CLINICAL SITE INFORMATION FORM (CSIF)
developed by
APTA Department of Physical Therapy Education
(revised 11-1-99)

Why have a consistent Clinical Site Information Form?
The primary purpose of this form is for Physical Therapist (PT) and Physical Therapist Assistant (PTA) academic programs to collect information from clinical education sites. This information will facilitate clinical site selection, student placements, assessment of learning experiences and clinical practice opportunities available to students; and provide assistance with completion of documentation for accreditation in clinical education.

How is the form designed?
The form is divided into two sections, Information for Academic Programs - Part I (pages 3-14) and Information for Students - Part II (pages 15-17), to allow ease in retrieval of information for academic programs and for students, especially if the academic program is using a database to manage the information. Duplication of information being requested is kept to a minimum except when separation of Part I and Part II of the form would omit critical information needed by both students and the academic program. The form is also designed using a check-off format wherever possible to reduce the amount of time required for completion. This instrument can be retrieved from APTA's website at www.apta.org. Simply select the link titled "PT Education", then the link titled "Clinical Education" and choose "Clinical Site Information Form".

Although using a computer to complete the form is not mandatory, it is highly recommended to facilitate legible updates with minimal time investment from your facility. Additionally, the information provided will be more legible to students, academic programs, and the APTA's Department of Physical Therapy Education. The form includes several features designed to streamline navigation, including a hyperlinked index on page 18. (Please notes that several of the hyperlinks contained in the document require your computer to have an open internet connection and a web browser).

If you prefer to complete the form manually, you may download the CSIF from APTA's website (see above). If you do not have access to a computer for this purpose, hard copies of the CSIF are available from the APTA Department of Physical Therapy Education, as well as from all PT and PTA academic programs through their Academic Coordinator of Clinical Education (ACCE).

What should I do once the form has been completed?
We encourage you to invest the time to complete the form thoroughly and accurately. Once the form has been completed, the clinical education site may e-mail the instrument to each academic program with which it affiliates, minimizing administrative time and associated costs. **Please remember to make a copy of this form and retain for your records!** To assist in maintaining accurate and relevant information about your physical therapy service for academic programs and students, we encourage you to update this form on an annual basis

In addition, to develop and maintain an accurate and comprehensive national database of clinical education sites, we request that a copy of the completed form be e-mailed to the Department of Physical Therapy Education at csif@apta.org or mail to:

APTA
American Physical Therapy Association
Department of Physical Therapy Education
1111 North Fairfax Street
Alexandria, Virginia 22314

DIRECTIONS FOR COMPLETION:

If using a computer to complete this form:
When completing this form, after opening the original form, and before entering your facility's information, **save the**

form. The title should be your zip code, your site's name, and the date (eg, 90210BevHillsRehab10-26-99. Please note that the date must be set apart with dashes; if slashes are used, the computer will unsuccessfully search for a directory and return an error message). Saving the document will preserve the original copy on the disk or hard drive, allowing for you to easily update your information. When completing, 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 easier data entry). Enter relevant information only in blank spaces as appropriate to your clinical site.

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 (for example, corporate hospital mergers) that offer clinical learning experiences, such as an acute care hospital that also provides clinical rotations at associated sports medicine and long-term care facilities, you will need to complete ***pages 3 and 4***. On ***page 3***, provide the primary clinical site for the clinical experience. On ***page 4***, indicate other clinical sites or satellites associated with the primary clinical site. ***Please note that if the individual facility information varies with each satellite site that offers a clinical experience, it will be necessary to duplicate a blank CSIF and complete the form for each satellite site that offers different clinical learning experiences.***

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 form do not apply to your clinical education site at the time you are completing the form, please leave the item blank. Opportunities to provide comments have been made available throughout the form.

