

CLINICAL SITE INFORMATION FORM (CSIF)

APTA Department of Physical Therapy Education

Revised January 2006

INTRODUCTION:

The primary purpose of the Clinical Site Information Form (CSIF) is for Physical Therapist (PT) and Physical Therapist Assistant (PTA) academic programs to collect information from clinical education sites to:

- Facilitate clinical site selection,
- Assist in student placements,
- Assess the learning experiences and clinical practice opportunities available to students; and
- Provide assistance with completion of documentation required for accreditation.

The CSIF is divided into two sections:

- Part I: Information for Academic Programs (pages 4-16)
 - Information About the Clinical Site (pages 4-6)
 - Information About the Clinical Teaching Faculty (pages 7-10)
 - Information About the Physical Therapy Service (pages 10-12)
 - Information About the Clinical Education Experience (pages 13-16)
- Part II: Information for Students (pages 17-20)

Duplication of requested information is kept to a minimum except when separation of Part I and Part II of the CSIF would omit critical information needed by both students and the academic program. The CSIF is also designed using a check-off format wherever possible to reduce the amount of time required for completion.



American Physical Therapy Association

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

DIRECTIONS FOR COMPLETION:

To complete the CSIF go to APTA's website at under “**Education Programs,**” click on “Clinical” and choose “Clinical Site Information Form.” This document is available as a Word document.

1. **Save the CSIF on your computer** before entering your facility’s information. The title should be the clinical site’s zip code, clinical site’s name, and the date (e.g., 90210BevHillsRehab10-26-2005). Using this format for titling the document allows the users to quickly identify the facility and most recent version of the CSIF from a folder. Saving the document will preserve the original copy on the disk or hard drive, allowing for ease in updating the document as changes in the clinical site information occurs.
2. **Complete the CSIF thoroughly and accurately.** 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 quicker data entry. Use the Comment section to provide addition information as needed.
3. **Save the completed CSIF.**
4. **E-mail** the completed CSIF to each academic program with whom the clinic affiliates (accepts students).
5. In addition, to develop and maintain an accurate and comprehensive national database of clinical education sites, **e-mail** a copy of the completed CSIF Word document to the Department of Physical Therapy Education at kristinestoneley@apta.org.
6. **Update the CSIF on an annual basis** to assist in maintaining accurate and relevant information about your physical therapy service for academic programs, students, and the national database.

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 that offer a variety of clinical learning experiences, such as an acute care hospital that also provides clinical rotations at associated sports medicine and long-term care facilities, provide information regarding the primary clinical site for the clinical experience on **page 4**. Complete **page 4**, to provide essential information on all additional clinical sites or satellites associated with the primary clinical site. ***Please note that if the satellite site(s) offering a clinical experience differs from the primary clinical site, a separate CSIF must be completed for each satellite site. Additionally, if any of the satellite sites have a different CCCE, an abbreviated resume must be completed for each individual serving as CCCE.***

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 CSIF do not apply to your clinical education site at the time you are completing the form, please leave the item(s) blank. Provide additional information and/or comments in the Comment box associated with the item.

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CLINICAL SITE INFORMATION FORM

Part I: Information For the Academic Program
Information About the Clinical Site – Primary

| |
|-----------------------|
| Initial Date |
| Revision Date 11/3/09 |

| | | | | | |
|---|---|-------|----|-----|-------|
| Person Completing CSIF | Kristin Oliverio | | | | |
| E-mail address of person completing CSIF | koliverio@kort.com | | | | |
| Name of Clinical Center | KORT-Shively Physical Therapy | | | | |
| Street Address | 4420 Dixie Highway, Ste. 118 | | | | |
| City | Louisville | State | KY | Zip | 40216 |
| Facility Phone | 502-447-2750 | Ext. | | | |
| PT Department Phone | 502-447-2750 | Ext. | | | |
| PT Department Fax | 502-449-9062 | | | | |
| PT Department E-mail | koliverio@kort.com | | | | |
| Clinical Center Web Address | www.kort.com | | | | |
| Director of Physical Therapy | Kristin Oliverio | | | | |
| Director of Physical Therapy E-mail | koliverio@kort.com | | | | |
| Center Coordinator of Clinical Education (CCCE) / Contact Person | Kristin Oliverio | | | | |
| CCCE / Contact Person Phone | 502-447-2750 | | | | |
| CCCE / Contact Person E-mail | koliverio@kort.com | | | | |
| APTA Credentialed Clinical Instructors (CI) (List name and credentials) | Kristin Oliverio, PT, DPT Amy Wells, PT, DPT | | | | |
| Other Credentialed CIs (List name and credentials) | Kim Holmes, PTA Melinda Hayes, PT, DPT | | | | |
| Indicate which of the following are required by your facility prior to the clinical education experience: | <input type="checkbox"/> Proof of student health clearance <input type="checkbox"/> Criminal background check <input type="checkbox"/> Child clearance <input type="checkbox"/> Drug screening <input checked="" type="checkbox"/> First Aid and CPR <input checked="" type="checkbox"/> HIPAA education <input type="checkbox"/> OSHA education <input checked="" type="checkbox"/> Other: Please list student liability insurance (usually provided by university) | | | | |

