This form should be completed by the Ultrasound Department Manager.

student's name . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

MANAGER’S name . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

name and address of hospital (including site of ultrasound units)

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

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Telephone number AND email address OF CLINICAL SUPERVISOR

. . . . .. . . . . . . . . . .. . . . . . . . . . .. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

NAME OF person responsible for ultrasound service

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

name of clinical supervisor

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

QUALIFICATIONS OF CLINICAL SUPERVISOR including dates

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ULTRASOUND EXPERIENCE OF CLINICAL SUPERVISOR

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| POSITION | HOSPITAL | TYPE OF EXPERIENCE | FROM | UNTIL |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

details of time allocated by clinical supervisor for students' clinical education (ie frequency, length of sessions and when they will take place).

Please note that your department be need to be able to provide the student with a minimum of 15 hours a week supervised “hands on” clinical based training as required by UWE Bristol ultrasound professional practice module.

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

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name and qualifications of other supervising sonographers/ SONOLOGISTS

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

details of clinical EXPERIENCE AVAILABLE TO THE STUDENT

(Please tick box)

**OBSTETRIC ULTRASOUND**

FETAL BIOMETRY  PLACENTOGRAPHY 

ANOMALY SCREENING  POST PARTUM 

EARLY PREGNANCY  TRANSVAGINAL ULTRASOUND 

GROWTH EXAMINATION  DOPPLER ULTRASOUND 

BIOPHYSICAL PROFILE  AMNIOCENTESIS / CVS 

**GYNAECOLOGY**

TRANSABDOMINAL ULTRASOUND  DOPPLER ULTRASOUND 

TRANSVAGINAL ULTRASOUND  INFERTILITY STUDIES 

EARLY PREGNANCY  HYSTEROCONTRAST SONOGRAPHY 

**ABDOMINAL AND GENERAL**

ABDOMEN AND PELVIS  BREAST 

DOPPLER ULTRASOUND  NEONATAL HEAD 

THYROID AND PARATHYROIDS  MUSCULO-SKELETAL 

TESTES  INTERVENTIONAL TECHNIQUES 

**VASCULAR ULTRASOUND**

ABDOMEN AND AORTACAROTID 

LOWER LIMB DVT  LOWER LIMB VENOUS INSUFFICIENCY 

LOWER LIMB ARTERIAL  UPPER LIMB 

VENOUS ACCESS/HAEMODYALISIS  GRAFT SURVEILLANCE 

INTRACRANIAL DOPPLER  RENAL/LIVER TRANSPLANTATION 

I declare that . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . will be given the opportunity to train in the above department for a minimum of **two days per week**, while s/he is studying for her/his postgraduate medical ultrasound qualification.

During this time, s/he will gain “hands on” ultrasound experience and receive appropriate tuition and supervision from experienced sonographers.

SIGNATURE . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . DATE . . . . . . . . . . . . . . . . .

**If there are different managers for different** **departments, then a separate declaration should be signed for each department.**