CLINICAL SITE INFORMATION FORM

I. Information About the Clinical Site

Date (8 / 8 / 05)

Person Completing Questionnaire	Eric Shamus, PT. PhD				
E-mail address of person completing questionnaire	eshamus@nova.edu				
Name of Clinical Center	Osteopathic Treatment Center, Nova Southeastern University				
Street Address	3200 S University Drive, suite 4316				
City	Davie	State Fl		Zip 33328	
Facility Phone	954-262-1153		Ext.		
PT Department Phone	954-262-4316		Ext.		
PT Department Fax	954-262-3538				
PT Department E-mail	eshamus@nova.edu				
Web Address	www.nova.edu				
Director of Physical Therapy	Eric Shamus, PT. PhD				
Director of Physical Therapy E-mail	eshamus@nova.edu				
Center Coordinator of Clinical Education (CCCE) / Contact Person	Eric Shamus, PT. PhD				
CCCE / Contact Person Phone	954-262-1153				
CCCE / Contact Person E-mail	eshamus@nova.edu				

Complete the following table(s) if there are multiple sites that are part of the same health care system or practice. Copy this table before entering information if you need more space.

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			
Center Coordinator of Clinical Education/contact (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			
Center Coordinator of Clinical Education/contact (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			
Center Coordinator of Clinical Education/contact (CCCE)		E-mail			

Clinical Site Accreditation/Ownership

Yes	No		Date of Last Accreditation/Certification
	x	1. Is your clinical site certified/ accredited? If no, go to #3.	
		2. If yes, by whom?	
		JCAHO	
		CARF	
		Government Agency (eg, CORF, PTIP, rehab agency, state, etc.)	
		Other	
		3. Who or what type of entity owns your clinical site? ____ PT owned ____ Hospital Owned ____ General business / corporation _x___ Other (please specify)__Not for profit University_____	

4. Place the **number 1** next to your clinical site's primary classification -- noted in **bold type**. Next, if appropriate, mark (X) **up to four additional bold typed categories** that describe other clinical centers associated with your primary classification. Beneath each of the **five possible bold typed categories**, mark (X) the specific learning experiences/settings that best describe that facility.

	Acute Care/Hospital Facility		Functional Capacity Exam- FCE		spinal cord injury
	university teaching hospital		industrial rehab		traumatic brain injury
	pediatric		other (please specify)		other
	cardiopulmonary		**Federal/State/County Health**		**School/Preschool Program**
	orthopedic		Veteran's Administration		school system
	other		pediatric develop. ctr.		preschool program
	Ambulatory Care/Outpatient		adult develop. ctr.		early intervention
	geriatric		other		other
	hospital satellite		**Home Health Care**		**Wellness/Prevention Program**
x	medicine for the arts		agency		on-site fitness center
1	orthopedic		contract service		other
	pain center		hospital based		**Other**
	pediatric		other		international clinical site
	podiatric		**Rehab/Subacute Rehab**		administration
x	sports PT		inpatient		research
	other	x	outpatient		other
	ECF/Nursing Home/SNF		pediatric		
	Ergonomics		adult		
	work hardening/conditioning		geriatric		

4a. Which of these best characterizes your clinic's location? Indicate with an 'X'.

rural		suburban	x	urban	

5. If your clinical site provides inpatient care, what are the number of:

	Acute beds
	ECF beds
	Long term beds
	Psych beds
	Rehab beds
	Step down beds
	Subacute/transitional care unit
	Other beds (please specify):
	Total Number of Beds

II. Information about the Provider of Physical Therapy Service at the Primary Center

6. PT Service hours

Days of the Week	From: (a.m.)	To: (p.m.)	Comments
Monday	9:00am	8:00pm	
Tuesday	9:00am	5:00pm	
Wednesday	9:00am	8:00pm	
Thursday	9:00am	5:00pm	
Friday	9:00am	5:00pm	
Saturday			
Sunday			

7. Describe the staffing pattern for your facility: Standard 8 hour day____ Varied schedules___x__
(Enter additional remarks in space below, including description of weekend physical therapy staffing pattern).

