**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](#InformationforAcadProg) (pages 3-14) and [Information for Students - Part II](#InfoforStudents) (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](http://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](#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](mailto:csif@apta.org) or mail to:



**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 (04/07/2009) | | |
| Person Completing Questionnaire | | | | | Charlotte Simmonds, MS, CSCS | | | | | | |
| E-mail address of person completing questionnaire | | | | | csimmonds@ossrpt.com | | | | | | |
| Name of Clinical Center | | | Olympic Sports and Spine Rehabilitation**- Puyallup** | | | | | | | | |
| Street Address | | | 8011 112th St. Ct. E | | | | | | | | |
| City | | | Puyallup | | St. | | WA | | Zip | 98373 | |
| Facility Phone | | | 253-848-0662 | | | | Ext. |  | | | |
| PT Department Phone | | |  | | | | Ext. |  | | | |
| PT Department Fax | | | 253-848-8567 | | | | | | | | |
| PT Department E-mail | | |  | | | | | | | | |
| Web Address | | | | www.ossrpt.com | | | | | | | |
| Director of Physical Therapy | | | | | Pam Kikillus, PT, DSc, OCS, COMT, FAAOMT | | | | | | |
| Director of Physical Therapy E-mail | | | | | | | pkikillus@ossrpt.com | | | | |
| Center Coordinator of Clinical Education (CCCE) /  Contact Person | | | | | | | Charlotte Simmonds, MS, CSCS | | | | |
| CCCE / Contact Person Phone | | | | | | | 253-581-5200 | | | | |
| CCCE / Contact Person E-mail | | | | | | | csimmonds@ossrpt.com | | | | |
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**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 | Olympic Sports and Spine Rehabilitation **(East Tacoma Clinic**) | | | | | | |
| Street Address | 7250 Pacific Ave. Ste. C. | | | | | | |
| City | Tacoma | | State | WA | | Zip | 98408 |
| Facility Phone | 253-475-4870 | | | Ext. |  | | |
| PT Department Phone |  | | | Ext. |  | | |
| Fax Number | 253-475-4873 | Facility E-mail | | | easttacoma@ossrpt.com | | |
| Director of Physical Therapy | Greg Harada, DPT, OCS | | | E-mail | greghs@ossrpt.com | | |
| Center Coordinator of Clinical Education/contact (CCCE) | Charlotte Simmonds, MS, CSCS | | | E-mail | csimmonds@ossrpt.com | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name of Clinical Site | Olympic Sports and Spine Rehabilitation (**Lakewood Colonial Center**) | | | | | | |
| Street Address | 9514 Gravelly Lake Dr. S.W. | | | | | | |
| City | Lakewood | | State | WA | | Zip | 98499 |
| Facility Phone | 253-983-9395 | | | Ext. |  | | |
| PT Department Phone |  | | | Ext. |  | | |
| Fax Number | 253-983-9411 | Facility E-mail | | | [ColonialCenter@ossrpt.com](mailto:ColonialCenter@ossrpt.com) | | |
| Director of Physical Therapy | Vern Essenberg, MPT, OCS, COMT, FAAOMPT | | | E-mail | vessenberg@ossrpt.com | | |
| Center Coordinator of Clinical Education/contact (CCCE) | Charlotte Simmonds, MS, CSCS | | | E-mail | csimmonds@ossrpt.com | | |

