

CLINICAL SITE INFORMATION FORM (CSIF)
developed by
APTA Department of Physical Therapy Education

Why have a consistent Clinical Site Information Form?

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

How is the form designed?

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

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

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

What should I do once the form has been completed?

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

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



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

DIRECTIONS FOR COMPLETION:

If using a computer to complete this form:

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

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

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

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

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

CLINICAL SITE INFORMATION FORM

I. Information About the Clinical Site

Date (/ /)

| | | | | | |
|---|--|-------|--|------|--|
| Person Completing Questionnaire | | | | | |
| E-mail address of person completing questionnaire | | | | | |
| Name of Clinical Center | | | | | |
| Street Address | | | | | |
| City | | State | | Zip | |
| Facility Phone | | | | Ext. | |
| PT Department Phone | | | | Ext. | |
| PT Department Fax | | | | | |
| PT Department E-mail | | | | | |
| Web Address | | | | | |
| Director of Physical Therapy | | | | | |
| Director of Physical Therapy E-mail | | | | | |
| Center Coordinator of Clinical Education (CCCE) / Contact Person | | | | | |
| CCCE / Contact Person Phone | | | | | |
| CCCE / Contact Person E-mail | | | | | |

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

| | | | | | |
|---|--|-------|-----------------|--------|--|
| Name of Clinical Site | | | | | |
| Street Address | | | | | |
| City | | State | | Zip | |
| Facility Phone | | | | Ext. | |
| PT Department Phone | | | | Ext. | |
| Fax Number | | | Facility E-mail | | |
| Director of Physical Therapy | | | | E-mail | |
| Center Coordinator of Clinical Education/contact (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 | |
| Center Coordinator of Clinical Education/contact (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 | |
| Center Coordinator of Clinical Education/contact (CCCE) | | | | E-mail | |

Clinical Site Accreditation/Ownership

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

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

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

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

| | | | | |
|-------|--|----------|--|-------|
| rural | | suburban | | urban |
|-------|--|----------|--|-------|

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

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

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

6. PT Service hours

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

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

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

| | Full-time budgeted | Part-time budgeted |
|-------------|--------------------|--------------------|
| PTs | | |
| PTAs | | |
| Aides/Techs | | |

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

| INPATIENT | | OUTPATIENT | |
|-----------|--------------------------|------------|--------------------------|
| | Individual PT | | Individual PT |
| | Individual PTA | | Individual PTA |
| | Total PT service per day | | Total PT service per day |

III. Available Learning Experiences

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

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

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

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

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

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

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

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

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

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

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

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

| | | | |
|--------------------------|--|--------------------------|---|
| <input 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 type="checkbox"/> | APTA Clinical Instructor Credentialing | <input type="checkbox"/> | Professional continuing education (eg, chapter, CEU course) |
| <input type="checkbox"/> | Clinical center inservices | <input type="checkbox"/> | Other (please specify) |
| <input type="checkbox"/> | Continuing education by academic program | <input type="checkbox"/> | |

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

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

Please update as each new CCCE assumes this position.

| | | |
|---|--|--|
| NAME: | | Length of time as the CCCE: |
| DATE: (mm/dd/yy) | | Length of time as the CI: |
| PRESENT POSITION: (Title, Name of Facility) | Mark (X) all that apply: ___ PT ___ PTA ___ Other, specify | Length of time in clinical practice: |
| LICENSURE: (State/Numbers) | | Credentialed Clinical Instructor: Yes_____ No_____ |
| Eligible for Licensure: Yes_____ No_____ | | Certified Clinical Specialist: |
| | | Area of Clinical Specialization: |
| | | Other credentials: |

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

| INSTITUTION | PERIOD OF STUDY | | MAJOR | DEGREE |
|-------------|-----------------|----|-------|--------|
| | FROM | TO | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

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

| EMPLOYER | POSITION | PERIOD OF EMPLOYMENT | |
|----------|----------|----------------------|----|
| | | FROM | TO |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

CLINICAL INSTRUCTOR INFORMATION

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

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

CLINICAL INSTRUCTOR INFORMATION (continued)

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

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

| Physical Therapist | | Physical Therapist Assistant | |
|--------------------------|--------------------------|------------------------------|--------------------------|
| <input type="checkbox"/> | First experience | <input type="checkbox"/> | First experience |
| <input type="checkbox"/> | Intermediate experiences | <input type="checkbox"/> | Intermediate experiences |
| <input type="checkbox"/> | Final experience | <input type="checkbox"/> | Final experience |
| <input type="checkbox"/> | Internship | <input type="checkbox"/> | |

