

## CLINICAL SITE INFORMATION FORM

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

Initial Date: 11/28/07

Revision Date: NA

Person Completing CSIF	Bret Swigard MPT, OCS, CMPT, c.MDT			
E-mail address of person completing CSIF	bswigard@physiocarept.com			
Name of Clinical Center	PhysioCare Physical Therapy			
Street Address	17644 140 <sup>th</sup> Ave NE, Woodinville, WA 98072			
City	Woodinville	State	WA	Zip 98072
Facility Phone	425-402-9772	Ext.		
PT Department Phone	425-402-9772	Ext.		
PT Department Fax	425-402-9443			
PT Department E-mail	NA			
Clinical Center Web Address	<a href="http://www.physiocarept.com">www.physiocarept.com</a>			
Director of Physical Therapy	Andy Lodato MPT, CMPT, c. MDT			
Director of Physical Therapy E-mail	alodato@physiocarept.com			
Center Coordinator of Clinical Education (CCCE) / Contact Person	Bret Swigard			
CCCE / Contact Person Phone	425-402-9772			
CCCE / Contact Person E-mail	bswigard@physiocarept.com			
APTA Credentialed Clinical Instructors (CI) (List name and credentials)	Bret Swigard MPT, OCS, CMPT, c. MDT, c. CI Mary Beth Ackerman PT, c. CI			
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	SAME				
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	SAME				
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	SAME				
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 checked="" 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/Privately 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 checked="" 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 (≥ 50%) of the time.
- B. Next, if appropriate, check (✓) up to four additional categories that describe the other clinical centers associated with your facility.

<input type="checkbox"/>	Acute Care/Inpatient Hospital Facility	<input type="checkbox"/>	Industrial/Occupational Health Facility	<input type="checkbox"/>	School/Preschool Program		
X	<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	1	<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
- X 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.*

<b>NAME:</b> Bret Swigard		Length of time as the CCCE: New Clinic, CCCE since July 07.	
<b>DATE:</b> (mm/dd/yy) 11/28/07		Length of time as a CI: 7 years	
<b>PRESENT POSITION:</b> Staff Therapist, Partial Owner, CCCE (Title, Name of Facility) PhysioCare Physical Therapy, Woodinville.		<b>Mark (X) all that apply:</b> X <input type="checkbox"/> PT <input type="checkbox"/> PTA <input type="checkbox"/> Other, specify	Length of time in clinical practice: 8 years
<b>LICENSURE:</b> (State/Numbers) PT 0000008160	<b>APTA Credentialed CI</b> Yes X No <input type="checkbox"/>	<b>Other CI Credentialing</b> Yes No X	
<b>Eligible for Licensure:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>Certified Clinical Specialist:</b> Yes X No <input type="checkbox"/>	
<b>Area of Clinical Specialization:</b> Orthopedics, Manual Therapy, Biomechanics/ Gait/ Orthotics			
<b>Other credentials:</b> OCS (Orthopedic Specialist APTA), CMPT (Certified Manual Therapist, Level 3 NAIOMT), c. MDT (Certified Mechanical Diagnosis and Treatment, McKenzie Institute)			

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

INSTITUTION	PERIOD OF STUDY		MAJOR	DEGREE
	FROM	TO		
Eastern Washington University	June 97	Dec 99	Master PT	MPT
Eastern Washington University	Jan 92	June 97	Human 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
PhysioCare Physical Therapy	Owner/ PT	July 07	Current
Eastside Sports Rehabilitation Clinics	Staff PT/ CCCE	Sept 05	July 07
Knee Foot Ankle Center	Staff PT/ CCCE	March 02	Sept 05
Pacific Medical Clinics	Staff PT	Dec 99	April 02



## CLINICAL INSTRUCTOR INFORMATION

Provide the following information on all PTs or PTAs employed at your clinical site who are CIs. 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	Licensure	
								L/E/T Number	State of Licensure
Andy Lodato MPT, CMPT, c. MDT	UTEP	2000	MPT	7	3	c. MDT, CMPT	No	PT 8264	WA
Mary Beth Ackerman PT	U. of Montana	1997	BSPT	10	8	c. CI	No	PT 8405	WA
Bret Swigard MPT, OCS, CMPT, c. MDT	EWU	1999	MPT	7	5	OCS, CMPT, c. MDT, c. CI	Yes	PT 000000 8160	WA

