supervise and evaluate the clinical experience in cooperation with Iowa Western Community College (IWCC) at _____ for the _____ course.

While functioning as clinical evaluator for this clinical experience, I agree:

1. Our employee is of good standing and has been employed at our facility or agency for a minimum of six months or longer. Start date: _____.
2. IF sponsoring agency is considered a long-term care facility, our candidate is on the Direct Care Worker's Registry. Yes or NO
3. To supervise and evaluate clinical in accordance with the curriculum developed by the Department of Education in cooperation with the area schools and approved by the appropriate state agency, i.e., the Iowa Department of Health, Iowa Board of Pharmacy, Iowa Department of Social Services.
4. To act in accordance with IWCC in meeting the requirements and objectives of this course as approved by the appropriate state agency.
5. To accurately and completely evaluate each student according to the clinical checklists during the clinical experience and submit the completed instructor evaluations to the Long-Term Care Coordinator or designated IWCC personnel.
6. To direct my complete attention to the clinical experience during actual clinical time.

I understand that IWCC's role may include:

1. Providing guidance and support when requested or deemed necessary.
2. Supplying the course manual and clinical checklists as needed for a fee.
3. Providing certificates of completion for students successfully completing both the classroom and clinical experience.

I will accept the above conditions:

RN Evaluator's Signature	Date	RN License #
<i>Rhonda Casson</i>		
IWCC Representative	Date	

I will support the above evaluator in meeting the conditions outlined in this agreement and agree to provide administrative assistance in implementing this clinical experience at our facility.

Administrator's Signature	Date
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