# 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 (eg, 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. If you need additional space please attach a separate sheet of paper.
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 to the Department of Physical Therapy Education at angelaboyd@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

| Initial Date 8/21/09 |
|---|
| Revision Date |

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

| | | | | | |
|---|---|---|---|---|---|
| Person Completing CSIF | Jason Wambold, MSPT - Senior Facility Manager | | | | |
| E-mail address of person completing CSIF | jwambold@sptny.com | | | | |
| Name of Clinical Center | Sports Physical Therapy of New York, PC- East Syracuse Location | | | | |
| Street Address | 6319 Fly Road, Suite 4 | | | | |
| City | E. Syracuse | State | NY | Zip | 13057 |
| Facility Phone | (315) 410-0060 | Ext. | | | |
| PT Department Phone | same | Ext. | | | |
| PT Department Fax | (315) 410-0063 | | | | |
| PT Department E-mail | jwambold@sptny.com | | | | |
| Clinical Center Web Address | www.sptny.com | | | | |
| Director of Physical Therapy | Jason Wambold, MSPT | | | | |
| Director of Physical Therapy E-mail | jwambold@sptny.com | | | | |
| Center Coordinator of Clinical Education (CCCE) / Contact Person | Aimee Alexander, PT, MS, CCCE, OCS | | | | |
| CCCE / Contact Person Phone | (518) 583-7537 | | | | |
| CCCE / Contact Person E-mail | aalexander@sptny.com | | | | |
| APTA Credentialed Clinical Instructors (CI)<br>(List name and credentials) | | | | | |
| Other Credentialed CIs<br>(List name and credentials) | | | | | |
| Indicate which of the following are required by your facility prior to the clinical education experience: | ☒ Proof of student health clearance<br>☐ Criminal background check<br>☐ Child clearance<br>☐ Drug screening<br>☒ First Aid and CPR<br>☐ HIPAA education<br>☐ OSHA education<br>☒ Other: Please list Proof of Liability Insurance | | | | |

***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 | PLEASE VISIT SPTNY FOR SPECIFIFC SITE INFORMATION | | | | |
| 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 |
|---|---|---|---|
| ☐ | ☒ | Is your clinical site certified/ accredited? If no, go to #3. | N/A |
| | | If yes, has your clinical site been certified/accredited by: | |
| ☐ | ☒ | JCAHO | N/A |
| ☐ | ☒ | CARF | N/A |
| ☐ | ☒ | Government Agency (eg, CORF, PTIP, rehab agency, state, etc.) | N/A |
| ☐ | ☒ | Other | N/A |
| | | Which of the following best describes the ownership category for your clinical site? (check all that apply)<br><br>☐ Corporate/Privately Owned<br>☐ Government Agency<br>☐ Hospital/Medical Center Owned<br>☐ Nonprofit Agency<br>☐ Physician/Physician Group Owned<br>☒ PT Owned<br>☐ PT/PTA Owned<br>☐ 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 (≥ 50%) of the time. Click on the drop down box to the left to select the number 1.

B. Next, if appropriate, check **(√)** up to four additional categories that describe the other clinical centers associated with your facility.

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Acute Care/Inpatient Hospital Facility | ☐ | Industrial/Occupational Health Facility | ☐ | School/Preschool Program |
| ☐ | Ambulatory Care/Outpatient | ☐ | Multiple Level Medical Center | ☐ | Wellness/Prevention/Fitness Program |
| ☐ | ECF/Nursing Home/SNF | 1 ☒ | Private Practice | ☐ | Other**:** Specify |
| ☐ | Federal/State/County Health | ☐ | 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: AIMEE C. ALEXANDER, PT, MS**, OCS | | **Length of time as the CCCE: 2** | |
| **DATE: (mm/dd/yy) 8/20/09** | | **Length of time as a CI: 13 YEARS** | |
| **PRESENT POSITION**: SENIOR VICE PRESIDENT AND DIRECTOR OF CLINICAL SERVICES, SPORTS PHYSICAL THERAPY OF NEW YORK, PC<br>(Title, Name of Facility) | | **Mark (X) all that apply:**<br>☒ **PT**<br>☐ **PTA**<br>☐ **Other, specify** | **Length of time in clinical practice: 14 YEARS** |
| **LICENSURE:** (State/Numbers)<br>016323-1 | **APTA Credentialed CI**<br>**Yes** ☒ **No** ☐ | **Other CI Credentialing**<br>**Yes** ☐ **No** ☐ | |
| **Eligible for Licensure: Yes** ☒ **No** ☐ | | **Certified Clinical Specialist: Yes** ☐ **No** ☒ | |
| **Area of Clinical Specialization:** | | | |
| **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** | | |
| D'YOUVILLE COLLEGE | **1993** | **1996** | PHYSICAL THERAPY | MS, PT |
| SUNY ONEONTA | **1988** | **1993** | BIO/CHEM | BA |
| | | | | |
| | | | | |
| | | | | |

