

CLINICAL SITE INFORMATION FORM (CSIF)

developed by

APTA Department of Physical Therapy Education

Why have a consistent Clinical Site Information Form?

The primary purpose of this form is for Physical Therapist (PT) and Physical Therapist Assistant (PTA) academic programs to collect information from clinical education sites. This information will facilitate clinical site selection, student placements, assessment of learning experiences and clinical practice opportunities available to students; and provide assistance with completion of documentation for accreditation in clinical education.

How is the form designed?

The form is divided into two sections, [Information for Academic Programs - Part I](#) (pages 3-14) and [Information for Students - Part II](#) (pages 15-17), to allow ease in retrieval of information for academic programs and for students, especially if the academic program is using a database to manage the information. Duplication of information being requested is kept to a minimum except when separation of Part I and Part II of the form would omit critical information needed by both students and the academic program. The form is also designed using a check-off format wherever possible to reduce the amount of time required for completion. This instrument can be retrieved from APTA's website at www.apta.org. Simply select the link titled "PT Education", then the link titled "Clinical Education" and choose "Clinical Site Information Form".

Although using a computer to complete the form is not mandatory, it is highly recommended to facilitate legible updates with minimal time investment from your facility. Additionally, the information provided will be more legible to students, academic programs, and the APTA's Department of Physical Therapy Education. The form includes several features designed to streamline navigation, including a hyperlinked [index](#) on page 18. (Please note that several of the hyperlinks contained in the document require your computer to have an open internet connection and a web browser).

If you prefer to complete the form manually, you may download the CSIF from APTA's website (see above). If you do not have access to a computer for this purpose, hard copies of the CSIF are available from the APTA Department of Physical Therapy Education, as well as from all PT and PTA academic programs through their Academic Coordinator of Clinical Education (ACCE).

What should I do once the form has been completed?

We encourage you to invest the time to complete the form thoroughly and accurately. Once the form has been completed, the clinical education site may e-mail the instrument to each academic program with which it affiliates, minimizing administrative time and associated costs. **Please remember to make a copy of this form and retain for your records!** To assist in maintaining accurate and relevant information about your physical therapy service for academic programs and students, we encourage you to update this form on an annual basis.

In addition, to develop and maintain an accurate and comprehensive national database of clinical education sites, we request that a copy of the completed form be e-mailed to the Department of Physical Therapy Education at csif@apta.org or mail to:



American Physical Therapy Association
Department of Physical Therapy Education
1111 North Fairfax Street
Alexandria, Virginia 22314

DIRECTIONS FOR COMPLETION:

If using a computer to complete this form:

When completing this form, after opening the original form, and before entering your facility's information, **save the form**. The title should be your zip code, your site's name, and the date (eg, 90210BevHillsRehab10-26-99. Please note that the date must be set apart with dashes; if slashes are used, the computer will unsuccessfully search for a directory and return an error message). Saving the document will preserve the original copy on the disk or hard drive, allowing for you to easily update your information. When completing, use the tab key or arrow keys to move to the desired blank space (the form is comprised of a series of tables to enable use of the tab key for easier data entry). Enter relevant information only in blank spaces as appropriate to your clinical site.

What should I do if my physical therapy service is associated with multiple satellite sites that also provide clinical learning experiences?

If your physical therapy service is associated with multiple satellite sites (for example, corporate hospital mergers) that offer clinical learning experiences, such as an acute care hospital that also provides clinical rotations at associated sports medicine and long-term care facilities, you will need to complete *pages 3 and 4*. On *page 3*, provide the primary clinical site for the clinical experience. On *page 4*, indicate other clinical sites or satellites associated with the primary clinical site. *Please note that if the individual facility information varies with each satellite site that offers a clinical experience, it will be necessary to duplicate a blank CSIF and complete the form for each satellite site that offers different clinical learning experiences.*

What should I do if specific items are not applicable to my clinical site or I need to further clarify a response?

If specific items on the form do not apply to your clinical education site at the time you are completing the form, please leave the item blank. Opportunities to provide comments have been made available throughout the form.

