CLINICAL SITE INFORMATION FORM (CSIF)

APTA Department of Physical Therapy Education

Revised January 2006

INTRODUCTION:

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

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

The CSIF is divided into two sections:

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

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

APTA
American Physical Therapy Association

Department of Physical Therapy Education
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DIRECTIONS FOR COMPLETION:

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

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

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

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

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

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

Table of Contents

CLINICAL SITE INFORMATION FORM

Initial Date
Revision Date

Part I: Information For the Academic Program

Information About the Clinical Site – Primary

Person Completing CSIF					
E-mail address of person completing CSIF					
Name of Clinical Center					
Street Address					
City		State		Zip	
Facility Phone		Ext.			
PT Department Phone		Ext.			
PT Department Fax					
PT Department E-mail					
Clinical Center Web Address					
Director of Physical Therapy					
Director of Physical Therapy E-mail					
Center Coordinator of Clinical Education (CCCE) / Contact Person					
CCCE / Contact Person Phone					
CCCE / Contact Person E-mail					
APTA Credentialed Clinical Instructors (CI) (List name and credentials)					
Other Credentialed CIs (List name and credentials)					
Indicate which of the following are required by your facility prior to the clinical education experience:	☐ Proof of student health clearance ☐ Criminal background check ☐ Child clearance ☐ Drug screening ☐ First Aid and CPR ☐ HIPAA education ☐ OSHA education ☐ 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, and paste additional sections of this table before entering the requested information. Note that you must complete an abbreviated resume for each CCCE.

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

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

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

Clinical Site Accreditation/Ownership

Yes	No		Date of Last Accreditation/Certification
☐	☐	Is your clinical site certified/ accredited? If no, go to #3.	
		If yes, has your clinical site been certified/accredited by:	
☐	☐	JCAHO	
☐	☐	CARF	
☐	☐	Government Agency (eg, CORF, PTIP, rehab agency, state, etc.)	
☐	☐	Other	
		Which of the following best describes the ownership category for your clinical site? (check all that apply) ☐ Corporate/Privately Owned ☐ Government Agency ☐ Hospital/Medical Center Owned ☐ Nonprofit Agency ☐ Physician/Physician Group Owned ☐ PT Owned ☐ PT/PTA Owned ☐ 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. Click on the drop down box to the left to select the number 1.
B. Next, if appropriate, check **(√)** up to four additional categories that describe the other clinical centers associated with your facility.

☐	Acute Care/Inpatient Hospital Facility	☐	Industrial/Occupational Health Facility	☐	School/Preschool Program
☐	Ambulatory Care/Outpatient	☐	Multiple Level Medical Center	☐	Wellness/Prevention/Fitness Program
☐	ECF/Nursing Home/SNF	☐	Private Practice	☐	Other**:** Specify
☐	Federal/State/County Health	☐	Rehabilitation/Sub-acute Rehabilitation		

Clinical Site Location

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

☐ Rural
☐ Suburban
☐ Urban

Information About the Clinical Teaching Faculty

ABBREVIATED RESUME FOR CENTER COORDINATORS OF CLINICAL EDUCATION

Please update as each new CCCE assumes this position.

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

SUMMARY OF COLLEGE AND UNIVERSITY EDUCATION (Start with most current): Tab to add additional rows.

INSTITUTION	**PERIOD OF STUDY**		**MAJOR**	**DEGREE**
	FROM	**TO**		

SUMMARY OF PRIMARY EMPLOYMENT (For current and previous four positions since graduation from college; start with most current): Tab to add additional rows.

EMPLOYER	**POSITION**	**PERIOD OF EMPLOYMENT**	
		FROM	**TO**

CONTINUING PROFESSIONAL PREPARATION RELATED DIRECTLY TO CLINICAL TEACHING RESPONSIBILITIES (for example, academic for credit courses [dates and titles], continuing education [courses and instructors], research, clinical practice/expertise, etc. in the **last three (3) years**): Tab to add additional rows.

Course	**Provider/Location**	**Date**