

Site: Off Season Sports and Physical Therapy

Section Title	Last Update	Action
CCCE Sign Off	07/14/16 04:59 PM	
<p><b>CCCE Sign Off</b></p> <p><b>CCCE Sign Off:</b> Click the box below to indicate that you have reviewed all sections of your clinical site survey.</p> <p><input checked="" type="checkbox"/> This survey has been reviewed.</p>		

Information For the Academic Program	07/14/16 04:59 PM	
<p><b>Information For the Academic Program</b></p> <p><b>Person Completing CSIF:</b> Katie McMahon</p> <p><b>E-mail address of person completing CSIF:</b> k.mcmahon@theoffseason.net</p> <p><b>Name of Clinical Center (Note: To correct the name of your site, as it appears in both CSIF Web and CPI Web, update it in this field):</b> Off Season Sports and Physical Therapy</p> <p><b>Street Address</b></p> <p><b>Address:</b> 1820 Turnpike Street, Suite 200</p> <p><b>City:</b> North Andover</p> <p><b>State:</b> MA</p> <p><b>Postal Code:</b> 01845</p> <p><b>Facility Phone</b></p> <p><b>Phone Number:</b> 978 688 6181</p> <p><b>Ext:</b></p> <p><b>PT Department Phone</b></p> <p><b>Phone Number:</b> 978 688 6181</p> <p><b>Ext:</b></p> <p><b>PT Department Fax</b></p> <p><b>Phone Number:</b> 9786885120</p> <p><b>Clinical Center Web Address:</b> Offseasonpt.com</p> <p><b>Director of Physical Therapy:</b> Larry Bourdeau, PT</p> <p><b>Center Coordinator of Clinical Education (CCCE) / Contact Person:</b> Larry Bourdeau, PT</p> <p><b>CCCE / Contact Person Phone:</b></p>		

9786886181

CCCE / Contact Person E-mail:

9786886181

**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

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**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:**

Same as above

**Contact Name:**

Larry Bourdeau

**Address**

**Address:**

as above

**City:**

**State:**

**Postal Code:**

**Phone**

**Phone Number:**

same

**Ext:**

**Fax**

**Phone Number:**

same

**E-mail:**

same

**Affiliation Agreement Contract Fulfillment**

**Contact Person:**

same

**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

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**Clinical Site Accreditation/Ownership**

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

<input type="checkbox"/> Corporate/Privatey Owned	<input type="checkbox"/> Government Agency	<input type="checkbox"/> Hospital/Medical Center Owned
<input type="checkbox"/> Nonprofit Agency	<input checked="" 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

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

Private Practice

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

<input type="checkbox"/> Acute Care/ Inpatient Hospital Facility	<input type="checkbox"/> Ambulatory Care/ Outpatient	<input type="checkbox"/> ECF/ Nursing Home/ SNF
<input type="checkbox"/> Federal/ State/ County Health	<input type="checkbox"/> Home Health	<input type="checkbox"/> Industrial/ Occupational Health Facility
<input type="checkbox"/> Multiple Level Medical Center	<input checked="" type="checkbox"/> Private Practice	<input type="checkbox"/> Rehabilitation/ Sub-acute Rehabilitation
<input type="checkbox"/> School/ Preschool Program	<input checked="" type="checkbox"/> Wellness/ Prevention/ Fitness Program	<input type="checkbox"/> Other

**Section Sign Off:**

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

This section has been completed.

