

## Site Manager Site Survey —

### Site: Memorial Hospital - South Bend

Section Title	Last Update	Action
CCCE Sign Off	07/19/16 08:06 AM	
<b>CCCE Sign Off</b>		
<div><b>CCCE Sign Off:</b> Click the box below to indicate that you have reviewed all sections of your clinical site survey. <input checked="" type="checkbox"/> This survey has been reviewed.</div>		
Information For the Academic Program	07/19/16 08:06 AM	
<b>Information For the Academic Program</b>		
<b>Person Completing CSIF:</b> Erin Yeoman		
<b>E-mail address of person completing CSIF:</b> yeomane@findlay.edu		
<b>Name of Clinical Center (Note: To correct the name of your site, as it appears in both CSIF Web and CPI Web, update it in this field):</b> Memorial Hospital - South Bend		
<b>Street Address</b>		
<b>Address:</b> 615 North Michigan		
<b>City:</b> South Bend		
<b>State:</b> IN		
<b>Postal Code:</b> 46601		
<b>Facility Phone</b>		
<b>Phone Number:</b>		
<b>Ext:</b>		
<b>PT Department Phone</b>		
<b>Phone Number:</b>		
<b>Ext:</b>		
<b>PT Department Fax</b>		
<b>Phone Number:</b>		
<b>Clinical Center Web Address:</b> <a href="https://qualityoflife.org/rehab/programs/outpatient-orthopedic-and-sports-therapy-clinic/">https://qualityoflife.org/rehab/programs/outpatient-orthopedic-and-sports-therapy-clinic/</a>		
<b>Director of Physical Therapy:</b> Brock Haut		
<b>Center Coordinator of Clinical Education (CCCE) / Contact Person:</b> Elizabeth Kresse		
<b>CCCE / Contact Person Phone:</b> 574-647-6575		
<b>CCCE / Contact Person E-mail:</b> EKresse@beaconhealthsystem.org		

**Section Sign Off:**

Click the box below to indicate you have reviewed and finished with this section of the survey.

☒ This section has been completed.

Information About the Corporate/Healthcare Systems Organization

07/19/16 08:06 AM

**Information About the Corporate/Healthcare Systems Organization**

If your facility is part of a larger corporation or has multiple sites or clinical centers, include the contact information for the corporate/healthcare system organization.

Corporate/Healthcare System Organization:

Contact Name:

Address

Address:

City:

State:

Postal Code:

Phone

Phone Number:

Ext:

Fax

Phone Number:

E-mail:

Affiliation Agreement Contract Fulfillment

Contact Person:

**Section Sign Off:**

Click the box below to indicate you have reviewed and finished with this section of the survey.

☒ This section has been completed.

Clinical Site Accreditation/Ownership

07/19/16 08:06 AM

**Clinical Site Accreditation/Ownership**

Which of the following best describes the ownership category for your clinical site? (check all that apply)

<input type="checkbox"/>	Corporate/Privatey Owned	<input type="checkbox"/>	Government Agency	<input checked="" type="checkbox"/>	Hospital/Medical Center Owned
<input type="checkbox"/>	Nonprofit Agency	<input type="checkbox"/>	PT Owned	<input type="checkbox"/>	PT/PTA Owned
<input type="checkbox"/>	Physician/Physician Group Owned	<input type="checkbox"/>	Other		

**Section Sign Off:**

Click the box below to indicate you have reviewed and finished with this section of the survey.

☒ This section has been completed.

Clinical Site Primary Classification

07/19/16 08:06 AM

**Clinical Site Primary Classification**

Choose the category that best describes how your facility functions the majority (> 50%) of the time.

Ambulatory Care/Outpatient

If appropriate, check ( ) 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"/>	Ambulatory Care/ Outpatient	<input type="checkbox"/>	ECF/ Nursing Home/ SNF
<input type="checkbox"/>	Federal/ State/ County Health	<input type="checkbox"/>	Home Health	<input type="checkbox"/>	Industrial/ Occupational Health Facility

<input type="checkbox"/>	Multiple Level Medical Center	<input type="checkbox"/>	Private Practice	<input type="checkbox"/>	Rehabilitation/Sub-acute Rehabilitation
<input type="checkbox"/>	School/Preschool Program	<input checked="" type="checkbox"/>	Wellness/Prevention/Fitness Program	<input type="checkbox"/>	Other

**Section Sign Off:**

Click the box below to indicate you have reviewed and finished with this section of the survey.