Information About Multi-Center Facilities

If your health care system or practice has multiple sites or clinical centers, complete the following table(s) for each of the sites. Where information is the same as the primary clinical site, indicate "SAME." If more than three sites, copy, and paste additional sections of this table before entering the requested information. Note that you must complete an abbreviated resume for each CCCE.

| | | | | | |
|------------------------------|-------------------------------|-----------------|--------|--|-------|
| Name of Clinical Site | KORT-Shively Physical Therapy | | | | |
| Street Address | 4420 Dixie Highway, Ste 118 | | | | |
| City | Louisville | State | KY | Zip | 40216 |
| Facility Phone | 502-447-2750 | | Ext. | | |
| PT Department Phone | 502-447-2750 | | Ext. | | |
| Fax Number | 502-449-9062 | Facility E-mail | | | |
| Director of Physical Therapy | Kristin Oliverio | | E-mail | koliverio@kort.com | |
| CCCE | Kristin Oliverio | | E-mail | koliverio@kort.com | |

| | | | | | |
|------------------------------|--|-----------------|--------|-----|--|
| Name of Clinical Site | | | | | |
| Street Address | | | | | |
| City | | State | | Zip | |
| Facility Phone | | | Ext. | | |
| PT Department Phone | | | Ext. | | |
| Fax Number | | Facility E-mail | | | |
| Director of Physical Therapy | | | E-mail | | |
| CCCE | | | E-mail | | |

| | | | | | |
|------------------------------|--|-----------------|--------|-----|--|
| Name of Clinical Site | | | | | |
| Street Address | | | | | |
| City | | State | | Zip | |
| Facility Phone | | | Ext. | | |
| PT Department Phone | | | Ext. | | |
| Fax Number | | Facility E-mail | | | |
| Director of Physical Therapy | | | E-mail | | |
| CCCE | | | E-mail | | |

Clinical Site Accreditation/Ownership

| Yes | No | | Date of Last Accreditation/Certification |
|-------------------------------------|-------------------------------------|--|--|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | Is your clinical site certified/ accredited? If no, go to #3. | |
| | | If yes, has your clinical site been certified/accredited by: | |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | JCAHO | |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | CARF | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | Government Agency (eg, CORF, PTIP, rehab agency, state, etc.) | 11/7/08 |
| <input type="checkbox"/> | <input type="checkbox"/> | Other | |
| | | Which of the following best describes the ownership category for your clinical site? (check all that apply) | |
| | | <input checked="" type="checkbox"/> Corporate/Privately Owned <input type="checkbox"/> Government Agency <input type="checkbox"/> Hospital/Medical Center Owned <input type="checkbox"/> Nonprofit Agency <input type="checkbox"/> Physician/Physician Group Owned <input checked="" type="checkbox"/> PT Owned <input type="checkbox"/> PT/PTA Owned <input type="checkbox"/> Other (please specify) | |

Clinical Site Primary Classification

To complete this section, please:

- A. Place the number 1 (**1**) beside the category that best describes how your facility functions the majority ($\geq 50\%$) of the time. Click on the drop down box to the left to select the number 1.
- B. Next, if appropriate, check (\checkmark) up to four additional categories that describe the other clinical centers associated with your facility.

| | | | | | |
|--------------------------|--|---------------------------------------|---|--------------------------|-------------------------------------|
| <input type="checkbox"/> | Acute Care/Inpatient Hospital Facility | <input checked="" type="checkbox"/> | Industrial/Occupational Health Facility | <input type="checkbox"/> | School/Preschool Program |
| <input type="checkbox"/> | Ambulatory Care/Outpatient | <input type="checkbox"/> | Multiple Level Medical Center | <input type="checkbox"/> | Wellness/Prevention/Fitness Program |
| <input type="checkbox"/> | ECF/Nursing Home/SNF | 1 <input checked="" type="checkbox"/> | Private Practice | <input type="checkbox"/> | Other: Specify |
| <input type="checkbox"/> | Federal/State/County Health | <input type="checkbox"/> | Rehabilitation/Sub-acute Rehabilitation | | |

Clinical Site Location

Which of the following best describes your clinical site's location?

