## Site Manager Site Survey —

## Site: Performance Physical Therapy - Chelsea

| 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.**

| Section Title | Last Update | Action |
|---|---|---|
| Information For the Academic Program | 07/10/18 07:55 AM | |

### Information For the Academic Program

**Person Completing CSIF:**

**E-mail address of person completing CSIF:**

**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).:**

Performance Physical Therapy - Chelsea

**Street Address**

**Address:**

99 Fourth St

Suite 102

**City:**

Chelsea

**State:**

MA

**Postal Code:**

02150

**Facility Phone**

**Phone Number:**

**Ext:**

**PT Department Phone**

**Phone Number:**

617-889-2500

**Ext:**

**PT Department Fax**

**Phone Number:**

617-889-2511

**Clinical Center Web Address:**

**Director of Physical Therapy:**

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

**CCCE / Contact Person Phone:**

**CCCE / Contact Person E-mail:**

**Section Sign Off:**

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

☑ **This section has been completed.**

| Information About the Corporate/Healthcare Systems Organization | 07/10/18 07:55 AM |
|---|---|

## Information About the Corporate/Healthcare Systems Organization

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

**Corporate/Healthcare System Organization:**

**Contact Name:**

**Address**

**Address:**

**City:**

**State:**

**Postal Code:**

**Phone**

**Phone Number:**

**Ext:**

**Fax**

**Phone Number:**

**E-mail:**

**Affiliation Agreement Contract Fulfillment**

**Contact Person:**

**Section Sign Off:**

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

☑ **This section has been completed.**

| Clinical Site Accreditation/Ownership | 07/10/18 07:55 AM |
|---|---|

## Clinical Site Accreditation/Ownership

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

| | | | | | |
|---|---|---|---|---|---|
| ☑ | Corporate/Privately Owned | ☐ | Government Agency | ☐ | Hospital/Medical Center Owned |
| ☐ | Nonprofit Agency | ☐ | PT Owned | ☐ | PT/PTA Owned |
| ☐ | Physician/Physician Group Owned | ☐ | Other | | |

**Section Sign Off:**

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

☑ **This section has been completed.**

| Clinical Site Primary Classification | 07/10/18 07:55 AM |
|---|---|

## 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.**

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Acute Care/Inpatient Hospital Facility | ☐ | Ambulatory Care/Outpatient | ☐ | ECF/Nursing Home/SNF |
| ☐ | Federal/State/County Health | ☐ | Home Health | ☐ | Industrial/Occupational Health Facility |
| ☐ | Multiple Level Medical Center | ☐ | Private Practice | ☐ | Rehabilitation/Sub-acute Rehabilitation |
| ☐ | School/Preschool Program | ☐ | Wellness/Prevention/Fitness Program | ☐ | Other |

**Section Sign Off:**

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

☑ **This section has been completed.**

| Clinical Site Location | 07/10/18 07:55 AM |
|---|---|

## 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 | 07/10/18 07:55 AM |
|---|---|

## Affiliated PT and PTA Educational Programs

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

| Program Name | City | State | PT / PTA |
|---|---|---|---|

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

By A-Z: Any

By State: Any

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

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

Program Name:

City:

State: AB

PT / PTA: PT

Add Clear

### Section Sign Off:

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

☑ **This section has been completed.**

| Information About the Clinical Teaching Faculty | 07/19/18 07:02 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:**

Eric M. Goldberg

**Email Address / CPI2 Login:**

egoldberg.ppt@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 |
| ☐ | 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 — 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 07/10/18 07:50 AM

## Clinical Instructor Information

Provide the following information on all PTs or PTAs employed at your clinical site who are CIs.

| CI Name Followed By Credentials | CI Username | Actions |
|---|---|---|
| Hurley, Robert | hurley8201@gmail.com | |
| Huskins, Denise | denisehuskins@yahoo.com | |
| Pekor, Jonathan | jonathan.pekor@gmail.com | |
| Ritchie, Brian | brianpt85@gmail.com | |
| Wu, Mei-Chun | antigent@gmail.com | |

**Add New CI** Displaying **all 5** 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 07/10/18 07:50 AM

## Clinical Instructors

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

| | | | | | |
|---|---|---|---|---|---|
| ☐ | APTA Clinical Instructor Credentialing | ☐ | Career ladder opportunity | ☐ | Certification/training course |
| ☐ | Clinical competence | ☐ | Delegated in position description | ☐ | Demonstrated strength in clinical teaching |
| ☐ | No criteria | ☐ | Other (not APTA) clinical instructor credentialing | ☐ | Therapist initiative/volunteer |
| ☐ | Years of experience | ☐ | Other | | |