CLINICAL SITE INFORMATION FORM

I. Information About the Clinical Site

Date (08/24/09)

Person Completing Questionnaire		Christopher M. Kaczmarek, PT, DPT, OCS, CSCS			
E-mail address of person completing questionnaire		ckaczmarek@kort.com			
Name of Clinical Center	KORT-Bryan Station Physical Therapy				
Street Address	1650 Bryan Station Road, Suite 110				
City	Lexington	State	KY	Zip	40505
Facility Phone	859-293-6133		Ext.		
PT Department Phone	859-293-6133		Ext.		
PT Department Fax	859-293-6730				
PT Department E-mail					
Web Address	www.kort.com				
Director of Physical Therapy		Christopher M. Kaczmarek, PT, DPT, OCS, CSCS			
Director of Physical Therapy E-mail			ckaczmarek@kort.com		
Center Coordinator of Clinical Education (CCCE) / Contact Person			Christopher M. Kaczmarek, PT, DPT, OCS, CSCS		
CCCE / Contact Person Phone			859-293-6133		
CCCE / Contact Person E-mail			ckaczmarek@kort.com		

Complete the following table(s) if there are multiple sites that are part of the same health care system or practice. Copy this table before entering information if you need more space.

Name of Clinical Site	KORT – Georgetown Physical Therapy				
Street Address	101 Eastside Drive, Suite A				
City	Georgetown	State	KY	Zip	40324
Facility Phone	502-867-0111		Ext.		
PT Department Phone	502-867-0111		Ext.		
Fax Number	502-867-0041	Facility E-mail			
Director of Physical Therapy	Chad Thompson, PT, MSPT		E-mail	cthompson@selectmedicalcorp.com	
Center Coordinator of Clinical Education/contact (CCCE)	Chad Thompson, PT, MSPT		E-mail	cthompson@selectmedicalcorp.com	

Name of Clinical Site	KORT – Nicholasville Physical Therapy				
Street Address	102 Williams Road				
City	Nicholasville	State	KY	Zip	40356
Facility Phone	859-881-0333		Ext.		
PT Department Phone	859-881-0333		Ext.		
Fax Number	859-881-9583	Facility E-mail			
Director of Physical Therapy	Matt Lee, PT , MSPT		E-mail	mlee@selectmedicalcorp.com	
Center Coordinator of Clinical Education/contact (CCCE)	Matt Lee, PT , MSPT		E-mail	mlee@selectmedicalcorp.com	

Name of Clinical Site	KORT Tates Creek Physical Therapy				
Street Address	4101 Tates Creek Centre Drive, Suite 158				
City	Lexington	State	KY	Zip	40517
Facility Phone	859-271-2887		Ext.		
PT Department Phone	859-271-2887		Ext.		
Fax Number	859-271-2889	Facility E-mail			
Director of Physical Therapy	Matt Hall, PT, MSPT		E-mail	mhall@selectmedicalcorp.com	
Center Coordinator of Clinical Education/contact (CCCE)	Matt Hall, PT, MSPT		E-mail	mhall@selectmedicalcorp.com	

Clinical Site Accreditation/Ownership

Yes	No		Date of Last Accreditation/Certification
x		1. Is your clinical site certified/ accredited? If no, go to #3.	
		2. If yes, by whom?	
		JCAHO	
		CARF	
x		Government Agency (eg, CORF, PTIP, rehab agency, state, etc.)	
		Other	
		3. Who or what type of entity owns your clinical site? <input type="checkbox"/> PT owned <input type="checkbox"/> Hospital Owned <input checked="" type="checkbox"/> General business / corporation <input type="checkbox"/> Other (please specify) _____	

4. Place the **number 1** next to your clinical site’s primary classification -- noted in **bold type**. Next, if appropriate, mark (X) **up to four additional bold typed categories** that describe other clinical centers associated with your primary classification. Beneath each of the **five possible bold typed categories**, mark (X) the specific learning experiences/settings that best describe that facility.