- Rural
 Suburban
 Urban

Information About the Clinical Teaching Faculty

ABBREVIATED RESUME FOR CENTER COORDINATORS OF CLINICAL EDUCATION

Please update as each new CCCE assumes this position.

| | | | |
|---|--|--|---|
| NAME: Kristin Oliverio | | Length of time as the CCCE: 2 | |
| DATE: (mm/dd/yy) 11/3/09 | | Length of time as a CI: 3 | |
| PRESENT POSITION: Clinic director-KORT Shively Physical Therapy (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: 4 years |
| LICENSURE: (State/Numbers) KY004822 | APTA Credentialed CI Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | Other CI Credentialing Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| Eligible for Licensure: Yes <input type="checkbox"/> No <input type="checkbox"/> | | Certified Clinical Specialist: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| Area of Clinical Specialization: Orthopedics | | | |
| Other credentials: DPT | | | |

SUMMARY OF COLLEGE AND UNIVERSITY EDUCATION (Start with most current): Tab to add additional rows.

| INSTITUTION | PERIOD OF STUDY | | MAJOR | DEGREE |
|------------------------|-----------------|-------|-------|--------|
| | FROM | TO | | |
| Regis University | 1/06 | 12/07 | PT | DPT |
| University of Kentucky | 1/03 | 5/05 | PT | MSPT |
| | | | | |
| | | | | |

SUMMARY OF PRIMARY EMPLOYMENT (For current and previous four positions since graduation from college; start with most current): Tab to add additional rows.

| EMPLOYER | POSITION | PERIOD OF EMPLOYMENT | |
|-----------------------|---------------------|----------------------|---------|
| | | FROM | TO |
| KORT Physical Therapy | PT, Clinic director | 7/05 | Present |
| | | | |
| | | | |
| | | | |
| | | | |

CLINICAL INSTRUCTOR INFORMATION

Provide the following information on all PTs or PTAs employed at your clinical site who are CIs. **For clinical sites with multiple locations, use one form for each location and identify the location here.** Tab to add additional rows.

| Name followed by credentials (e.g., Joe Therapist, DPT, OCS Jane Assistant, PTA, BS) | PT/PTA Program from Which CI Graduated | Year of Graduation | Highest Earned Physical Therapy Degree | No. of Years of Clinical Practice | No. of Years of Clinical Teaching | List Certifications KEY: A = APTA credentialed. CI B = Other CI credentialing C = Cert. clinical specialist List others | APTA Member Yes/No | L= Licensed, Number E= Eligible T= Temporary | |
|--|--|-----------------------|--|--|---|--|--------------------------|--|-----------------------|
| | | | | | | | | L/E/T Number | State of Licensure |
| Amy Wells, PT, DPT | Bellarmino University | 2004 | DPT | 5 | 4 | A | Yes | L-004762 | KY |
| Kim Holmes, PTA | JCC | 1981 | PTA | 28 | 6 | NA | Yes | L-125 | KY |
| Melinda Hayes | Bellarmino University | 2009 | DPT | New-grad (<6 months) | 0 | NA | No | L-005428 | KY |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

Clinical Instructors

What criteria do you use to select clinical instructors? (Mark (X) all that apply):

| | | | |
|-------------------------------------|--|-------------------------------------|--|
| <input type="checkbox"/> | APTA Clinical Instructor Credentialing | <input type="checkbox"/> | No criteria |
| <input type="checkbox"/> | Career ladder opportunity | <input type="checkbox"/> | Other (not APTA) clinical instructor credentialing |
| <input type="checkbox"/> | Certification/training course | <input checked="" type="checkbox"/> | Therapist initiative/volunteer |
| <input checked="" type="checkbox"/> | Clinical competence | <input type="checkbox"/> | Years of experience: Number: |
| <input type="checkbox"/> | Delegated in job description | <input checked="" type="checkbox"/> | Other (please specify): Demonstrated interest |
| <input checked="" type="checkbox"/> | Demonstrated strength in clinical teaching | | |

How are clinical instructors trained? (Mark (X) all that apply)

| | | | |
|-------------------------------------|--|-------------------------------------|---|
| <input checked="" type="checkbox"/> | 1:1 individual training (CCCE:CI) | <input type="checkbox"/> | Continuing education by consortia |
| <input type="checkbox"/> | Academic for-credit coursework | <input type="checkbox"/> | No training |
| <input checked="" type="checkbox"/> | APTA Clinical Instructor Education and Credentialing Program | <input type="checkbox"/> | Other (not APTA) clinical instructor credentialing program |
| <input type="checkbox"/> | Clinical center inservices | <input checked="" type="checkbox"/> | Professional continuing education (e.g., chapter, CEU course) |
| <input type="checkbox"/> | Continuing education by academic program | <input type="checkbox"/> | Other (please specify): |

