

CLINICAL SITE INFORMATION FORM (CSIF)

APTA Department of Physical Therapy Education

Revised January 2006

INTRODUCTION:

The primary purpose of the Clinical Site Information Form (CSIF) is for Physical Therapist (PT) and Physical Therapist Assistant (PTA) academic programs to collect information from clinical education sites to:

- Facilitate clinical site selection,
- Assist in student placements,
- Assess the learning experiences and clinical practice opportunities available to students; and
- Provide assistance with completion of documentation required for accreditation.

The CSIF is divided into two sections:

- Part I: Information for Academic Programs (pages 4-16)
 - Information About the Clinical Site (pages 4-6)
 - Information About the Clinical Teaching Faculty (pages 7-10)
 - Information About the Physical Therapy Service (pages 10-12)
 - Information About the Clinical Education Experience (pages 13-16)
- Part II: Information for Students (pages 17-20)

Duplication of requested information is kept to a minimum except when separation of Part I and Part II of the CSIF would omit critical information needed by both students and the academic program. The CSIF is also designed using a check-off format wherever possible to reduce the amount of time required for completion.



American Physical Therapy Association

**Department of Physical Therapy Education
1111 North Fairfax Street
Alexandria, Virginia 22314**

DIRECTIONS FOR COMPLETION:

To complete the CSIF go to APTA's website at under “**Education Programs,**” click on “Clinical” and choose “Clinical Site Information Form.” This document is available as a Word document.

1. **Save the CSIF on your computer** before entering your facility’s information. The title should be the clinical site’s zip code, clinical site’s name, and the date (eg, 90210BevHillsRehab10-26-2005). Using this format for titling the document allows the users to quickly identify the facility and most recent version of the CSIF from a folder. Saving the document will preserve the original copy on the disk or hard drive, allowing for ease in updating the document as changes in the clinical site information occurs.
2. **Complete the CSIF thoroughly and accurately.** Use the tab key or arrow keys to move to the desired blank space. The form is comprised of a series of tables to enable use of the tab key for quicker data entry. Use the Comment section to provide addition information as needed. If you need additional space please attach a separate sheet of paper.
3. **Save the completed CSIF.**
4. **E-mail** the completed CSIF to each academic program with whom the clinic affiliates (accepts students).
5. In addition, to develop and maintain an accurate and comprehensive national database of clinical education sites, **e-mail** a copy of the completed CSIF to the Department of Physical Therapy Education at angelaboyd@apta.org.
6. **Update the CSIF on an annual basis** to assist in maintaining accurate and relevant information about your physical therapy service for academic programs, students, and the national database.

What should I do if my physical therapy service is associated with multiple satellite sites that also provide clinical learning experiences?

If your physical therapy service is associated with multiple satellite sites that offer a variety of clinical learning experiences, such as an acute care hospital that also provides clinical rotations at associated sports medicine and long-term care facilities, provide information regarding the primary clinical site for the clinical experience on **page 4**. Complete **page 4**, to provide essential information on all additional clinical sites or satellites associated with the primary clinical site. *Please note that if the satellite site(s) offering a clinical experience differs from the primary clinical site, a separate CSIF must be completed for each satellite site. Additionally, if any of the satellite sites have a different CCCE, an abbreviated resume must be completed for each individual serving as CCCE.*

What should I do if specific items are not applicable to my clinical site or I need to further clarify a response?

If specific items on the CSIF do not apply to your clinical education site at the time you are completing the form, please leave the item(s) blank. Provide additional information and/or comments in the Comment box associated with the item.

