

Site Manager Site Survey —

Site: Encompass Health Rehabilitation Hospital - Woburn

Section Title	Last Update	Action
CCCE Sign Off	Never	

**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	01/20/14 02:22 PM	
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**Information For the Academic Program**

**Person Completing CSIF:**  
Danielle Dreyfus

**E-mail address of person completing CSIF:**  
ddreyfus@5s qc.com

**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):**  
New England Rehabilitation Hospital

**Street Address**

**Address:**  
2 Rehabilitation Way

**City:**  
Woburn

**State:**  
MA

**Postal Code:**  
01801

**Facility Phone**

**Phone Number:**  
(781)935-5050

**Ext:**

**PT Department Phone**

**Phone Number:**  
(781)935-5050

**Ext:**  
301450

**PT Department Fax**

**Phone Number:**  
(781)939-1812

**Clinical Center Web Address:**  
www.gettingbacktolife.com

**Director of Physical Therapy:**  
Keith Poulin

**Center Coordinator of Clinical Education (CCCE) / Contact Person:**  
Danielle Dreyfus

CCCE / Contact Person Phone:

(781)935-5050 x301450

CCCE / Contact Person E-mail:

ddreyfus@5sqc.com

**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

01/20/14 02:22 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:**

Reliant Hospital Partners

**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

01/20/14 02:22 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

01/20/14 02:22 PM

**Clinical Site Primary Classification**

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

Rehabilitation/Sub-acute Rehabilitation

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 checked="" 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 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

01/20/14 02:22 PM

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

01/20/14 02:22 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	
American International College	Springfield	MA	PT	
Boston University	Boston	MA	PT	
Clarkson University	Potsdam	NY	PT	
Drexel University	Philadelphia	PA	PT	
D'Youville College	Buffalo	NY	PT	
Duquesne University	Pittsburgh	PA	PT	
East Carolina University	Greenville	NC	PT	
Emerson College	Boston	MA	PT	
Fitchburg State College	Fitchburg	MA	PT	
Framingham State College	Framingham	MA	PT	
Husson University	Bangor	ME	PT	
Massachusetts College of Pharmacy and Health Sciences	Worcester	MA	PT	
Medical Professional Institute		MA	PT	
New York University	New York	NY	PT	
Quinnipiac University	Hamden	CT	PT	
Rivier College		MA	PT	
Salem State College	Salem	MA	PT	
Springfield College	Springfield	MA	PT	
Tufts University	Medford	MA	PT	

Select the program(s) your site is currently affiliated with:

By A-Z:  Any

By State:  Any

If not found in the list, please enter the program information here:

Program Name:

City:

State:  AB

PT / PTA:  PT

Add Clear

ACCE Demo University,		
ACCE Demo University,		
ACCE Demo University,		
ACCE PTA Demo,		
<b>Section Sign Off:</b>		
Check the boxes below if you have reviewed and finished with this section of the survey.		
Center for Health Sciences AZ		
Academy for Nursing and Health Occupations, FL		
<input checked="" type="checkbox"/> This section has been completed, FL		
Alabama State University, AL		

**Information About the Clinical Teaching Faculty**

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

**Name:**  
Amy Wedge

**Email Address / CPI2 Login:**  
amy.wedge@gmail.com

**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

**Licensing/Registration Status**  
Please choose:

**State of Licensure/Registration**  
Please choose:

**License/Registration Number:**

**Highest Earned Physical Therapy Degree**  
Doctor in Physical Therapy

**Highest Earned Degree**  
Post-professional Doctor in Physical Therapy (Transition)

**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

<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:**

Danielle Dreyfus

**Email Address / CPI2 Login:**

ddreyfus@5sqc.com

**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

Licensing/Registration Status

Please choose: ▼

State of Licensure/Registration

Please choose: ▼

License/Registration Number:

Highest Earned Physical Therapy Degree

Masters in Physical Therapy ▼

Highest Earned Degree

Masters degree ▼

APTA Credentialed CI

Yes  No

APTA Advanced Credentialed CI

Yes  No

Other CI Credentialing

Yes  No

Please explain:

CKTP

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

Name:

Jessica Therrien

Email Address / CPI2 Login:

Jessica.Therrien@encompasshealth.com

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

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**

**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**

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
Baldwin, Lauren	kennedy16@gmail.com	
Barackman, Heather	Heather.Barackman@healthsouth.com	
Buckley, Allison E	ABuckley@relianthcp.com	
Casiello, Emma	ecasiello@relianthcp.com	
Chow, L	lchow@5sqc.com	
Conway, Megan C	megan.conway@healthsouth.com	
Coviello, Natalie	nataliecoviello@gmail.com	
Dennis, Laura L	laura.renaghan@gmail.com	
Donigian, Laura	laurafaith1028@gmail.com	
Dreyfus, Danielle	ddreyfus@partners.org	
Faulk, Catherine	CFAULK@5sqc.com	
Feeney, Allison	Allison.Feeney@healthsouth.com	
Gallione, Jennifer	Jennifer.Gallione@healthsouth.com	
Grabowski, Caitlin	cgrabowski@5sqc.com	
Grady Landers, Anne	anne.gradylanders@healthsouth.com	
Grushynsky, Derek	derek.grushynsky@healthsouth.com	
Hattan, Karla	KHattan@5sqc.com	
Hauschild, Emily	empeter2@gmail.com	
Ishioka, Amy	Amy.Ishioka@healthsouth.com	
King, Allison	aking@jstartpt.com	
Ma, Kevin L	Kevin.Ma@healthsouth.com	
MacVane, Heather	hmacvane@5sqc.com	
Marhefka, Dale R	DMarhefka@5sqc.com	
Martel, Kathryn	Kmartel@5sqc.com	
McDonough, Stacy	SMcDonough@5sqc.com	

[Add New CI](#)

Displaying Clinical instructor 1 - 25 of 38 in total

[Previous](#) **1** [2](#) [Next](#)
**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.

