Clinical Site Information Form

Physical Therapist Assistant Technology

Introduction:

The primary purpose of the Clinical Site Information Form is for the Physical Therapist Assistant Technology Program at Washington State Community College to collect information from clinical education sites to:

- Facilitate clinical site selection
- Assist in Student placement
- Assess the learning experiences and clinical practice opportunities that are available to students at a particular site
- Provide assistance with the completion of documentation required for accreditation of our program

The CSIF is divided into two sections:

- Part I: Information for the Academic Program needed by the Academic Coordinator for Clinical Education
- Part II: Information for Students

I thank you for taking the time to complete this form. Your assistance will help to maximize the clinical education experience that we provide to our students.

Sincerely,

Emily Taylor, LPTA, BS

Academic Coordinator for Clinical Education/Asst. Professor Physical Therapist Assistant Technology

Part I: Information for the Academic Program

Information about the Clinical Site – Primary

Name of the Clinical Center:		
Name of Person Completing the CSIF:		
Email address of person completing CSIF:		
Street address of Clinical Center:		
City:	State:	Zip:
Facility Phone #	Ext:	
PT Dept. Phone #:	Ext:	
PT Dept. Fax:		
PT Dept Email:		
Clinical Center Web Address:		
Director of Physical Therapy:		
Center Coordinator of Clinical Education (CCCE)/Contact Person:		
CCCE/Contact Person Phone:		Ext.
CCCE/Contact Person Email:		
APTA Credentialed Clinical Instructors(CI) (List Name and Credentials)		
Other Credentialed Cis (Please list name and credentials)	Name	Credentials

Indicate which of the following are required by your facility prior to the clinical education experience:	☐ Proof of student health clearance from WSCC ☐ CPR card ☐ Current Physical Evaluation ☐ Documentation of TDap ☐ Documentation of MMR ☐ Documentation of Hep B ☐ Documentation of TB (PPD) ☐ Flu ☐ Criminal background check ☐ Child clearance ☐ Drug screening ☐ First Aid ☐ HIPAA education ☐ OSHA education ☐ Other: (Please list)

Information About Multi-Center Facilities

If your health care system or practice has multiple sites or clinical centers, please complete the following tables(s) for each of the sites. Where information is the same as the primary clinical site, indicate "SAME". If your facility has more than 10 associated sites, please attach an addendum. ~Thank you

Name of Clinical Site:		
Street Address:		
City:	State:	Zip:
Facility Phone:		Ext:
PT Dept Phone:		Ext.
Fax Number:	Facility Email:	
Director of Physical Therapy:		Email:
CCCE:		Email:

Name of Clinical Site:		
Street Address:		
City:	State:	Zip:
Facility Phone:		Ext:
PT Dept Phone:		Ext.
Fax Number:	Facility Email:	
Director of Physical Therapy:		Email:
CCCE:		Email:

Name of Clinical Site:		
Street Address:		
City:	State:	Zip:
Facility Phone:		Ext:
PT Dept Phone:		Ext.
Fax Number:	Facility Email:	
Director of Physical Therapy:		Email:
CCCE:		Email:

Name of Clinical Site:		
Street Address:		
City:	State:	Zip:
Facility Phone:		Ext:
PT Dept Phone:		Ext.
Fax Number:	Facility Email:	
Director of Physical Therapy:		Email:
CCCE:		Email:

Name of Clinical Site:		
Street Address:		
City:	State:	Zip:
Facility Phone:		Ext:
PT Dept Phone:		Ext.
Fax Number:	Facility Email:	
Director of Physical Therapy:		Email:
CCCE:		Email:

Name of Clinical Site:		
Street Address:		
City:	State:	Zip:
Facility Phone:		Ext:
PT Dept Phone:		Ext.
Fax Number:	Facility Email:	
Director of Physical Therapy:		Email:
CCCE:		Email:

Name of Clinical Site:		
Street Address:		
City:	State:	Zip:
Facility Phone:		Ext:
PT Dept Phone:		Ext.
Fax Number:	Facility Email:	
Director of Physical Therapy:		Email:
CCCE:		Email:

Name of Clinical Site:		
Street Address:		
City:	State:	Zip:
Facility Phone:		Ext:
PT Dept Phone:		Ext.
Fax Number:	Facility Email:	
Director of Physical Therapy:		Email:
CCCE:		Email:

Name of Clinical Site:		
Street Address:		
City:	State:	Zip:
Facility Phone:		Ext:
PT Dept Phone:		Ext.
Fax Number:	Facility Email:	
Director of Physical Therapy:		Email:
CCCE:		Email:

Name of Clinical Site:		
Street Address:		
City:	State:	Zip:
Facility Phone:		Ext:
PT Dept Phone:		Ext.
Fax Number:	Facility Email:	
Director of Physical Therapy:		Email:
CCCE:		Email:

Clinical Site Primary Classification:

To complete this section, please:

1. Place the number 1 (1) beside the category that best describes how your facility functions the majority (≥ 50%) of the time.
2. 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	☐ Private Practice	☐ Other: Specify
☐ Federal/State/County Health	☐ Rehabilitation/ Sub-acute Rehabiliation	

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 COORDINATOR OF CLINICAL EDUCATION

Please update as each new CCCE assumes this position.

Name:		Length of time as CCCE:
Date:	Length of time as CI:	
Present Position:		
Mark all that apply: ☐ PT ☐ PTA ☐ Other, specify:	Length of time in clinical practice:	Licensure: (State/Lic #)
APTA Credentialed CI: ☐ Yes ☐ No	Other CI Credentialing: ☐ Yes ☐ No	Certified Clinical Specialist: ☐ Yes ☐ No
Area(s) 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

PROFESSIONAL EDUCATION COURSES RELATED DIRECTLY TO CLINICAL TEACHING

This may include academic for credit courses, continuing education courses, and research.

Course	Provider/Location	Date

CLINICAL INSTRUCTOR INFORMATION

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

Name: followed by credentials)	PT/PTA program from which CI graduated	Year of Graduation	Highest Earned PT Degree	No. of years of Clinical Experience	No. of Years of Clinical Teaching	List Certifications: A – APTA Cred. CI B – Other CI Cred C – Cert. Clinical Spec.	State of Licensure

Name: followed by credentials)	PT/PTA program from which CI graduated	Year of Graduation	Highest Earned PT Degree	No. of years of Clinical Experience	No. of Years of Clinical Teaching	List Certifications: A – APTA Cred. CI B – Other CI Cred C – Cert. Clinical Spec.	State of Licensure

Information About the Physical Therapy Services Offered

Hours of Operation:

Facilities with multiple sites with different hours, please give an average. Please note in box any special circumstances.

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

Student Schedule

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

- ☐ Standard 8 hour day
- ☐ Varied Schedules

Describe the schedule(s) the student is expected to follow during the clinical experience:

Information About the Clinical Experience

Special Programs/Activities/Learning Opportunities

☐ 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: ○ Classroom Consultation ○ Cognitive Impairment ○ Musculoskeletal ○ Neurological	☐ Team Meetings/ Rounds
☐ Critical care/ Intensive care		☐ Vestibular Rehab
☐ Departmental Administration		☐ Women's Health/ OB-GYN
☐ Early Intervention		☐ Work Hardening/ conditioning
☐ Employee Intervention		☐ Wound care
☐ Employee Wellness		☐ Other (please specify)
☐ Group Programs/Classes	☐ Prevention/Wellness	
☐ Home Health Program	☐ Pulmonary Rehabilitation	

Specialty Clinics

☐ Arthritis	☐ Orthopedic Clinic	☐ Support Groups (please specify)
☐ Balance	☐ Pain Clinic	
☐ Feeding Clinic	☐ Parkinson's Group	
☐ Hand Clinic	☐ Prosthetic/Orthotic Clinic	
☐ Hemophilia Clinic	☐ Seating/Mobility Clinic	
☐ Industry	☐ Sport Medicine Clinic	☐ Wellness
☐ Neurology Clinic	☐ Screening Clinic	☐ Women's Health
☐ Other:		

Affiliated PT and PTA Education Programs:

List all PT and PTA education programs with which you currently affiliate. Include Name of Educational Institution, City and State.

