ANGELO STATE UNIVERSITY
College of Health and Human Services
Doctor of Physical Therapy Program

<u>Clinical Site Update Form</u>

Date _____

Facility Name _____

Facility Address _____

Facility Phone (____)_____   Facility Fax (____)_____

PT Program Phone (____)_____   PT Program Fax (____)_____

Web Address _____   E-mail _____

PT Program Director _____
CCCE _____

I.   Facility

A.   Owned by (Name and location) _____
      _____

B.   Has there been a change in facility ownership? ___ No ___ Yes
      If yes, date of new ownership _____

C.   PT Program owned by (Name and location) _____
      _____

D.   Has there been a change in PT Program ownership? ___ No ___ Yes
      If yes, date of new ownership _____
      Is this a POPTS? ___ No ___ Yes

E.   Type of Facility (check one)

	Acute Care/Hospital Facility		Ambulatory Care/Outpatient Center		ECF/Nursing Home/SNF
	Federal/State/County Health		Home Health Care		Industrial Rehabilitation Facility
	Private Practice		Rehabilitation/Sub-acute Rehabilitation		School/Preschool System
	Wellness/Prevention Program		Psychiatric Unit		National/State/Local Agency
	Other (Please specify)		Other (specify)		

F.   Accreditation/certification by: (place date of last accreditation in blank)

	JCAHO		CARF		CORF
	Health Department		Medicare		Other (Please specify)

Reviewed.may12

II. Personnel

    A.   Staffing: number of PT's ___ PTAs ___ Support personnel ___ Any changes? No ___ Yes ___

        Explain _____

        Number of CI's _____

        Has there been a change in (check all that apply):

            1. PT Program administration? No __ Yes ___Explain _____

            2. CCCE?   No__   Yes__   Explain _____

            _____

        Has there been a change in (check appropriate spaces)

            3. CI's? No ___ Yes ___ Explain _____

    B.   Staff training and development:

        1.   Continuing Education courses attended _____

        2.   Special/Advanced training received: _____

        3.   Continuing Education needs: _____

III. Program news

    A.   Available student opportunities: _____

    B.   New programs/services offered: _____

    C.   New Equipment: _____

    D.   Additional Information/Comments: _____

Completed by: _____ __Date: _____