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| | ryce Kinnas, DPT,CCCE | | | |
| CCCE / Contact Person Phone: | | | | |

| (239)947-4440 | | | | | |
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| CCCE / Contact Person E-mail: | | | | | |
| Bryce.Kinnas@NCHMD.org | | | | | |
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| Section Sign Off: | | | | | |
| Click the box below to indicate you have reviewed and finished w | ith this | section of the survey. | | | |
| This section has been completed. | | | | | |
| Information About the Corporate/Healthcare Systems Organ | nizatio | 'n | | 12/08/13 03:13 PM | |
| Information About the Corporate/Healthcare Sys | tems | Organization | | | |
| If your facility is part of a larger corporation or has multi | iple si | tes or clinical centers, include the contact informatio | on for | the corporate/healthcare system org | anization. |
| Corporate/Healthcare System Organization: | | | | | |
| NCH Downtown Naples Hospitaltel: | | | | | |
| Contact Name: | | | | | |
| Naples Community Hospital Corperation | | | | | |
| Address | | | | | |
| Address: | | | | | |
| 350 7th Street North Naples FL 34102 | | | | | |
| 11190 Health Park Blvd. Naples FL34110 | | | | | |
| | | | | | |
| City: | | | | | |
| Naples | | | | | |
| State: | | | | | |
| FI | | | | | |
| Postal Code: | | | | | |
| 34110 | | | | | |
| Dhama | | | | | |
| Phone Phone Number: | | | | | |
| 239-624-5000 | | | | | |
| Ext: | | | | | |
| Fax | | | | | |
| Phone Number: | | | | | |
| E-mail: | | | | | |
| Affiliation Agreement Contract Fulfillment | | | | | |
| Contact Person: | | | | | |
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| Section Sign Off: | | | | | |
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| Clinical Site Accreditation/Ownership | | | | 12/08/13 03:13 PM | |
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| Clinical Site Accreditation/Ownership | | | | | |
| Which of the following best describes the ownership categor | ry for | your clinical site? (check all that apply) | | | |
| Corporate/Privately Owned | | Government Agency | | Hospital/Medical Center Owned | |
| | | PT Owned | | PT/PTA Owned | |
| | | | | 1 I/I IA Owned | |
| Physician/Physician Group Owned | | Other | | | |
| | | | | | |
| Section Sign Off: | | | | | |
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| Jini | cal Site Primary Classification | | | | | | | | |
| Clin | ical Site Primary Classification | | | | | | | | |
| | | | | 1 | | | | | |
| | ese the category that best describes how your facility fu | nction | is the majority (> 50%) of t | he time. | | | | | |
| Plea | ase choose: | | | | | | | | |
| f ap | propriate, check () up to four additional categories that | t descr | ibe the other clinical cent | ers associated with you | r facility. | | | | |
| 7 | Acute Care/Inpatient Hospital Facility | V | Ambulatory Care/Outpatie | nt | Г | ECF/Nursing Home/SNF | | | |
| | Federal/State/County Health | | Home Health | | | Industrial/Occupational I | Iealth Facil | ity | |
| _ | Multiple Level Medical Center | Г | Private Practice | | | Rehabilitation/Sub-acute | | | |
| _ | | | | | _ | | nenaointau | 011 | |
| | School/Preschool Program | | Wellness/Prevention/Fitne | ss Program | | Other | | | |
| | | | | | | | | | |
| Se | ction Sign Off: | | | | | | | | |
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| Jini | cal Site Location | | | | | 12/08/13 03:13 PM | | | |
| Clin | ical Site Location | | | | | | | | |
| | | | | | | | | | |
| Vhic | h of the following best describes your clinical site's loca | tion | | | | | | | |
| Sub | urban 💌 | | | | | | | | |
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| 50 | ction Sign Off: | | | | | | | | |
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| | ck the box below to indicate you have reviewed and finished w | rith this | section of the survey. | | | | | | |
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| bbreviated Resume for Center Coordinators of Clinical Ed | lucation - Please update as each new CCCE a | ssumes this position. | |
| Nomo | | | |
| Name: Andrei J. Altavas | | | |
| Email Address / CPI2 Login: | | | |
| | | | |
| Andrei.Altavas@nchmd.org | | | |
| Present Position (Title, Name of Facility): | | | |
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| Joshua Lewis | | | | | | | |
| Email Address / CP12 Login: | | | | | | | |
| Joshua.Lewis@nchmd.org | | | | | | | |
| Present Position (Title, Name of Facility): | | | | | | | |