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**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 | Olympic Sports and Spine Rehabilitation (**South hill Clinic-Puyallup**) | | | | | | |
| Street Address | 17510 Meridian East Suite B | | | | | | |
| City | Puyallup | | State | WA | | Zip | 98375 |
| Facility Phone | (253)864-7595 | | | Ext. | SouthHill@ossrpt.com | | |
| PT Department Phone |  | | | Ext. |  | | |
| Fax Number | (253)864-0457 | Facility E-mail | | |  | | |
| Director of Physical Therapy | Joe Krugh, PT, CSCS, COMT, FAAOMPT | | | E-mail | Joe.krugh@ossrpt.com | | |
| Center Coordinator of Clinical Education/contact (CCCE) | Charlotte Simmonds, MS, CSCS | | | E-mail | csimmonds@ossrpt.com | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name of Clinical Site | Olympic Sports and Spine Rehabilitation (**Spanaway Clinic**) | | | | | | |
| Street Address | 144 South 169th Street, Suite B | | | | | | |
| City | Spanaway | | State | WA | | Zip | 98387 |
| Facility Phone | 253-846-8918 | | | Ext. |  | | |
| PT Department Phone |  | | | Ext. |  | | |
| Fax Number | 253-846-8126 | Facility E-mail | | | [spanaway@ossrpt.com](mailto:spanrehab@seanet.com) | | |
| Director of Physical Therapy | Joy Wada, DPT, CSCS, ATC | | | E-mail | [joyw@ossrpt.com](mailto:joyw@ossrpt.com) | | |
| Center Coordinator of Clinical Education/contact (CCCE) | Charlotte Simmonds, MS, CSCS | | | E-mail | [csimmonds@ossrpt.com](mailto:csimmonds@ossrpt.com) | | |

**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 | Olympic Sports and Spine Rehabilitation- (University Place clinic) | | | | | | |
| Street Address | 7727 40th St. W. Suite A. | | | | | | |
| City | University Place | | State | WA | | Zip | 98466 |
| Facility Phone | 253-460-1362 | | | Ext. |  | | |
| PT Department Phone |  | | | Ext. |  | | |
| Fax Number | 253-460-6628 | Facility E-mail | | | [Up2@ossrpt.com](mailto:Up2@ossrpt.com) | | |
| Director of Physical Therapy | Greg Wellman, DPT, CMPT | | | E-mail | gwellman@ossrpt.com | | |
| Center Coordinator of Clinical Education/contact (CCCE) | Charlotte Simmonds, MS, CSCS | | | E-mail | csimmonds@ossrpt.com | | |

*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 |  |
|  | | 1. Who or what type of entity owns your clinical site?   \_X\_\_ PT owned  \_\_\_\_ Hospital Owned  \_\_\_\_ General business / corporation  \_\_\_\_ Other (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

1. 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** | X | Functional Capacity Exam- FCE |  | spinal cord injury |
|  | university teaching hospital | X | industrial rehabilitation |  | 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 |
| **1** | **Ambulatory Care/Outpatient** |  | adult develop. ctr. |  | early intervention |
|  | Geriatric |  | other |  | other |
|  | hospital satellite |  | **Home Health Care** |  | **Wellness/Prevention Program** |
|  | medicine for the arts |  | Agency | X | on-site fitness center |
| X | Orthopedic |  | contract service |  | other |
|  | Pain center |  | hospital based |  | **Other** |
|  | Pediatric |  | other |  | international clinical site |
|  | Podiatric |  | **Rehab/Subacute Rehab** |  | administration |
| X | Sports PT |  | Inpatient |  | research |
| X | Other- Amputee Clinic at Puyallup |  | Outpatient |  | Other |
|  | **ECF/Nursing Home/SNF** |  | Pediatric | X | **NOTE: Industrial/work hardening only at Puyallup and UP II Clinics** |
| X | Ergonomics |  | Adult | X | **Fitness center at Puyallup only** |
| X | work hardening/conditioning |  | Geriatric |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 4a. Which of these best characterizes your clinic’s location? Indicate with an ‘X’. | | | | | |
| rural |  | suburban | X | urban |  |

Puyallup Clinic

1. If your clinical site provides inpatient care: N/A
2. ***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 | 7:30 | 6:00 |  |
| Tuesday | 7:30 | 6:00 |  |
| Wednesday | 7:30 | 6:00 |  |
| Thursday | 7:30 | 6:00 |  |
| Friday | 7:30 | 6:00 |  |
| Saturday | Closed |  |  |
| Sunday | closed |  |  |

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).