	Acute Care/Hospital Facility	X	Functional Capacity Exam- FCE		spinal cord injury
	university teaching hospital	X	industrial rehab		traumatic brain injury
	pediatric		other (please specify)		other
	cardiopulmonary		Federal/State/County Health		School/Preschool Program
	orthopedic		Veteran’s Administration		school system
	other		pediatric develop. ctr.		preschool program
	Ambulatory Care/Outpatient		adult develop. ctr.		early intervention
	geriatric		other		other
	hospital satellite		Home Health Care		Wellness/Prevention Program
	medicine for the arts		agency		on-site fitness center
1	orthopedic		contract service		other
	pain center		hospital based		Other
	pediatric		other		international clinical site
	podiatric		Rehab/Subacute Rehab		administration
x	sports PT		inpatient		research
	other		outpatient		other
	ECF/Nursing Home/SNF		pediatric		
	Ergonomics		adult		
X	work hardening/conditioning		geriatric		

4a. Which of these best characterizes your clinic’s location? Indicate with an ‘X’.

rural		suburban		urban	X
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5. If your clinical site provides inpatient care, what are the number of:

	Acute beds
	ECF beds
	Long term beds
	Psych beds
	Rehab beds
	Step down beds
	Subacute/transitional care unit
	Other beds (please specify):
	Total Number of Beds

II. Information about the Provider of Physical Therapy Service at the Primary Center

6. PT Service hours

Days of the Week	From: (a.m.)	To: (p.m.)	Comments
Monday	7am	7pm	
Tuesday	8am	7pm	
Wednesday	7am	7pm	
Thursday	8am	7pm	
Friday	7am	4:30 pm	
Saturday			
Sunday			

7. Describe the staffing pattern for your facility: Standard 8 hour day Varied schedules
 (Enter additional remarks in space below, including description of weekend physical therapy staffing pattern).

8. Indicate the number of full-time and part-time budgeted and filled positions:

	Full-time budgeted	Part-time budgeted
PTs	2	
PTAs		
Aides/Techs	1	1

9. Estimate an average number of **patients per therapist treated per day** by the provider of physical therapy.

INPATIENT		OUTPATIENT	
	Individual PT	15-18	Individual PT
	Individual PTA		Individual PTA
	Total PT service per day	18-26	Total PT service per day

III. Available Learning Experiences

10. Please mark (X) the *diagnosis related* learning experiences available at your clinical site:

	Amputations		Critical care/Intensive care	x	Neurologic conditions
x	Arthritis	x	Degenerative diseases	x	Spinal cord injury
x	Athletic injuries	x	General medical conditions	x	Traumatic brain injury
	Burns		General surgery/Organ Transplant	x	Other neurologic conditions
	Cardiac conditions	x	Hand/Upper extremity		Oncologic conditions
x	Cerebral vascular accident	x	Industrial injuries	x	Orthopedic/Musculoskeletal
x	Chronic pain/Pain		ICU (Intensive Care Unit)		Pulmonary conditions
x	Connective tissue diseases		Mental retardation		Wound Care
	Congenital/Developmental				Other (specify below)

11. Please mark (X) all *special programs/activities/learning opportunities* available to students during clinical experiences, or as part of an independent study.

	Administration	x	Industrial/Ergonomic PT	x	Prevention/Wellness
	Aquatic therapy		Inservice training/Lectures		Pulmonary rehabilitation
	Back school		Neonatal care	x	Quality Assurance/CQI/TQM
	Biomechanics lab		Nursing home/ECF/SNF		Radiology
	Cardiac rehabilitation		On the field athletic injury	x	Research experience
	Community/Re-entry activities		Orthotic/Prosthetic fabrication	x	Screening/Prevention
	Critical care/Intensive care	x	Pain management program	x	Sports physical therapy
	Departmental administration		Pediatric-General (emphasis on):	x	Surgery (observation)
	Early intervention		Classroom consultation		Team meetings/Rounds
	Employee intervention		Developmental program		Women's Health/OB-GYN
	Employee wellness program		Mental retardation	x	Work Hardening/Conditioning
	Group programs/Classes	x	Musculoskeletal		Wound care
	Home health program	x	Neurological		Other (specify below)

12. Please mark (X) all *Specialty Clinics* available as student learning experiences.

	Amputee clinic		Neurology clinic		Screening clinics
	Arthritis		Orthopedic clinic		Developmental
	Feeding clinic		Pain clinic		Scoliosis
	Hand clinic		Preparticipation in sports		Sports medicine clinic
	Hemophilia Clinic		Prosthetic/Orthotic clinic		Other (specify below)
	Industry		Seating/Mobility clinic		