**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** |
| SPORTS PHYSICAL THERAPY OF NEW YORK PC | SVP CLINICAL SERVICES (formerly multi-site administrator and staff PT) | **1996** | **present** |
| | | | |

**CONTINUING PROFESSIONAL PREPARATION RELATED DIRECTLY TO CLINICAL TEACHING RESPONSIBILITIES** (for example, academic for credit courses [dates and titles], continuing education [courses and instructors], research, clinical practice/expertise, etc. in the **last three (3) years**): Tab to add additional rows.

| **Course** | **Provider/Location** | **Date** |
|---|---|---|
| Available only upon request | | |
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## 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 (eg, 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** |
| Jason Wambold, MSPT | Thomas Jefferson University | 1999 | MSPT | 9 | 7 | A | Yes | 028339-1 | NY |
| | | | | | | | | | |
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***Clinical Instructors***

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

| | | | |
|---|---|---|---|
| ☒ | APTA Clinical Instructor Credentialing | ☐ | No criteria |
| ☐ | Career ladder opportunity | ☐ | Other (not APTA) clinical instructor credentialing |
| ☐ | Certification/training course | ☒ | Therapist initiative/volunteer |
| ☒ | Clinical competence | ☒ | Years of experience: Number: 1+ |
| ☐ | Delegated in job description | ☐ | Other (please specify): |
| ☒ | Demonstrated strength in clinical teaching | | |

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

| | | | |
|---|---|---|---|
| ☒ | 1:1 individual training (CCCE:CI) | ☐ | Continuing education by consortia |
| ☐ | Academic for-credit coursework | ☐ | No training |
| ☒ | APTA Clinical Instructor Education and Credentialing Program | ☐ | Other (not APTA) clinical instructor credentialing program |
| ☐ | Clinical center inservices | ☐ | Professional continuing education (eg, chapter, CEU course) |
| ☐ | Continuing education by academic program | ☐ | 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 | 0 | Psychiatric center | 0 |
| Intensive care | 0 | Rehabilitation center | 0 |
| Step down | 0 | Other specialty centers: Specify | 0 |
| Subacute/transitional care unit | 0 | | |
| Extended care | 0 | **Total Number of Beds** | 0 |

