

Site: Worcester Physical Therapy Services Inc

Section Title	Last Update	Action
CCCE Sign Off	Never	
<p><b>CCCE Sign Off</b></p> <p>Click the box below to indicate that you have reviewed all sections of your clinical site survey.</p> <p><input type="checkbox"/> This survey has been reviewed.</p>		
Information For the Academic Program	10/07/16 09:28 AM	
<p><b>Information For the Academic Program</b></p> <p><b>Person Completing CSIF:</b></p> <p><b>E-mail address of person completing CSIF:</b></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> Worcester Physical Therapy Services Inc</p> <p><b>Street Address</b></p> <p><b>Address:</b> 30 Glennie Street</p> <p><b>City:</b> Worcester</p> <p><b>State:</b> MA</p> <p><b>Postal Code:</b> 01605</p> <p><b>Facility Phone</b></p> <p><b>Phone Number:</b></p> <p><b>Ext:</b></p> <p><b>PT Department Phone</b></p> <p><b>Phone Number:</b> 508-791-8740</p> <p><b>Ext:</b></p> <p><b>PT Department Fax</b></p> <p><b>Phone Number:</b></p> <p><b>Clinical Center Web Address:</b></p> <p><b>Director of Physical Therapy:</b></p> <p><b>Center Coordinator of Clinical Education (CCCE) / Contact Person:</b></p> <p><b>CCCE / Contact Person Phone:</b></p> <p><b>CCCE / Contact Person E-mail:</b></p>		
<p><b>Section Sign Off:</b></p> <p>Click the box below to indicate you have reviewed and finished with this section of the survey.</p> <p><input type="checkbox"/> This section has been completed.</p>		
Information About the Corporate/Healthcare Systems Organization	10/07/16 09:28 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

10/07/16 09:28 AM

### 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 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

10/07/16 09:28 AM

### Clinical Site Primary Classification

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

Please choose:

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 type="checkbox"/>	Private Practice	<input 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

10/07/16 09:28 AM

### Clinical Site Location

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

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.

Affiliated PT and PTA Educational Programs

Never

### Affiliated PT and PTA Educational Programs

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

Program Name	City	State	PT / PTA
<b>Select the program(s) your site is currently affiliated with:</b>		<b>If not found in the list, please enter the program information here:</b>	
By A-Z: <input type="text" value="Any"/>		Program Name: <input type="text"/>	
By State: <input type="text" value="Any"/>		City: <input type="text"/>	
		State: <input type="text" value="AB"/>	
		PT / PTA: <input type="text" value="PT"/>	
ACCE Demo University, <input type="checkbox"/>			
ACCE Demo University, <input type="checkbox"/>			
ACCE Demo University, <input type="checkbox"/>			
ACCE PTA Demo, <input type="checkbox"/>			
ASA College, FL, <input type="checkbox"/>			
AT Still University of Health Sciences, AZ, <input type="checkbox"/>			
Academy for Nursing and Health Occupations, FL, <input type="checkbox"/>			
Adventist University of Health Sciences, FL, <input type="checkbox"/>			
Alabama State University, AL, <input type="checkbox"/>			
		<input type="button" value="Add"/>	<input type="button" value="Clear"/>

#### Section Sign Off:

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This section has been completed.

Information About the Clinical Teaching Faculty

10/07/16 09:28 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:

Jimmy Kakouris

Email Address / CPI2 Login:

Jimmy.kakouris@worcpt.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

Professional Doctor in Physical Therapy ▼

APTA Credentialed CI

Yes  No

APTA Advanced Credentialed CI

Yes  No

Other CI Credentialing

Yes  No

Please explain:

C.S.C.S

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

**Section Sign Off:**

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

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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
Almstrom, Lisa M	AlmstromL@yahoo.com	
Clayton, Sarah	sclay611@gmail.com	
Delage, Patti	patti.delage@worcpt.com	
Elliot, David	theelliots56@yahoo.com	
Fredette, Nash W	nash.fredette@worcpt.com	
Harrison, Matthew S	harrie424@yahoo.com	
Tersigni, Ashlyn	A.Tersigni03@gmail.com	

[Add New CI](#)    Displaying all 7 Clinical instructor

**Section Sign Off:**

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This section has been completed.

Clinical Instructors

10/07/16 09:28 AM

**Clinical Instructors**

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

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

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

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

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Information About the Physical Therapy Service

10/07/16 09:28 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:

**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

Never

**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:
Total patient/client visits per day:	Total patient/client visits per day:

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Patient/Client Lifespan and Continuum of Care

10/07/16 09:28 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:**

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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**

Please choose: ▼

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

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

**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 type="checkbox"/> General medical conditions	<input type="checkbox"/> General surgery
<input type="checkbox"/> Oncologic conditions	<input type="checkbox"/> Organ transplant	<input type="checkbox"/> Wellness/ Prevention
<input type="checkbox"/> Other		

