Clerk Name: _____
Hospital Location:_____
Date of Rotation: _____

CERVICAL CHECKLIST

DATE	CERVICAL CHECK CORRECT	SIGNATURE
	YES / NO	
	YES / NO	
	YES / NO	
	YES / NO	
	YES / NO	
	YES / NO	
	YES / NO	
	YES / NO	
	YES / NO	
	YES / NO	
	YES / NO	
	YES / NO	
	YES / NO	
	YES / NO	
	YES / NO	
	YES / NO	
	YES / NO	
	YES / NO	
	YES / NO	
	YES / NO	

Please note: Each Clerk is required to successfully complete 10 cervical checks.