☒ This section has been completed.

Clinical Site Location

07/19/16 08:06 AM

**Clinical Site Location**

Which of the following best describes your clinical site's location

Suburban

**Section Sign Off:**

Click the box below to indicate you have reviewed and finished with this section of the survey.

☒ This section has been completed.

Affiliated PT and PTA Educational Programs

07/19/16 08:06 AM

**Affiliated PT and PTA Educational Programs**

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

Program Name	City	State	PT / PTA
Select the program(s) your site is currently affiliated with:			
By A-Z:	Any		
By State:	Any		
ACCE Demo University,			
ACCE Demo University,			
ACCE Demo University,			
ACCE PTA Demo,			
ASA College, FL			
AT Still University of Health Sciences, AZ			
Academy for Nursing and Health Occupations, FL			
Adventist University of Health Sciences, FL			
Alabama State University, AL			
If not found in the list, please enter the program information here:			
Program Name:			
City:			
State:	AB		
PT / PTA:	PT		
			Add Clear

**Section Sign Off:**

Click the box below to indicate you have reviewed and finished with this section of the survey.

☒ This section has been completed.

Information About the Clinical Teaching Faculty

05/24/16 11:57 AM

**Information About the Clinical Teaching Faculty**

Abbreviated Resume for Center Coordinators of Clinical Education - Please update as each new CCCE assumes this position.

Name:

Brock Haut

Email Address / CPI2 Login:

bhaut@beaconhealthsystem.org

Present Position (Title, Name of Facility):

No. of Years as the CCCE

Please choose:

**No. of Years of Clinical Practice**

Please choose: ▼

**No. of Years of Clinical Teaching**

Please choose: ▼

**No. of Years Working at this Site**

Please choose: ▼

**Check all that apply:**

<input type="checkbox"/>	PT	<input type="checkbox"/>	PTA	
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**Highest Earned Physical Therapy Degree**

Please choose: ▼

**Highest Earned Degree**

Please choose: ▼

**APTA Credentialed CI**☐ Yes ☒ No**APTA Advanced Credentialed CI**☐ Yes ☒ No**Other CI Credentialing**☐ Yes ☒ No**ABPTS Certified Clinical Specialist (Check all that apply)**

<input type="checkbox"/>	OCS	<input type="checkbox"/>	GCS
<input type="checkbox"/>	PCS	<input type="checkbox"/>	NCS
<input type="checkbox"/>	CCS	<input type="checkbox"/>	SCS
<input type="checkbox"/>	ECS	<input type="checkbox"/>	WCS

**APTA Recognition of Advanced Proficiency for PTAs (Check all that apply)**

<input type="checkbox"/>	Aquatic	<input type="checkbox"/>	Musculoskeletal
<input type="checkbox"/>	Cardiopulmonary	<input type="checkbox"/>	Neuromuscular
<input type="checkbox"/>	Geriatric	<input type="checkbox"/>	Pediatrics
<input type="checkbox"/>	Integumentary		

**Other credentials:****Summary of College and University Education**

(Start with most current)

**Institution:****Period of Study**

(If the user is currently enrolled, please type in the word 'CURRENT' into the box labeled 'To'.)

From  &mdash; To **Major:****Degree:****Summary of Primary Employment**

(For current and previous four positions since graduation from college; start with most current)

**Employer:****Position:****Period of Employment**

(If the user is currently employed, please type in the word 'CURRENT' into the box labeled 'To'.)

