

Site Manager Site Survey —

Site: D'Youville Senior Care

Section Title	Last Update	Action
CCCE Sign Off	Never	

CCCE Sign Off

CCCE Sign Off:
Click the box below to indicate that you have reviewed all sections of your clinical site survey.

This survey has been reviewed.

Information For the Academic Program	12/07/14 06:59 PM	
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Information For the Academic Program

Person Completing CSIF:
Elaina Kapuranis

E-mail address of person completing CSIF:
ekapuran@salud.unm.edu

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):
D'Youville Senior Care

Street Address

Address:
981 Varnum Avenue

City:
Lowell

State:
MA

Postal Code:
01854

Facility Phone

Phone Number:
(978) 454-5681

Ext:

PT Department Phone

Phone Number:
(978) 454-5681

Ext:

PT Department Fax

Phone Number:

Clinical Center Web Address:
www.dyouville.com

Director of Physical Therapy:
Keri Belmonte

Center Coordinator of Clinical Education (CCCE) / Contact Person:
Sue LaRoche

CCCE / Contact Person Phone:

CCCE / Contact Person E-mail:
slaroche@dyouville.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

12/07/14 06:59 PM

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

12/07/14 06:59 PM

Clinical Site Accreditation/Ownership

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

<input checked="" type="checkbox"/> Corporate/Privatey Owned	<input type="checkbox"/> Government Agency	<input 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

12/07/14 06:59 PM

Clinical Site Primary Classification

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

ECF/Nursing Home/SNF

If appropriate, check () up to four additional categories that describe the other clinical centers associated with your facility.

<input checked="" type="checkbox"/> Acute Care/ Inpatient Hospital Facility	<input type="checkbox"/> Ambulatory Care/ Outpatient	<input checked="" 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 checked="" type="checkbox"/> Rehabilitation/Sub-acute Rehabilitation
<input type="checkbox"/> School/Preschool Program	<input 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 12/07/14 06:59 PM

Clinical Site Location

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

Urban

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 12/07/14 06:59 PM

Affiliated PT and PTA Educational Programs

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

Program Name	City	State	PT / PTA
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Select the program(s) your site is currently affiliated with:		If not found in the list, please enter the program information here:	
By A-Z: <input type="button" value="v"/>	<input type="button" value="v"/>	Program Name: <input type="text"/>	
By State: <input type="button" value="v"/>	<input type="button" value="v"/>	City: <input type="text"/>	
		State: <input type="button" value="v"/>	AB <input type="button" value="v"/>
		PT / PTA: <input type="button" value="v"/>	PT <input type="button" value="v"/>
<ul style="list-style-type: none"> ACCE Demo University, <input type="button" value="+"/> ACCE Demo University, <input type="button" value="+"/> ACCE Demo University, <input type="button" value="+"/> ACCE PTA Demo, <input type="button" value="+"/> ASA College, FL <input type="button" value="+"/> AT Still University of Health Sciences, AZ <input type="button" value="+"/> Academy for Nursing and Health Occupations, FL <input type="button" value="+"/> Adventist University of Health Sciences, FL <input type="button" value="+"/> Alabama State University, AL <input type="button" value="+"/> 		<input type="button" value="Add"/> <input type="button" value="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 08/24/16 05:42 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:
Susan LaRoche

Email Address / CPI2 Login:
slaroche@dyouville.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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Licensing/Registration Status

Please choose: ▼

State of Licensure/Registration

Please choose: ▼

License/Registration Number:

Highest Earned Physical Therapy Degree

Bachelor in Physical Therapy ▼

Highest Earned Degree

Bachelors degree ▼

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 — 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 — 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 12:50 PM

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
Anselmo, Nicole	dinisa63@aol.com	
Fanning, SherryLee	sherrylee_0203@comcast.net	
Manolis, Elaina	edmanolis1@gmail.com	
Varnum, Lori	lreible@gmail.com	

[Add New CI](#) Displaying all 4 Clinical instructor

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

12/07/14 06:52 PM

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 12/10/14 10:36 AM

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 12/10/14 10:36 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 12/10/14 10:36 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

Please choose: ▼

13-21 years

Please choose: ▼

22-65 years

Please choose: ▼

Over 65 years

Please choose: ▼

Continuum of Care

Critical care, ICU, acute

Please choose: ▼

SNF/ECF/sub-acute

Please choose: ▼

Rehabilitation

Please choose: ▼

Ambulatory/outpatient

Please choose: ▼

Home health/hospice

Please choose: ▼

Wellness/fitness/industry

Please choose: ▼

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

12/10/14 10:36 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 checked="" type="checkbox"/> Amputation	<input type="checkbox"/> Arthritis
<input checked="" type="checkbox"/> Bone disease/ dysfunction	<input checked="" 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 checked="" type="checkbox"/> Cerebral vascular accident	<input type="checkbox"/> Chronic pain
<input type="checkbox"/> Congenital/ developmental	<input checked="" 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

1% - 25%

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

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

Integumentary

Please choose:

Which Integumentary sub-categories are available to the student:

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

Other (May cross a number of diagnostic groups)

Please choose:

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 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.