**Clinical Instructors**

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

<input checked="" 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 checked="" type="checkbox"/>	Certification/training course	<input checked="" type="checkbox"/>	Therapist initiative/volunteer
<input checked="" type="checkbox"/>	Clinical competence	<input checked="" type="checkbox"/>	Years of experience: Number: 5+
<input type="checkbox"/>	Delegated in job description	<input type="checkbox"/>	Other (please specify):
<input checked="" type="checkbox"/>	Demonstrated strength in clinical teaching		

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

<input checked="" 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 checked="" type="checkbox"/>	APTA Clinical Instructor Education and Credentialing Program	<input type="checkbox"/>	Other (not APTA) clinical instructor credentialing program
<input checked="" 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	NA	Psychiatric center	
Intensive care		Rehabilitation center	
Step down		Other specialty centers: Specify	
Subacute/transitional care unit			
Extended care		<b>Total Number of Beds</b>	

**Number of Patients/Clients**

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

INPATIENT		OUTPATIENT	
NA	Individual PT	10	Individual PT
	Student PT	5	Student PT (only for students that demonstrate competency and desire)
	Individual PTA		Individual PTA
	Student PTA		Student PTA
	PT/PTA Team		PT/PTA Team
	<b>Total patient/client visits per day</b>	15	<b>Total patient/client visits per day</b>

### 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
2	0-12 years		Critical care, ICU, acute
3	13-21 years		SNF/ECF/sub-acute
3	22-65 years		Rehabilitation
2	Over 65 years	5	Ambulatory/outpatient
			Home health/hospice
			Wellness/fitness/industry

### Patient/Client Diagnoses

1. 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%)

2. Check (✓) those patient/client diagnostic sub-categories available to the student.

(1-5)	<b>Musculoskeletal</b>		
2, X	Acute injury	3, X	Muscle disease/dysfunction
1	Amputation	3, X	Musculoskeletal degenerative disease
2, X	Arthritis	3, X	Orthopedic surgery
2, X	Bone disease/dysfunction	<input type="checkbox"/>	Other: (Specify)
2, X	Connective tissue disease/dysfunction		
(1-5)	<b>Neuro-muscular</b>		
1	Brain injury	2, X	Peripheral nerve injury
1	Cerebral vascular accident	1	Spinal cord injury
2, X	Chronic pain	1	Vestibular disorder
1	Congenital/developmental	<input type="checkbox"/>	Other: (Specify)
2, X	Neuromuscular degenerative disease		
(1-5)	<b>Cardiovascular-pulmonary</b>		
2, X	Cardiac dysfunction/disease	1	Peripheral vascular dysfunction/disease
2, X	Fitness	<input type="checkbox"/>	Other: (Specify)
1	Lymphedema		
1	Pulmonary dysfunction/disease		
(1-5)	<b>Integumentary</b>		
1	Burns	<input type="checkbox"/>	Other: (Specify)
1	Open wounds		
1	Scar formation		
(1-5)	<b>Other (May cross a number of diagnostic groups)</b>		
1	Cognitive impairment	1	Organ transplant
2	General medical conditions	2	Wellness/Prevention
2	General surgery	<input type="checkbox"/>	Other: (Specify)
1	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	7:00	7:00	Sat. hours are flexible based on demand
Tuesday	7:00	7:00	
Wednesday	7:00	7:00	
Thursday	7:00	7:00	
Friday	7:00	7:00	
Saturday	8:00	1:00	
Sunday	na		

**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:

Hours are determined by student and CI during orientation. We have some flexibility provided the student meets 35-40 hours per week of observation and/or clinical care.

