

# 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](mailto: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

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

Initial Date 9/1/09
Revision Date

Person Completing CSIF	Alison Synakowski - PT, DPT, OCS, ATC, CSCS - Facility Manager				
E-mail address of person completing CSIF	asynakowski@sptny.com				
Name of Clinical Center	Sports Physical Therapy of NY, P.C. - Saratoga Location				
Street Address	1 West Avenue				
City	Saratoga Springs	State	NY	Zip	12866
Facility Phone	518-583-7537	Ext.			
PT Department Phone	same	Ext.			
PT Department Fax	518-583-7606				
PT Department E-mail	asynakowski@sptny.com				
Clinical Center Web Address	www.sptny.com				
Director of Physical Therapy	Alison Synakowski, PT, DPT, OCS, ATC, CSCS				
Director of Physical Therapy E-mail	asynakowski@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) (List name and credentials)	Jeff Fear, MPT Jennifer Szymanski - PT, DPT, ATC				
Other Credentialed CIs (List name and credentials)					
Indicate which of the following are required by your facility prior to the clinical education experience:	<input checked="" 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 type="checkbox"/> HIPAA education <input type="checkbox"/> OSHA education <input checked="" type="checkbox"/> 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
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Is your clinical site certified/ accredited? If no, go to #3.	N/A
		If yes, has your clinical site been certified/accredited by:	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	JCAHO	N/A
<input type="checkbox"/>	<input checked="" type="checkbox"/>	CARF	N/A
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Government Agency (eg, CORF, PTIP, rehab agency, state, etc.)	N/A
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Other	N/A
		Which of the following best describes the ownership category for your clinical site? (check all that apply)	
		<input type="checkbox"/> Corporate/Private 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 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.*

<b>NAME:</b> AIMEE C. ALEXANDER, PT, MS, OCS		<b>Length of time as the CCCE:</b> 2	
<b>DATE:</b> (mm/dd/yy) 8/20/09		<b>Length of time as a CI:</b> 13 YEARS	
<b>PRESENT POSITION:</b> SENIOR VICE PRESIDENT AND DIRECTOR OF CLINICAL SERVICES, SPORTS PHYSICAL THERAPY OF NEW YORK, PC (Title, Name of Facility)		<b>Mark (X) all that apply:</b> <input checked="" type="checkbox"/> PT <input type="checkbox"/> PTA <input type="checkbox"/> Other, specify	<b>Length of time in clinical practice:</b> 14 YEARS
<b>LICENSURE:</b> (State/Numbers) 016323-1	<b>APTA Credentialed CI</b> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	<b>Other CI Credentialing</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>Eligible for Licensure:</b> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>Certified Clinical Specialist:</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>Area of Clinical Specialization:</b>			
<b>Other credentials:</b>			

**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



## CLINICAL INSTRUCTOR INFORMATION

Provide the following information on all PTs or PTAs employed at your clinical site who are **CI**s. **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
Jeffrey B. Fear, MPT	Notre Dame College	2001	MPT	11	9	A	Yes	023991 -1	NY
Jennifer Szymanski	Gannon University	2006	DPT	6	2	A	Yes	028333 -1	NY
Zoe Devito	Boston University	1999	MSPT	10	9		No	019459 -1	NY
Alison Synakowski	SUNY Upstate	2009	DPT	3			Yes	031710 -1	NY

**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 type="checkbox"/>	Certification/training course	<input checked="" type="checkbox"/>	Therapist initiative/volunteer
<input checked="" type="checkbox"/>	Clinical competence	<input checked="" type="checkbox"/>	Years of experience: Number: 1+
<input type="checkbox"/>	Delegated in job description	<input type="checkbox"/>	Other (please specify):
<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 type="checkbox"/>	Professional continuing education (eg, 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	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	<b>Total Number of Beds</b>	0