Staffing

12/10/14 10:36 AM

Staffing

	Full-time Budgeted	Part-time Budgeted	Current Staffing
PTs			
PTAs			
Aides/Techs			
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 Clinical Education Experience

12/10/14 10:33 AM

Information About the Clinical Education Experience

Special Programs/Activities/Learning Opportunities

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

<input type="checkbox"/> Administration	<input type="checkbox"/> Aquatic Therapy	<input type="checkbox"/> Athletic Venue Coverage
<input type="checkbox"/> Back School	<input type="checkbox"/> Biomechanics Lab	<input checked="" type="checkbox"/> Cardiac Rehabilitation
<input type="checkbox"/> Community/Re-entry Activities	<input type="checkbox"/> Critical Care/Intensive Care	<input 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 checked="" type="checkbox"/> Home Health Program	<input type="checkbox"/> Industrial/Ergonomic PT
<input checked="" type="checkbox"/> Inservice Training/Lectures	<input type="checkbox"/> Neonatal Care	<input checked="" type="checkbox"/> Nursing Home/ECF/SNF
<input checked="" type="checkbox"/> Orthotic/Prosthetic Fabrication	<input checked="" 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 type="checkbox"/> Pediatric - General
<input type="checkbox"/> Pediatric - Musculoskeletal Emphasis	<input type="checkbox"/> Pediatric - Neurological Emphasis	<input checked="" 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 checked="" type="checkbox"/> Screening/Prevention	<input type="checkbox"/> Sports Physical Therapy
<input type="checkbox"/> Surgery (observation)	<input checked="" type="checkbox"/> Team Meetings/Rounds	<input type="checkbox"/> Vestibular Rehabilitation
<input type="checkbox"/> Women's Health/OB-GYN	<input checked="" 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
<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 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 type="checkbox"/> Sports medicine clinic	<input type="checkbox"/> Wellness	<input 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 checked="" 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 checked="" type="checkbox"/> Nurses	<input checked="" type="checkbox"/> Occupational therapists
<input type="checkbox"/> Physician assistants	<input checked="" type="checkbox"/> Physicians	<input type="checkbox"/> Podiatrists
<input checked="" 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 checked="" 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

12/10/14 10:33 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 type="checkbox"/> Full days	<input type="checkbox"/> Half days	<input type="checkbox"/> Other
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Physical Therapist

Intermediate Experiences:

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

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

Intermediate Experiences:

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

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

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

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

PTA

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

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

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

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

12/10/14 10:33 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 checked="" type="checkbox"/> At mid-clinical experience	<input checked="" type="checkbox"/> Beginning of the clinical experience
<input type="checkbox"/> Daily	<input checked="" type="checkbox"/> Weekly	<input type="checkbox"/> Other

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

<input 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 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

06/19/15 03:43 PM

Student Requirements

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

Yes No

Please explain:

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.

7:30 AM

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

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

Please explain:

CPR training

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

<input type="checkbox"/>	Child clearance	<input type="checkbox"/>	Criminal background check	<input type="checkbox"/>	Drug screening
<input type="checkbox"/>	HIPAA education	<input type="checkbox"/>	OSHA education	<input 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

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

06/19/15 03:43 PM

Special Information

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

Yes No

Please explain:

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

Is the student responsible for emergency health care costs?

Yes No

Is other non-emergency medical care available to students?

Yes No

Is the student required to have proof of health insurance?

Yes No

Is the student required to provide proof of OSHA training?

Yes No

Is the student required to provide proof of HIPAA training?

Yes No

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

Can the student receive CPR certification while on-site?

Yes No

Is the student required to be certified in First Aid?

Yes No

Can the student receive First Aid certification on-site?

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.

Student Schedule

06/19/15 03:43 PM

Student Schedule

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:

5 days per week, or 4 days per week and 1 day on the weekend

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"