

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
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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 11/2008 |
| Revision Date |

| | | | | | |
|---|---|-------|----|-----|-------|
| Person Completing CSIF | Karen Brandenburg,PT | | | | |
| E-mail address of person completing CSIF | kbrandenburg@kort.com | | | | |
| Name of Clinical Center | KORT Physical Therapy Richmond | | | | |
| Street Address | 5006 Atwood Dr, Suite 2 | | | | |
| City | Richmond | State | KY | Zip | 40475 |
| Facility Phone | 859-623-2057 | Ext. | | | |
| PT Department Phone | | Ext. | | | |
| PT Department Fax | 859-623-2058 | | | | |
| PT Department E-mail | | | | | |
| Clinical Center Web Address | www.kort.com | | | | |
| Director of Physical Therapy | Karen Brandenburg, PT | | | | |
| Director of Physical Therapy E-mail | kbrandenburg@kort.com | | | | |
| Center Coordinator of Clinical Education (CCCE) / Contact Person | Karen Brandenburg | | | | |
| CCCE / Contact Person Phone | | | | | |
| CCCE / Contact Person E-mail | | | | | |
| APTA Credentialed Clinical Instructors (CI) (List name and credentials) | Karen Brandenburg, PT, MSPT, OCS | | | | |
| Other Credentialed CIs (List name and credentials) | | | | | |
| 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 type="checkbox"/> Other: Please list | | | | |

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 | | | | | |
| 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 | |

| | | | | | |
|------------------------------|--|-------|-----------------|--------|--|
| 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 type="checkbox"/> | JCAHO | |
| <input type="checkbox"/> | <input type="checkbox"/> | CARF | |
| <input type="checkbox"/> | <input type="checkbox"/> | Government Agency (eg, CORF, PTIP, rehab agency, state, etc.) | |
| <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 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 type="checkbox"/> | Industrial/Occupational Health Facility | <input type="checkbox"/> | School/Preschool Program |
| 1 <input checked="" 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 | 2 <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: Karen Brandenburg, PT, MSPT, OCS | | Length of time as the CCCE: 3 years | |
| DATE: (mm/dd/yy) 11/09/08 | | Length of time as a CI: 3 years | |
| PRESENT POSITION: Director, KORT Physical Therapy Richmond (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: 8 years |
| LICENSURE: (State/Numbers) 3903 | 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 checked="" type="checkbox"/> No <input type="checkbox"/> | | Certified Clinical Specialist: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| Area of Clinical Specialization: orthopedics | | | |
| Other credentials: | | | |

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

| INSTITUTION | PERIOD OF STUDY | | MAJOR | DEGREE |
|------------------------|-----------------|------|----------------|-----------|
| | FROM | TO | | |
| University of Kentucky | 1993 | 2000 | PT | Masters |
| University of Kentucky | 1993 | 2000 | Health Science | Bachelors |
| | | | | |
| | | | | |

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 |
| See Resume/CV | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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 |
| Karen Brandenburg, PT, MSPT, OCS | Univ. of Kentucky | 2000 | MSPT | 8 | 3 | A= APTA credentialed CI B= Certified orthopedic specialist | No | L=3903 | KY |
| | | | | | | | | | |
| | | | | | | | | | |
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| | | | | | | | | | |

Clinical Instructors

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

| | | | |
|-------------------------------------|--|-------------------------------------|--|
| <input checked="" 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 checked="" 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 type="checkbox"/> | Other (please specify): |
| <input 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 checked="" type="checkbox"/> | Other (not APTA) clinical instructor credentialing program |
| <input checked="" type="checkbox"/> | Clinical center inservices | <input 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 | 12 | Individual PT |
| | Student PT | 10 | Student PT |
| | Individual PTA | NA | Individual PTA |
| | Student PTA | 10 | Student PTA |
| | PT/PTA Team | | PT/PTA Team |
| | Total patient/client visits per day | 20 | 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 |
| 3 | Over 65 years | 5 | Ambulatory/outpatient |
| | | | Home health/hospice |
| | | | 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 | | |
| 2 <input checked="" type="checkbox"/> | Acute injury | 2 <input checked="" type="checkbox"/> | Muscle disease/dysfunction |
| <input type="checkbox"/> | Amputation | 3 <input checked="" type="checkbox"/> | Musculoskeletal degenerative disease |
| 4 <input checked="" type="checkbox"/> | Arthritis | 3 <input checked="" type="checkbox"/> | Orthopedic surgery |
| 2 <input checked="" type="checkbox"/> | Bone disease/dysfunction | <input type="checkbox"/> | Other: (Specify) |
| 3 <input checked="" type="checkbox"/> | Connective tissue disease/dysfunction | | |
| (1-5) | Neuro-muscular | | |
| <input type="checkbox"/> | Brain injury | <input type="checkbox"/> | Peripheral nerve injury |
| <input type="checkbox"/> | Cerebral vascular accident | <input type="checkbox"/> | Spinal cord injury |
| 2 <input checked="" type="checkbox"/> | Chronic pain | <input 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 | | |
| <input 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) |
| <input 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 | 8:00 | 7:00 | TWO PT'S |
| Tuesday | 8:00 | 7:00 | |
| Wednesday | 8:00 | 7:00 | |
| Thursday | 8:00 | 7:00 | |
| Friday | 8:00 | 4:00 | |
| Saturday | NA | NA | |
| Sunday | NA | NA | |