|  |
| --- |
| Most PT’s- Four 10 hour days  Some part time and some other variations |

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

|  |  |  |
| --- | --- | --- |
|  | **Full-time budgeted** | **Part-time budgeted** |
| PTs | 4 | 2 |
| PTAs | 4 | 1 |
| Aides/Techs |  | 2 (PT-student Work Study Positions) |

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

physical therapy.

|  |  |  |  |
| --- | --- | --- | --- |
| **INPATIENT** | | **OUTPATIENT** | |
| n/a | Individual PT | 12 | Individual PT |
| n/a | Individual PTA | 10 | Individual PTA |
| n/a | Total PT service per day | 50-100 | Total PT service per day |

**East Tacoma Clinic**

5. If your clinical site provides inpatient care: N/A

1. ***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 | 7:30 | 6:00 |  |
| Tuesday | 7:30 | 6:00 |  |
| Wednesday | 7:30 | 6:00 |  |
| Thursday | 7:30 | 6:00 |  |
| Friday | 7:30 | 6:00 |  |
| Saturday | NOT OPEN |  |  |
| Sunday | NOT OPEN |  |  |

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).

|  |
| --- |
| Four ten hour days with some variability. |

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

|  |  |  |
| --- | --- | --- |
|  | **Full-time budgeted** | **Part-time budgeted** |
| PTs | 2 |  |
| PTAs | 1 |  |
| Aides/Techs |  |  |

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

physical therapy.

|  |  |  |  |
| --- | --- | --- | --- |
| **INPATIENT** | | **OUTPATIENT** | |
| n/a | Individual PT | 12 | Individual PT |
| n/a | Individual PTA | 10 | Individual PTA |
| n/a | Total PT service per day | 30 | Total PT service per day |

**Lakewood Colonial Center Clinic**

5. If your clinical site provides inpatient care: N/A

1. ***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 | 7:30 | 6:00 |  |
| Tuesday | 7:30 | 6:00 |  |
| Wednesday | 7:30 | 6:00 |  |
| Thursday | 7:30 | 6:00 |  |
| Friday | 7:30 | 6:00 |  |
| Saturday | NOT OPEN |  |  |
| Sunday | NOT OPEN |  |  |

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).

|  |
| --- |
| Most PT’s- Four 10 hour days  Some part time and some other variations |

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

|  |  |  |
| --- | --- | --- |
|  | **Full-time budgeted** | **Part-time budgeted** |
| PTs | 2 | 1 |
| PTAs | 1 | 1 |
| Aides/Techs |  |  |

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

physical therapy.

|  |  |  |  |
| --- | --- | --- | --- |
| **INPATIENT** | | **OUTPATIENT** | |
|  | Individual PATIENT | 12 | Individual PT |
|  | Individual PTA | 10 | Individual PTA |
|  | Total PT service per day | 30-40 | Total PT service per day |

**South Hill Clinic**

5. If your clinical site provides inpatient care: N/A

1. ***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 | 7:30 | 6:00 |  |
| Tuesday | 7:30 | 6:00 |  |
| Wednesday | 7:30 | 6:00 |  |
| Thursday | 7:30 | 6:00 |  |
| Friday | 7:30 | 6:00 |  |
| Saturday | NOT OPEN |  |  |
| Sunday | NOT OPEN |  |  |

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).

|  |
| --- |
| 3 Ten hour days, 2 five hour days |

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

|  |  |  |
| --- | --- | --- |
|  | **Full-time budgeted** | **Part-time budgeted** |
| PTs | 2 |  |
| PTAs | 1 | 1 |
| Aides/Techs |  |  |

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

physical therapy.

|  |  |  |  |
| --- | --- | --- | --- |
| **INPATIENT** | | **OUTPATIENT** | |
|  | Individual PATIENT | 12 | Individual PT |
|  | Individual PTA | 12 | Individual PTA |
|  | Total PT service per day | 24 | Total PT service per day |