From  &mdash; To

**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)

Course:

Provider/Location:

Date

Name:

Elizabeth Kresse

Email Address / CPI2 Login:

ekresse@beaconhealthsystem.org

Present Position (Title, Name of Facility):

No. of Years as the CCCE

Please choose: ▼

No. of Years of Clinical Practice

Please choose: ▼

No. of Years of Clinical Teaching

Please choose: ▼

No. of Years Working at this Site

Please choose: ▼

Check all that apply:

☐

PT

☐

PTA

Highest Earned Physical Therapy Degree

Doctor in Physical Therapy ▼

Highest Earned Degree

Professional Doctor in Physical Therapy ▼

APTA Credentialed CI

☐ Yes

☒ No

APTA Advanced Credentialed CI

☐ Yes

☒ No

Other CI Credentialing

☐ Yes

☒ No

ABPTS Certified Clinical Specialist (Check all that apply)

☒

OCS

☐

GCS

☐

PCS

☐

NCS

☐

CCS

☐

SCS

☐

ECS

☐

WCS

APTA Recognition of Advanced Proficiency for PTAs (Check all that apply)

☐

Aquatic

☐

Musculoskeletal

☐

Cardiopulmonary

☐

Neuromuscular

☐ Geriatric

☐ Pediatrics

☐ Integumentary

Other credentials:

Summary of College and University Education

(Start with most current)

Institution:

Period of Study

(If the user is currently enrolled, please type in the word 'CURRENT' into the box labeled 'To'.)

From  &mdash; To

Major:

Degree:

Summary of Primary Employment

(For current and previous four positions since graduation from college; start with most current)

Employer:

Position:

Period of Employment

(If the user is currently employed, please type in the word 'CURRENT' into the box labeled 'To'.)

From  &mdash; To

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)

Course:

Provider/Location:

Date

Section Sign Off:

Click the box below to indicate you have reviewed and finished with this section of the survey.

☐ This section has been completed.

Clinical Instructor Information

05/24/16 11:57 AM

Clinical Instructor Information

Provide the following information on all PTs or PTAs employed at your clinical site who are CIs.		
CI Name Followed By Credentials	CI Username	Actions
Bartholomew, PT, CWS, Starley s	sbartholomew@beaconhealthsystem.org	
Bilionis, Joanne I	JBilionis@beaconhealthsystem.org	
Chizum, PT, Dedra	dchizum@beaconhealthsystem.org	
Clifford, DPT, Anne	aclifford@beaconhealthsystem.org	
Craig, Catherine	ccraig@beaconhealthsystem.org	
Cuthbert, Angie M	acuthbert@beaconhealthsystem.org	
Gaynor, PT, Amy L	agaynor@beaconhealthsystem.org	

Habenicht, Kandace C	khabenicht@beaconhealthsystem.org
Henry, PT, MHS, OCS, Tom	Thenry@beaconhealthsystem.org
Jasinski, PT, MS, MBA, GCS, Jeff	jjasinski@beaconhealthsystem.org
Jaskiewicz, Maciej J	MJaskiewicz@beaconhealthsystem.org
Laird, Lauren	llaird@beaconhealthsystem.org
Linden, Katelyn	klinden@beaconhealthsystem.org
Pelletier, Lori A	lpelletier@beaconhealthsystem.org
Pollock, Leslie	lpollock@beaconhealthsystem.org
Ryman, PT, Christine K	cryman@beaconhealthsystem.org
Ryman, PT, Christine K	cryman@beaconhealthsystem.org
Sebast, Heather	HSEBASTY@beaconhealthsystem.org
Snyder, Angela	asnyder@memorialsb.org
Tomasek, Mike	mtomasek@beaconhealthsystem.org
Wadler, Michal	mkwadler@gmail.com
West, Peter	pwest2@beaconhealthsystem.org
<div>Add New CI</div> <div>Displaying all 22 Clinical instructor</div>	

#### Section Sign Off:

Click the box below to indicate you have reviewed and finished with this section of the survey.

☐ This section has been completed.

Clinical Instructors	11/10/15 09:39 PM
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#### Clinical Instructors

What criteria do you use to select clinical instructors? (Check all that apply)

<input type="checkbox"/> APTA Clinical Instructor Credentialing	<input type="checkbox"/> Career ladder opportunity	<input type="checkbox"/> Certification/ training course
<input type="checkbox"/> Clinical competence	<input type="checkbox"/> Delegated in position description	<input type="checkbox"/> Demonstrated strength in clinical teaching
<input type="checkbox"/> No criteria	<input type="checkbox"/> Other (not APTA) clinical instructor credentialing	<input type="checkbox"/> Therapist initiative/ volunteer
<input type="checkbox"/> Years of experience	<input type="checkbox"/> Other	

How are clinical instructors trained? (Check all that apply)