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CLINICAL SITE INFORMATION FORM

Part I: Information For the Academic Program
Information About the Clinical Site – Primary

Initial Date
Revision Date

Person Completing CSIF					
E-mail address of person completing CSIF					
Name of Clinical Center					
Street Address					
City		State		Zip	
Facility Phone			Ext.		
PT Department Phone			Ext.		
PT Department Fax					
PT Department E-mail					
Clinical Center Web Address					
Director of Physical Therapy					
Director of Physical Therapy E-mail					
Center Coordinator of Clinical Education (CCCE) / Contact Person					
CCCE / Contact Person Phone					
CCCE / Contact Person E-mail					
APTA Credentialed Clinical Instructors (CI) (List name and credentials)					
Other Credentialed CIs (List name and credentials)					
Indicate which of the following are required by your facility prior to the clinical education experience:	<input type="checkbox"/> Proof of student health clearance <input type="checkbox"/> Criminal background check <input type="checkbox"/> Child clearance <input type="checkbox"/> Drug screening <input type="checkbox"/> First Aid and CPR <input type="checkbox"/> HIPAA education <input type="checkbox"/> OSHA education <input type="checkbox"/> Other: Please list				

Information About Multi-Center Facilities

If your health care system or practice has multiple sites or clinical centers, complete the following table(s) for each of the sites. Where information is the same as the primary clinical site, indicate "SAME." If more than three sites, copy this table before entering the requested information. Note that you must complete an abbreviated resume for each CCCE.

Name of Clinical Site					
Street Address					
City		State		Zip	
Facility Phone				Ext.	
PT Department Phone				Ext.	
Fax Number			Facility E-mail		
Director of Physical Therapy				E-mail	
CCCE				E-mail	

Name of Clinical Site					
Street Address					
City		State		Zip	
Facility Phone				Ext.	
PT Department Phone				Ext.	
Fax Number			Facility E-mail		
Director of Physical Therapy				E-mail	
CCCE				E-mail	

Name of Clinical Site					
Street Address					
City		State		Zip	
Facility Phone				Ext.	
PT Department Phone				Ext.	
Fax Number			Facility E-mail		
Director of Physical Therapy				E-mail	
CCCE				E-mail	

Clinical Site Accreditation/Ownership

Yes	No		Date of Last Accreditation/Certification
<input type="checkbox"/>	<input type="checkbox"/>	Is your clinical site certified/ accredited? If no, go to #3.	
		If yes, has your clinical site been certified/accredited by:	
<input type="checkbox"/>	<input type="checkbox"/>	JCAHO	
<input type="checkbox"/>	<input type="checkbox"/>	CARF	
<input type="checkbox"/>	<input type="checkbox"/>	Government Agency (eg, CORF, PTIP, rehab agency, state, etc.)	
<input type="checkbox"/>	<input type="checkbox"/>	Other	
		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"/> Physician/Physician Group Owned <input type="checkbox"/> PT Owned <input type="checkbox"/> PT/PTA Owned <input checked="" type="checkbox"/> Other (please specify)	

Clinical Site Primary Classification

To complete this section, please:

- A. Place the number 1 (1) beside the category that best describes how your facility functions the majority ($\geq 50\%$) of the time.
- B. Next, if appropriate, check (\surd) 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"/>	Industrial/Occupational Health Facility	<input type="checkbox"/>	School/Preschool Program
<input type="checkbox"/>	Ambulatory Care/Outpatient	<input type="checkbox"/>	Multiple Level Medical Center	<input type="checkbox"/>	Wellness/Prevention/Fitness Program
<input type="checkbox"/>	ECF/Nursing Home/SNF	<input type="checkbox"/>	Private Practice	<input type="checkbox"/>	Other: Specify
<input type="checkbox"/>	Federal/State/County Health	<input type="checkbox"/>	Rehabilitation/Sub-acute Rehabilitation		

Clinical Site Location

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

- Rural
- Suburban
- Urban

Information About the Clinical Teaching Faculty

ABBREVIATED RESUME FOR CENTER COORDINATORS OF CLINICAL EDUCATION

Please update as each new CCCE assumes this position.