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| inical Instructor Information | | 01/25/17 10:03 AM | | | | | |
| linical Instructor Information | | | | | | | |
| Provide the following information on all PTs of | PTAs employed at your clinical site who are CIs. | | | | | | |
| CI Name Followed By Credentials | CI Username | Actions | | | | | |
| Algigi, AnnMarie | annmarie.algigi@nchmd.org | | | | | | |
| | | | | | | | |
| Baldwin, Sara K | sara.baldwin@nchmd.org | | | | | | |
| Banfield, Mary Lynn H | marylynn.hodges@nchmd.org | | | | | | |
| Burns, Kathleen | kathleen.burns@nchmd.org | | | | | | |
| Carroll, Diane | diane.carroll@nchmd.org | | | | | | |
| Christianson, Melinda j | melinda.christianson@nchmd.org | | | | | | |
| Cirino, Carin r | carin.cirino@nchmd.org | | | | | | |
| Crick, James P | james.crick@nchmd.org | | | | | | |
| Hiller, Alyssa N | | | | | | | |
| | alvssafolk@gmail.com | | | | | | |
| Kinnag Bruco T | alyssafolk@gmail.com | | | | | | |
| Kinnas, Bryce T | alyssafolk@gmail.com bryce.kinnas@nchmd.org | | | | | | |
| Listowski, Stephanie | | | | | | | |
| | bryce.kinnas@nchmd.org | | | | | | |
| Listowski, Stephanie | bryce.kinnas@nchmd.org stephanie.listowski@nchmd.org | | | | | | |

| Ne | elsen, Anna M | Ar | nna.Nelsen@nchmd.org | | | | | | |
|--|---|----------|---|---------|---|--|--|--|--|
| Pe | rez, Janet | Ja | net.Perez@nchmd.org | | | | | | |
| Rit | Ritchie, Marilyn marilyn.ritchie@nchmd.org | | | | | | | | |
| | | | | | | | | | |
| Ro | jas, PT/DPT, Marlen | М | arlen.Rojas@nchmd.org | | | | | | |
| Ry | an, Shelley | Sh | uelley.Ryan@nchmd.org | | | | | | |
| Til | lotson, Richard | tra | avtillo@hotmail.com | | | | | | |
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| | cal Instructors criteria do you use to select clinical instructors? (Checl | call th | at apply) | | | | | | |
| V | APTA Clinical Instructor Credentialing | | Career ladder opportunity | V | Certification/training course | | | | |
| 7 | Clinical competence | | Delegated in position description | | Demonstrated strength in clinical teaching | | | | |
| | No criteria | | Other (not APTA) clinical instructor credentialing | | Therapist initiative/volunteer | | | | |
| V | Years of experience | | Other | | | | | | |
| How a | are clinical instructors trained? (Check all that apply) | | | | | | | | |
| | 1:1 individual training (CCCE:CI) | | APTA Clinical Instructor Education and Credentialing Program | | Academic for-credit coursework | | | | |
| 7 | Clinical center inservices | | Continuing education by academic program | | Continuing education by consortia | | | | |
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| | | | | | | | | | |
| Num to yo | ur facility, please skip and move to the next table.) | t care | , please provide the number of beds available in eac | h of tl | he subcategories listed below: (If this does not apply | | | | |
| Acute Psvchi | care: iatric center: | | | | | | | | |
| Psychiatric center: Intensive care: | | | | | | | | | |
| Rehabilitation center: | | | | | | | | | |
| Step d | own: | | | | | | | | |
| Step down: Subacute/transitional care unit: | | | | | | | | | |
| | | | | | | | | | |
| | led care: | | | | | | | | |
| Extend Other | led care: specialty centers: | | | | | | | | |
| Extend Other | led care: | | | | | | | | |