***Number of Patients/Clients***

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

| **INPATIENT** | | **OUTPATIENT** | |
|---|---|---|---|
| N/A | Individual PT | 15 | Individual PT |
| N/A | Student PT | 1-12 | Student PT |
| N/A | Individual PTA | n/a | Individual PTA |
| N/A | Student PTA | n/a | Student PTA |
| N/A | PT/PTA Team | 15-25 | PT/PTA Team |
| N/A | **Total** patient/client visits per day | 15-30 | **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 |
|---|---|---|---|
| 1 | 0-12 years | | Critical care, ICU, acute |
| 1 | 13-21 years | | SNF/ECF/sub-acute |
| 4 | 22-65 years | 5 | Rehabilitation |
| 3 | Over 65 years | | Ambulatory/outpatient |
| | | | Home health/hospice |
| | | 1 | 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 ☒ | Acute injury | 2 ☒ | Muscle disease/dysfunction |
| 1 ☒ | Amputation | 2 ☒ | Musculoskeletal degenerative disease |
| 4 ☒ | Arthritis | 3 ☒ | Orthopedic surgery |
| 2 ☒ | Bone disease/dysfunction | ☐ | Other: (Specify) |
| 5 ☒ | Connective tissue disease/dysfunction | | |
| **(1-5)** | **Neuro-muscular** | | |
| ☐ | Brain injury | ☐ | Peripheral nerve injury |
| ☐ | Cerebral vascular accident | ☐ | Spinal cord injury |
| ☐ | Chronic pain | ☐ | Vestibular disorder |
| ☐ | Congenital/developmental | ☐ | Other: (Specify) |
| ☐ | Neuromuscular degenerative disease | | |
| **(1-5)** | **Cardiovascular-pulmonary** | | |
| ☐ | Cardiac dysfunction/disease | ☐ | Peripheral vascular dysfunction/disease |
| ☐ | Fitness | ☐ | Other: (Specify) |
| ☐ | Lymphedema | | |
| ☐ | Pulmonary dysfunction/disease | | |
| **(1-5)** | **Integumentary** | | |
| ☐ | Burns | ☐ | Other: (Specify) |
| ☐ | Open wounds | | |
| ☐ | Scar formation | | |
| **(1-5)** | **Other** (May cross a number of diagnostic groups) | | |
| ☐ | Cognitive impairment | ☐ | Organ transplant |
| 2 ☐ | General medical conditions | 3 ☐ | Wellness/Prevention |
| 2 ☐ | General surgery | ☐ | Other: (Specify) |
| ☐ | 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 | 7:30AM | 6:00PM | |
| Tuesday | 1:30PM | 6:00PM | |
| Wednesday | 7:30AM | 6:00PM | |
| Thursday | 1:30PM | 6:00PM | |
| Friday | 7:30AM | 6:00PM | |
| Saturday | N/A | N/A | |
| Sunday | N/A | N/A | |

***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 to follow CI's schedule which may vary amongst open clinic hours throughout internship. Missed time must be made up. Saturdays and some holidays are included at times.

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

| | Full-time budgeted | Part-time budgeted | Current Staffing |
|---|---|---|---|
| PTs | 1.0 | .5 | 2.0 |
| PTAs | 0 | 0 | 0 |
| Aides/Techs | 0 | 0 | 0 |
| Others: Specify | 0 | 0 | 0 |

**Information About the Clinical Education Experience**

***Special Programs/Activities/Learning Opportunities***

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

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

***Specialty Clinics***

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

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Arthritis | ☐ | Orthopedic clinic | ☐ | Screening clinics |
| ☐ | Balance | ☐ | Pain clinic | ☐ | Developmental |
| ☐ | Feeding clinic | ☐ | Prosthetic/orthotic clinic | ☐ | Scoliosis |
| ☐ | Hand clinic | ☐ | Seating/mobility clinic | ☒ | Preparticipation sports |
| ☐ | Hemophilia clinic | ☐ | Sports medicine clinic | ☐ | Wellness |
| ☐ | Industry | ☐ | Women's health | ☐ | Other (specify below) |
| ☐ | 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.

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

***Affiliated PT and PTA Educational Programs***

List all PT and PTA education programs with which you currently affiliate. Tab to add additional rows.

| Program Name | City and State | PT | PTA |
|---|---|---|---|
| ALL NYS PT SCHOOLS | NEW YORK STATE | ☒ | ☐ |
| OTHER UPON SPECIFIC REQUEST | | ☒ | ☐ |
| | | ☐ | ☐ |
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***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 |
|---|---|---|---|
| | First experience: Check all that apply.<br>☐ Half days<br>☒ Full days<br>☐ Other: (Specify) | | First experience: Check all that apply.<br>☐ Half days<br>☐ Full days<br>☐ Other: (Specify) |
| | Intermediate experiences: Check all that apply.<br>☐ Half days<br>☒ Full days<br>☐ Other: (Specify) | | Intermediate experiences: Check all that apply.<br>☐ Half days<br>☐ Full days<br>☐ Other: (Specify) |
| | ☒ Final experience | | ☐ Final experience |
| | ☐ Internship (6 months or longer) | | |
| | ☐ 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. | 6-12+ | | | |
| 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 per year. Clarify if multiple sites. | 2-3 | |

| Yes | No | | Comments |
|---|---|---|---|
| ☒ | ☐ | 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?<br>Involvement of CCCE, ACCE. Use of weekly summary forms. |

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.
Arrangements will be made to follow other therapists.