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:
 Student will mirror CI's schedule. Schedule is subject to change at any time but is typically an 8 hour day with a one hour lunch period.

Staffing

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

| | Full-time budgeted | Part-time budgeted | Current Staffing |
|-----------------|--------------------|--------------------|------------------|
| PTs | 2 | | 2 |
| PTAs | 0 | | 0 |
| Aides/Techs | | 2 | 2 |
| Others: Specify | | | |

Information About the Clinical Education Experience

Special Programs/Activities/Learning Opportunities

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

| | | | | | |
|-------------------------------------|-------------------------------|-------------------------------------|----------------------------------|-------------------------------------|-----------------------------|
| <input checked="" type="checkbox"/> | Administration | <input type="checkbox"/> | Industrial/ergonomic PT | <input type="checkbox"/> | Quality Assurance/CQI/TQM |
| <input 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 type="checkbox"/> | Back school | <input type="checkbox"/> | Nursing home/ECF/SNF | <input 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 checked="" 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 type="checkbox"/> | Team meetings/rounds |
| <input type="checkbox"/> | Critical care/intensive care | <input type="checkbox"/> | Classroom consultation | <input checked="" type="checkbox"/> | Vestibular rehab |
| <input 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 type="checkbox"/> | Orthopedic clinic | <input type="checkbox"/> | Screening clinics |
| <input type="checkbox"/> | Balance | <input type="checkbox"/> | Pain clinic | <input type="checkbox"/> | Developmental |
| <input type="checkbox"/> | Feeding clinic | <input type="checkbox"/> | Prosthetic/orthotic clinic | <input type="checkbox"/> | Scoliosis |
| <input type="checkbox"/> | Hand clinic | <input type="checkbox"/> | Seating/mobility clinic | <input type="checkbox"/> | Preparticipation sports |
| <input type="checkbox"/> | Hemophilia clinic | <input type="checkbox"/> | Sports medicine clinic | <input type="checkbox"/> | Wellness |
| <input type="checkbox"/> | Industry | <input type="checkbox"/> | Women's health | <input type="checkbox"/> | Other (specify below) |
| <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 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 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 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 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 | 52 | 4 | 52 |
| Indicate the range of weeks you will accept students for any one part-time (< 36 hrs/wk) clinical experience. | 4 | 52 | 4 | 52 |

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

| Yes | No | | Comments |
|-------------------------------------|--------------------------|--|----------|
| <input checked="" type="checkbox"/> | <input 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?
 Immediate 1 to 1 counseling to the student and relaying of issue to ACCE for resolution.

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.

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 type="checkbox"/> | <input checked="" 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 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 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]).

Program will be tailored to fit each student's strengths and weaknesses. There is quite a bit of manual therapy and clinical reasoning that can be used at any level of student educational level.

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 checked="" type="checkbox"/> | <input type="checkbox"/> | 1. Do students need to contact the clinical site for specific work hours related to the clinical experience? | |
| <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. | please call |
| <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? | Must be done before starting rotation. Additional testing not required if current through university program |
| <input checked="" type="checkbox"/> | <input 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. | 859-623-2057 |
| | | 9. How current are student physical exam records required to be? | within 1 year |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 10. Are any other health tests or immunizations required on-site? If yes, please specify: | |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 11. Is the student required to provide proof of OSHA training? | |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 12. Is the student required to provide proof of HIPAA training? | |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 13. Is the student required to provide proof of any other training prior to orientation at your facility? If yes, please list. | |
| <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 checked="" type="checkbox"/> | <input 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 type="checkbox"/> | <input checked="" 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.) | |