Information About the Physical Therapy Service

Number of Inpatient Beds

For clinical sites with inpatient care, please provide the number of beds available in each of the subcategories listed below: (If this does not apply to your facility, please skip and move to the next table.)

| | | | |
|---------------------------------|--|----------------------------------|--|
| Acute care | | Psychiatric center | |
| Intensive care | | Rehabilitation center | |
| Step down | | Other specialty centers: Specify | |
| Subacute/transitional care unit | | | |
| Extended care | | Total Number of Beds | |

Number of Patients/Clients

Estimate the average number of patient/client visits **per day**:

| INPATIENT | | OUTPATIENT | |
|-----------|--|------------|--|
| | Individual PT | 14 | Individual PT |
| | Student PT | 10 | Student PT |
| | Individual PTA | 12 | Individual PTA |
| | Student PTA | 8-10 | Student PTA |
| | PT/PTA Team | | PT/PTA Team |
| | Total patient/client visits per day | 54 | Total patient/client visits per day |

Patient/Client Lifespan and Continuum of Care

Indicate the frequency of time typically spent with patients/clients in each of the categories using the key below:

1=(0%) 2=(1-25%) 3=(26-50%) 4=(51-75%) 5=(76-100%)

Click on the gray bar under rating to select from the drop down box.

| Rating | Patient Lifespan | Rating | Continuum of Care |
|--------|------------------|--------|---------------------------|
| 2 | 0-12 years | | Critical care, ICU, acute |
| 2 | 13-21 years | | SNF/ECF/sub-acute |
| 4 | 22-65 years | | Rehabilitation |
| 2 | Over 65 years | 5 | Ambulatory/outpatient |
| | | | Home health/hospice |
| | | 2 | Wellness/fitness/industry |

Patient/Client Diagnoses

1. Indicate the frequency of time typically spent with patients/clients in the primary diagnostic groups (bolded) using the key below:

1 = (0%) 2 = (1-25%) 3 = (26-50%) 4 = (51-75%) 5 = (76-100%)

2. Check (✓) those patient/client diagnostic sub-categories available to the student.

Click on the gray bar under rating to select from the drop down box.

| | | | |
|---------------------------------------|--|---------------------------------------|---|
| (1-5) | Musculoskeletal | | |
| <input type="checkbox"/> | Acute injury | 2 <input checked="" type="checkbox"/> | Muscle disease/dysfunction |
| <input type="checkbox"/> | Amputation | 2 <input checked="" type="checkbox"/> | Musculoskeletal degenerative disease |
| 4 <input checked="" type="checkbox"/> | Arthritis | 3 <input checked="" type="checkbox"/> | Orthopedic surgery |
| <input type="checkbox"/> | Bone disease/dysfunction | <input type="checkbox"/> | Other: (Specify) |
| <input type="checkbox"/> | Connective tissue disease/dysfunction | | |
| (1-5) | Neuro-muscular | | |
| <input type="checkbox"/> | Brain injury | 2 <input checked="" type="checkbox"/> | Peripheral nerve injury |
| <input type="checkbox"/> | Cerebral vascular accident | <input type="checkbox"/> | Spinal cord injury |
| 2 <input checked="" type="checkbox"/> | Chronic pain | 2 <input checked="" type="checkbox"/> | Vestibular disorder |
| <input type="checkbox"/> | Congenital/developmental | <input type="checkbox"/> | Other: (Specify) |
| <input type="checkbox"/> | Neuromuscular degenerative disease | | |
| (1-5) | Cardiovascular-pulmonary | | |
| <input type="checkbox"/> | Cardiac dysfunction/disease | <input type="checkbox"/> | Peripheral vascular dysfunction/disease |
| <input type="checkbox"/> | Fitness | <input type="checkbox"/> | Other: (Specify) |
| <input type="checkbox"/> | Lymphedema | | |
| <input type="checkbox"/> | Pulmonary dysfunction/disease | | |
| (1-5) | Integumentary | | |
| <input type="checkbox"/> | Burns | <input type="checkbox"/> | Other: (Specify) |
| <input type="checkbox"/> | Open wounds | | |
| 3 <input checked="" type="checkbox"/> | Scar formation | | |
| (1-5) | Other (May cross a number of diagnostic groups) | | |
| <input type="checkbox"/> | Cognitive impairment | <input type="checkbox"/> | Organ transplant |
| <input type="checkbox"/> | General medical conditions | <input type="checkbox"/> | Wellness/Prevention |
| <input type="checkbox"/> | General surgery | <input type="checkbox"/> | Other: (Specify) |
| 2 <input checked="" type="checkbox"/> | Oncologic conditions | | |