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Staffing

**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 10/07/16 09:28 AM

**Information About the Clinical Education Experience**

Special Programs/ Activities/ Learning Opportunities

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

<input type="checkbox"/> Administration	<input type="checkbox"/> Aquatic Therapy	<input type="checkbox"/> Athletic Venue Coverage
<input type="checkbox"/> Back School	<input type="checkbox"/> Biomechanics Lab	<input type="checkbox"/> Cardiac Rehabilitation
<input type="checkbox"/> Community/ Re-entry Activities	<input type="checkbox"/> Critical Care/ Intensive Care	<input type="checkbox"/> Departmental Administration
<input type="checkbox"/> Early Intervention	<input type="checkbox"/> Employee Intervention	<input type="checkbox"/> Employee Wellness Program
<input type="checkbox"/> Group Programs/ Classes	<input type="checkbox"/> Home Health Program	<input type="checkbox"/> Industrial/ Ergonomic PT
<input type="checkbox"/> Inservice Training/ Lectures	<input type="checkbox"/> Neonatal Care	<input type="checkbox"/> Nursing Home/ ECF/ SNF
<input 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 type="checkbox"/> Pediatric - General
<input 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 type="checkbox"/> Screening/ Prevention	<input 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 type="checkbox"/> Work Hardening/Conditioning	<input type="checkbox"/> Wound Care
<input type="checkbox"/> Other		

Specialty Clinics

Please check all specialty clinics available as student learning experiences.

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Balance	<input type="checkbox"/> Developmental
<input type="checkbox"/> Feeding clinic	<input type="checkbox"/> Hand clinic	<input type="checkbox"/> Hemophilia clinic
<input type="checkbox"/> Industry	<input type="checkbox"/> Neurology clinic	<input type="checkbox"/> Orthopedic clinic
<input type="checkbox"/> Pain clinic	<input type="checkbox"/> Preparticipation sports	<input type="checkbox"/> Prosthetic/orthotic clinic
<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Screening clinics	<input type="checkbox"/> Seating/mobility clinic
<input type="checkbox"/> Sports medicine clinic	<input type="checkbox"/> Wellness	<input type="checkbox"/> Women's health
<input type="checkbox"/> Other		

Health and Educational Providers at the Clinical Site

Please check all health care and educational providers at your clinical site students typically observe and/or with whom they interact.

<input type="checkbox"/> Administrators	<input type="checkbox"/> Alternative therapies	<input type="checkbox"/> Athletic trainers
<input type="checkbox"/> Audiologists	<input type="checkbox"/> Dietitians	<input type="checkbox"/> Enterostomal / wound specialists
<input type="checkbox"/> Exercise physiologists	<input type="checkbox"/> Fitness professionals	<input type="checkbox"/> Health information technologists
<input type="checkbox"/> Massage therapists	<input 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 type="checkbox"/> Students from other disciplines	<input type="checkbox"/> Students from other physical therapy education programs	<input type="checkbox"/> Therapeutic recreation therapists
<input type="checkbox"/> Vocational rehabilitation counselors	<input type="checkbox"/> Other	

**Section Sign Off:**

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This section has been completed.

Availability of the Clinical Education Experience

10/07/16 09:28 AM

**Availability of the Clinical Education Experience**

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

**Physical Therapist**

**First Experience:**

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

**Intermediate Experiences:**

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

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

**Physical Therapist Assistant**

**First Experience:**

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

**Intermediate Experiences:**

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

**Physical Therapist Assistant**

<input type="checkbox"/> Final Experience	<input type="checkbox"/> Other
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PT

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

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

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

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

PTA

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

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

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

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

Average number of PT students affiliating per year.:

Average number of PTA students affiliating per year.:

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

Yes     No

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

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

**Section Sign Off:**

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This section has been completed.

Clinical Site's Learning Objectives and Assessment

10/07/16 09:28 AM

**Clinical Site's Learning Objectives and Assessment**

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

Yes     No

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

Yes     No

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

<input type="checkbox"/> At end of clinical experience	<input type="checkbox"/> At mid-clinical experience	<input 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 type="checkbox"/> As per student request in addition to formal and ongoing	<input type="checkbox"/> Ongoing feedback throughout the clinical	<input type="checkbox"/> Student self-assessment throughout the clinical
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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

10/07/16 09:28 AM

**Student Requirements**

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

Yes  No

Do students receive the same official holidays as staff?

Yes  No

Does your clinical site require a student interview?

Yes  No

Indicate the time the student should report to the clinical site on the first day of the experience.

Please choose:

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

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

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

<input type="checkbox"/> Child clearance	<input type="checkbox"/> Criminal background check	<input type="checkbox"/> Drug screening
<input type="checkbox"/> HIPAA education	<input type="checkbox"/> OSHA education	<input type="checkbox"/> Proof of student health clearance
<input type="checkbox"/> Other		

Is a criminal background check required (e.g., Criminal Offender Record Information)? If yes, please indicate which background check is required and time frame.

Yes  No

Is a child abuse clearance required?

Yes  No

Is the student responsible for the cost of required clearances?

Yes  No

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

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:**

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This section has been completed.

Special Information

10/07/16 09:28 AM

**Special Information**

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

Yes  No

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

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

Yes  No

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

Yes  No

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

10/07/16 09:28 AM

**Student Schedule**

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

Please choose:

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

Is physical therapy provided on the weekends?

Yes     No

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