### Clinical Site Location

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

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

Program Name	City	State	PT / PTA
North Shore Community College	Danvers	MA	PTA
Northeastern University	Boston	MA	PT
Boston University	Boston	MA	PT
Louisiana State University HSC in New Orleans	New Orleans	LA	PT
U Mass Lowell	Lowell	MA	PT
Stony Brook University	Stony Brook	NY	PT

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

By A-Z: Any

By State: Any

- ACCE Demo University, +
- ACCE Demo University, +
- ACCE Demo University, +
- ACCE PTA Demo, +
- ASA College, FL +
- AT Still University of Health Sciences, AZ +
- Academy for Nursing and Health Occupations, FL +
- Adventist University of Health Sciences, FL +
- Alabama State University, AL +

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

Program Name:

City:

State: AB

PT / PTA: PT

Add Clear

**Section Sign Off:**

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

### Information About the Clinical Teaching Faculty

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

Name:

Lawrence Bourdeau

Email Address / CPI2 Login:

L.Bourdeau@theoffseason.net

Present Position (Title, Name of Facility):

No. of Years as the CCCE

Please choose:

No. of Years of Clinical Practice

8

No. of Years of Clinical Teaching

7

No. of Years Working at this Site

6

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

Professional Doctor in Physical Therapy

APTA Credentialed CI

Yes  No

APTA Advanced Credentialed CI

Yes  No

Other CI Credentialing

Yes  No

Please explain:

AT, CSCS

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)

<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:**

AT, CSCS

**Summary of College and University Education**

(Start with most current)

**Institution:**  
University of Miami

**Period of Study**  
(If the user is currently enrolled, please type in the word 'CURRENT' into the box labeled 'To'.)  
From  &mdash; To

**Major:**  
DPT

**Degree:**  
DPT

**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
Bevan, Scott	s.bevan@theoffseason.net	
Manley, Michelle	M.Manley@theoffseason.net	
McMahon, Katelyn R	k.mcmahon@theoffseason.net	

[Add New CI](#)

Displaying all 3 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**

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

<input checked="" type="checkbox"/> APTA Clinical Instructor Credentialing	<input type="checkbox"/> Career ladder opportunity	<input type="checkbox"/> Certification/training course
<input checked="" type="checkbox"/> Clinical competence	<input 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 type="checkbox"/> Clinical center inservices	<input type="checkbox"/> Continuing education by academic program	<input checked="" 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 checked="" type="checkbox"/> Other		

Please explain:

**Section Sign Off:**

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 This section has been completed.
**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:

0

Psychiatric center:

0

Intensive care:

0

Rehabilitation center:

0

Step down:

0

Subacute/transitional care unit:

0

Extended care:

0

Other specialty centers:

0

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

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**Number of Patients/Clients**

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

Inpatient	Outpatient
Individual PT:	12 Individual PT:
Student PT:	7 Student PT:
Individual PTA:	12 Individual PTA:
Student PTA:	7 Student PTA:
PT/PTA Team:	0 PT/PTA Team:
0	38
Total patient/client visits per day:	Total patient/client visits per day:

**Section Sign Off:**

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This section has been completed.

Patient/Client Lifespan and Continuum of Care

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**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

1% - 25%

13-21 years

51% - 75%

22-65 years

26% - 50%

Over 65 years

1% - 25%

**Continuum of Care**

**Critical care, ICU, acute**

0% ▾

**SNF/ECF/sub-acute**

0% ▾

**Rehabilitation**

0% ▾

**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

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

Please explain:

**Neuro-muscular**

Please choose: ▾

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

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

**Cardiovascular-pulmonary**

Please choose: ▾

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

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

**Integumentary**

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 checked="" type="checkbox"/> General medical conditions	<input checked="" type="checkbox"/> General surgery
<input checked="" 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 07/13/16 02:33 PM

