

ANGELO STATE UNIVERSITY
 College of Nursing and Allied Health
 Physical Therapy Department

Clinical Site Update Form

Date _____

Facility Name _____

Facility Address _____

Facility Phone (____) _____

Facility Fax (____) _____

PT Department Phone (____) _____

PT Department Fax (____) _____

Web Address _____

E-mail _____

PT Department 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 Department owned by (Name and location) _____

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

E. Type of Facility (check one)

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

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

<input type="checkbox"/>	JCAHO	<input type="checkbox"/>	CARF	<input type="checkbox"/>	CORF
<input type="checkbox"/>	Health Department	<input type="checkbox"/>	Medicare	<input type="checkbox"/>	Other (Please specify)

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 Department 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. Department news

A. Available student opportunities: _____

B. New programs/services offered: _____

C. New Equipment: _____

D. Additional Information/Comments: _____

Completed by: _____ Date: _____