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

	Full-time budgeted	Part-time budgeted
PTs	1	
PTAs		
Aides/Techs		

9. Estimate an average number of **patients per therapist treated per day** by the provider of physical therapy.

INPATIENT		OUTPATIENT	
	Individual PT	12	Individual PT
	Individual PTA		Individual PTA

	Total PT service per day	12	Total PT service per day

III. Available Learning Experiences

10. Please mark (X) the *diagnosis related* learning experiences available at your clinical site:

	Amputations		Critical care/Intensive care		Neurologic conditions
x	Arthritis		Degenerative diseases		Spinal cord injury
x	Athletic injuries	x	General medical conditions		Traumatic brain injury
	Burns		General surgery/Organ Transplant		Other neurologic conditions
	Cardiac conditions	x	Hand/Upper extremity		Oncologic conditions
	Cerebral vascular accident		Industrial injuries	x	Orthopedic/Musculoskeletal
	Chronic pain/Pain		ICU (Intensive Care Unit)		Pulmonary conditions
	Connective tissue diseases		Mental retardation		Wound Care
	Congenital/Developmental				Other (specify below)

11. Please mark (X) all *special programs/activities/learning opportunities* available to students during clinical experiences, or as part of an independent study.

	Administration		Industrial/Ergonomic PT	x	Prevention/Wellness
	Aquatic therapy		Inservice training/Lectures		Pulmonary rehabilitation
	Back school		Neonatal care		Quality Assurance/CQI/TQM
x	Biomechanics lab		Nursing home/ECF/SNF		Radiology
	Cardiac rehabilitation	x	On the field athletic injury	x	Research experience
	Community/Re-entry activities	x	Orthotic/Prosthetic fabrication	x	Screening/Prevention
	Critical care/Intensive care		Pain management program	x	Sports physical therapy
	Departmental administration		Pediatric-General (emphasis on):		Surgery (observation)
	Early intervention		Classroom consultation		Team meetings/Rounds
	Employee intervention		Developmental program		Women's Health/OB-GYN
	Employee wellness program		Mental retardation		Work Hardening/Conditioning
x	Group programs/Classes		Musculoskeletal		Wound care
	Home health program		Neurological		Other (specify below)

12. Please mark (X) all *Specialty Clinics* available as student learning experiences.

	Amputee clinic		Neurology clinic		Screening clinics
	Arthritis		Orthopedic clinic		Developmental
	Feeding clinic		Pain clinic		Scoliosis
	Hand clinic	x	Preparticipation in sports	x	Sports medicine clinic
	Hemophilia Clinic		Prosthetic/Orthotic clinic		Other (specify below)
	Industry		Seating/Mobility clinic		

13. Please mark (X) all *health professionals* at your clinical site with whom students might observe and/or interact.

x	Administrators		Health information technologists		Psychologists
x	Alternative Therapies		Nurses		Respiratory therapists
	Athletic trainers		Occupational therapists		Therapeutic recreation therapists
	Audiologists	x	Physicians (list specialties) D.O.		Social workers
	Dietitians		Physician assistants		Special education teachers
	Enterostomal Therapist		Podiatrists		Vocational rehabilitation counselors
	Exercise physiologists		Prosthetists /Orthotists		Others (specify below)

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

Nova Southeastern University	
Florida International University	
University of Miami	

15. What criteria do you use to select clinical instructors? **(mark** (X) **all that apply)**:

x	APTA Clinical Instructor Credentialing	x	Demonstrated strength in clinical teaching
	Career ladder opportunity		No criteria
x	Certification/Training course		Therapist initiative/volunteer
x	Clinical competence	x	Years of experience
	Delegated in job description		Other (please specify)

16. How are clinical instructors trained? **(mark** (X) **all that apply)**

x	1:1 individual training (CCCE:CI)	x	Continuing education by consortia
	Academic for-credit coursework		No training
x	APTA Clinical Instructor Credentialing	x	Professional continuing education (eg, chapter, CEU course)
	Clinical center inservices		Other (please specify)
x	Continuing education by academic program		

17. On *pages 9 and 10* please provide information about individual(s) serving as the CCCE(s), and on *pages 11 and 12* please provide information about individual(s) serving as the CI(s) at your clinical site.

ABBREVIATED RESUME FOR CENTER COORDINATORS OF CLINICAL EDUCATION

Please update as each new CCCE assumes this position.

