

Site Manager Site Survey —

Site: Whittier Rehabilitation Hospital - Bradford

Section Title	Last Update	Action
CCCE Sign Off	Never	

CCCE Sign Off

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

This survey has been reviewed.

Information For the Academic Program	05/24/18 03:02 PM	
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Information For the Academic Program

Person Completing CSIF:
Elizabeth Toerne, BS, COTA/L, CCCE

E-mail address of person completing CSIF:
etoerne@whittierhealth.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):
Whittier Rehabilitation Hospital - Bradford

Street Address

Address:
145 Ward Hill ave

City:
Bradford

State:
MA

Postal Code:
01835

Facility Phone

Phone Number:
978-372-8000

Ext:

PT Department Phone

Phone Number:
978-469-1407

Ext:

PT Department Fax

Phone Number:
978-478-0503

Clinical Center Web Address:
www.whittierhealth.com

Director of Physical Therapy:
Laurie Lemire-Faust

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

CCCE / Contact Person Phone:

978-469-1407

CCCE / Contact Person E-mail:

etoeme@whittierhealth.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

05/24/18 03:02 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:

Whittier Health Network

Contact Name:

Address

Address:

City:

State:

Postal Code:

Phone

Phone Number:

Ext:

Fax

Phone Number:

E-mail:

Affiliation Agreement Contract Fulfillment

Contact Person:

Elizabeth Toerne

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

05/24/18 03:02 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

05/24/18 03:02 PM

Clinical Site Primary Classification

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

Other

Please explain:

Long Term Acute Care Hospital and General Outpatient

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 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 checked="" type="checkbox"/> Other

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.

Clinical Site Location

05/24/18 03:02 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

05/24/18 03:02 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	
Massachusetts College of Pharmacy and Health Sciences	Worcester	MA	PT	
North Shore Community College	Danvers	MA	PTA	
Northeastern University	Boston	MA	PT	
Simmons College	Boston	MA	PT	
Springfield College	Springfield	MA	PT	
University of Massachusetts - Lowell	Lowell	MA	PT	
University of New England	Portland	ME	PT	
Quinnipiac University	Hamden	CT	PT	
Bay State College	Boston	MA	PTA	
MGHHP	Boston	MA	PT	
University of Connecticut	Storrs	CT	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,		
Section Sign Off:		
ASA College, IA		
Click the box below to indicate you have reviewed and finished with this section of the survey.		
Academy for Nursing and Health Occupations, FL		
<input checked="" type="checkbox"/> This section has been completed.		
Adventist University of Health Sciences, FL		
Alabama State University, AL		
Information About the Clinical Teaching Faculty		

06/13/18 08:30 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:

Heather Popp

Email Address / CPI2 Login:

heatherpopp1@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:

<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

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)

<input type="checkbox"/>	OCS	<input type="checkbox"/>	GCS
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<input type="checkbox"/>	PCS	<input checked="" type="checkbox"/>	NCS
<input type="checkbox"/>	CCS	<input type="checkbox"/>	SCS
<input type="checkbox"/>	ECS	<input type="checkbox"/>	WCS

APTA Recognition of Advanced Proficiency for PTAs (Check all that apply)

<input type="checkbox"/>	Aquatic	<input type="checkbox"/>	Musculoskeletal
<input type="checkbox"/>	Cardiopulmonary	<input type="checkbox"/>	Neuromuscular
<input type="checkbox"/>	Geriatric	<input type="checkbox"/>	Pediatrics
<input type="checkbox"/>	Integumentary		

Other credentials:

Summary of College and University Education

(Start with most current)

Institution:

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

From — To

Major:

Degree:

Summary of Primary Employment

(For current and previous four positions since graduation from college; start with most current)

Employer:

Position:

Period of Employment
 (If the user is currently employed, please type in the word 'CURRENT' into the box labeled 'To'.)

From — To

Continuing Professional Preparation Related Directly to Clinical Teaching Responsibilities

(for example, academic for credit courses [dates and titles], continuing education [courses and instructors], research, clinical practice/expertise, etc. in the last three (3) years)

Course:

Provider/Location:

Date

Name:
Elizabeth Toerne

Email Address / CPI2 Login:
etoerne@whittierhealth.com

Present Position (Title, Name of Facility):

No. of Years as the CCCE

No. of Years of Clinical Practice

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

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)

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

05/24/18 03:07 PM

Clinical Instructor Information

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

CI Name Followed By Credentials	CI Username	Actions
Blanchette, Amanda	ABlanchette@whittierhealth.com	
Jimenez, Cristian	cdrjimenez@gmail.com	
Kiley, Sandy L	skiley@whittierhealth.com	
Kim, Benjamin D	Benjamin.david.kim@gmail.com	
Manship, Shelby	shelbybennett84@gmail.com	
Milad, Nicole	nicolemilad@gmail.com	
Nicoll, Joyce	aunniejoyce6@aol.com	
Packowski, Michelle	spackowski@comcast.net	
SLaurent, Laurie A	LaSullivan23@gmail.com	

[Add New CI](#) Displaying all 9 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

05/24/18 03:08 PM

Clinical Instructors

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

<input checked="" type="checkbox"/> APTA Clinical Instructor Credentialing	<input checked="" type="checkbox"/> Career ladder opportunity	<input checked="" 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 checked="" type="checkbox"/>	Clinical center inservices	<input type="checkbox"/>	Continuing education by academic program	<input type="checkbox"/>	Continuing education by consortia
<input type="checkbox"/>	No training	<input type="checkbox"/>	Other (not APTA) clinical instructor credentialing program	<input checked="" 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