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

| | | | | | |
|---|---|---|---|---|---|
| ☐ | 1:1 individual training (CCCE:CI) | ☐ | APTA Clinical Instructor Education and Credentialing Program | ☐ | Academic for-credit coursework |
| ☐ | Clinical center inservices | ☐ | Continuing education by academic program | ☐ | Continuing education by consortia |

| | | | | | |
|---|---|---|---|---|---|
| ☐ | No training | ☐ | Other (not APTA) clinical instructor credentialing program | ☐ | Professional continuing education (e.g., chapter, CEU course) |
| ☐ | 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 07/10/18 07:50 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 07/10/18 07:50 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<br>Total patient/client visits per day: | 0<br>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 07/10/18 07:50 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 | 07/10/18 07:50 AM |
|---|---|

## Patient/Client Diagnoses

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

**Musculoskeletal**

Please choose:

**Which Musculoskeletal sub-categories are available to the student:**

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Acute injury | ☐ | Amputation | ☐ | Arthritis |
| ☐ | Bone disease/dysfunction | ☐ | Connective tissue disease/dysfunction | ☐ | Muscle disease/dysfunction |
| ☐ | Musculoskeletal degenerative disease | ☐ | Orthopedic surgery | ☐ | Other |

**Neuro-muscular**

Please choose:

**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**

Please choose:

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

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

**Integumentary**

Please choose:

**Which Integumentary sub-categories are available to the student:**

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Burns | ☐ | Open wounds | ☐ | Scar formation |
| ☐ | Other | | | | |

**Other (May cross a number of diagnostic groups)**

Please choose:

**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 07/10/18 07:50 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 07/10/18 07:55 AM

## Information About the Clinical Education Experience

Special Programs/Activities/Learning Opportunities

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

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Administration | ☐ | Aquatic Therapy | ☐ | Athletic Venue Coverage |
| ☐ | Back School | ☐ | Biomechanics Lab | ☐ | Cardiac Rehabilitation |
| ☐ | Community/Re-entry Activities | ☐ | Critical Care/Intensive Care | ☐ | Departmental Administration |
| ☑ | Early Intervention | ☐ | Employee Intervention | ☐ | Employee Wellness Program |
| ☐ | Group Programs/Classes | ☐ | Home Health Program | ☐ | Industrial/Ergonomic PT |
| ☐ | Inservice Training/Lectures | ☐ | Neonatal Care | ☐ | Nursing Home/ECF/SNF |
| ☐ | Orthotic/Prosthetic Fabrication | ☐ | Pain Management Program | ☐ | Pediatric - Classroom Consultation Emphasis |
| ☐ | Pediatric - Cognitive Impairment Emphasis | ☐ | Pediatric - Developmental Program Emphasis | ☐ | Pediatric - General |
| ☐ | Pediatric - Musculoskeletal Emphasis | ☐ | Pediatric - Neurological Emphasis | ☑ | Prevention/Wellness |
| ☐ | Pulmonary Rehabilitation | ☐ | Quality Assurance/CQI/TQM | ☐ | Radiology |
| ☐ | Research Experience | ☐ | Screening/Prevention | ☑ | Sports Physical Therapy |

| | | |
|---|---|---|
| [ ] Surgery (observation) | [ ] Team Meetings/Rounds | [ ] Vestibular Rehabilitation |
| [ ] Women's Health/OB-GYN | [ ] Work Hardening/Conditioning | [x] Wound Care |
| [ ] Other | | |

Specialty Clinics

**Please check all specialty clinics available as student learning experiences.**

| | | |
|---|---|---|
| [ ] Arthritis | [ ] Balance | [ ] Developmental |
| [ ] Feeding clinic | [ ] Hand clinic | [ ] Hemophilia clinic |
| [ ] Industry | [ ] Neurology clinic | [ ] Orthopedic clinic |
| [ ] Pain clinic | [ ] Preparticipation sports | [ ] Prosthetic/orthotic clinic |
| [ ] Scoliosis | [ ] Screening clinics | [ ] Seating/mobility clinic |
| [ ] Sports medicine clinic | [ ] Wellness | [ ] Women's health |
| [ ] 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.**

| | | |
|---|---|---|
| [ ] Administrators | [ ] Alternative therapies | [ ] Athletic trainers |
| [ ] Audiologists | [ ] Dietitians | [ ] Enterostomal / wound specialists |
| [ ] Exercise physiologists | [ ] Fitness professionals | [ ] Health information technologists |
| [ ] Massage therapists | [ ] Nurses | [ ] Occupational therapists |
| [ ] Physician assistants | [x] Physicians | [ ] Podiatrists |
| [x] Prosthetists / orthotists | [ ] Psychologists | [ ] Respiratory therapists |
| [ ] Social workers | [ ] Special education teachers | [ ] Speech/language pathologists |
| [ ] Students from other disciplines | [ ] Students from other physical therapy education programs | [ ] Therapeutic recreation therapists |
| [ ] Vocational rehabilitation counselors | [ ] Other | |