NAME:		Length of time as the CCCE:	
DATE: (mm/dd/yy)		Length of time as a CI:	
PRESENT POSITION: (Title, Name of Facility)		Mark (X) all that apply: <input type="checkbox"/> PT <input type="checkbox"/> PTA <input type="checkbox"/> Other, specify	Length of time in clinical practice:
LICENSURE: (State/Numbers)	APTA Credentialed CI Yes <input type="checkbox"/> No <input type="checkbox"/>	Other CI Credentialing Yes <input type="checkbox"/> No <input type="checkbox"/>	
Eligible for Licensure: Yes <input type="checkbox"/> No <input type="checkbox"/>		Certified Clinical Specialist: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Area of Clinical Specialization:			
Other credentials:			

SUMMARY OF COLLEGE AND UNIVERSITY EDUCATION (Start with most current):

INSTITUTION	PERIOD OF STUDY		MAJOR	DEGREE
	FROM	TO		

SUMMARY OF PRIMARY EMPLOYMENT (For current and previous four positions since graduation from college; start with most current):

EMPLOYER	POSITION	PERIOD OF EMPLOYMENT	
		FROM	TO

CLINICAL INSTRUCTOR INFORMATION

Provide the following information on all PTs or PTAs employed at your clinical site who are **CI**s. **For clinical sites with multiple locations, use one form for each location and identify the location here.**

Name followed by credentials (eg, Joe Therapist, DPT, OCS Jane Assistant, PTA, BS)	PT/PTA Program from Which CI Graduated	Year of Graduation	Highest Earned Physical Therapy Degree	No. of Years of Clinical Practice	No. of Years of Clinical Teaching	List Certifications KEY: A = APTA credentialed. CI B = Other CI credentialing C = Cert. clinical specialist List others	APTA Member Yes/No	L= Licensed, Number E= Eligible T= Temporary	
								L/E/T Number	State of Licensure

Clinical Instructors

What criteria do you use to select clinical instructors? (Mark (X) all that apply):

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

How are clinical instructors trained? (Mark (X) all that apply)

<input type="checkbox"/>	1:1 individual training (CCCE:CI)	<input type="checkbox"/>	Continuing education by consortia
<input type="checkbox"/>	Academic for-credit coursework	<input type="checkbox"/>	No training
<input type="checkbox"/>	APTA Clinical Instructor Education and Credentialing Program	<input type="checkbox"/>	Other (not APTA) clinical instructor credentialing program
<input type="checkbox"/>	Clinical center inservices	<input type="checkbox"/>	Professional continuing education (eg, chapter, CEU course)
<input type="checkbox"/>	Continuing education by academic program	<input type="checkbox"/>	Other (please specify):

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		Other specialty centers: Specify	
Subacute/transitional care unit			
Extended care		Total Number of Beds	

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

Patient/Client Lifespan and Continuum of Care

Indicate the frequency of time typically spent with patients/clients in each of the categories using the key below:
 1 = (0%) 2=(1-25%) 3=(26-50%) 4=(51-75%) 5=(76-100%)

Rating	Patient Lifespan	Rating	Continuum of Care
	0-12 years		Critical care, ICU, acute
	13-21 years		SNF/ECF/sub-acute
	22-65 years		Rehabilitation
	Over 65 years		Ambulatory/outpatient
			Home health/hospice
			Wellness/fitness/industry

Patient/Client Diagnoses

- Indicate the frequency of time typically spent with patients/clients in the primary diagnostic groups (bolded) using the key below:
 1 = (0%) 2 = (1-25%) 3 = (26-50%) 4 = (51-75%) 5 = (76-100%)
- Check (√) those patient/client diagnostic sub-categories available to the student.