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

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

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

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

| | | |
|------------|-----------|--|
| Yes | No | |
|------------|-----------|--|

| | | |
|--|--|--|
| | | 24. Does your clinical site provide written clinical education objectives to students? If no, go to # 27. |
| | | 25. Do these objectives accommodate: |
| | | the student's objectives? |
| | | students prepared at different levels within the academic curriculum? |
| | | academic program's objectives for specific learning experiences? |
| | | students with disabilities? |
| | | 26. Are all professional staff members who provide physical therapy services acquainted with the site's learning objectives? |

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

(mark (X) all that apply)

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

28. How do you provide the student with an evaluation of his/her 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 | | |

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

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

Information for Students - Part II

I. Information About the Clinical Site

| Yes | No | |
|-----|----|--|
| | | 1. Do students need to contact the clinical site for specific work hours related to the clinical experience? |
| | | 2. Do students receive the same official holidays as staff? |
| | | 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: |

Medical Information

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

| Yes | No | | Comments |
|-----|----|--|----------|
|-----|----|--|----------|

| | | | |
|--|--|---|--|
| | | 17. Is a criminal background check required (eg, Criminal Offender Record Information)? | |
| | | a) Is the student responsible for this cost? | |
| | | 18. Is the student required to submit to a drug test? | |
| | | 19. Is medical testing available on-site for students? | |

Housing

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

Transportation

| Yes | No | | |
|-----|----|---|--|
| | | 26. Will a student need a car to complete the clinical experience? | |
| | | 27. Is parking available at the clinical center? | |
| \$ | | a) What is the cost? | |
| | | 28. Is public transportation available? | |
| | | 29. How close is the nearest bus stop (in miles) to your site? | |
| | | a) train station? | |
| | | b) subway station? | |
| | | 30. Briefly describe the area, population density, and any safety issues regarding where the clinical center is located. | |
| | | 31. Please enclose printed directions and/or a map to your facility. Travel directions can be obtained from several travel directories on the internet. (eg, Delorme, Microsoft, Yahoo). | |

Meals

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

Stipend/Scholarship

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

Special Information

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

Other Student Information

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

In appreciation...

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

Index

| | |
|---|------------|
| <u>Saving the Completed Form</u> | Page 2 |
| <u>Affiliated PT and PTA Educational Programs</u> | Page 8 |
| <u>Arranging the Experience</u> | Page 15 |
| <u>Required Background</u> | Page 16 |
| <u>Required Medical Tests</u> | Page 15 |
| <u>Available Learning Experiences</u> | |
| <u>Diagnosis</u> | Page 7 |
| <u>Health Professionals on Site</u> | Page 8 |
| <u>Specialty Clinics</u> | Page 7 |
| <u>Special Programs/Activities/Learning Opportunities</u> | Page 7 |
| <u>Center Coordinators of Clinical Education (CCCEs)</u> | |
| <u>Education</u> | Page 9 |
| <u>Employment Summary</u> | Page 9 |
| <u>Information</u> | Page 9 |
| <u>Teaching Preparation</u> | Page 10 |
| <u>Clinical Instructors</u> | |
| <u>Information</u> | Page 11-12 |
| <u>Selection Criteria</u> | Page 8 |
| <u>Training</u> | Page 8 |
| <u>Clinical Site Accreditation</u> | Page 5 |
| <u>Clinical Site Ownership</u> | Page 5 |
| <u>Clinical Site Primary Classification</u> | Page 5 |
| <u>Information about the Clinical Site</u> | Page 3 |
| <u>Information about Physical Therapy Service</u> | |
| <u>at Primary Center</u> | Page 6 |
| <u>Satellite Site Information</u> | Page 4 |
| <u>Physical Therapy Service</u> | |
| <u>Hours</u> | Page 6 |
| <u>Number of Patients</u> | Page 6 |
| <u>Staffing</u> | Page 6 |
| <u>Student Information</u> | |
| <u>Housing</u> | Page 16 |
| <u>Meals</u> | Page 17 |
| <u>Other</u> | Page 17 |
| <u>Stipends</u> | Page 17 |
| <u>Transportation</u> | Page 17 |