### Section Sign Off:

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

[x] **This section has been completed.**

Availability of the Clinical Education Experience 07/10/18 07:55 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:**

| | | |
|---|---|---|
| [x] Full days | [ ] Half days | [ ] Other |

**Physical Therapist**
**Intermediate Experiences:**

| | | |
|---|---|---|
| [ ] Full days | [ ] Half days | [ ] Other |

**Physical Therapist**

| | | |
|---|---|---|
| [ ] Final Experience | [ ] Internship (6 months or longer) | [ ] Specialty experience |
| [ ] Other | | |

**Physical Therapist Assistant**
**First Experience:**

| | | |
|---|---|---|
| [ ] Full days | [ ] Half days | [ ] Other |

**Physical Therapist Assistant**
**Intermediate Experiences:**

| | | |
|---|---|---|
| [ ] Full days | [ ] Half days | [ ] Other |

**Physical Therapist Assistant**

| | | | |
|---|---|---|---|
| ☐ | Final Experience | ☐ | Other |

PT

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

| | | | | | |
|---|---|---|---|---|---|
| ☐ | January | ☐ | February | ☐ | March |
| ☐ | April | ☐ | May | ☐ | June |
| ☐ | July | ☐ | August | ☐ | September |
| ☐ | October | ☐ | November | ☐ | December |

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

| | | | | | |
|---|---|---|---|---|---|
| ☐ | January | ☐ | February | ☐ | March |
| ☐ | April | ☐ | May | ☐ | June |
| ☐ | July | ☐ | August | ☐ | September |
| ☐ | October | ☐ | November | ☐ | December |

PTA

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

| | | | | | |
|---|---|---|---|---|---|
| ☐ | January | ☐ | February | ☐ | March |
| ☐ | April | ☐ | May | ☐ | June |
| ☐ | July | ☐ | August | ☐ | September |
| ☐ | October | ☐ | November | ☐ | December |

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

| | | | | | |
|---|---|---|---|---|---|
| ☐ | January | ☐ | February | ☐ | March |
| ☐ | April | ☐ | May | ☐ | June |
| ☐ | July | ☐ | August | ☐ | September |
| ☐ | October | ☐ | November | ☐ | December |

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

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

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

○ Yes ○ No

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

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

### Section Sign Off:

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

☑ **This section has been completed.**

Clinical Site's Learning Objectives and Assessment | 07/10/18 07:55 AM

## Clinical Site's Learning Objectives and Assessment

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

◉ Yes ○ No

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

◉ Yes ○ No

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

| | | | | | |
|---|---|---|---|---|---|
| ☐ | At end of clinical experience | ☐ | At mid-clinical experience | ☐ | Beginning of the clinical experience |
| ☐ | Daily | ☑ | Weekly | ☐ | Other |

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

| | | | | | |
|---|---|---|---|---|---|
| | As per student request in addition to formal and ongoing | | Ongoing feedback throughout the clinical | | Student self-assessment throughout the clinical |

| | | | | | |
|---|---|---|---|---|---|
| ☑ | written & oral feedback | ☑ | | ☐ | |
| ☐ | 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 07/10/18 07:48 AM

### 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

**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:

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

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Child clearance | ☐ | Criminal background check | ☐ | Drug screening |
| ☑ | HIPAA education | ☐ | OSHA education | ☐ | Proof of student health clearance |
| ☑ | Other | | | | |

Please explain:

**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.

[x] **This section has been completed.**

| Special Information | 07/10/18 07:48 AM |
|---|---|

## 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
Please explain:

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

( ) Yes (•) No
Please explain:

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

( ) Yes (•) No
Please explain:

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

( ) Yes (•) No
Please explain:

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

(•) Yes ( ) No
Please explain:

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

(•) Yes ( ) No
Please explain:

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

( ) Yes (•) No
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.

[x] **This section has been completed.**

| Student Schedule | 07/10/18 07:48 AM |
|---|---|

### Student Schedule

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

Varied schedules

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

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

( ) Yes (•) No

**Section Sign Off:**

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

[x] **This section has been completed.**

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

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