(1-5)	Musculoskeletal		
<input type="checkbox"/>	Acute injury	<input type="checkbox"/>	Muscle disease/dysfunction
<input type="checkbox"/>	Amputation	<input type="checkbox"/>	Musculoskeletal degenerative disease
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Orthopedic surgery
<input type="checkbox"/>	Bone disease/dysfunction	<input type="checkbox"/>	Other: (Specify)
<input type="checkbox"/>	Connective tissue disease/dysfunction		
(1-5)	Neuro-muscular		
<input type="checkbox"/>	Brain injury	<input type="checkbox"/>	Peripheral nerve injury
<input type="checkbox"/>	Cerebral vascular accident	<input type="checkbox"/>	Spinal cord injury
<input type="checkbox"/>	Chronic pain	<input type="checkbox"/>	Vestibular disorder
<input type="checkbox"/>	Congenital/developmental	<input type="checkbox"/>	Other: (Specify)
<input type="checkbox"/>	Neuromuscular degenerative disease		
(1-5)	Cardiovascular-pulmonary		
<input type="checkbox"/>	Cardiac dysfunction/disease	<input type="checkbox"/>	Peripheral vascular dysfunction/disease
<input type="checkbox"/>	Fitness	<input type="checkbox"/>	Other: (Specify)
<input type="checkbox"/>	Lymphedema		
<input type="checkbox"/>	Pulmonary dysfunction/disease		
(1-5)	Integumentary		
<input type="checkbox"/>	Burns	<input type="checkbox"/>	Other: (Specify)
<input type="checkbox"/>	Open wounds		
<input type="checkbox"/>	Scar formation		
(1-5)	Other (May cross a number of diagnostic groups)		
<input type="checkbox"/>	Cognitive impairment	<input type="checkbox"/>	Organ transplant
<input type="checkbox"/>	General medical conditions	<input type="checkbox"/>	Wellness/Prevention
<input type="checkbox"/>	General surgery	<input type="checkbox"/>	Other: (Specify)
<input type="checkbox"/>	Oncologic conditions		

Hours of Operation

Facilities with multiple sites with different hours must complete this section for each clinical center.

Days of the Week	From: (a.m.)	To: (p.m.)	Comments
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

Student Schedule

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

- Standard 8 hour day
- Varied schedules

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

Staffing

Indicate the number of full-time and part-time budgeted and filled positions:

	Full-time budgeted	Part-time budgeted	Current Staffing
PTs			
PTAs			
Aides/Techs			
Others: Specify			

Information About the Clinical Education Experience

Special Programs/Activities/Learning Opportunities

Please mark (X) all special programs/activities/learning opportunities available to students.

<input type="checkbox"/>	Administration	<input type="checkbox"/>	Industrial/ergonomic PT	<input type="checkbox"/>	Quality Assurance/CQI/TQM
<input type="checkbox"/>	Aquatic therapy	<input type="checkbox"/>	Inservice training/lectures	<input type="checkbox"/>	Radiology
<input type="checkbox"/>	Athletic venue coverage	<input type="checkbox"/>	Neonatal care	<input type="checkbox"/>	Research experience
<input type="checkbox"/>	Back school	<input type="checkbox"/>	Nursing home/ECF/SNF	<input type="checkbox"/>	Screening/prevention
<input type="checkbox"/>	Biomechanics lab	<input type="checkbox"/>	Orthotic/Prosthetic fabrication	<input type="checkbox"/>	Sports physical therapy
<input type="checkbox"/>	Cardiac rehabilitation	<input type="checkbox"/>	Pain management program	<input type="checkbox"/>	Surgery (observation)
<input type="checkbox"/>	Community/re-entry activities	<input type="checkbox"/>	Pediatric-general (emphasis on):	<input type="checkbox"/>	Team meetings/rounds
<input type="checkbox"/>	Critical care/intensive care	<input type="checkbox"/>	Classroom consultation	<input type="checkbox"/>	Vestibular rehab
<input type="checkbox"/>	Departmental administration	<input type="checkbox"/>	Developmental program	<input type="checkbox"/>	Women's Health/OB-GYN
<input type="checkbox"/>	Early intervention	<input type="checkbox"/>	Cognitive impairment	<input type="checkbox"/>	Work Hardening/conditioning
<input type="checkbox"/>	Employee intervention	<input type="checkbox"/>	Musculoskeletal	<input type="checkbox"/>	Wound care
<input type="checkbox"/>	Employee wellness program	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	Other (specify below)
<input type="checkbox"/>	Group programs/classes	<input type="checkbox"/>	Prevention/wellness		
<input type="checkbox"/>	Home health program	<input type="checkbox"/>	Pulmonary rehabilitation		

Specialty Clinics

Please mark (X) all specialty clinics available as student learning experiences.