NAME:Eric Shamus	9	**Length of time as the CCCE:9**
DATE: (mm/dd/yy)	10	**Length of time as the CI:10**
PRESENT POSITION: (Title, Name of Facility) Assistant professor, Nova Southeastern Univesity	**Mark (X) all that apply:** __x__PT ____PTA ____Other, specify	**Length of time in clinical practice: 13**
LICENSURE: (State/Numbers) fl 008921		**Credentialed Clinical Instructor:** **Yes____x__ No_____**
Eligible for Licensure: Yes__x__ No____		**Certified Clinical Specialist:**
		Area of Clinical Specialization:
		Other credentials: CSCS

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

INSTITUTION	PERIOD OF STUDY		MAJOR	DEGREE
	FROM	TO		
FIU	**1987**	**1992**	PT	BS
Lynn University	1995	1997	Biomechanics	MS
Lynn University	1998	2001	Education	PhD

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
Park Place Therapeutics	Staff, CCCE, CI	**1992**	**1995**
Lynn University	ACCE, Program Director	1995	1997
Nova Southeastern University	Assistant Professor, CCCE, CI	1997	present

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 five years):

National Clinical Education Conference	
National certified clinical instructor	
FCCE certified clinical instructor	
See resume at www.nova.edu/~eshamus	

CLINICAL INSTRUCTOR INFORMATION

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

Name	School from Which CI Graduated	PT/PTA	Year of Graduation	No. of Years of Clinical Practice	No. of Years of Clinical Teaching	Credentialed CI Specialist Certification Other	L= Licensed, Number E= Eligible T= Temporary	
							L/E/T Number	State of Licensure
Eric Shamus	FIU	PT	1992	13	10	CI certified, APTA, FCCE	L 8921	Fl

(Continued on next page)

CLINICAL INSTRUCTOR INFORMATION (*continued*)

Name	School from Which CI Graduated	PT/PTA	Year of Graduation	No. of Years of Clinical Practice	No. of Years of Clinical Teaching	Credentialed CI Specialist Certification Other	L= Licensed, Number E= Eligible T= Temporary	
							L/E/T Number	State of Licensure

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

Physical Therapist		Physical Therapist Assistant	
x	First experience		First experience
x	Intermediate experiences		Intermediate experiences
x	Final experience		Final experience
x	Internship		

	PT		PTA	
	From	**To**	**From**	**To**
19. Indicate the range of weeks you will accept students for any single full-time (36 hrs/wk) clinical experience.	2	10		
20. Indicate the range of weeks you will accept students for any one part-time (< 36 hrs/wk) clinical experience.	2	16		

	PT	PTA
21. Average number of PT and PTA students affiliating per year.	4	

22. What is the procedure for managing students with exceptional qualities that might affect clinical performance (eg, outstanding students, students with learning/performance deficits, learning disability, physically challenged, visually impaired)?

This internship is an advanced manipulation experience.

23. **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.

There is another general PT clinic on campus that the student can rotate.

Yes	**No**	

	x	24. Does your clinical site provide written clinical education objectives to students? If no, go to # 27.
		25. Do these objectives accommodate:
		the student's objectives?
		students prepared at different levels within the academic curriculum?
		academic program's objectives for specific learning experiences?
		students with disabilities?
x		26. Are all professional staff members who provide physical therapy services acquainted with the site's learning objectives?

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

x	Beginning of the clinical experience	x	At mid-clinical experience
x	Daily	x	At end of clinical experience
x	Weekly		Other

28. How do you provide the student with an evaluation of his/her performance? **(mark (X) all that apply)**

x	Written and oral mid-evaluation	x	Ongoing feedback throughout the clinical
x	Written and oral summative final evaluation	x	As per student request in addition to formal and ongoing written & oral feedback
x	Student self-assessment throughout the clinical		

Yes	No	
	x	29. Do you require a specific student evaluation instrument other than that of the affiliating academic program? If yes, please specify:

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]).