| 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 | 12/08/13 03:31 PM | | | | | | |
| 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 Total patient/client visits per day: | 0 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 | 12/08/13 03:31 PM | | | | | | |
| Patient/Client Lifespan and Continuum of Care | | | | | | | |
| Indicate the frequency of time typically spent with patients/clients in each of the cate | gories: | | | | | | |
| Patient Lifespan | | | | | | | |
| 0-12 years | | | | | | | |
| 0% | | | | | | | |
| 13-21 years | | | | | | | |
| 0% | | | | | | | |
| 23.65 маля | | | | | | | |
| 22-65 years Please choose: | | | | | | | |
| Over 65 years | | | | | | | |
| 76% - 100% | | | | | | | |
| Continuum of Care | | | | | | | |
| Critical care, ICU, acute | | | | | | | |
| 0% | | | | | | | |
| SNF/ECF/sub-acute | | | | | | | |
| 1%-25% | | | | | | | |
| Rehabilitation | | | | | | | |
| 76%-100% | | | | | | | |
| Ambulatory/outpatient | | | | | | | |
| 0% | | | | | | | |
| Home health/hospice | | | | | | | |

| 1%-25% | | | | | | | | |
|--|----------------|---|---|----------------------------------|--|--|--|--|
| Wellness/fitness/industry | | | | | | | | |
| 0% | | | | | | | | |
| | | | | | | | | |
| Section Sign Off: | | | | | | | | |
| Click the box below to indicate you have reviewed and finit | shed with this | section of the survey. | | | | | | |
| This section has been completed. | | | | | | | | |
| Patient/Client Diagnoses | | | | 12/08/13 03:31 PM | | | | |
| Patient/Client Diagnoses | | | | | | | | |
| Indicate the frequency of time typically spent with | patients/clie | ents in each of the categories: | | | | | | |
| Musculoskeletal | | | | | | | | |
| 1%-25% | | | | | | | | |
| Which Musculoskeletal sub-categories are available to | o the student | • | | | | | | |
| Acute injury | | Amputation | | Arthritis | | | | |
| Bone disease/ dysfunction | | Connective tissue disease/dysfunction | | Muscle disease/dysfunction | | | | |
| Musculoskeletal degenerative disease | | Orthopedic surgery | | Other | | | | |
| | | | | | | | | |
| Neuro-muscular 26% - 50% ▼ | | | | | | | | |
| | | | | | | | | |
| Which Neuro-muscular sub-categories are available to | | | _ | | | | | |
| Brain injury | | Cerebral vascular accident | | Chronic pain | | | | |
| Congenital/developmental | | Neuromuscular degenerative disease Vestibular disorder | | Peripheral nerve injury Other | | | | |
| Spinal cord injury | | vesubulai disorder | | ouler | | | | |
| Cardiovascular-pulmonary | | | | | | | | |
| 1%-25% | | | | | | | | |
| Which Cardiovascular-pulmonary sub-categories are | available to | the student: | | | | | | |
| Cardiac dysfunction/disease | | Fitness | V | Lymphedema | | | | |
| Peripheral vascular dysfunction/disease | | Pulmonary dysfunction/disease | | Other | | | | |
| Integumentary | | | | | | | | |
| 1% - 25% | | | | | | | | |
| Which Integumentary sub-categories are available to | the student: | | | | | | | |
| Burns | | Open wounds | | Scar formation | | | | |
| Other | | | | | | | | |
| Other (May cross a number of diagnostic groups) | | | | | | | | |
| 1%-25% | | | | | | | | |
| Which other sub-categories are available to the student: | | | | | | | | |
| Cognitive impairment | III. | General medical conditions | V | General surgery | | | | |
| Oncologic conditions | | Organ transplant | | Wellness/Prevention | | | | |
| Other | | | | | | | | |
| | | | | | | | | |
| Section Sign Off: | | | | | | | | |
| Click the box below to indicate you have reviewed and finite | shed with this | section of the survey. | | | | | | |
| This section has been completed. | | | | | | | | |
| | | | | | | | | |