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

Availability of the Clinical Education Experience

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

Physical Therapist		Physical Therapist Assistant	
<input type="checkbox"/> First experience: Check all that apply. <input type="checkbox"/> Half days <input type="checkbox"/> Full days <input type="checkbox"/> Other: (Specify)		<input type="checkbox"/> First experience: Check all that apply. <input type="checkbox"/> Half days <input type="checkbox"/> Full days <input type="checkbox"/> Other: (Specify)	
<input type="checkbox"/> Intermediate experiences: Check all that apply. <input type="checkbox"/> Half days <input type="checkbox"/> Full days <input type="checkbox"/> Other: (Specify)		<input type="checkbox"/> Intermediate experiences: Check all that apply. <input type="checkbox"/> Half days <input type="checkbox"/> Full days <input type="checkbox"/> Other: (Specify)	
<input type="checkbox"/> Final experience		<input type="checkbox"/> Final experience	
<input type="checkbox"/> Internship (6 months or longer)			
<input type="checkbox"/> Specialty experience			

	PT		PTA	
	From	To	From	To
Indicate the range of weeks you will accept students for any single full-time (36 hrs/wk) clinical experience.				
Indicate the range of weeks you will accept students for any one part-time (< 36 hrs/wk) clinical experience.				

	PT	PTA
Average number of PT and PTA students affiliating <u>per year</u> . Clarify if multiple sites.		

Yes	No		Comments
<input type="checkbox"/>	<input type="checkbox"/>	Is your clinical site willing to offer reasonable accommodations for students under ADA?	

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

Answer if the clinical center employs only one PT or PTA.

Explain what provisions are made for students if the clinical instructor is ill or away from the clinical site.

Clinical Site's Learning Objectives and Assessment

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	1. Does your clinical site provide written clinical education objectives to students? If no, go to # 3.
		2. Do these objectives accommodate:
<input type="checkbox"/>	<input type="checkbox"/>	• The student's objectives?
<input type="checkbox"/>	<input type="checkbox"/>	• Students prepared at different levels within the academic curriculum?
<input type="checkbox"/>	<input type="checkbox"/>	• The academic program's objectives for specific learning experiences?
<input type="checkbox"/>	<input type="checkbox"/>	• Students with disabilities?
<input type="checkbox"/>	<input type="checkbox"/>	3. Are all professional staff members who provide physical therapy services acquainted with the clinical site's learning objectives?

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

<input type="checkbox"/>	Beginning of the clinical experience	<input type="checkbox"/>	At mid-clinical experience
<input type="checkbox"/>	Daily	<input type="checkbox"/>	At end of clinical experience
<input type="checkbox"/>	Weekly	<input type="checkbox"/>	Other

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

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

OPTIONAL: Please feel free to use the space provided below to share additional information about your clinical site (eg, strengths, special learning opportunities, clinical supervision, organizational structure, clinical philosophies of treatment, pacing expectations of students [early, final]).