05/29/13 12:02 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:

60

Step down:

Subacute/transitional care unit:

Extended care:

Other specialty centers:

Total Number of Beds:

60

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

05/29/13 12:02 PM

Number of Patients/Clients

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

Inpatient	Outpatient
6 Individual PT:	10 Individual PT:
6 Student PT:	10 Student PT:
6 Individual PTA:	10 Individual PTA:
6 Student PTA:	10 Student PTA:
PT/PTA Team:	PT/PTA Team:
24 Total patient/client visits per day:	40 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

05/29/13 12:02 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

Please choose: ▼

13-21 years

1% - 25% ▼

22-65 years

1% - 25% ▼

Over 65 years

76% - 100% ▼

Continuum of Care

Critical care, ICU, acute

Please choose: ▼

SNF/ECF/sub-acute

26% - 50% ▼

Rehabilitation

26% - 50% ▼

Ambulatory/outpatient

76% - 100% ▼

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

05/29/13 12:02 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 type="checkbox"/> Acute injury	<input checked="" type="checkbox"/> Amputation	<input checked="" type="checkbox"/> Arthritis
<input type="checkbox"/> Bone disease/ dysfunction	<input 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 type="checkbox"/> Other

Neuro-muscular

51% - 75%

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

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

Cardiovascular-pulmonary

51% - 75%

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

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

Integumentary

1% - 25%

Which Integumentary sub-categories are available to the student:

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

Other (May cross a number of diagnostic groups)

1% - 25%

Which other sub-categories are available to the student:

<input checked="" type="checkbox"/> Cognitive impairment	<input checked="" type="checkbox"/> General medical conditions	<input checked="" type="checkbox"/> General surgery
<input checked="" type="checkbox"/> Oncologic conditions	<input checked="" 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 05/29/13 12:02 PM

Staffing

	Full-time Budgeted	Part-time Budgeted	Current Staffing
PTs	6	4	10
PTAs	4		4
Aides/Techs	2		2
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 05/29/13 02:02 PM

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
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<input type="checkbox"/>	Back School	<input checked="" type="checkbox"/>	Biomechanics Lab	<input 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 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 checked="" 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 type="checkbox"/>	Vestibular Rehabilitation
<input type="checkbox"/>	Women's Health/OB-GYN	<input type="checkbox"/>	Work Hardening/Conditioning	<input checked="" 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 checked="" 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 checked="" 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:

Vision Clinic 1xMonth, Wound Clinic

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 type="checkbox"/>	Administrators	<input type="checkbox"/>	Alternative therapies	<input type="checkbox"/>	Athletic trainers
<input type="checkbox"/>	Audiologists	<input checked="" type="checkbox"/>	Dietitians	<input checked="" 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 checked="" type="checkbox"/>	Nurses	<input checked="" type="checkbox"/>	Occupational therapists
<input checked="" 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 checked="" 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

05/29/13 02:02 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 checked="" type="checkbox"/>	Other
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Please explain:

Observation Only

**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

Please explain:

Observation Only

**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.:

8

Average number of PTA students affiliating per year.:

3

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?:

Contact with the school and potential removal from Clinical Site

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

Section Sign Off:

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

This section has been completed.

Clinical Site's Learning Objectives and Assessment

05/29/13 02:02 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 type="checkbox"/> At mid-clinical experience	<input checked="" type="checkbox"/> Beginning of the clinical experience
<input type="checkbox"/> Daily	<input checked="" type="checkbox"/> Weekly	<input type="checkbox"/> Other

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

<input type="checkbox"/> As per student request in addition to formal and ongoing written & oral feedback	<input checked="" type="checkbox"/> Ongoing feedback throughout the clinical	<input 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 checked="" type="checkbox"/> Other

Please explain:

Weekly Review & Goal sheets filled out by CI and 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.

Student Requirements

07/01/15 04:48 PM

Student Requirements

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

Yes No

Please explain:

Interview and initial meeting Set up 2-3 months prior to experience to obtain necessary paperwork and determine work hours.

Do students receive the same official holidays as staff?

Yes No

Please explain:

In-patient holidays only 3: Thanksgiving, Christmas day, New Years day OP: Thanksgiving, Christmas day, New Years day, Memorial day, Labor 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:

• Immunization record including: o 2 Step TB check within a year (year must not end during affiliation) o Hepatitis series o MMR X 2 o Varicella vaccine X 2, titer, or proof of chicken pox disease o Flu vaccine or must wear mask during flu season

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

Sent by School or Student. Confidential Mail preferred or email to CCCE

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

12 mo

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:

Completed by site, 1 month prior to affiliation

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

Please explain:

• Drug Screening One week prior to affiliation (Student must provide driver's license and social security card, not laminated)

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.):

• Shadow Day (half day of student following appointed clinical instructor) Name tag from school White lab coat

If an individual is responsible for Compliance items, please fill out the Compliance contact information below:

Compliance Contact Person Name:

CCCE

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

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

Yes No

Please explain:

Final project/ clinical inservice presentation

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:

Journal Club

Does your site have a written policy for missed days due to illness, emergency situations, other? If yes, please summarize.

Yes No

Please explain:

defer to schools policy

Will the student have access to the Internet at the clinical site?

Yes No

Please explain:

limited computer use

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

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:

Students scheduled the same as CI, may include 4x 10 hour days, may include one weekend day with day off during the week

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"