13. Please mark (X) all *health professionals* at your clinical site with whom students might observe and/or interact.

<input checked="" type="checkbox"/>	Administrators		Health information technologists		Psychologists
	Alternative Therapies		Nurses		Respiratory therapists
	Athletic trainers		Occupational therapists		Therapeutic recreation therapists
	Audiologists		Physicians (list specialties)		Social workers
	Dietitians		Physician assistants		Special education teachers
	Enterostomal Therapist		Podiatrists		Vocational rehabilitation counselors
	Exercise physiologists		Prosthetists /Orthotists		Others (specify below)

14. List all PT and PTA education programs with which you currently affiliate.

University of Kentucky (PT)	
Jefferson Community College (PTA)	
Bellarmino University (PT)	
Shawnee State University (PTA)	

15. What criteria do you use to select clinical instructors? **(mark (X) all that apply):**

<input checked="" type="checkbox"/>	APTA Clinical Instructor Credentialing	<input checked="" type="checkbox"/>	Demonstrated strength in clinical teaching
<input checked="" type="checkbox"/>	Career ladder opportunity		No criteria
<input checked="" type="checkbox"/>	Certification/Training course	<input checked="" type="checkbox"/>	Therapist initiative/volunteer
<input checked="" type="checkbox"/>	Clinical competence	<input checked="" type="checkbox"/>	Years of experience
<input checked="" type="checkbox"/>	Delegated in job description		Other (please specify)

16. How are clinical instructors trained? **(mark (X) all that apply)**

<input checked="" type="checkbox"/>	1:1 individual training (CCCE:CI)		Continuing education by consortia
	Academic for-credit coursework		No training
<input checked="" type="checkbox"/>	APTA Clinical Instructor Credentialing	<input checked="" type="checkbox"/>	Professional continuing education (eg. chapter, CEU course)
<input checked="" type="checkbox"/>	Clinical center inservices		Other (please specify)
<input checked="" type="checkbox"/>	Continuing education by academic program		

17. On *pages 9 and 10* please provide information about individual(s) serving as the CCCE(s), and on *pages 11 and 12* please provide information about individual(s) serving as the CI(s) at your clinical site.

**ABBREVIATED RESUME FOR CENTER COORDINATORS OF CLINICAL
EDUCATION**

Please update as each new CCCE assumes this position.

NAME:	Christopher M. Kaczmarek, PT, DPT	Length of time as the CCCE:
DATE: (mm/dd/yy)	8/23/09	Length of time as the CI:8
PRESENT POSITION: Team Leader/PT (II) (Title, Name of Facility)	Mark (X) all that apply: <input checked="" type="checkbox"/> PT <input type="checkbox"/> PTA <input type="checkbox"/> Other, specify	Length of time in clinical practice: 9 years
LICENSURE: (State/Numbers)	KY PT# 003847 PA 013136L	Credentialed Clinical Instructor: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Eligible for Licensure: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Certified Clinical Specialist: Y
		Area of Clinical Specialization:OCS
		Other credentials:CSCS

SUMMARY OF COLLEGE AND UNIVERSITY EDUCATION (start with most current):

INSTITUTION	PERIOD OF STUDY		MAJOR	DEGREE
	FROM	TO		
Regis University	2006	2008	Physical Therapy	tDPT
Thomas Jefferson University	9/96	10/99	Physical Therapy	MSPT
California Univ of PA	9/93	5/96	Biology	-----

SUMMARY OF PRIMARY EMPLOYMENT (For current and previous four positions since graduation from college; start with most current):

EMPLOYER	POSITION	PERIOD OF EMPLOYMENT	
		FROM	TO
Kentucky Orthopedic Rehab Team (KORT); Bryan Station	Team Leader, PT Regional Director	06/01/04	Present
Body Structure Clinic	Staff PT	11/03	5/04
Lexington Back and Neck Clinic	Staff Physical Therapist	8/03	11/03
Richmond Place	Staff Physical Therapist	7/03	8/03
CMPT Associates Physical Therapy	Staff Physical Therapist	10/00	7/03

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CLINICAL INSTRUCTOR INFORMATION

Provide the following information on all PTs or PTAs employed at your clinical site **who are CIs**.