<input type="checkbox"/> 1:1 individual training (CCCE:CI)	<input type="checkbox"/> APTA Clinical Instructor Education and Credentialing Program	<input type="checkbox"/> Academic for-credit coursework
<input type="checkbox"/> Clinical center inservices	<input type="checkbox"/> Continuing education by academic program	<input type="checkbox"/> Continuing education by consortia
<input type="checkbox"/> No training	<input type="checkbox"/> Other (not APTA) clinical instructor credentialing program	<input type="checkbox"/> Professional continuing education (e.g., chapter, CEU course)
<input type="checkbox"/> Other		

#### Section Sign Off:

Click the box below to indicate you have reviewed and finished with this section of the survey.

☐ This section has been completed.

Information About the Physical Therapy Service	06/27/16 12:36 AM
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#### Information About the Physical Therapy Service

Number of Inpatient Beds For clinical sites with inpatient care, please provide the number of beds available in each of the subcategories listed below: (If this does not apply to your facility, please skip and move to the next table.)

Acute care:

Psychiatric center:

Intensive care:

Rehabilitation center:

Step down:

Subacute/transitional care unit:

Extended care:

Other specialty centers:

Total Number of Beds:

0

#### Section Sign Off:

Click the box below to indicate you have reviewed and finished with this section of the survey.

☒ This section has been completed.

Number of Patients/Clients

06/27/16 12:36 AM

#### Number of Patients/Clients

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

Inpatient	Outpatient
Individual PT:	Individual PT:
Student PT:	Student PT:
Individual PTA:	Individual PTA:
Student PTA:	Student PTA:
PT/PTA Team:	PT/PTA Team:
0	0
Total patient/client visits per day:	Total patient/client visits per day:

#### Section Sign Off:

Click the box below to indicate you have reviewed and finished with this section of the survey.

☒ This section has been completed.

Patient/Client Lifespan and Continuum of Care

06/27/16 12:36 AM

#### Patient/Client Lifespan and Continuum of Care

Indicate the frequency of time typically spent with patients/clients in each of the categories:

##### Patient Lifespan

0-12 years

0%

13-21 years

1% - 25%

22-65 years

1% - 25%

Over 65 years

51% - 75%

##### Continuum of Care

Critical care, ICU, acute



0%

SNF/ECF/sub-acute

0%

Rehabilitation

76% - 100%

Ambulatory/outpatient

76% - 100%

Home health/hospice

0%

Wellness/fitness/industry

1% - 25%

#### Section Sign Off:

Click the box below to indicate you have reviewed and finished with this section of the survey.

☒ This section has been completed.

Patient/Client Diagnoses

06/27/16 12:36 AM

#### Patient/Client Diagnoses

Indicate the frequency of time typically spent with patients/ clients in each of the categories:

Musculoskeletal

76% - 100%

Which Musculoskeletal sub-categories are available to the student:

<input checked="" type="checkbox"/>	Acute injury	<input type="checkbox"/>	Amputation	<input checked="" type="checkbox"/>	Arthritis
<input checked="" type="checkbox"/>	Bone disease/ dysfunction	<input type="checkbox"/>	Connective tissue disease/ dysfunction	<input checked="" type="checkbox"/>	Muscle disease/ dysfunction
<input checked="" type="checkbox"/>	Musculoskeletal degenerative disease	<input checked="" type="checkbox"/>	Orthopedic surgery	<input type="checkbox"/>	Other

Neuro-muscular

1% - 25%

Which Neuro-muscular sub-categories are available to the student:

<input type="checkbox"/>	Brain injury	<input type="checkbox"/>	Cerebral vascular accident	<input checked="" type="checkbox"/>	Chronic pain
<input type="checkbox"/>	Congenital/ developmental	<input type="checkbox"/>	Neuromuscular degenerative disease	<input type="checkbox"/>	Peripheral nerve injury
<input type="checkbox"/>	Spinal cord injury	<input type="checkbox"/>	Vestibular disorder	<input type="checkbox"/>	Other

Cardiovascular-pulmonary

0%

Which Cardiovascular-pulmonary sub-categories are available to the student:

<input type="checkbox"/>	Cardiac dysfunction/ disease	<input type="checkbox"/>	Fitness	<input type="checkbox"/>	Lymphedema
<input type="checkbox"/>	Peripheral vascular dysfunction/ disease	<input type="checkbox"/>	Pulmonary dysfunction/ disease	<input type="checkbox"/>	Other

Integumentary

1% - 25%

Which Integumentary sub-categories are available to the student:

<input type="checkbox"/>	Burns	<input type="checkbox"/>	Open wounds	<input checked="" type="checkbox"/>	Scar formation
<input type="checkbox"/>	Other				

Other (May cross a number of diagnostic groups)

1% - 25% ▼

Which other sub-categories are available to the student:

<input type="checkbox"/>	Cognitive impairment	<input type="checkbox"/>	General medical conditions	<input type="checkbox"/>	General surgery
<input type="checkbox"/>	Oncologic conditions	<input type="checkbox"/>	Organ transplant	<input type="checkbox"/>	Wellness/ Prevention
<input checked="" type="checkbox"/>	Other				

Please explain:

#### Section Sign Off:

Click the box below to indicate you have reviewed and finished with this section of the survey.

☒ This section has been completed.

Staffing

06/27/16 12:36 AM

#### Staffing

	Full-time Budgeted	Part-time Budgeted	Current Staffing
PTs	2	0	2
PTAs	1	0	1
Aides/Techs	0	0	0
Other: Secretary	1	0	1

#### Section Sign Off:

Click the box below to indicate you have reviewed and finished with this section of the survey.

☒ This section has been completed.

Information About the Clinical Education Experience

06/27/16 12:55 AM

#### Information About the Clinical Education Experience

Special Programs/Activities/ Learning Opportunities

Please check all special programs/activities/learning opportunities available to students.

<input checked="" type="checkbox"/>	Administration	<input checked="" type="checkbox"/>	Aquatic Therapy	<input type="checkbox"/>	Athletic Venue Coverage
<input type="checkbox"/>	Back School	<input type="checkbox"/>	Biomechanics Lab	<input type="checkbox"/>	Cardiac Rehabilitation
<input type="checkbox"/>	Community/Re-entry Activities	<input type="checkbox"/>	Critical Care/Intensive Care	<input checked="" type="checkbox"/>	Departmental Administration
<input type="checkbox"/>	Early Intervention	<input type="checkbox"/>	Employee Intervention	<input type="checkbox"/>	Employee Wellness Program
<input type="checkbox"/>	Group Programs/ Classes	<input type="checkbox"/>	Home Health Program	<input checked="" type="checkbox"/>	Industrial/Ergonomic PT
<input checked="" type="checkbox"/>	Inservice Training/Lectures	<input type="checkbox"/>	Neonatal Care	<input type="checkbox"/>	Nursing Home/ ECF/SNF
<input type="checkbox"/>	Orthotic/ Prosthetic Fabrication	<input type="checkbox"/>	Pain Management Program	<input type="checkbox"/>	Pediatric - Classroom Consultation Emphasis
<input type="checkbox"/>	Pediatric - Cognitive Impairment Emphasis	<input type="checkbox"/>	Pediatric - Developmental Program Emphasis	<input checked="" type="checkbox"/>	Pediatric - General
<input type="checkbox"/>	Pediatric - Musculoskeletal Emphasis	<input type="checkbox"/>	Pediatric - Neurological Emphasis	<input type="checkbox"/>	Prevention/Wellness
<input type="checkbox"/>	Pulmonary Rehabilitation	<input type="checkbox"/>	Quality Assurance/ CQI/TQM	<input type="checkbox"/>	Radiology
<input type="checkbox"/>	Research Experience	<input type="checkbox"/>	Screening/ Prevention	<input checked="" type="checkbox"/>	Sports Physical Therapy
<input checked="" type="checkbox"/>	Surgery (observation)	<input type="checkbox"/>	Team Meetings/Rounds	<input type="checkbox"/>	Vestibular Rehabilitation
<input checked="" type="checkbox"/>	Women's Health/OB-GYN	<input type="checkbox"/>	Work Hardening/Conditioning	<input type="checkbox"/>	Wound Care
<input type="checkbox"/>	Other				

Specialty Clinics

Please check all specialty clinics available as student learning experiences.