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 checked="" type="checkbox"/> | <input type="checkbox"/> | 33. Will a student need a car to complete the clinical experience? | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 34. Is parking available at the clinical center? | |
| | | a) What is the cost for parking? | 0 |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 35. Is public transportation available? | |
| | | 36. How close is the nearest transportation (in miles) to your site? | |
| | | a) Train station? | NA miles |
| | | b) Subway station? | NA miles |
| | | c) Bus station? | NA miles |
| | | d) Airport? | 50 miles |
| | | 37. Briefly describe the area, population density, and any safety issues regarding where the clinical center is located. Rural city area, clinic located in stripmall off busy bypass road | |
| | | 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 type="checkbox"/> | <input checked="" type="checkbox"/> | 39. Are meals available for students on-site? (If no, go to #40) | |
| | | Breakfast (if yes, indicate approximate cost) | |
| | | 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 casual |
| | | b) Specify dress code for women: | business casual |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 45. Do you require a case study or inservice from all students (part-time and full-time)? | |
| <input checked="" type="checkbox"/> | <input 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. | Missed days must be made up either through extra hours or additional days on a case by case basis. |
| <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 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 outlined plan for emergency responses) | <input type="checkbox"/> | Other (specify below – e.g., bloodborne pathogens, hazardous materials, etc.) |
| <input checked="" type="checkbox"/> | Quality assurance | | |
| <input 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.

KAREN BRANDENBURG, PT, MSPT, OCS

1221 Kenzie Ct. Berea, KY 40403
(859) 986-0642

OBJECTIVE

To use my professional skills as a physical therapist and my interpersonal skills to restore patients' function, in an effort to improve their quality of life in the Madison County area.

EDUCATION

| | | |
|-----------|--|---------------|
| 1993-2000 | University of Kentucky | Lexington, KY |
| | ■ Bachelors of Health Science | |
| | ■ Masters of Science in Physical Therapy | |

CERTIFICATIONS AND ACHIEVEMENTS

- Kentucky State License PT 3903
- Board Certified Orthopedic Clinical Specialist
- APTA Credentialed Clinical Instructor
- Certified ErgoScience FCE Provider
- Certified ASTYM Provider
- Published an interactive CD-ROM entitled "Orthopedic Special Tests for Physical Therapists" and was presented at the APTA National Conference in Anaheim, CA

CLINICAL EXPERIENCE

| | | |
|----------------------|---|---------------|
| OCT 2002-PRESENT | KORT Physical Therapy/Select Medical Corp. | Richmond, KY |
| | ■ Outpatient Orthopedic Physical Therapist with emphasis in manual techniques, industrial rehab, sports medicine | |
| | ■ Promoted to Clinic Director 10/01/04 | |
| | ■ Went to PRN status from April 2007 to April 2008 | |
| APRIL 2007-present | Family Home Health/Amedisys Corp. | Richmond, KY |
| | ■ Home health staff physical therapist full time from April 2007 to April 2008, then PRN from April 2008 to present | |
| | ■ General debility, pulmonary, cardiac, total joints, and other orthopedic diagnoses. | |
| APRIL 2001-OCT 2002 | Pattie A. Clay Regional Medical Center | Richmond, KY |
| | ■ Outpatient Orthopedic Staff Physical Therapist | |
| | ■ Inpatient/Acute Care Coverage PRN | |
| JUNE 2000-April 2001 | Patient Focus Physical Therapy d.b.a. HCI, Inc | Cynthiana, KY |
| | ■ Outpatient Orthopedic Staff Physical Therapist | |
| | ■ Home Health Coverage Harrison County PRN | |

Clinical Instructor: University of Kentucky Physical Therapy Program
Somerset Community College Physical Therapist Assistant Program

****REFERENCES AVAILABLE UPON REQUEST****

CONTINUING EDUCATION

- April 2003 Isolating and Integrating the Functional Chain. Gary Gray course. McEwan.
- October 2003 Physical Work Performance Evaluation. ErgoScience. Lechner.
- March 2005 APTA Clinical Instructor Education and Credentialing Program
- June 2005 PR Polestar Pilates Rehabilitation Principles. Veltkamp
- June 2005 Evidence-based Examination and Selected Manipulative Interventions for Patients with Extremity Disorders. Wainner and Childs.
- October 2005 Kinesiotaping I & II: Fundamentals and Corrective Techniques. Morrison.
- October 2005 An Evidenced Based Course on Differential Diagnosis of Complex Shoulder Disorders. KPTA Conference.
- May 2006 The ASTYM System to the Upper Extremity and Shoulder Girdle. Stover, Helfst, and Larson
- May 2006 The ASTYM System to the Lower Extremity, Pelvis and Lumbar Spine. Stover, Helfst, and Larson.
- June 2006 Evidence-based Examination and Selected Interventions for Patients with Knee Disorders. Fitzgerald.
- July 2006 Evidence-based Examination and Selected Interventions for Patients with Cervical Spine Disorders. Cleland
- Sept 2008 Advanced Hip Problems—From Differentiation to Diagnosis to Discharge. Poulter