**Spanaway Clinic**

5. If your clinical site provides inpatient care: N/A

1. ***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 | 7:30 | 6:00 |  |
| Tuesday | 7:30 | 6:00 |  |
| Wednesday | 7:30 | 6:00 |  |
| Thursday | 7:30 | 6:00 |  |
| Friday | 7:30 | 6:00 |  |
| Saturday | NOT OPEN |  |  |
| Sunday | NOT OPEN |  |  |

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).

|  |
| --- |
| Most PT’s- Four 10 hour days |

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

|  |  |  |
| --- | --- | --- |
|  | **Full-time budgeted** | **Part-time budgeted** |
| PTs | 2 |  |
| PTAs | 1 | 1 |
| Aides/Techs |  |  |

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

physical therapy.

|  |  |  |  |
| --- | --- | --- | --- |
| **INPATIENT** | | **OUTPATIENT** | |
| n/a | Individual PATIENT | 10 | Individual PT |
| n/a | Individual PTA | 10 | Individual PTA |
| n/a | Total PT service per day | 40 | Total PT service per day |

**University Place Clinic**

5. If your clinical site provides inpatient care: N/A

1. ***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 | 7:30 | 6:00 |  |
| Tuesday | 7:30 | 6:00 |  |
| Wednesday | 7:30 | 6:00 |  |
| Thursday | 7:30 | 6:00 |  |
| Friday | 7:30 | 6:00 |  |
| Saturday | NOT OPEN |  |  |
| Sunday | NOT OPEN |  |  |

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).

|  |
| --- |
| Most PT’s- Four 10 hour days  Some part time and some other variations |

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

|  |  |  |
| --- | --- | --- |
|  | **Full-time budgeted** | **Part-time budgeted** |
| PTs | 2 | 1 |
| PTAs | 2 |  |
| Aides/Techs |  |  |

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

physical therapy.

|  |  |  |  |
| --- | --- | --- | --- |
| **INPATIENT** | | **OUTPATIENT** | |
| n/a | Individual PATIENT | 10 | Individual PT |
| n/a | Individual PTA | 10 | Individual PTA |
| n/a | Total PT service per day | 40-60 | Total PT service per day |

***III.*** ***Available Learning Experiences***

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| X | Amputations- Puyallup Only |  | Critical care/Intensive care |  | Neurologic conditions |
| X | Arthritis |  | Degenerative diseases |  | Spinal cord injury |
| X | Athletic injuries |  | General medical conditions |  | Traumatic brain injury |
|  | Burns |  | General surgery/Organ Transplant |  | Other neurologic conditions |
|  | Cardiac conditions | X | Hand/Upper extremity Puyallup and UP2 only |  | Oncologic conditions |
|  | Cerebral vascular accident | X | Industrial injuries | X | Orthopedic/Musculoskeletal |
| X | Chronic pain/Pain |  | ICU (Intensive Care Unit) |  | Pulmonary conditions |
| X | Connective tissue diseases |  | Mental retardation |  | Wound Care |
|  | Congenital/Developmental |  |  | X | Other – Manual Therapy- NAIOMT |

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Administration | X | Industrial/Ergonomic PT |  | Prevention/Wellness |
| X | Aquatic therapy (**Puyallup clinic only)** | X | Inservice training/Lectures |  | Pulmonary rehabilitation |
| X | Back school |  | Neonatal care |  | Quality Assurance/CQI/TQM |
|  | Biomechanics lab |  | Nursing home/ECF/SNF |  | Radiology |
|  | Cardiac rehabilitation | X | On the field athletic injury |  | Research experience |
|  | Community/Re-entry activities | X | Orthotic/Prosthetic fabrication (Orthotic only) |  | 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 | X | Team meetings/Rounds |
|  | Employee intervention |  | Developmental program | X | Women’s Health/OB-GYN |
|  | Employee wellness program |  | Mental retardation | X | Work Hardening/Conditioning  (Puyallup and U. P. only) |
|  | Group programs/Classes | X | 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 |
| X | Hand clinic (Puyallup and UP2 only) |  | Preparticipation in sports |  | 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 |
|  | Alternative Therapies |  | Nurses |  | Respiratory therapists |
| X | Athletic trainers | X | Occupational therapists (Puyallup and U.P. only) |  | Therapeutic recreation   therapists |
|  | Audiologists |  | Physicians (list specialties) |  | Social workers |
|  | Dietitians |  | Physician assistants |  | Special education teachers |
|  | Enterostomal Therapist |  | Podiatrists |  | Vocational rehabilitation counselors |
|  | Exercise physiologists |  | Prosthetists /Orthotists |  | Others (specify below)  Occupational Therapist |