**Staffing**

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

	Full-time budgeted	Part-time budgeted	Current Staffing
PTs	3		3
PTAs	NA		
Aides/Techs	NA		
Others: Specify	2 ADMINISTRATION		2

## Information About the Clinical Education Experience

### Special Programs/Activities/Learning Opportunities

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

<input checked="" type="checkbox"/>	Administration	<input checked="" type="checkbox"/>	Industrial/ergonomic PT	<input checked="" type="checkbox"/>	Quality Assurance/CQI/TQM
<input type="checkbox"/>	Aquatic therapy	<input checked="" 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 checked="" type="checkbox"/>	Screening/prevention
<input checked="" type="checkbox"/>	Biomechanics lab	<input checked="" type="checkbox"/>	Orthotic/Prosthetic fabrication	<input checked="" type="checkbox"/>	Sports physical therapy
<input type="checkbox"/>	Cardiac rehabilitation	<input type="checkbox"/>	Pain management program	<input checked="" 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 checked="" type="checkbox"/>	Departmental administration	<input type="checkbox"/>	Developmental program	<input checked="" type="checkbox"/>	Women's Health/OB-GYN
<input type="checkbox"/>	Early intervention	<input type="checkbox"/>	Cognitive impairment	<input type="checkbox"/>	Work Hardening/conditioning
<input checked="" type="checkbox"/>	Employee intervention	<input checked="" type="checkbox"/>	Musculoskeletal	<input type="checkbox"/>	Wound care
<input checked="" type="checkbox"/>	Employee wellness program	<input checked="" type="checkbox"/>	Neurological	<input type="checkbox"/>	Other (specify below)
<input type="checkbox"/>	Group programs/classes	<input checked="" 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 checked="" 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 checked="" 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 checked="" type="checkbox"/>	Sports medicine clinic	<input type="checkbox"/>	Wellness
<input type="checkbox"/>	Industry	<input checked="" 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	
First experience: Check all that apply. <input type="checkbox"/> Half days <input type="checkbox"/> Full days <input type="checkbox"/> Other: (Specify)	NA	First experience: Check all that apply. <input type="checkbox"/> Half days <input type="checkbox"/> Full days <input type="checkbox"/> Other: (Specify)	
Intermediate experiences: Check all that apply. <input type="checkbox"/> Half days <input checked="" type="checkbox"/> Full days <input type="checkbox"/> Other: (Specify)	NA	Intermediate experiences: Check all that apply. <input type="checkbox"/> Half days <input type="checkbox"/> Full days <input type="checkbox"/> Other: (Specify)	
<input checked="" type="checkbox"/> Final experience		<input type="checkbox"/> Final experience	
<input checked="" 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.	6	20	NA	
Indicate the range of weeks you will accept students for any one part-time (< 36 hrs/wk) clinical experience.	6	20		

	PT	PTA
Average number of PT and PTA students affiliating per year. Clarify if multiple sites.	NA, START UP	

Yes	No		Comments
<input checked="" 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?

Issues are to be dealt with at the time of the incident(s). Documentation and objective goals are identified and reviewed weekly or more frequently. If poor performance persists or unsafe behaviors persist then a meeting is called with the ACCE. Severity of incident(s) influences severity of intervention.

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.  
Student has the opportunity to work with other CIs or perform alternative relevant observations such as surgery, orthotics lab operation, acupuncture, chiropractic, etc.

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

Yes	No	
x	<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:
x	<input type="checkbox"/>	• The student's objectives?
x	<input type="checkbox"/>	• Students prepared at different levels within the academic curriculum?
x	<input type="checkbox"/>	• The academic program's objectives for specific learning experiences?
x	<input type="checkbox"/>	• Students with disabilities?
x	<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)

x	Beginning of the clinical experience	x	At mid-clinical experience
<input type="checkbox"/>	Daily	x	At end of clinical experience
x	Weekly	x	Other, depending on student performance.

Indicate which of the following methods are typically utilized to inform students about their clinical 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	<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]).

PhysioCare Physical Therapy is dedicated to providing the highest quality of student learning. All of our therapists are compassionate and specialists in their own fields. Students have the opportunity to learn from certified specialists in the niches of: manual therapy, biomechanics, orthotics, gait analysis, sports rehab, post surgical rehab, women's health (participation dependant on interview with Mary Beth Ackerman PT) and dancer rehab. PhysioCare emphasizes team learning in a positive environment. Our internships are challenging and rewarding. We even attempt to help the student with job placement after the academic and internship completion.

Students also have the ability to observe surgery, orthotics production, acupuncture, chiropractic, physiatrist practice, needle EMG, etc. Special interests of the student will be fostered.