**Number of Patients/Clients**

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

INPATIENT		OUTPATIENT	
N/A	Individual PT	10	Individual PT
N/A	Student PT	6	Student PT
N/A	Individual PTA	N/A	Individual PTA
N/A	Student PTA	N/A	Student PTA
N/A	PT/PTA Team	N/A	PT/PTA Team
N/A	<b>Total patient/client visits per day</b>	15	<b>Total patient/client visits per day</b>

**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
5	0-12 years	1	Critical care, ICU, acute
4	13-21 years	1	SNF/ECF/sub-acute
4	22-65 years	5	Rehabilitation
5	Over 65 years	5	Ambulatory/outpatient
		1	Home health/hospice
		4	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.

<b>(1-5)</b>	<b>Musculoskeletal</b>		
4 <input checked="" type="checkbox"/>	Acute injury	4 <input checked="" type="checkbox"/>	Muscle disease/dysfunction
<input type="checkbox"/>	Amputation	4 <input checked="" type="checkbox"/>	Musculoskeletal degenerative disease
4 <input checked="" type="checkbox"/>	Arthritis	4 <input checked="" type="checkbox"/>	Orthopedic surgery
4 <input checked="" type="checkbox"/>	Bone disease/dysfunction	<input type="checkbox"/>	Other: (Specify)
4 <input checked="" type="checkbox"/>	Connective tissue disease/dysfunction		
<b>(1-5)</b>	<b>Neuro-muscular</b>		
1 <input type="checkbox"/>	Brain injury	2 <input checked="" type="checkbox"/>	Peripheral nerve injury
2 <input checked="" type="checkbox"/>	Cerebral vascular accident	1 <input type="checkbox"/>	Spinal cord injury
4 <input checked="" type="checkbox"/>	Chronic pain	2 <input checked="" type="checkbox"/>	Vestibular disorder
4 <input checked="" type="checkbox"/>	Congenital/developmental	<input type="checkbox"/>	Other: (Specify)
1 <input type="checkbox"/>	Neuromuscular degenerative disease		
<b>(1-5)</b>	<b>Cardiovascular-pulmonary</b>		
1 <input type="checkbox"/>	Cardiac dysfunction/disease	2 <input checked="" type="checkbox"/>	Peripheral vascular dysfunction/disease
1 <input type="checkbox"/>	Fitness	<input type="checkbox"/>	Other: (Specify)
1 <input type="checkbox"/>	Lymphedema		
1 <input type="checkbox"/>	Pulmonary dysfunction/disease		
<b>(1-5)</b>	<b>Integumentary</b>		
1 <input type="checkbox"/>	Burns	<input type="checkbox"/>	Other: (Specify)
1 <input type="checkbox"/>	Open wounds		
1 <input type="checkbox"/>	Scar formation		
<b>(1-5)</b>	<b>Other (May cross a number of diagnostic groups)</b>		
2 <input checked="" type="checkbox"/>	Cognitive impairment	1 <input type="checkbox"/>	Organ transplant
4 <input checked="" type="checkbox"/>	General medical conditions	3 <input checked="" type="checkbox"/>	Wellness/Prevention
2 <input checked="" 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	7	
Tuesday	7	7	
Wednesday	7	7	
Thursday	7	7	
Friday	7	6	
Saturday	8	12	
Sunday	closed		