| Staffir | ffing 12/08/13 03:31 PM | | | | | | | |
|---|---|-------------------|----------|-------------------------------|-------------------------|-------------|---|--|
| Staffing | | | | | | | | |
| | | | | | | | | |
| | | Full-time Bud | lgeted | | Part-time Budgeted | | Current Staffing | |
| PTs | | 8 | | | 2 | | 10 | |
| PTAs | | | | | | | | |
| Aides | /Techs | 3 | | | 3 | | 6 | |
| | | | | | | | | |
| Other: DT, C | | 8 | | | 1 | | 9 | |
| , . | | | | | | | | |
| Clic | tion Sign Off: k the box below to indicate you have reviewed a Chis section has been completed. | and finished with | h this s | ection of the survey. | | | | |
| nforn | nation About the Clinical Education Exper | rience | | | | | 12/08/13 03:42 PM | |
| | al Programs/Activities/Learning Oppor | | nities | available to students. | | | | |
| 7 | Administration | I | | Aquatic Therapy | | | Athletic Venue Coverage | |
| | Back School | I | | Biomechanics Lab | | | Cardiac Rehabilitation | |
| 7 | Community/Re-entry Activities | I | | Critical Care/Intensive Care | | | Departmental Administration | |
| 7 | Early Intervention | I | V | Employee Intervention | | | Employee Wellness Program | |
| 7 | Group Programs/Classes | I | | Home Health Program | | | Industrial/Ergonomic PT | |
| 7 | Inservice Training/Lectures | I | | Neonatal Care | | | Nursing Home/ECF/SNF | |
| 7 | Orthotic/Prosthetic Fabrication | I | V | Pain Management Program | | | Pediatric - Classroom Consultation Emphasis | |
| | Pediatric - Cognitive Impairment Emphasis | I | | Pediatric - Developmental P | rogram Emphasis | | Pediatric - General | |
| | Pediatric - Musculoskeletal Emphasis | | | Pediatric - Neurological Emp | phasis | | Prevention/Wellness | |
| | Pulmonary Rehabilitation | | V | Quality Assurance/CQI/TQM | IN | | Radiology | |
| 7 | Research Experience | I | | Screening/Prevention | | | Sports Physical Therapy | |
| 7 | Surgery (observation) | | V | Team Meetings/Rounds | | | Vestibular Rehabilitation | |
| | Women's Health/OB-GYN | I | | Work Hardening/Condition | ing | | Wound Care | |
| C Other Specialty Clinics Please check all specialty clinics available as student learning experiences. | | | | | | | | |
| | Arthritis | I | | Balance | | | Developmental | |
| | Feeding clinic | I | | Hand clinic | | | Hemophilia clinic | |
| | Industry | I | | Neurology clinic | | | Orthopedic clinic | |
| | Pain clinic | 1 | | Preparticipation sports | | | Prosthetic/orthotic clinic | |
| | Scoliosis | I | | Screening clinics | | | Seating/mobility clinic | |
| | Sports medicine clinic | I | | Wellness | | | Women's health | |
| | Other | | | | | | | |
| lealth and Educational Providers at the Clinical Site | | | | | | | | |
| lease | check all health care and educational pro | oviders at you | r clini | cal site students typically o | observe and/or with who | om they int | eract. | |
| 7 | Administrators | | | Alternative therapies | | | Athletic trainers | |
| | Audiologists | I | V | Dietitians | | | Enterostomal / wound specialists | |
| | Exercise physiologists | 1 | | Fitness professionals | | | Health information technologists | |