**Staffing**

	Full-time Budgeted	Part-time Budgeted	Current Staffing
PTs	3	1	
PTAs	1		
Aides/Techs		0	
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 07/13/16 02:20 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 type="checkbox"/> Aquatic Therapy	<input type="checkbox"/> Athletic Venue Coverage
<input type="checkbox"/> Back School	<input type="checkbox"/> Biomechanics Lab	<input type="checkbox"/> Cardiac Rehabilitation
<input type="checkbox"/> Community/Re-entry Activities	<input type="checkbox"/> Critical Care/Intensive Care	<input type="checkbox"/> Departmental Administration
<input checked="" type="checkbox"/> Early Intervention	<input type="checkbox"/> Employee Intervention	<input type="checkbox"/> Employee Wellness Program
<input type="checkbox"/> Group Programs/Classes	<input type="checkbox"/> Home Health Program	<input 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 checked="" type="checkbox"/> Pediatric - Musculoskeletal Emphasis	<input type="checkbox"/> Pediatric - Neurological Emphasis	<input type="checkbox"/> Prevention/Wellness
<input type="checkbox"/> Pulmonary Rehabilitation	<input type="checkbox"/> Quality Assurance/ CQI/ TQM	<input type="checkbox"/> Radiology
<input type="checkbox"/> Research Experience	<input checked="" type="checkbox"/> Screening/Prevention	<input checked="" type="checkbox"/> Sports Physical Therapy
<input type="checkbox"/> Surgery (observation)	<input 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 checked="" type="checkbox"/> Balance	<input type="checkbox"/> Developmental
<input type="checkbox"/> Feeding clinic	<input checked="" type="checkbox"/> Hand clinic	<input type="checkbox"/> Hemophilia clinic
<input type="checkbox"/> Industry	<input type="checkbox"/> Neurology clinic	<input checked="" type="checkbox"/> Orthopedic clinic
<input type="checkbox"/> Pain clinic	<input checked="" type="checkbox"/> Preparticipation sports	<input type="checkbox"/> Prosthetic/orthotic clinic
<input checked="" type="checkbox"/> Scoliosis	<input type="checkbox"/> Screening clinics	<input type="checkbox"/> Seating/mobility clinic
<input checked="" 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 checked="" type="checkbox"/> Alternative therapies	<input checked="" 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 checked="" type="checkbox"/> Massage therapists	<input type="checkbox"/> Nurses	<input type="checkbox"/> Occupational therapists
<input type="checkbox"/> Physician assistants	<input type="checkbox"/> Physicians	<input type="checkbox"/> Podiatrists
<input type="checkbox"/> Prosthetists / orthotists	<input type="checkbox"/> Psychologists	<input type="checkbox"/> Respiratory therapists
<input type="checkbox"/> Social workers	<input type="checkbox"/> Special education teachers	<input type="checkbox"/> Speech/language pathologists
<input 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	

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This section has been completed.

Availability of the Clinical Education Experience

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**Availability of the Clinical Education Experience**

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

**Physical Therapist  
First Experience:**

<input checked="" type="checkbox"/> Full days	<input type="checkbox"/> Half days	<input type="checkbox"/> Other
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**Physical Therapist  
Intermediate Experiences:**

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

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

**Physical Therapist Assistant  
First Experience:**

<input 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
--	--------------------------------

**PT**

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

<input checked="" type="checkbox"/> January	<input checked="" type="checkbox"/> February	<input checked="" type="checkbox"/> March
---	--	---

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

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

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

PTA

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

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

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

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

Average number of PT students affiliating per year.:

5

Average number of PTA students affiliating per year.:

5

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?:

Coach the student, give constructive feedback, monitor the situation, talk to clinical coordinator at the school.

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.):

N/A

**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

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**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 type="checkbox"/>	Daily	<input type="checkbox"/>	Weekly	<input type="checkbox"/>	Other

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

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

Written and oral summative final evaluation

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

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### 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.

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:

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

Clinic requires whatever the school requires. Clinic gets information either, fax, email or mail.

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

yearly

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:**

Larry Bourdeau

**Compliance Contact Person Phone Number**

**Phone Number:**

(978) 688-6181

**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

07/13/16 02:32 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

Please explain:

**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

Please explain:

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

Yes  No

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

Yes  No

Please explain:

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

Yes  No

Please explain:

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

Yes  No

Please explain:

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

Yes  No

Please explain:

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

Yes  No

Please explain:

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

Yes  No

Please explain:

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

Yes  No

Please explain:

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

Yes  No

Please explain:

**Section Sign Off:**

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

This section has been completed.

Student Schedule

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**Student Schedule**

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

Varied schedules

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

mon-8-8 tues 8-8 wed 1-8 thurs 12-8

**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"