**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:  
 Same as CI

**Staffing**

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

	Full-time budgeted	Part-time budgeted	Current Staffing
PTs	3		3
PTAs			
Aides/Techs			
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 type="checkbox"/>	Administration	<input type="checkbox"/>	Industrial/ergonomic PT	<input type="checkbox"/>	Quality Assurance/CQI/TQM
<input type="checkbox"/>	Aquatic therapy	<input type="checkbox"/>	Inservice training/lectures	<input type="checkbox"/>	Radiology
<input 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 type="checkbox"/>	Orthotic/Prosthetic fabrication	<input checked="" type="checkbox"/>	Sports physical therapy
<input type="checkbox"/>	Cardiac rehabilitation	<input type="checkbox"/>	Pain management program	<input 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 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 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 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 checked="" 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 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 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 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 type="checkbox"/> First experience: Check all that apply. <input type="checkbox"/> Half days <input 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 type="checkbox"/> Intermediate experiences: Check all that apply. <input type="checkbox"/> Half days <input type="checkbox"/> Full days <input type="checkbox"/> Other: (Specify)	
<input checked="" type="checkbox"/> Final experience		<input 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	12		
Indicate the range of weeks you will accept students for any one part-time (< 36 hrs/wk) clinical experience.	4	12		

	PT	PTA
Average number of PT and PTA students affiliating <u>per year</u> . Clarify if multiple sites.	4	

Yes	No		Comments
<input 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?  
Call to schools CCCE

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 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 type="checkbox"/>	At mid-clinical experience
<input checked="" type="checkbox"/>	Daily	<input 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 checked="" type="checkbox"/>	<input type="checkbox"/>	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
<input checked="" type="checkbox"/>	<input type="checkbox"/>	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
<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.	variable
<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?	
<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.	
		9. How current are student physical exam records required to be?	According to contract language
<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?	Facility will provide training in first week for student
<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 type="checkbox"/>	<input checked="" 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 type="checkbox"/>	<input checked="" type="checkbox"/>	16. Is emergency health care available for students?	911 only
<input checked="" type="checkbox"/>	<input type="checkbox"/>	a) Is the student responsible for emergency health care costs?	
<input type="checkbox"/>	<input checked="" 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).	
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Yes	No		Comments
<input type="checkbox"/>	<input checked="" type="checkbox"/>	a) Can the student receive CPR certification while on-site?	sometimes
<input checked="" type="checkbox"/>	<input 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?	sometimes
<input type="checkbox"/>	<input checked="" type="checkbox"/>	20. Is a criminal background check required (eg, Criminal Offender Record Information)? If yes, please indicate which background check is required and time frame.	only employees
<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?	n/a
<input checked="" type="checkbox"/>	<input type="checkbox"/>	23. Is the student required to submit to a drug test? If yes, please describe parameters.	only if suspected of drug use per contract language
<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.)	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
<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?	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 <b>not</b> 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 checked="" type="checkbox"/>	<input type="checkbox"/>	35. Is public transportation available?		
		36. How close is the nearest transportation (in miles) to your site?		
		a) Train station?	<1 miles	
		b) Subway station?	miles	
		c) Bus station?	miles	
		d) Airport?	30 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. <b>Travel directions can be obtained from several travel directories on the internet.</b> (eg, <a href="#">Delorme</a> , <a href="#">Microsoft</a> , <a href="#">Yahoo</a> , Mapquest).		

### 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 checked="" 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?	NA

**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:	Professional dress, no shorts, jeans, tshirts
		b) Specify dress code for women:	Professional dress: no shorts, jeans, tshirts, short skirts, low cut shirts.
<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 (eg, article critiques, journal review, patient/client education handout/brochure)?	Facility specific
<input type="checkbox"/>	<input checked="" type="checkbox"/>	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.
<input checked="" type="checkbox"/>	<input type="checkbox"/>	48. Will the student have access to the Internet at the clinical site?	For work purposes only. Very limited

**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?	
<b>(mark X below)</b>		a) Please indicate the typical orientation content by marking an <b>X</b> 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 type="checkbox"/>	Patient information/assignments	<input checked="" type="checkbox"/>	Tour of facility/department
<input type="checkbox"/>	Policies and procedures (specifically outlined plan for emergency responses)	<input checked="" type="checkbox"/>	Other (specify below - eg, bloodborne pathogens, hazardous materials, etc.) HIPAA training
<input type="checkbox"/>	Quality assurance		
<input type="checkbox"/>	Reimbursement issues		
<input checked="" type="checkbox"/>	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.