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

|  |  |
| --- | --- |
| * Andrews University * Azusa Pacific * Baylor Army-Medical * Belmont University * Chatham College * Creighton University * Eastern Washington University * Green River Community College * Hardin Simmons University * Idaho State University * Long Beach State * Olympic College * Pacific University * Pima College * Provo College * University of Indianapolis * University of Kansas * University of Puget Sound * University of Southern California * University of St. Augustine * University of the Pacific * University of Washington * University of Wisconsin * Whatcom Community College |  |
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15. What criteria do you use to select clinical instructors? **(mark** (X) **all that apply)**:

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

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

|  |  |  |  |
| --- | --- | --- | --- |
|  | 1:1 individual training (CCCE:CI) |  | Continuing education by consortia |
|  | Academic for-credit coursework |  | No training |
| X | APTA Clinical Instructor Credentialing | X | Professional continuing education (eg, chapter, CEU course) |
| X | Clinical center inservices |  | Other (please specify) |
|  | 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:** | Charlotte Simmonds | **Length of time as the CCCE: 3Year** |
| **DATE: (mm/dd/yy)** | 3/15/2007 | **Length of time as the CI:** |
| **PRESENT POSITION**:  (Title, Name of Facility)  Marketing Coordinator, Corporate Office, Lakewood, WA  Athletic Trainer, Fife High School | Mark (X) all that apply:  \_ \_PT  \_\_\_\_PTA  \_\_X\_\_Other, specify  Athletic Trainer, Marketing Coordinator | **Length of time in clinical practice:**  **Have worked for OSSR since 1998** |
| **LICENSURE:** (State/Numbers) |  | **Credentialed Clinical Instructor:**  **Yes\_\_\_\_\_\_ No\_\_ X\_\_\_\_\_** |
| **Eligible for Licensure:** Yes\_\_\_\_ No\_\_X\_\_ | | **Certified Clinical Specialist: No** |
|  | | **Area of Clinical Specialization:** |
|  | | **Other credentials: ATC, CSCS** |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **INSTITUTION** | **PERIOD OF STUDY** | | **MAJOR** | **DEGREE** |
|  | **FROM** | **TO** |  |  |
| University of Oregon | **1995** | **1997** | Exercise Science | MS |
| Pacific University | 1989 | 1994 | Biology | BS |
|  |  |  |  |  |
|  |  |  |  |  |

**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** |
| Olympic Sports and Spine Rehabilitation | Athletic Trainer, Marketing Coordinator | **8/12/98** | **Present** |
| McKinely High School, Honolulu, HI | Athletic Trainer | 1/6/98 | 7/1/98 |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**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):