Information for Students - Part II

I. Information About the Clinical Site

Yes	No	
x		1. Do students need to contact the clinical site for specific work hours related to the clinical experience?
x		2. Do students receive the same official holidays as staff?
x		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: contact the facility

Medical Information

Yes	No		Comments
x		5. Is a Mantoux TB test required? a) one step____x_____ b) two step_____	
		5a. If yes, within what time frame? 1 year	
		6. Is a Rubella Titer Test or immunization required?	As per University
		7. Are any other health tests/immunizations required prior to the clinical experience?	
		a) If yes, please specify:	
		8. How current are student physical exam records required to be?	As per University
		9. Are any other health tests or immunizations required on-site?	
		a) If yes, please specify:	
x		10. Is the student required to provide proof of OSHA training?	Yes
x		11. Is the student required to attest to an understanding of the benefits and risks of Hepatitis-B immunization?	Yes
x		12. Is the student required to have proof of health insurance?	Yes
x		a) Can proof be on file with the academic program or health center?	
	x	13. Is emergency health care available for students?	
		a) Is the student responsible for emergency health care costs?	
x		14. Is other non-emergency medical care available to students?	
x		15. Is the student required to be CPR certified? (Please note if a specific course is required).	
	x	a) Can the student receive CPR certification while on-site?	Additional cost
		16. Is the student required to be certified in First Aid?	As per University
		a) Can the student receive First Aid certification on-site?	

Yes	No		Comments

x		17. Is a criminal background check required (eg, Criminal Offender Record Information)?	Level one
x		a) Is the student responsible for this cost?	Yes
		18. Is the student required to submit to a drug test?	As per University
x		19. Is medical testing available on-site for students?	

Housing

Yes	No				Comments
	x	20. Is housing provided for male students?			
		for female students? (If no, go to #26)			
$		21. What is the average cost of housing?			
		22. If housing is **not** provided for either gender:			
		a) Is there a contact person for information on housing in the area of the clinic? (Please list contact person and phone #).			
		b) Is there a list available concerning housing in the area of the clinic? If yes, please attach to the end of this form.			
		23. Description of the type of housing provided:			
		24. How far is the housing from the facility?			
		25. Person to contact to obtain/confirm housing:			
		Name:			
		Address:			
		City:	State:	Zip:	

Transportation

Yes	No		
	x	26. Will a student need a car to complete the clinical experience?	
x		27. Is parking available at the clinical center?	
$ zero		a) What is the cost?	
x		28. Is public transportation available?	
		29. How close is the nearest bus stop (in miles) to your site?	
		a) train station?	
		b) subway station?	
		30. Briefly describe the area, population density, and any safety issues regarding where the clinical center is located.	College students
		31. Please enclose printed directions and/or a map to your facility. **Travel directions can be obtained from several travel directories on the internet. (eg,** Delorme**,** Microsoft**,** Yahoo**).**	*3200 s University drive, Davie, Fl 33328* *Ziff clinic building 3rd floor suite 4316*

Meals

Yes	No		Comments
x		32. Are meals available for students on-site? (If no, go to #33)	
x		Breakfast (if yes, indicate approximate cost)	$_4.00_____
x		Lunch (if yes, indicate approximate cost)	$___5.00_____
	x	Dinner (if yes, indicate approximate cost)	$_____
x		a) Are facilities available for the storage and preparation of food?	Microwave and fridge

Stipend/Scholarship

Yes	No		Comments
	x	33. Is a stipend/salary provided for students? If no, go to #36	
$		a) How much is the stipend/salary? ($ / week)	
		34. Is this stipend/salary in lieu of meals or housing?	
		35. 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
x		36. Is there a student dress code? If no, go to # 37.	
		a) Specify dress code for men:	*Dress slacks, collared shirt, lab coat*
		b) Specify dress code for women:	*same*
x		37. Do you require a case study or inservice from all students?	
	x	38. Does your site have a written policy for missed days due to illness, emergency situations, other?	

Other Student Information

Yes	No			
x		39. Do you provide the student with an on-site orientation to your clinical site?		
(mark X)		a) What does the orientation include? **(mark (X) all that apply)**		
x	Documentation/billing		x	Required assignments (eg, case study, diary/log, inservice)
	Learning style inventory		x	Review of goals/objectives of clinical experience
x	Patient information/assignments		x	Student expectations
x	Policies and procedures		x	Supplemental readings
	Quality assurance		x	Tour of facility/department
	Reimbursement issues			Other (specify below)

In appreciation...

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

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