<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Balance	<input type="checkbox"/>	Developmental
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<input type="checkbox"/>	Feeding clinic	<input type="checkbox"/>	Hand clinic	<input type="checkbox"/>	Hemophilia clinic
<input type="checkbox"/>	Industry	<input type="checkbox"/>	Neurology clinic	<input checked="" type="checkbox"/>	Orthopedic clinic
<input type="checkbox"/>	Pain clinic	<input type="checkbox"/>	Preparticipation sports	<input type="checkbox"/>	Prosthetic/orthotic clinic
<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	Screening clinics	<input type="checkbox"/>	Seating/mobility clinic
<input checked="" type="checkbox"/>	Sports medicine clinic	<input checked="" type="checkbox"/>	Wellness	<input checked="" type="checkbox"/>	Women's health
<input type="checkbox"/>	Other				

#### Health and Educational Providers at the Clinical Site

Please check 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"/>	Alternative therapies	<input type="checkbox"/>	Athletic trainers
<input type="checkbox"/>	Audiologists	<input type="checkbox"/>	Dietitians	<input type="checkbox"/>	Enterostomal / wound specialists
<input type="checkbox"/>	Exercise physiologists	<input type="checkbox"/>	Fitness professionals	<input type="checkbox"/>	Health information technologists
<input type="checkbox"/>	Massage therapists	<input type="checkbox"/>	Nurses	<input type="checkbox"/>	Occupational therapists
<input type="checkbox"/>	Physician assistants	<input type="checkbox"/>	Physicians	<input type="checkbox"/>	Podiatrists
<input type="checkbox"/>	Prosthetists / orthotists	<input type="checkbox"/>	Psychologists	<input type="checkbox"/>	Respiratory therapists
<input type="checkbox"/>	Social workers	<input type="checkbox"/>	Special education teachers	<input type="checkbox"/>	Speech/language pathologists
<input type="checkbox"/>	Students from other disciplines	<input type="checkbox"/>	Students from other physical therapy education programs	<input type="checkbox"/>	Therapeutic recreation therapists
<input type="checkbox"/>	Vocational rehabilitation counselors	<input type="checkbox"/>	Other		

#### Section Sign Off:

Click the box below to indicate you have reviewed and finished with this section of the survey.

☒ This section has been completed.

Availability of the Clinical Education Experience

06/27/16 12:52 AM

#### Availability of the Clinical Education Experience

Indicate educational levels at which you accept PT and PTA students for clinical experiences (Check all that apply).

##### Physical Therapist

##### First Experience:

<input checked="" type="checkbox"/>	Full days	<input type="checkbox"/>	Half days	<input type="checkbox"/>	Other
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##### Physical Therapist

##### Intermediate Experiences:

<input checked="" type="checkbox"/>	Full days	<input type="checkbox"/>	Half days	<input type="checkbox"/>	Other
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##### Physical Therapist

<input checked="" type="checkbox"/>	Final Experience	<input type="checkbox"/>	Internship (6 months or longer)	<input type="checkbox"/>	Specialty experience
<input type="checkbox"/>	Other				

##### Physical Therapist Assistant

##### First Experience:

<input checked="" type="checkbox"/>	Full days	<input type="checkbox"/>	Half days	<input type="checkbox"/>	Other
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##### Physical Therapist Assistant

##### Intermediate Experiences:

<input checked="" type="checkbox"/>	Full days	<input type="checkbox"/>	Half days	<input type="checkbox"/>	Other
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##### Physical Therapist Assistant

<input checked="" type="checkbox"/>	Final Experience	<input type="checkbox"/>	Other	
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PT

Indicate which months you will accept students for any single full-time (36 hrs/wk) clinical experience.

<input checked="" type="checkbox"/>	January	<input checked="" type="checkbox"/>	February	<input checked="" type="checkbox"/>	March
<input checked="" type="checkbox"/>	April	<input checked="" type="checkbox"/>	May	<input checked="" type="checkbox"/>	June

<input checked="" type="checkbox"/>	July	<input checked="" type="checkbox"/>	August	<input checked="" type="checkbox"/>	September
<input checked="" type="checkbox"/>	October	<input checked="" type="checkbox"/>	November	<input checked="" type="checkbox"/>	December

Indicate which months you will accept students for any one part-time (< 36 hrs/wk) clinical experience.