Box will expand to accommodate response.

*Clinical Site's Learning Objectives and Assessment*

| Yes | No | |
|---|---|---|
| ☒ | ☐ | 1. Does your clinical site provide written clinical education objectives to students?<br>If no, go to # 3. |
| | | 2. Do these objectives accommodate: |
| ☒ | ☐ | • The student's objectives? |
| ☒ | ☐ | • Students prepared at different levels within the academic curriculum? |
| ☒ | ☐ | • The academic program's objectives for specific learning experiences? |
| ☒ | ☐ | • Students with disabilities? |
| ☒ | ☐ | 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)**

| | | | |
|---|---|---|---|
| ☒ | Beginning of the clinical experience | ☒ | At mid-clinical experience |
| ☒ | Daily | ☒ | At end of clinical experience |
| ☒ | Weekly | ☐ | Other |

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

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

**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]).**

**Golf evaluation and conditioning program PT/non PT related.**

**Developed Power Groove Rehabilitation Program.**

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 |
|---|---|---|---|
| ☒ | ☐ | 1. Do students need to contact the clinical site for specific work hours related to the clinical experience? | Students will be sent a welcome packet one month prior to affiliation |
| ☒ | ☐ | 2. Do students receive the same official holidays as staff? | Students are expected to work the same hours as CI, including holidays and weekends if applicable |
| ☐ | ☒ | 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. | variable |
| ☒ | ☐ | 5. Is a Mantoux TB test (PPD) required?<br>a) one step_____ (√ check)<br>b) two step_____ (√ check)<br>If yes, within what time frame? | |
| ☒ | ☐ | 6. Is a Rubella Titer Test or immunization required? | |
| ☐ | ☒ | 7. Are any other health tests/immunizations required prior to the clinical experience?<br>If yes, please specify: | |
| | | 8. How is this information communicated to the clinic? Provide fax number if required. | |
| | | 9. How current are student physical exam records required to be? | According to contract language |
| ☐ | ☒ | 10. Are any other health tests or immunizations required on-site?<br>If yes, please specify: | |
| ☐ | ☒ | 11. Is the student required to provide proof of OSHA training? | |
| ☐ | ☒ | 12. Is the student required to provide proof of HIPAA training? | Facility will provide training in first week for student |
| ☐ | ☒ | 13. Is the student required to provide proof of any other training prior to orientation at your facility?<br>If yes, please list. | |
| ☐ | ☒ | 14. Is the student required to attest to an understanding of the benefits and risks of Hepatitis-B immunization? | |
| ☒ | ☐ | 15. Is the student required to have proof of health insurance? | |
| ☐ | ☒ | 16. Is emergency health care available for students? | 911 only |
| ☒ | ☐ | a) Is the student responsible for emergency health care costs? | |
| ☐ | ☒ | 17. Is other non-emergency medical care available to students? | |
| ☒ | ☐ | 18. Is the student required to be CPR certified? | |

| | | | |
|---|---|---|---|
| | | (Please note if a specific course is required). | |

| Yes | No | | Comments |
|---|---|---|---|
| ☐ | ☒ | a) Can the student receive CPR certification while on-site? | sometimes |
| ☒ | ☐ | 19. Is the student required to be certified in First Aid? | |
| ☐ | ☒ | a) Can the student receive First Aid certification on-site? | sometimes |
| ☐ | ☒ | 20. Is a criminal background check required (eg, Criminal Offender Record Information)?<br>If yes, please indicate which background check is required and time frame. | only employees |
| ☐ | ☒ | 21. Is a child abuse clearance required? | |
| ☐ | ☒ | 22. Is the student responsible for the cost or required clearances? | n/a |
| ☒ | ☐ | 23. Is the student required to submit to a drug test?<br>If yes, please describe parameters. | only if suspected of drug use per contract language |
| ☐ | ☒ | 24. Is medical testing available on-site for students? | |
| | | 25. Other requirements: (On-site orientation, sign an ethics statement, sign a confidentiality statement.) | Student will undergo an orientation, including HIPAA training, sign off on alcohol and drug abuse policy and any other facility related documents (professional demeanor) |