| Γ | Massage therapists | | Nurses | V | Occupational therapists | | |
|---|--|------------|---|----|-----------------------------------|--|--|
| | Physician assistants | | Physicians | | Podiatrists | | |
| | Prosthetists / orthotists | | Psychologists | | Respiratory therapists | | |
| V | Social workers | | Special education teachers | | Speech/language pathologists | | |
| | Students from other disciplines | | Students from other physical therapy education programs | | Therapeutic recreation therapists | | |
| | Vocational rehabilitation counselors | | Other | | | | |
| Sec | tion Sign Off: | | | | | | |
| | k the box below to indicate you have reviewed and finished w | rith this: | section of the survey. | | | | |
| | **-: | | | | | | |
| | This section has been completed. | | | | | | |
| Availa | bility of the Clinical Education Experience | | | | 12/08/13 03:42 PM | | |
| Avail | ability of the Clinical Education Experience | | | | | | |
| | | | | | | | |
| Indica | ate educational levels at which you accept PT and P | TA stu | dents for clinical experiences (Check all that apply) | • | | | |
| | cal Therapist | | | | | | |
| | Experience: | | Halfdave | | Other | | |
| | Full days | | Half days | | Other | | |
| | cal Therapist | | | | | | |
| | nediate Experiences: | | 77 IG 1 | | | | |
| | Full days | | Half days | | Other | | |
| Physi | cal Therapist | | | | | | |
| | Final Experience | П | Internship (6 months or longer) | Г | Specialty experience | | |
| | Other | | | | | | |
| | | | | | | | |
| | cal Therapist Assistant Experience: | | | | | | |
| V | Full days | П | Half days | Г | Other | | |
| | | | | | | | |
| | cal Therapist Assistant nediate Experiences: | | | | | | |
| • | Full days | | Half days | | Other | | |
| I. | | | | | | | |
| Physi | cal Therapist Assistant | | | | | | |
| V | Final Experience | | Other | | | | |
| т | | | | | | | |
| | | | | | | | |
| | ate which months you will accept students for any sing | 1 | - | _ | | | |
| | January | | February | | March | | |
| | April | | May | | June | | |
| | July | | August | | September | | |
| | October | | November | | December | | |
| Indicate which months you will accept students for any one part-time (< 36 hrs/wk) clinical experience. | | | | | | | |
| | January | | February | | March | | |
| V | April | | May | | June | | |
| | - July | | August | | September | | |
| | October | | November | | December | | |
| | | | | 1. | | | |
| PTA | | | | | | | |
| Indica | ate which months you will accept students for any sing | le full- | time (36 hrs/wk) clinical experience. | | | | |
| V | January | | February | | March | | |
| V | April | | May | | June | | |
| | | | | | | | |

| V | July | | August | | September | | | | |
|--|--|------------|---|----------|---|-----|--|--|--|
| | October | | November | | December | | | | |
| Indica | te which months you will accept students for any one | nart-ti | ma (~ 36 hrs/wk) clinical experience | | | | | | |
| | January | | February | | March | | | | |
| V | April | V | May | V | June | | | | |
| | July | T V | August | V | September | | | | |
| V | October | V | November | V | December | | | | |
| | | | | | | | | | |
| | e number of PT students affiliating per year.: | | | | | | | | |
| 7 | | | | | | | | | |
| - | e number of PTA students affiliating per year.: | | | | | | | | |
| 1 | | | | | | | | | |
| | r clinical site willing to offer reasonable accommodatio | ns for | students under ADA? | | | | | | |
| • Ye Please | es 🖸 No explain: | | | | | | | | |
| | * the procedure for managing students whose performance is | below | expectations or unsafe?: | | | | | | |
| | unication with ACCE. Set up a week to week goal shee | | | | | | | | |
| Explair | what provisions are made for students if the clinical instruc | tor is ill | l or away from the clinical site. (Answer if the clinical ce | enter en | nploys only one PT or PTA.): | | | | |
| | | | | | | | | | |
| Sect | tion Sign Off: | | | | | | | | |
| Click | the box below to indicate you have reviewed and finished with | ith this s | section of the survey. | | | | | | |
| V 1 | 'his section has been completed. | | | | | | | | |
| | ll Site's Learning Objectives and Assessment | | | | 12/08/13 03:42 PM | | | | |
| Cinne | | | | | , 00, 10 00,72 I M | | | | |
| Clinic | cal Site's Learning Objectives and Assessmen | t | | | | | | | |
| Doesy | our clinical site provide written clinical education obj | ectives | to students? | | | | | | |
| • Ye | | | | | | | | | |
| Are all | professional staff members who provide physical the | ranys | ervices acquainted with the clinical site's learning obj | ectives | 2 | | | | |
| • Ye | | rup y o | | | | | | | |
| When | do the CCCE and (or CI traitedly discuss the eliminal side | ala la a | ming chicotivos with students? (Chock all that any b) | | | | | | |
| _ | do the CCCE and/or CI typically discuss the clinical sit | | | | Designing of the clinical summinuum | | | | |
| | - | | At mid-clinical experience | | Beginning of the clinical experience | | | | |
| | Daily | | Weekly | | Other | | | | |
| Indica | te which of the following methods are typically utilized | d to inf | form students about their clinical performance? (Chec | k all th | at apply) | | | | |
| | As per student request in addition to formal and ongoing written & oral feedback | | Ongoing feedback throughout the clinical | V | Student self-assessment throughout the clinic | cal | | | |
| | Written and oral mid-evaluation | V | Written and oral summative final evaluation | | Other | | | | |
| | | | | | | | | | |
| Sect | tion Sign Off: | | | | | | | | |
| | the box below to indicate you have reviewed and finished w | ith this s | section of the survey. | | | | | | |
| | | | | | | | | | |
| | 'his section has been completed. | | | | | | | | |
| Studer | nt Requirements | | | | 07/23/15 08:23 AM | | | | |
| Stude | ent Requirements | | | | | | | | |
| D | | 1 | | | | | | | |
| | dents need to contact the clinical site for specific work | hours | related to the clinical experience? | | | | | | |
| Ye Please | es 🖸 No explain: | | | | | | | | |
| Do students reasive the same official holidays as staff? | | | | | | | | | |
| Do students receive the same official holidays as staff? • Yes • No | | | | | | | | | |
| (•) Vo | s O No | | | | | | | | |
| | es 🔿 No explain: | | | | | | | | |