Part II. Information for Students

Use the check (√) boxes provided for Yes/No responses. **For all other responses or to provide additional detail, please use the Comment box.**

Arranging the Experience

Yes	No		Comments
<input type="checkbox"/>	<input type="checkbox"/>	1. Do students need to contact the clinical site for specific work hours related to the clinical experience?	
<input type="checkbox"/>	<input type="checkbox"/>	2. Do students receive the same official holidays as staff?	
<input type="checkbox"/>	<input type="checkbox"/>	3. Does your clinical site require a student interview?	
		4. Indicate the time the student should report to the clinical site on the first day of the experience.	
<input type="checkbox"/>	<input type="checkbox"/>	5. Is a Mantoux TB test (PPD) required? a) one step _____ (√ check) b) two step _____ (√ check) If yes, within what time frame?	
<input type="checkbox"/>	<input type="checkbox"/>	6. Is a Rubella Titer Test or immunization required?	
<input type="checkbox"/>	<input type="checkbox"/>	7. Are any other health tests/immunizations required prior to the clinical experience? If yes, please specify:	
		8. How is this information communicated to the clinic? Provide fax number if required.	
		9. How current are student physical exam records required to be?	
<input type="checkbox"/>	<input type="checkbox"/>	10. Are any other health tests or immunizations required on-site? If yes, please specify:	
<input type="checkbox"/>	<input type="checkbox"/>	11. Is the student required to provide proof of OSHA training?	
<input type="checkbox"/>	<input type="checkbox"/>	12. Is the student required to provide proof of HIPAA training?	
<input type="checkbox"/>	<input type="checkbox"/>	13. Is the student required to provide proof of any other training prior to orientation at your facility? If yes, please list.	
<input type="checkbox"/>	<input type="checkbox"/>	14. Is the student required to attest to an understanding of the benefits and risks of Hepatitis-B immunization?	
<input type="checkbox"/>	<input type="checkbox"/>	15. Is the student required to have proof of health insurance?	
<input type="checkbox"/>	<input type="checkbox"/>	16. Is emergency health care available for students?	
<input type="checkbox"/>	<input type="checkbox"/>	a) Is the student responsible for emergency health care costs?	
<input type="checkbox"/>	<input type="checkbox"/>	17. Is other non-emergency medical care available to students?	
<input type="checkbox"/>	<input type="checkbox"/>	18. Is the student required to be CPR certified? (Please note if a specific course is required).	

Yes	No		Comments
<input type="checkbox"/>	<input type="checkbox"/>	a) Can the student receive CPR certification while on-site?	
<input type="checkbox"/>	<input type="checkbox"/>	19. Is the student required to be certified in First Aid?	
<input type="checkbox"/>	<input type="checkbox"/>	a) Can the student receive First Aid certification on-site?	
<input type="checkbox"/>	<input type="checkbox"/>	20. Is a criminal background check required (eg, Criminal Offender Record Information)? If yes, please indicate which background check is required and time frame.	
<input type="checkbox"/>	<input type="checkbox"/>	21. Is a child abuse clearance required?	
<input type="checkbox"/>	<input type="checkbox"/>	22. Is the student responsible for the cost or required clearances?	
<input type="checkbox"/>	<input type="checkbox"/>	23. Is the student required to submit to a drug test? If yes, please describe parameters.	
<input type="checkbox"/>	<input type="checkbox"/>	24. Is medical testing available on-site for students?	
		25. Other requirements: (On-site orientation, sign an ethics statement, sign a confidentiality statement.)	

Housing

Yes	No		Comments
<input type="checkbox"/>	<input type="checkbox"/>	26. Is housing provided for male students? (If no, go to #32)	
<input type="checkbox"/>	<input type="checkbox"/>	27. Is housing provided for female students? (If no, go to #32)	
		28. What is the average cost of housing?	
		29. Description of the type of housing provided:	
		30. How far is the housing from the facility?	
		31. Person to contact to obtain/confirm housing:	
		Name:	
		Address:	
		City:	State: Zip:
		Phone:	E-mail:

Yes	No		Comments
		32. If housing is not provided for either gender:	
<input type="checkbox"/>	<input type="checkbox"/>	a) Is there a contact person for information on housing in the area of the clinic? Please list contact person and phone #.	
<input type="checkbox"/>	<input type="checkbox"/>	b) Is there a list available concerning housing in the area of the clinic? If yes, please attach to the end of this form.	