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

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

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

<input checked="" type="checkbox"/>	1:1 individual training (CCCE:CI)	<input checked="" type="checkbox"/>	APTA Clinical Instructor Education and Credentialing Program	<input type="checkbox"/>	Academic for-credit coursework
<input checked="" type="checkbox"/>	Clinical center inservices	<input checked="" 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

12/11/13 03:03 PM

**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:

210

Step down:

Subacute/transitional care unit:

Extended care:

Other specialty centers:

Total Number of Beds:

210

**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

12/11/13 03:03 PM

**Number of Patients/Clients**

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

Inpatient	Outpatient
6	10
Individual PT:	Individual PT:
Student PT:	Student PT:
Individual PTA:	Individual PTA:
Student PTA:	Student PTA:
PT/PTA Team:	PT/PTA Team:
6	10
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

12/11/13 03:03 PM

**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

26% - 50%

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**

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.

Patient/Client Diagnoses

12/11/13 03:03 PM

**Patient/Client Diagnoses**

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

**Musculoskeletal**

1% - 25%

Which Musculoskeletal sub-categories are available to the student:

<input checked="" type="checkbox"/> Acute injury	<input checked="" type="checkbox"/> Amputation	<input checked="" 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

- Musculoskeletal degenerative disease
  Orthopedic surgery
  Other

**Neuro-muscular**

26% - 50%

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

- Brain injury
  Cerebral vascular accident
  Chronic pain  
 Congenital/ developmental
  Neuromuscular degenerative disease
  Peripheral nerve injury  
 Spinal cord injury
  Vestibular disorder
  Other

**Cardiovascular-pulmonary**

1% - 25%

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

- Cardiac dysfunction/ disease
  Fitness
  Lymphedema  
 Peripheral vascular dysfunction/ disease
  Pulmonary dysfunction/ disease
  Other

**Integumentary**

0%

**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
  General medical conditions
  General surgery  
 Oncologic conditions
  Organ transplant
  Wellness/ Prevention  
 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

12/11/13 03:03 PM

**Staffing**

	Full-time Budgeted	Part-time Budgeted	Current Staffing
PTs	14		13
PTAs	4		2
Aides/Techs	4		4
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

01/20/14 02:25 PM

**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 checked="" type="checkbox"/>	Aquatic Therapy	<input type="checkbox"/>	Athletic Venue Coverage
<input checked="" type="checkbox"/>	Back School	<input type="checkbox"/>	Biomechanics Lab	<input checked="" type="checkbox"/>	Cardiac Rehabilitation
<input checked="" 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 checked="" type="checkbox"/>	Group Programs/ Classes	<input type="checkbox"/>	Home Health Program	<input 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 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 type="checkbox"/>	Prevention/ Wellness
<input checked="" 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 type="checkbox"/>	Sports Physical Therapy
<input type="checkbox"/>	Surgery (observation)	<input checked="" type="checkbox"/>	Team Meetings/ Rounds	<input checked="" type="checkbox"/>	Vestibular Rehabilitation
<input 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
<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 checked="" 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 checked="" type="checkbox"/>	Other				

Please explain:

Wheelchair and orthotic clinic run on an as needed basis and individual basis

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 checked="" 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 checked="" type="checkbox"/>	Psychologists	<input checked="" type="checkbox"/>	Respiratory therapists
<input type="checkbox"/>	Social workers	<input type="checkbox"/>	Special education teachers	<input checked="" type="checkbox"/>	Speech/ language pathologists
<input checked="" type="checkbox"/>	Students from other disciplines	<input checked="" 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

01/20/14 02:25 PM

**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 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 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 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 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 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.:**

17

**Average number of PTA students affiliating per year.:**

4

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

Yes     No

Please explain:

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

Weekly planning forms, anecdotal forms, critical incidence reports, communication between CCCE and ACCE, CI, and student

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.):

A covering physical therapist will supervise the student.

**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

01/20/14 02:25 PM

**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 checked="" 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 checked="" 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 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

06/09/15 03:35 PM

**Student Requirements**

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

Yes  No

Please explain:

They will be mailed information about the date/time to begin the clinical. After the orientation, they will work the hours of their CI.

Do students receive the same official holidays as staff?

Yes  No

Please explain:

Thanksgiving Day, Christmas Day, and New Year's Day

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.

8:00 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

Please explain:

Hepatitis B vaccination

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

mail

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

TB within one year of the end date of the clinical

**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 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

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

06/09/15 03:35 PM

#### Special Information

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

Yes  No

Please explain:

Must be 30 minutes in length and relevant to the patient population that the student is treating. Further information provided on site

**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

Please explain:

2 days allotted. If more than 2 days are missed, the time must be made up on the weekends if able or added to the end of the clinical

**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

06/09/15 03:35 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:

Follow the schedule of the CI (8:00-4:30 or 8:30-5:00)

**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"