Hours of Operation

Facilities with multiple sites with different hours must complete this section for each clinical center.

| Days of the Week | From: (a.m.) | To: (p.m.) | Comments |
|------------------|--------------|------------|----------|
| Monday | 7 | 6 | |
| Tuesday | 7 | 6 | |
| Wednesday | 7 | 6 | |
| Thursday | 7 | 5 | |
| Friday | 7 | 5 | |
| Saturday | | | |
| Sunday | | | |

Student Schedule

Indicate which of the following best describes the typical student work schedule:

- Standard 8 hour day
- Varied schedules

Describe the schedule(s) the student is expected to follow during the clinical experience:
 The student schedule depends on the CI schedule. We work 40 hour work weeks, but each PT/PTA has a half day...4 (9 hour shifts) and 1 (4 hour shift).

Staffing

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

| | Full-time budgeted | Part-time budgeted | Current Staffing |
|---------------------|--------------------|--------------------|------------------|
| PTs | 3 | 1 | 4 |
| PTAs | 1 | NA | 1 |
| Aides/Techs | 1 | 2 | 3 |
| Others: Specify ATC | NA | 3 | 3 |

Information About the Clinical Education Experience

Special Programs/Activities/Learning Opportunities

Please mark (X) all special programs/activities/learning opportunities available to students.

| | | | | | |
|-------------------------------------|-------------------------------|-------------------------------------|----------------------------------|-------------------------------------|-----------------------------|
| <input type="checkbox"/> | Administration | <input checked="" type="checkbox"/> | Industrial/ergonomic PT | <input checked="" type="checkbox"/> | Quality Assurance/CQI/TQM |
| <input checked="" type="checkbox"/> | Aquatic therapy | <input checked="" type="checkbox"/> | Inservice training/lectures | <input type="checkbox"/> | Radiology |
| <input checked="" type="checkbox"/> | Athletic venue coverage | <input type="checkbox"/> | Neonatal care | <input type="checkbox"/> | Research experience |
| <input checked="" type="checkbox"/> | Back school | <input type="checkbox"/> | Nursing home/ECF/SNF | <input checked="" type="checkbox"/> | Screening/prevention |
| <input type="checkbox"/> | Biomechanics lab | <input checked="" type="checkbox"/> | Orthotic/Prosthetic fabrication | <input checked="" type="checkbox"/> | Sports physical therapy |
| <input type="checkbox"/> | Cardiac rehabilitation | <input type="checkbox"/> | Pain management program | <input checked="" type="checkbox"/> | Surgery (observation) |
| <input type="checkbox"/> | Community/re-entry activities | <input type="checkbox"/> | Pediatric-general (emphasis on): | <input checked="" type="checkbox"/> | Team meetings/rounds |
| <input type="checkbox"/> | Critical care/intensive care | <input type="checkbox"/> | Classroom consultation | <input checked="" type="checkbox"/> | Vestibular rehab |
| <input checked="" type="checkbox"/> | Departmental administration | <input type="checkbox"/> | Developmental program | <input type="checkbox"/> | Women's Health/OB-GYN |
| <input type="checkbox"/> | Early intervention | <input type="checkbox"/> | Cognitive impairment | <input checked="" type="checkbox"/> | Work Hardening/conditioning |
| <input type="checkbox"/> | Employee intervention | <input checked="" type="checkbox"/> | Musculoskeletal | <input type="checkbox"/> | Wound care |
| <input type="checkbox"/> | Employee wellness program | <input type="checkbox"/> | Neurological | <input type="checkbox"/> | Other (specify below) |
| <input type="checkbox"/> | Group programs/classes | <input type="checkbox"/> | Prevention/wellness | | |
| <input type="checkbox"/> | Home health program | <input type="checkbox"/> | Pulmonary rehabilitation | | |

Specialty Clinics

Please mark (X) all specialty clinics available as student learning experiences.