**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 checked="" type="checkbox"/>	<input type="checkbox"/>	1. Do students need to contact the clinical site for specific work hours related to the clinical experience?	PhysioCare is flexible in work hours.
<input checked="" type="checkbox"/>	<input type="checkbox"/>	2. Do students receive the same official holidays as staff?	
<input type="checkbox"/>	<input checked="" 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.	7:00 am, orientation provided prior to patient care.
<input checked="" 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 checked="" type="checkbox"/>	<input type="checkbox"/>	6. Is a Rubella Titer Test or immunization required?	
<input type="checkbox"/>	<input checked="" 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.	425-402-9443
		9. How current are student physical exam records required to be?	Within last 2 years.
<input type="checkbox"/>	<input checked="" type="checkbox"/>	10. Are any other health tests or immunizations required on-site? If yes, please specify:	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	11. Is the student required to provide proof of OSHA training?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	12. Is the student required to provide proof of HIPAA training?	
<input type="checkbox"/>	<input checked="" 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 checked="" 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 checked="" type="checkbox"/>	<input type="checkbox"/>	15. Is the student required to have proof of health insurance?	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	16. Is emergency health care available for students?	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	a) Is the student responsible for emergency health care costs?	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	17. Is other non-emergency medical care available to students?	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	18. Is the student required to be CPR certified? (Please note if a specific course is required).	CPR certified highly suggested, certification available here at facility.

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

### Housing

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

		32. If housing is <b>not</b> provided for either gender:	
X	<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 #.	Bret Swigard CCCE 425-402-9772
<input type="checkbox"/>	x	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"/>	x	33. Will a student need a car to complete the clinical experience?	
x	<input type="checkbox"/>	34. Is parking available at the clinical center?	
		a) What is the cost for parking?	free
x	<input type="checkbox"/>	35. Is public transportation available?	
		36. How close is the nearest transportation (in miles) to your site?	
		a) Train station?	15 miles
		b) Subway station?	NA
		c) Bus station?	One block
		d) Airport?	20 miles
		37. Briefly describe the area, population density, and any safety issues regarding where the clinical center is located. Woodinville WA, is a very safe suburban location just north of Bellevue WA. Short distance to Seattle, WA.	
		38. Please enclose a map of your facility, specifically the location of the department and parking. <b>Travel directions can be obtained from several travel directories on the internet.</b> (eg, <u>Delorme</u> , <u>Microsoft</u> , <u>Yahoo</u> , <u>Mapquest</u> ).	

**Meals**

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



**Stipend/Scholarship**

Yes	No		Comments
<input type="checkbox"/>	x	41. Is a stipend/salary provided for students? If no, go to #43.	
		a) How much is the stipend/salary? (\$ / week)	
<input type="checkbox"/>	x	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
x	<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:	No shorts or tank tops or open toe shoes. No jeans.
		b) Specify dress code for women:	No short skirts or revealing blouses. No jeans.
<input type="checkbox"/>	x	45. Do you require a case study or inservice from all students (part-time and full-time)?	Determined by CI during orientation.
<input type="checkbox"/>	x	46. Do you require any additional written or verbal work from the student (eg, article critiques, journal review, patient/client education handout/brochure)?	Verbal discussions throughout internship, determined by CI during orientation.
<input type="checkbox"/>	x	47. Does your site have a written policy for missed days due to illness, emergency situations, other? If yes, please summarize.	Make up hours will be provided and determined by CI.
x	<input type="checkbox"/>	48. Will the student have access to the Internet at the clinical site?	Only appropriate sites.

**Other Student Information**

Yes	No		
x	<input type="checkbox"/>	49. Do you provide the student with an on-site orientation to your clinical site?	
<b>(mark X below)</b>		a) Please indicate the typical orientation content by marking an X by all items that are included.	
x		x	Documentation/billing
x		x	Review of goals/objectives of clinical experience
x		x	Facility-wide or volunteer orientation
<input type="checkbox"/>		<input type="checkbox"/>	Student expectations
<input type="checkbox"/>		<input type="checkbox"/>	Learning style inventory
x		x	Supplemental readings
x		x	Patient information/assignments
x		x	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
x			Reimbursement issues
x			Required assignments (eg, case study, diary/log, inservice)
			We will place emphasis on the clinical interests of the student as discussed in the orientation. We will facilitate the learning style of the student as discussed in the orientation.

*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.