***Housing***

| Yes | No | | Comments |
|---|---|---|---|
| ☐ | ☒ | 26. Is housing provided for male students? (If no, go to #32) | |
| ☐ | ☒ | 27. Is housing provided for female students? (If no, go to #32) | |
| | | 28. What is the average cost of housing? | 0 |
| | | 29. Description of the type of housing provided: | n/a |
| | | 30. How far is the housing from the facility? | n/a |
| | | 31. Person to contact to obtain/confirm housing: | n/a |
| | | Name: | |
| | | Address: | |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| | | City: | State: | Zip: | |
| | | Phone: | E-mail: | | |
| **Yes** | **No** | | | | **Comments** |
| | | 32. If housing is **not** provided for either gender: | | | |
| ☐ | ☒ | a) Is there a contact person for information on housing in the area of the clinic?<br>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. | | | |

***Transportation***

| Yes | No | | Comments |
|---|---|---|---|
| ☒ | ☐ | 33. Will a student need a car to complete the clinical experience? | |
| ☒ | ☐ | 34. Is parking available at the clinical center? | |
| | | a) What is the cost for parking? | |
| ☐ | ☐ | 35. Is public transportation available? | Close to bus route |
| | | 36. How close is the nearest transportation (in miles) to your site? | |
| | | a) Train station? | 8 miles |
| | | b) Subway station? | 0 miles |
| | | c) Bus station? | 5 miles |
| | | d) Airport? | 8 miles |
| | | 37. Briefly describe the area, population density, and any safety issues regarding where the clinical center is located.<br>Suburb | |
| | | 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.** (eg, Delorme, Microsoft, Yahoo, Mapquest). | |

***Meals***

| Yes | No | | Comments |
|---|---|---|---|
| ☐ | ☒ | 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) | |
| ☒ | ☐ | 40. Are facilities available for the storage and preparation of food? | |

***Stipend/Scholarship***

| Yes | No | | Comments |
|---|---|---|---|
| ☐ | ☒ | 41. Is a stipend/salary provided for students? If no, go to #43. | |
| | | a) How much is the stipend/salary? ($ / week) | |
| ☐ | ☒ | 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 |
|---|---|---|---|
| ☒ | ☐ | 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: | Professional dress, no shorts, jeans, tshirts |
| | | b) Specify dress code for women: | Professional dress: no shorts, jeans, tshirts, short skirts, low cut shirts. |
| ☒ | ☐ | 45. Do you require a case study or inservice from all students (part-time and full-time)? | |
| ☒ | ☐ | 46. Do you require any additional written or verbal work from the student (eg, article critiques, journal review, patient/client education handout/brochure)? | Facility specific |
| ☐ | ☒ | 47. Does your site have a written policy for missed days due to illness, emergency situations, other? If yes, please summarize. | All missed days must be made up. |
| ☒ | ☐ | 48. Will the student have access to the Internet at the clinical site? | For work purposes only. Very limited |

***Other Student Information***

| Yes | No | |
|---|---|---|
| ☒ | ☐ | 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. |

| | | | |
|---|---|---|---|
| ☒ | Documentation/billing | ☒ | Review of goals/objectives of clinical experience |
| ☒ | Facility-wide or volunteer orientation | ☒ | Student expectations |
| ☒ | Learning style inventory | ☒ | Supplemental readings |
| ☐ | Patient information/assignments | ☒ | Tour of facility/department |
| ☐ | Policies and procedures (specifically outlined plan for emergency responses) | ☒ | Other (specify below - eg, bloodborne pathogens, hazardous materials, etc.) HIPAA training |
| ☐ | Quality assurance | | |
| ☐ | Reimbursement issues | | |
| ☒ | Required assignments (eg, 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.