<input checked="" type="checkbox"/>	January	<input checked="" type="checkbox"/>	February	<input checked="" type="checkbox"/>	March
<input checked="" type="checkbox"/>	April	<input checked="" type="checkbox"/>	May	<input checked="" type="checkbox"/>	June
<input checked="" type="checkbox"/>	July	<input checked="" type="checkbox"/>	August	<input checked="" type="checkbox"/>	September
<input checked="" type="checkbox"/>	October	<input checked="" type="checkbox"/>	November	<input checked="" type="checkbox"/>	December

PTA

Indicate which months you will accept students for any single full-time (36 hrs/wk) clinical experience.

<input checked="" type="checkbox"/>	January	<input checked="" type="checkbox"/>	February	<input checked="" type="checkbox"/>	March
<input checked="" type="checkbox"/>	April	<input checked="" type="checkbox"/>	May	<input checked="" type="checkbox"/>	June
<input checked="" type="checkbox"/>	July	<input checked="" type="checkbox"/>	August	<input checked="" type="checkbox"/>	September
<input checked="" type="checkbox"/>	October	<input checked="" type="checkbox"/>	November	<input checked="" type="checkbox"/>	December

Indicate which months you will accept students for any one part-time (< 36 hrs/wk) clinical experience.

<input checked="" type="checkbox"/>	January	<input checked="" type="checkbox"/>	February	<input checked="" type="checkbox"/>	March
<input checked="" type="checkbox"/>	April	<input checked="" type="checkbox"/>	May	<input checked="" type="checkbox"/>	June
<input checked="" type="checkbox"/>	July	<input checked="" type="checkbox"/>	August	<input checked="" type="checkbox"/>	September
<input checked="" type="checkbox"/>	October	<input checked="" type="checkbox"/>	November	<input checked="" type="checkbox"/>	December

Average number of PT students affiliating per year.:

Average number of PTA students affiliating per year.:

Is your clinical site willing to offer reasonable accommodations for students under ADA?

☐ Yes ☐ No

What is the procedure for managing students whose performance is below expectations or unsafe?:

Explain what provisions are made for students if the clinical instructor is ill or away from the clinical site.<br/>(Answer if the clinical center employs only one PT or PTA.):

#### Section Sign Off:

Click the box below to indicate you have reviewed and finished with this section of the survey.

☐ This section has been completed.

Clinical Site's Learning Objectives and Assessment

06/27/16 12:55 AM

### Clinical Site's Learning Objectives and Assessment

Does your clinical site provide written clinical education objectives to students?

☒ Yes ☐ No

Are all professional staff members who provide physical therapy services acquainted with the clinical site's learning objectives?

☒ Yes ☐ No

When do the CCCE and/or CI typically discuss the clinical site's learning objectives with students? (Check all that apply)

<input type="checkbox"/>	At end of clinical experience	<input type="checkbox"/>	At mid-clinical experience	<input checked="" type="checkbox"/>	Beginning of the clinical experience
<input type="checkbox"/>	Daily	<input type="checkbox"/>	Weekly	<input type="checkbox"/>	Other

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

<input checked="" type="checkbox"/>	As per student request in addition to formal and ongoing written & oral feedback	<input checked="" type="checkbox"/>	Ongoing feedback throughout the clinical	<input checked="" type="checkbox"/>	Student self-assessment throughout the clinical
<input checked="" type="checkbox"/>	Written and oral mid-evaluation	<input checked="" type="checkbox"/>	Written and oral summative final evaluation	<input type="checkbox"/>	Other

#### Section Sign Off:

Click the box below to indicate you have reviewed and finished with this section of the survey.

☒ This section has been completed.

**Student Requirements**

**Do students need to contact the clinical site for specific work hours related to the clinical experience?**

☐ Yes ☒ No

Please explain:

School sends students information about specific work hours related to the clinical experience.