|  |  |
| --- | --- |
| (OSSR is treating the CCCE position as an administrative position. Each of the CI have backgrounds in teaching and or have taken CI certification courses.) |  |
| Joe Krugh, DPT, COMT, CSCS, FAAOMPT is our physical therapist in charge of all clinical internships. I manage all placement issues. Please see our website for his bio. |  |
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###### 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 |
| Joe Krugh  (South Hill) | Bowling Green State University | PT | 1998 | 11 | 9 | CSCS, COMT, FAAOMPT | L,  PT 9072 | WA |
| Pam (Leerar) Kikillus  (Puyallup) | University of Indianapolis | PT | 1992 | 17 | 15 | OCS, DSc, COMT, FAAOMPT | L,  PT 5876 | WA |
| Greg Wellman  (University Place) | Creighton University | PT | 2003 | 6 | 4 | CMPT | L,  PT 9243 | WA |
| Michael Tollan  (Puyallup-Spanaway) | University of Puget Sound | PT | 1985 | 24 | 23 | OCS, COMT, FAAOMT, Ergonomic Certification | L,  PT 3296 | WA/HI |
| Joy Wade (Spanaway) | University of Puget Sound | PT | 2006 | 3 | 1 | CSCS, ATC | L,  PT 10196 | WA |
| Greg Harada  (East Tacoma) | University of Puget Sound | PT | 2002 | 6 | 2 | CI  OCS, CSCS | L,  PT 8931 |

###### 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 |
| Kirsten Sanford, MS, PTA  (Puyallup) | Green River CC- PTA | PTA | 2006 | 3 | 2 |  |  |  |
| Tyress Marcy, PT  (Puyallup) | California State University at Sacromento | PT | 1998 | 13 | 4 | Manual Therapy post grad in Austraila. | L  PT 7957 | WA |
| Vern Essenberg  (LCC) | US Army-Baylor | PT | 1986 | 22 | 21 | OCS, COMT,  PCE Certification Credentialed CI Podiatry | L,  PT 5640 | WA |
| Janet Todd  (South Hill) | UPS | DPT | 1997 | 11 | 7 | Orthopedics/ Interest in Lymphedema | L,  PT 7416 | WA |
| Char Angelosante  (Puyallup) | Green River Community College | PTA | 1999 | 9 | 7 | PTA, LMP |  |  |
| Lynnette Row  (UP clinic) | Denver Technical College | PTA | 1995 | 13 | 5 | Interest in Manual Therapy/Massage | L  2027993 | Texas |
| Rhonda Martin  (UP) | UPS | PT | 2001 | 7 | 5 | CMDT | L  PT | WA |
| JoAnna Karkosky  (Spanaway) | Green River Community College | PTA | 2005 | 3 | 2 |  |  |  |

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 | X | First experience |
| X | intermediate experiences | X | Intermediate experiences |
| X | final experience | X | 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. | 1 | 16 | 1 | 8 |
| 20. Indicate the range of weeks you will accept students for any one part-time (< 36 hrs/wk) clinical experience. | 1 | 8 | 1 | 8 |
|  |  | |  | | |
|  | **PT** | | **PTA** | | |
| 21. Average number of PT and PTA students affiliating per year. | 18 | | 8 | | |

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)?

|  |
| --- |
| No established/formalized procedure. Accommodations evaluated/made on an as needed basis. |

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.

|  |  |  |
| --- | --- | --- |
| N/A- Facilities are covered for staffing. | | |
| **YES** | | **No** | **Yes** | |
|  | | X | 24. Does your clinical site provide written clinical education objectives to students?  If no, go to # 27. **NOTE-in development-** | |
|  | | | 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? | |
|  | |  | 26. Are all professional staff members who provide physical therapy services acquainted with the clinical  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 |
|  | Daily | X | At end of clinical experience |
|  | Weekly | X | Other AS NEEDED |

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 |  | As per student request in addition to formal and ongoing written & oral feedback |
| X | Student self-assessment throughout the clinical | X |  |

|  |  |  |
| --- | --- | --- |
| **Yes** | **No** |  |
|  | **X** | 1. 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]).

|  |
| --- |
| **We are a fast paced outpatient orthopedic company with a high emphasis on manual therapy techniques and incorporation of exercise to compliment these techniques. Different Clinical sites may offer slightly different experiences with varied patient populations and some differing emphases on a variety of techniques. Long term students are encouraged to have a strong interest in orthopedics, a strong background in anatomy, and ability to be flexible.** |

**Information for Students - Part II**

***I. Information About the Clinical Site***

|  |  |  |
| --- | --- | --- |
| **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: 8:00 am |

