|  |  |  |  |
| --- | --- | --- | --- |
| **Student Name** |  | | |
| **Facility Name** |  | | |
| **Facility Physical Address-*for visitation purposes*** |  | | |
| **PT Department Phone-*direct line preferred*** |  | | |
|  |  | | |
| **CI Name:**  **CI Email address- to be used for CPI set up**  **Is there another preferred email for communication?** |  | | |
| **Is your CI Credentialed by the APTA as a CI?**  **If not APTA trained, then how trained for students?** | Yes or No | | |
| **Does your CI hold any certification or advanced clinical skill (ie ABPTS, FAAOMPT, ATC, CSCS, etc)? If yes, please indicate credentials** |  | | |
| **Which best describes the ownership category for your clinical site? Check or circle all that apply** | Government Agency  Corporate/Privately owned  Hospital/Medical Center owned  Non-Profit Agency  Physician/physician group owned  PT owned or PT/PTA owned  Other (specify) | |  |
| **Please indicate the number of students your CI has had previously (to the best of your ability)**  **How many of those students were from MUSOPT?** |  | | |
| **Please indicate the number of years of clinical practice for your CI** |  | | |
| **Please indicate the highest academic degree your CI has completed** |  | | |
| **Is your CI an APTA member?** |  | | |
|  |  | | |
| **How many total staff in this clinical site?** | PT  PTA  Aides/Techs | OT  OTA  SLP  Other? | |
| **Please indicate typical patient population/diagnoses:** | | | |
| **Please indicate the *percentage of time* at the following settings anticipated for this student:** | Acute care  Inpatient rehabilitation  Skilled nursing  Transitional Care  Outpatient  Other (explain) | | |
| (Comments?) |