Transportation

Yes	No		Comments
<input type="checkbox"/>	<input type="checkbox"/>	33. Will a student need a car to complete the clinical experience?	
<input type="checkbox"/>	<input type="checkbox"/>	34. Is parking available at the clinical center?	
		a) What is the cost for parking?	
<input type="checkbox"/>	<input type="checkbox"/>	35. Is public transportation available?	
		36. How close is the nearest transportation (in miles) to your site?	
		a) Train station?	miles
		b) Subway station?	miles
		c) Bus station?	miles
		d) Airport?	miles
		37. Briefly describe the area, population density, and any safety issues regarding where the clinical center is located.	
		38. Please enclose a map of your facility, specifically the location of the department and parking. Travel directions can be obtained from several travel directories on the internet. (eg, Delorme , Microsoft , Yahoo , Mapquest).	

Meals

Yes	No		Comments
<input type="checkbox"/>	<input type="checkbox"/>	39. Are meals available for students on-site? (If no, go to #40)	
		Breakfast (if yes, indicate approximate cost)	
		Lunch (if yes, indicate approximate cost)	
		Dinner (if yes, indicate approximate cost)	
<input type="checkbox"/>	<input type="checkbox"/>	40. Are facilities available for the storage and preparation of food?	

Stipend/Scholarship

Yes	No		Comments
<input type="checkbox"/>	<input type="checkbox"/>	41. Is a stipend/salary provided for students? If no, go to #43.	
		a) How much is the stipend/salary? (\$ / week)	
<input type="checkbox"/>	<input type="checkbox"/>	42. Is this stipend/salary in lieu of meals or housing?	
		43. What is the minimum length of time the student needs to be on the clinical experience to be eligible for a stipend/salary?	

Special Information

Yes	No		Comments
<input type="checkbox"/>	<input type="checkbox"/>	44. Is there a facility/student dress code? If no, go to # 45. If yes, please describe or attach.	
		a) Specify dress code for men:	
		b) Specify dress code for women:	
<input type="checkbox"/>	<input type="checkbox"/>	45. Do you require a case study or inservice from all students (part-time and full-time)?	
<input type="checkbox"/>	<input type="checkbox"/>	46. Do you require any additional written or verbal work from the student (eg, article critiques, journal review, patient/client education handout/brochure)?	
<input type="checkbox"/>	<input type="checkbox"/>	47. Does your site have a written policy for missed days due to illness, emergency situations, other? If yes, please summarize.	
<input type="checkbox"/>	<input type="checkbox"/>	48. Will the student have access to the Internet at the clinical site?	

Other Student Information

Yes	No		
<input type="checkbox"/>	<input type="checkbox"/>	49. Do you provide the student with an on-site orientation to your clinical site?	
(mark X below)		a) Please indicate the typical orientation content by marking an X by all items that are included.	
<input type="checkbox"/>	Documentation/billing	<input type="checkbox"/>	Review of goals/objectives of clinical experience
<input type="checkbox"/>	Facility-wide or volunteer orientation	<input type="checkbox"/>	Student expectations
<input type="checkbox"/>	Learning style inventory	<input type="checkbox"/>	Supplemental readings
<input type="checkbox"/>	Patient information/assignments	<input type="checkbox"/>	Tour of facility/department
<input type="checkbox"/>	Policies and procedures (specifically outlined plan for emergency responses)	<input type="checkbox"/>	Other (specify below - eg, bloodborne pathogens, hazardous materials, etc.)
<input type="checkbox"/>	Quality assurance		
<input type="checkbox"/>	Reimbursement issues		
<input type="checkbox"/>	Required assignments (eg, case study, diary/log, inservice)		

In appreciation...

Many thanks for your time and cooperation in completing the CSIF and continuing to serve the physical therapy profession as clinical mentors and role models. Your contributions to learners' professional growth and development ensure that patients/clients today and tomorrow receive high-quality patient/client care services.