**Do students receive the same official holidays as staff?**

☒ Yes ☐ No

Please explain:

**Does your clinical site require a student interview?**

☐ Yes ☒ No

Please explain:

**Indicate the time the student should report to the clinical site on the first day of the experience.**

Please choose: ▼

**Is a Mantoux TB test (PPD) required?**

**a) one step**

☒ Yes ☐ No

**b) two step**

☐ Yes ☐ No

**Is a Rubella Titer Test or immunization required?**

☒ Yes ☐ No

Please explain:

**Are any other health tests/immunizations required prior to the clinical experience? If yes, please specify:**

☒ Yes ☐ No

Please explain:

Flu shot

**How is this information communicated to the clinic? Provide fax number if required.:**

**How current are student physical exam records required to be?:**

**Are any other health tests or immunizations required on-site? If yes, please specify:**

☐ Yes ☒ No

**Is the student required to provide proof of any other training prior to orientation at your facility? If yes, please list.**

☐ Yes ☒ No

**Indicate which of the following are required by your facility prior to the clinical education experience:**

<input type="checkbox"/>	Child clearance	<input checked="" type="checkbox"/>	Criminal background check	<input type="checkbox"/>	Drug screening
<input checked="" type="checkbox"/>	HIPAA education	<input checked="" type="checkbox"/>	OSHA education	<input checked="" type="checkbox"/>	Proof of student health clearance
<input type="checkbox"/>	Other				

**Is a criminal background check required (e.g., Criminal Offender Record Information)? If yes, please indicate which background check is required and time frame.**

☒ Yes ☐ No

Please explain:

**Is a child abuse clearance required?**

☐ Yes ☒ No

Please explain:

**Is the student responsible for the cost of required clearances?**

☒ Yes ☐ No

Please explain:

**Is the student required to submit to a drug test? If yes, please describe parameters.**

☐ Yes ☒ No

**Is medical testing available on-site for students?**

☐ Yes ☒ No

Please explain:

**Other requirements: (On-site orientation, sign an ethics statement, sign a confidentiality statement.):**

If an individual is responsible for Compliance items, please fill out the Compliance contact information below:

**Compliance Contact Person Name:**

**Compliance Contact Person Phone Number**

**Phone Number:**

**Ext:**

**Compliance Contact Person Email:**

#### Section Sign Off:

Click the box below to indicate you have reviewed and finished with this section of the survey.

☒ This section has been completed.

Special Information

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#### Special Information

**Do you require a case study or inservice from all students (part-time and full-time)?**

☒ Yes ☐ No

Please explain:

Inservice

**Do you require any additional written or verbal work from the student (e.g., article critiques, journal review, patient/client education handout/brochure)?**

☐ Yes ☒ No

Please explain:

**Does your site have a written policy for missed days due to illness, emergency situations, other? If yes, please summarize.**

☐ Yes ☐ No

**Will the student have access to the Internet at the clinical site?**

☒ Yes ☐ No

Please explain:

**Is there a facility/student dress code?**

☒ Yes ☐ No

**Is emergency health care available for students?**

☒ Yes ☐ No

Please explain:

**Is the student responsible for emergency health care costs?**

☒ Yes ☐ No

Please explain:

**Is other non-emergency medical care available to students?**

☒ Yes ☐ No

Please explain:

**Is the student required to have proof of health insurance?**

☒ Yes ☐ No

Please explain:

**Is the student required to provide proof of OSHA training?**

☐ Yes ☒ No

Please explain:

**Is the student required to provide proof of HIPAA training?**

☒ Yes ☐ No

Please explain:

**Is the student required to attest to an understanding of the benefits and risks of Hepatitis-B immunization?**

☐ Yes ☐ No

**Is the student required to be CPR certified? (Please note if a specific course is required).**

☒ Yes ☐ No

Please explain:

**Can the student receive CPR certification while on-site?**

☐ Yes ☒ No

Please explain:

**Is the student required to be certified in First Aid?**

☒ Yes ☐ No

Please explain:

**Can the student receive First Aid certification on-site?**

☐ Yes ☒ No

Please explain:

#### Section Sign Off:

Click the box below to indicate you have reviewed and finished with this section of the survey.

☒ This section has been completed.

Student Schedule

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#### Student Schedule

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

Varied schedules

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

**Is physical therapy provided on the weekends?**

☒ Yes ☐ No

#### Section Sign Off:

Click the box below to indicate you have reviewed and finished with this section of the survey.

☒ This section has been completed.

"Key fields have been marked with an asterisks. Please see the CSIF Web Help Manual for more details about Key Fields"