| | | | | | |
|-------------------------------------|-------------------|-------------------------------------|----------------------------|-------------------------------------|---|
| <input type="checkbox"/> | Arthritis | <input checked="" type="checkbox"/> | Orthopedic clinic | <input checked="" type="checkbox"/> | Screening clinics |
| <input type="checkbox"/> | Balance | <input type="checkbox"/> | Pain clinic | <input type="checkbox"/> | Developmental |
| <input type="checkbox"/> | Feeding clinic | <input checked="" type="checkbox"/> | Prosthetic/orthotic clinic | <input type="checkbox"/> | Scoliosis |
| <input checked="" type="checkbox"/> | Hand clinic | <input type="checkbox"/> | Seating/mobility clinic | <input type="checkbox"/> | Preparticipation sports |
| <input type="checkbox"/> | Hemophilia clinic | <input checked="" type="checkbox"/> | Sports medicine clinic | <input type="checkbox"/> | Wellness |
| <input checked="" type="checkbox"/> | Industry | <input type="checkbox"/> | Women's health | <input checked="" type="checkbox"/> | Other (specify below) Fibromyalgia support group and lymphedema |
| <input type="checkbox"/> | Neurology clinic | | | | |

Health and Educational Providers at the Clinical Site

Please mark (X) all health care and educational providers at your clinical site students typically observe and/or with whom they interact.

| | | | | | |
|-------------------------------------|----------------------------------|--------------------------|-------------------------------|-------------------------------------|---|
| <input checked="" type="checkbox"/> | Administrators | <input type="checkbox"/> | Massage therapists | <input type="checkbox"/> | Speech/language pathologists |
| <input type="checkbox"/> | Alternative therapies: List: | <input type="checkbox"/> | Nurses | <input type="checkbox"/> | Social workers |
| <input checked="" type="checkbox"/> | Athletic trainers | <input type="checkbox"/> | Occupational therapists | <input type="checkbox"/> | Special education teachers |
| <input type="checkbox"/> | Audiologists | <input type="checkbox"/> | Physicians (list specialties) | <input type="checkbox"/> | Students from other disciplines |
| <input type="checkbox"/> | Dietitians | <input type="checkbox"/> | Physician assistants | <input checked="" type="checkbox"/> | Students from other physical therapy education programs |
| <input type="checkbox"/> | Enterostomal /wound specialists | <input type="checkbox"/> | Podiatrists | <input type="checkbox"/> | Therapeutic recreation therapists |
| <input checked="" type="checkbox"/> | Exercise physiologists | <input type="checkbox"/> | Prosthetists /orthotists | <input type="checkbox"/> | Vocational rehabilitation counselors |
| <input type="checkbox"/> | Fitness professionals | <input type="checkbox"/> | Psychologists | <input type="checkbox"/> | Others (specify below) |
| <input type="checkbox"/> | Health information technologists | <input type="checkbox"/> | Respiratory therapists | | |

Availability of the Clinical Education Experience

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

| Physical Therapist | | Physical Therapist Assistant | |
|--|--|--|--|
| <input checked="" type="checkbox"/> First experience: Check all that apply. <input checked="" type="checkbox"/> Half days <input checked="" type="checkbox"/> Full days <input type="checkbox"/> Other: (Specify) | | <input checked="" type="checkbox"/> First experience: Check all that apply. <input checked="" type="checkbox"/> Half days <input checked="" type="checkbox"/> Full days <input type="checkbox"/> Other: (Specify) | |
| <input checked="" type="checkbox"/> Intermediate experiences: Check all that apply. <input checked="" type="checkbox"/> Half days <input checked="" type="checkbox"/> Full days <input type="checkbox"/> Other: (Specify) | | <input checked="" type="checkbox"/> Intermediate experiences: Check all that apply. <input checked="" type="checkbox"/> Half days <input checked="" type="checkbox"/> Full days <input type="checkbox"/> Other: (Specify) | |
| <input checked="" type="checkbox"/> Final experience | | <input checked="" type="checkbox"/> Final experience | |
| <input checked="" type="checkbox"/> Internship (6 months or longer) | | | |
| <input type="checkbox"/> Specialty experience | | | |

| | PT | | PTA | |
|--|------|----|------|----|
| | From | To | From | To |
| Indicate the range of weeks you will accept students for any single full-time (36 hrs/wk) clinical experience. | 4 | 12 | 4 | 12 |
| Indicate the range of weeks you will accept students for any one part-time (< 36 hrs/wk) clinical experience. | | | | |

| | PT | PTA |
|--|-----|-----|
| Average number of PT and PTA students affiliating <u>per year</u> . Clarify if multiple sites. | 2-6 | 1-2 |

| Yes | No | | Comments |
|--------------------------|-------------------------------------|--|----------|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | Is your clinical site willing to offer reasonable accommodations for students under ADA? | |

What is the procedure for managing students whose performance is below expectations or unsafe?
 We usually follow the student's educational programs policy and procedures. Each student is handled case by case.

Box will expand to accommodate response.

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.

NA

Box will expand to accommodate response.