| Does your clinical site require a student interview? O Yes O No Please explain: | | | | | | | | | | |
|---|----------|--------------------------------------|--|-----------------------------------|--|--|--|--|--|--|
| Indicate the time the student should report to the clinical site | e on th | e first day of the experience. | | | | | | | | |
| Is a Mantoux TB test (PPD) required? | | | | | | | | | | |
| a) one step Yes O No | | | | | | | | | | |
| b) two step C Yes C No | | | | | | | | | | |
| Is a Rubella Titer Test or immunization required? Yes O No Please explain: | | | | | | | | | | |
| Are any other health tests/immunizations required prior to the clinical experience? If yes, please specify: | | | | | | | | | | |
| How is this information communicated to the clinic? Provide fax no | umber i | frequired.: | | | | | | | | |
| How current are student physical exam records required to be?: | | | | | | | | | | |
| Are any other health tests or immunizations required on-site? If yes, please specify: O Yes O No | | | | | | | | | | |
| Is the student required to provide proof of any other training prior to orientation at your facility? If yes, please list. | | | | | | | | | | |
| Indicate which of the following are required by your facility | prior to | o the clinical education experience: | | | | | | | | |
| Child clearance | | Criminal background check | | Drugscreening | | | | | | |
| HIPAA education | | OSHA education | | Proof of student health clearance | | | | | | |
| 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 • • • • • • • • • • • • • • • • • • • | | | | | | | | | | |
| Is a child abuse clearance required? | | | | | | | | | | |
| C Yes C No Please explain: | | | | | | | | | | |
| Is the student responsible for the cost of required clearances? C Yes C No Please explain: | | | | | | | | | | |
| Is the student required to submit to a drug test? If yes, please describe parameters. | | | | | | | | | | |
| Is medical testing available on-site for students? C Yes C 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: | | | | | | | | | | |
| 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. | 07/23/15 08:23 AM | |
|---|---|---|
| Special Information | | _ |
| Oo you require a case study or inservice from all students (part-time and full-time)? | | |
| ⊙Yes O No Please explain: | | |
| Do you require any additional written or verbal work from the student (e.g., article critiques, journal review, patie | ent/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 sum | ımarize. | |
| O Yes O No | | |
| Vill the student have access to the Internet at the clinical site? Yes O | | |
| Please explain: | | |
| computer privlages | | |
| s there a facility/student dress code? | | |
| | | |
| s emergency health care available for students? | | |
| s the student responsible for emergency health care costs? | | |
| O Yes O No | | |
| s other non-emergency medical care available to students? | | |
| O Yes O No | | |
| s the student required to have proof of health insurance? | | |
| s the student required to provide proof of OSHA training? | | |
| O Yes O No | | |
| s the student required to provide proof of HIPAA training? | | |
| O Yes O No | | |
| s the student required to attest to an understanding of the benefits and risks of Hepatitis-B immunization? | | |
| O Yes O No | | |
| s the student required to be CPR certified? (Please note if a specific course is required). | | |
| Can the student receive CPR certification while on-site? | | |
| O Yes O No | | |
| s the student required to be certified in First Aid? | | |
| O Yes O No | | |
| Can the student receive First Aid certification on-site? | | |
| O Yes O 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. | | |
| itudent Schedule | 07/23/15 08:23 AM | |

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

Standard 8 hour day 💌

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

Mon-fri 8am-4:30pm; and every other weekend

Is physical therapy provided on the weekends?

O Yes O 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"

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