Educational Institution	City	State

Part II: Information for Students

Arranging the Experience:

Please note: WSCC PTA students begin their clinical experiences with the following:

- Current (within 6 months) physical exam
- Proof of MMR, tDap, and PPD
- Documentation of Hep B vaccination or documentation of reason for refusal
- Documentation of current Flu vaccination or documentation of reason for refusal
- State of Ohio Background Check completed within 2 months of beginning of clinical rotations.
- Up to date CPR card

Yes	No		Comments
☐	☐	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 that the student should report to the clinical site on the first day of the clinical experience.	
☐	☐	5) Is a Mantoux TB test (PPD) required? a) One step _____ (√ check) b) Two step _____(√ check) c) If yes, within what time frame? _____	
☐	☐	6) Is a Rubella Titer Test or immunization required?	
☐	☐	7) Is a flu vaccine required?	
☐	☐	8) Are any other health tests/immunizations required prior to the clinical experience? If yes, please specify:	
		9) How is this information communicated to the clinic? Please provide fax number/email if required.	
		10) How current are exam records required to be?	
☐	☐	11) Are any other health tests or immunizations required on-site? If yes, please specify:	
☐	☐	12) Is the student required to provide proof of OSHA training?	
☐	☐	13) Is the student required to provide proof of HIPAA training?	

☐	☐	14) Is the student required to provide proof of any other training prior to orientation at your facility? If yes, please specify:	
☐	☐	15) Is the student require to attest to an understanding of the benefits and risks of Hepatitis-B immunization?	
☐	☐	16) Is the student required to have proof of health insurance?	
☐	☐	17) Is emergency health care available for students?	
☐	☐	18) Is the student responsible for the cost of any emergency health care?	
☐	☐	19) Is other non-emergency care available to students?	
☐	☐	20) Is the student required to be CPR certified? (Please note if a specific course is required)	
☐	☐	21) Is the student required to be certified in First Aid?	
☐	☐	22) Is a criminal background check required? (If yes, please indicate which background check is required and the time frame)	
☐	☐	23) Is a child abuse clearance required?	
☐	☐	24) Is the student responsible for the cost of required clearances?	
☐	☐	25) Is the student required to submit a drug test? (If yes, please describe the parameters.)	
		26) Other requirements: (On-site orientation, sign an ethics statement, sign a confidentiality statement)	

Housing

Is housing provided for students?

- ☐ Yes
- ☐ No

Name of person to contact regarding housing: _____

Contact Information: _____

_____

Transportation

Yes	No		Comments
☐	☐	1) Is parking available at the clinical center	
☐	☐	2) Is there a cost for parking? If yes, what is the cost?	
☐	☐	3) Does the student require a parking permit? If yes, please comment regarding how this is obtained?	
☐	☐	4) Is public transportation available?	
		Briefly describe the area, population density, and any safety issues regarding where the clinical center is located.	

**Please attach a map of your facility, specifically the location of the department and parking.*

Meals

Yes	No		Comments
☐	☐	1) Are meals available to the student on-site? (If no, go to #2)	
☐	☐	a) Breakfast? (if yes, please indicate approximate cost)	
☐	☐	b) Lunch? (if yes, please indicate approximate cost)	
☐	☐	c) Dinner? (if yes, please indicate approximate cost)	
☐	☐	2) Are facilities available for the storage and preparation of food?	

In appreciation….

Thank you so much for taking the time to complete 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.

We appreciate all that you do for the future of our profession.

Sincerely,

Emily Taylor, LPTA, BS

ACCE/Asst. Professor Physical Therapist Assistant Technology

Washington State Community College

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