Clinical Site's Learning Objectives and Assessment

| Yes | No | |
|-------------------------------------|--------------------------|--|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 1. Does your clinical site provide written clinical education objectives to students? If no, go to # 3. |
| | | 2. Do these objectives accommodate: |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | • The student's objectives? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | • Students prepared at different levels within the academic curriculum? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | • The academic program's objectives for specific learning experiences? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | • Students with disabilities? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 3. Are all professional staff members who provide physical therapy services acquainted with the clinical site's learning objectives? |

When do the CCCE and/or CI typically discuss the clinical site's learning objectives with students? **(Mark (X) all that apply)**

| | | | |
|-------------------------------------|--------------------------------------|-------------------------------------|-------------------------------|
| <input checked="" type="checkbox"/> | Beginning of the clinical experience | <input checked="" type="checkbox"/> | At mid-clinical experience |
| <input checked="" type="checkbox"/> | Daily | <input checked="" type="checkbox"/> | At end of clinical experience |
| <input checked="" type="checkbox"/> | Weekly | <input type="checkbox"/> | Other |

Indicate which of the following methods are typically utilized to inform students about their clinical performance? **(Mark (X) all that apply)**

| | | | |
|-------------------------------------|---|-------------------------------------|--|
| <input checked="" type="checkbox"/> | Written and oral mid-evaluation | <input checked="" type="checkbox"/> | Ongoing feedback throughout the clinical |
| <input checked="" type="checkbox"/> | Written and oral summative final evaluation | <input checked="" type="checkbox"/> | As per student request in addition to formal and ongoing written & oral feedback |
| <input checked="" type="checkbox"/> | Student self-assessment throughout the clinical | <input type="checkbox"/> | |

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]).

Box will expand to accommodate response.

Part II. Information for Students

Use the check (✓) boxes provided for Yes/No responses. **For all other responses or to provide additional detail, please use the Comment box.**

Arranging the Experience

| Yes | No | | Comments |
|-------------------------------------|-------------------------------------|--|--|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 1. Do students need to contact the clinical site for specific work hours related to the clinical experience? | The student will be provided with this information prior to the start of the clinical experience, but a phone call from the student is recommended. |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 2. Do students receive the same official holidays as staff? | |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 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. | Depends on the student's CI schedule. Will be 7 or 8 am. |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 5. Is a Mantoux TB test (PPD) required? a) one step_____ (✓ check) b) two step_____ (✓ check) If yes, within what time frame? | Proof of immunizations is required. We usually accept whatever is required by the student's educational program. |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 6. Is a Rubella Titer Test or immunization required? | |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 7. Are any other health tests/immunizations required prior to the clinical experience? If yes, please specify: | |
| | | 8. How is this information communicated to the clinic? Provide fax number if required. | Student can bring on his/her first day |
| | | 9. How current are student physical exam records required to be? | NA |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 10. Are any other health tests or immunizations required on-site? If yes, please specify: | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 11. Is the student required to provide proof of OSHA training? | Provided information by clinical site |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 12. Is the student required to provide proof of HIPAA training? | Provided information by clinical site |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 13. Is the student required to provide proof of any other training prior to orientation at your facility? If yes, please list. | All information will be sent to the student prior to the clinical experience: form needed for computer documentation, non-employee compliance training |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 14. Is the student required to attest to an understanding of the benefits and risks of Hepatitis-B immunization? | |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 15. Is the student required to have proof of health insurance? | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 16. Is emergency health care available for students? | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | a) Is the student responsible for emergency health care costs? | |

| | | | |
|-------------------------------------|--------------------------|---|--|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 17. Is other non-emergency medical care available to students? | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 18. Is the student required to be CPR certified? (Please note if a specific course is required). | |

| Yes | No | | Comments |
|--------------------------|-------------------------------------|---|---|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | a) Can the student receive CPR certification while on-site? | |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 19. Is the student required to be certified in First Aid? | |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | a) Can the student receive First Aid certification on-site? | |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 20. Is a criminal background check required (e.g., Criminal Offender Record Information)? If yes, please indicate which background check is required and time frame. | |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 21. Is a child abuse clearance required? | |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 22. Is the student responsible for the cost or required clearances? | |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 23. Is the student required to submit to a drug test? If yes, please describe parameters. | |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 24. Is medical testing available on-site for students? | |
| | | 25. Other requirements: (On-site orientation, sign an ethics statement, sign a confidentiality statement.) | Proof of the school's liability insurance |