Name	School from Which CI Graduated	PT/PTA	Year of Graduation	No. of Years of Clinical Practice	No. of Years of Clinical Teaching	Credentialed CI Specialist Certification Other	L= Licensed, Number E= Eligible T= Temporary	
							L/E/T Number	State of Licensure
Christopher M. Kaczmarek, PT,DPT	Thomas Jefferson University	PT	1999	10	8	None	013136 003847	PA KY

(Continued on next page)

CLINICAL INSTRUCTOR INFORMATION (continued)

Name	School from Which CI Graduated	PT/PTA	Year of Graduation	No. of Years of Clinical Practice	No. of Years of Clinical Teaching	Credentialed CI Specialist Certification Other	L= Licensed, Number E= Eligible T= Temporary	
							L/E/T Number	State of Licensure

18. Indicate professional educational levels at which you accept PT and PTA students for clinical experiences (**mark (X) all that apply**).

Physical Therapist		Physical Therapist Assistant	
X	First experience		First experience
X	Intermediate experiences		Intermediate experiences
X	Final experience		Final experience
X	Internship		

	PT		PTA	
	From	To	From	To
19. Indicate the range of weeks you will accept students for any single full-time (36 hrs/wk) clinical experience.	4	10		
20. Indicate the range of weeks you will accept students for any one part-time (< 36 hrs/wk) clinical experience.	4	10		

	PT	PTA
21. Average number of PT and PTA students affiliating <u>per year</u> .	4	

22. What is the procedure for managing students with exceptional qualities that might affect clinical performance (eg, outstanding students, students with learning/performance deficits, learning disability, physically challenged, visually impaired)?

23. **Answer if the clinical center employs only one PT or PTA.** Explain what provisions are made for students if the clinical instructor is ill or away from the clinical site.

Ability to transfer to any of 8 other regional clinics in Central Kentucky area, with Bryan Station being 1st alternate. Also typically have coverage when out

Yes	No	
X		24. Does your clinical site provide written clinical education objectives to students? If no, go to # 27.
		25. Do these objectives accommodate:
X		the student's objectives?
		students prepared at different levels within the academic curriculum?
		academic program's objectives for specific learning experiences?
		students with disabilities? – Not at current time
		26. Are all professional staff members who provide physical therapy services acquainted with the site's learning objectives?

27. When do the CCCE and/or CI discuss the clinical site's learning objectives with students?

(mark (X) all that apply)

x	Beginning of the clinical experience	x	At mid-clinical experience
	Daily	x	At end of clinical experience
x	Weekly	x	Other – or per students wishes if daily

28. How do you provide the student with an evaluation of his/her performance? **(mark (X) all that apply)**

x	Written and oral mid-evaluation	x	Ongoing feedback throughout the clinical
x	Written and oral summative final evaluation	x	As per student request in addition to formal and ongoing written & oral feedback
x	Student self-assessment throughout the clinical		

Yes	No	
	x	29. Do you require a specific student evaluation instrument other than that of the affiliating academic program? If yes, please specify:

OPTIONAL: Please feel free to use the space provided below to share additional information about your clinical site (eg, strengths, special learning opportunities, clinical supervision, organizational structure, clinical philosophies of treatment, pacing expectations of students [early, final]).

Information for Students - Part II

I. Information About the Clinical Site

Yes	No	
x		1. Do students need to contact the clinical site for specific work hours related to the clinical experience?
x		2. Do students receive the same official holidays as staff?
	x	3. Does your clinical site require a student interview?
		4. Indicate the time the student should report to the clinical site on the first day of the experience: 7-8 am