#### Medical Information

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Yes** | | **No** | |  | | **Comments** | |
|  | | X | | 5. Is a Mantoux TB test required?   1. one step\_\_\_\_\_\_\_\_\_ 2. two step\_\_\_\_\_\_\_\_\_ | |  | |
|  | | | | 5a. If yes, within what time frame? | |  | |
|  | | X | | 6. Is a Rubella Titer Test or immunization required? | |  | |
|  | | X | | 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? | |  | |
|  | | X | | 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? | |  | |
|  | | X | | 11. Is the student required to attest to an understanding of the  benefits and risks of Hepatitis-B immunization? | |  | |
| X | |  | | 12. Is the student required to have proof of health insurance? | |  | |
| X | |  | | 1. Can proof be on file with the academic program or health center? | |  | |
| X\* | |  | | 13. Is emergency health care available for students? | | \*Not on Site | |
| X | |  | | 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? | |  | |
| X | |  | | 16. Is the student required to be certified in First Aid? | |  | |
|  | | x | | 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)? | |  | |
|  | |  | | a) Is the student responsible for this cost? | |  | |
|  | | X | | 18. Is the student required to submit to a drug test? | |  | |
|  | | X | | 19. Is medical testing available on-site for students? | |  | |

#### Housing

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Yes** | **No** |  | |  | |  | **Comments** |
|  | X | 20. Is housing provided for male students? | | | | |  |
|  | X | 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 #). | | | | | Charlotte Simmonds, 253-581-5200 |
|  | | b) Is there a list available concerning housing in the area of the clinic? If yes, please attach to the end of this form. | | | | | Partial-Contact CCCE for info. |
|  | | 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: Charlotte Simmonds | |  | |  |  |
|  | | Address: 9315 Gravelly Lake Dr. SW Ste.203 | | | | |  |
|  | | City: Lakewood | State: WA | | Zip: 98499 | |  |

#### 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? |  |
| $ Free | | a) What is the cost? |  |
| X |  | 28. Is public transportation available? |  |
|  | | 29. How close is the nearest bus stop (in miles) to your site? | Yards |
|  | | a) train station? | N/A |
|  | | b) subway station? | N/A |
|  | | 30. Briefly describe the area, population density, and any safety issues regarding where the clinical center is located. | Puyallup Clinic is suburban free standing clinic. Others: suburban malls. |
|  | | 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,** [Google](http://www.delorme.com/cybermaps/)**,** [Microsoft](http://www.expediamaps.com/DrivingDirections.asp)**,** [Yahoo](http://maps.yahoo.com/py/maps.py)**) as well as our website.** [**www.ossrpt.com**](http://www.ossrpt.com) |  |

#### Meals

|  |  |  |  |
| --- | --- | --- | --- |
| Yes | **No** |  | **Comments** |
|  | X | 32. Are meals available for students on-site? (If no, go to #33) |  |
|  |  | Breakfast (if yes, indicate approximate cost) | $\_\_\_\_\_\_\_\_ |
|  |  | Lunch (if yes, indicate approximate cost) | $\_\_\_\_\_\_\_\_ |
|  |  | Dinner (if yes, indicate approximate cost) | $\_\_\_\_\_\_\_\_ |
| X |  | a) Are facilities available for the storage and preparation of food? |  |
|  |  |  |

*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) |  |
|  | X | 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: | Business Casual. Name tag required. No jeans/open toe shoes. Dress or collared knit shirts.Tie optional. Lab coat not required. |
|  |  | b) Specify dress code for women: | Business casual. Name tage required. No jeans/open toe shoes. Professional blouses or collared shirts. Lab coat not required. Bare midriff unacceptable. |
|  |  | 37. Do you require a case study or inservice from all students? | *School Dependent* |
|  | *X* | 38. Does your site have a written policy for missed days due to illness, emergency situations, other? | *No* |

*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) |
| X | 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 |
| X | Quality assurance | | X | Tour of facility/department |
| X | 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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