Housing

| Yes | No | | Comments |
|--------------------------|-------------------------------------|---|-------------|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 26. Is housing provided for male students? (If no, go to #32) | |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 27. Is housing provided for female students? (If no, go to #32) | |
| | | 28. What is the average cost of housing? | |
| | | 29. Description of the type of housing provided: | |
| | | 30. How far is the housing from the facility? | |
| | | 31. Person to contact to obtain/confirm housing: | |
| | | Name: | |
| | | Address: | |
| | | City: | State: Zip: |
| | | Phone: | E-mail: |

| Yes | No | | Comments |
|--------------------------|-------------------------------------|---|----------|
| | | 32. If housing is not provided for either gender: | |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | a) Is there a contact person for information on housing in the area of the clinic? Please list contact person and phone #. | |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | b) Is there a list available concerning housing in the area of the clinic? If yes, please attach to the end of this form. | |

Transportation

| Yes | No | | Comments |
|-------------------------------------|-------------------------------------|--|---|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 33. Will a student need a car to complete the clinical experience? | TARC is available. A car is recommended |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 34. Is parking available at the clinical center? | |
| | | a) What is the cost for parking? | 0 |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 35. Is public transportation available? | TARC |
| | | 36. How close is the nearest transportation (in miles) to your site? | |
| | | a) Train station? | miles |
| | | b) Subway station? | miles |
| | | c) Bus station? | 0.25 miles |
| | | d) Airport? | miles |
| | | 37. Briefly describe the area, population density, and any safety issues regarding where the clinical center is located. | |
| | | 38. Please enclose a map of your facility, specifically the location of the department and parking. Travel directions can be obtained from several travel directories on the internet. (e.g., Google Maps , Yahoo , MapQuest , Expedia). | |

Meals

| Yes | No | | Comments |
|-------------------------------------|--------------------------|---|--|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 39. Are meals available for students on-site? (If no, go to #40) | |
| | | Breakfast (if yes, indicate approximate cost) | Refrigerator, microwave, toaster oven on site. Several restaurants (sit down and fast food) within driving and walking distance. |
| | | Lunch (if yes, indicate approximate cost) | |
| | | Dinner (if yes, indicate approximate cost) | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 40. Are facilities available for the storage and preparation of food? | |

Stipend/Scholarship

| Yes | No | | Comments |
|--------------------------|-------------------------------------|--|----------|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 41. Is a stipend/salary provided for students? If no, go to #43. | |
| | | a) How much is the stipend/salary? (\$ / week) | |
| <input type="checkbox"/> | <input type="checkbox"/> | 42. Is this stipend/salary in lieu of meals or housing? | |
| | | 43. 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 |
|-------------------------------------|-------------------------------------|---|--|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 44. Is there a facility/student dress code? If no, go to # 45. If yes, please describe or attach. | |
| | | a) Specify dress code for men: | Business/professional. Neck tie not required. Dress pants or khaki's and collared shirt/polo shirt. Dress shoes recommended. |
| | | b) Specify dress code for women: | Business/professional. Dress pants or khaki's recommended. Dress shoes recommended. No sleeveless shirts or open toed shoes. |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 45. Do you require a case study or inservice from all students (part-time and full-time)? | Per education program requirement |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 46. Do you require any additional written or verbal work from the student (e.g., article critiques, journal review, patient/client education handout/brochure)? | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 47. Does your site have a written policy for missed days due to illness, emergency situations, other? If yes, please summarize. | 6 or more unexcused absences in a 12 month period or 3 or more unexcused absences in a quarter is considered unacceptable attendance |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 48. Will the student have access to the Internet at the clinical site? | |

Other Student Information

| Yes | No | | |
|-------------------------------------|--------------------------|--|--|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 49. Do you provide the student with an on-site orientation to your clinical site? | |
| (mark X below) | | a) Please indicate the typical orientation content by marking an X by all items that are included. | |
| <input checked="" type="checkbox"/> | | Documentation/billing | <input checked="" type="checkbox"/> Review of goals/objectives of clinical experience |
| <input checked="" type="checkbox"/> | | Facility-wide or volunteer orientation | <input checked="" type="checkbox"/> Student expectations |
| <input checked="" type="checkbox"/> | | Learning style inventory | <input checked="" type="checkbox"/> Supplemental readings |
| <input checked="" type="checkbox"/> | | Patient information/assignments | <input checked="" type="checkbox"/> Tour of facility/department |
| <input checked="" type="checkbox"/> | | Policies and procedures (specifically | <input checked="" type="checkbox"/> Other (specify below – e.g., bloodborne pathogens, |

| | | | |
|-------------------------------------|---|--|----------------------------------|
| | outlined plan for emergency responses) | | hazardous materials, etc.) HIPAA |
| <input checked="" type="checkbox"/> | Quality assurance | | |
| <input checked="" type="checkbox"/> | Reimbursement issues | | |
| <input checked="" type="checkbox"/> | Required assignments (e.g., case study, diary/log, inservice) | | |

In appreciation...

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