Medical Information

Yes	No		Comments
x		5. Is a Mantoux TB test required? a) one step _____ b) two step _____	
		5a. If yes, within what time frame?	Prior to clinical assignment
	x	6. Is a Rubella Titer Test or immunization required?	
x		7. Are any other health tests/immunizations required prior to the clinical experience? a) If yes, please specify:	Hepatitis B (or signed refusal after info given)
		8. How current are student physical exam records required to be?	Prior to clinical assignment
	x	9. Are any other health tests or immunizations required on-site? a) If yes, please specify:	
	x	10. Is the student required to provide proof of OSHA training?	
x		11. Is the student required to attest to an understanding of the benefits and risks of Hepatitis-B immunization?	
x		12. Is the student required to have proof of health insurance?	
x		a) Can proof be on file with the academic program or health center?	
x		13. Is emergency health care available for students?	
x		a) Is the student responsible for emergency health care costs?	
x		14. Is other non-emergency medical care available to students?	
x		15. Is the student required to be CPR certified? (Please note if a specific course is required).	
	x	a) Can the student receive CPR certification while on-site?	
	x	16. Is the student required to be certified in First Aid?	
	x	a) Can the student receive First Aid certification on-site?	

Yes	No		Comments
x		17. Is a criminal background check required (eg, Criminal Offender Record Information)?	
x		a) Is the student responsible for this cost?	
	x	18. Is the student required to submit to a drug test?	
	x	19. Is medical testing available on-site for students?	

Housing

Yes	No		Comments
	x	20. Is housing provided for male students?	
	x	for female students? (If no, go to #26)	
\$		21. What is the average cost of housing?	
		22. If housing is not provided for either gender:	
		a) Is there a contact person for information on housing in the area of the clinic? (Please list contact person and phone #).	
		b) Is there a list available concerning housing in the area of the clinic? If yes, please attach to the end of this form.	
		23. Description of the type of housing provided:	
		24. How far is the housing from the facility?	
		25. Person to contact to obtain/confirm housing:	
		Name:	
		Address:	
		City: State: Zip:	

Transportation

Yes	No		Comments
x		26. Will a student need a car to complete the clinical experience?	
x		27. Is parking available at the clinical center?	
\$		a) What is the cost?	none
x		28. Is public transportation available?	
		29. How close is the nearest bus stop (in miles) to your site?	1
		a) train station?	
		b) subway station?	
		30. Briefly describe the area, population density, and any safety issues regarding where the clinical center is located.	Safe, secure shopping area
		31. Please enclose printed directions and/or a map to your facility. Travel directions can be obtained from several travel directories on the internet. (eg, Delorme, Microsoft, Yahoo).	

Meals

Yes	No		Comments
	x	32. Are meals available for students on-site? (If no, go to #33)	
		Breakfast (if yes, indicate approximate cost)	\$ _____
		Lunch (if yes, indicate approximate cost)	\$ _____
		Dinner (if yes, indicate approximate cost)	\$ _____
x		a) Are facilities available for the storage and preparation of food?	

Stipend/Scholarship

Yes	No		Comments
	x	33. Is a stipend/salary provided for students? If no, go to #36	
\$		a) How much is the stipend/salary? (\$ / week)	
		34. Is this stipend/salary in lieu of meals or housing?	
		35. What is the minimum length of time the student needs to be on the clinical experience to be eligible for a stipend/salary?	

Special Information

Yes	No		Comments
x		36. Is there a student dress code? If no, go to # 37.	
		a) Specify dress code for men:	Casual Business Attire
		b) Specify dress code for women:	Casual Business Attire
x		37. Do you require a case study or inservice from all students?	
x		38. Does your site have a written policy for missed days due to illness, emergency situations, other?	

Other Student Information

Yes	No			Comments
x		39. Do you provide the student with an on-site orientation to your clinical site?		
(mark X)		a) What does the orientation include? (mark (X) all that apply)		
x	Documentation/billing	x	Required assignments (eg, case study, diary/log, inservice)	
x	Learning style inventory	x	Review of goals/objectives of clinical experience	
x	Patient information/assignments	x	Student expectations	
x	Policies and procedures	x	Supplemental readings	
x	Quality assurance	x	Tour of facility/department	
x	Reimbursement issues		Other (specify below)	

In appreciation...

Many thanks for your time and cooperation in completing the CSIF and continuing to serve the physical therapy profession as clinical teachers and role models. Your contributions to students' professional growth and development ensure that patients today and tomorrow receive high-quality patient care services.

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