

**CREDENTIALED CLINICAL INSTRUCTOR PROGRAM (CCIP)**

**Participant Dossier**

**Each participant must complete and submit this form electronically to receive CEU credit.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Participant Name: | | | |  | | | | | | |  | Date of Birth: | |  | |
|  | | | |  | | | | | | |  |  | |  | |
| E-Mail Address: | | | |  | | | | | | |  | Phone: | |  | |
|  | | | |  | | | | | | |  |  | |  | |
| APTA ID# | |  | | | (non-members leave blank) | | | | | | |  | |  | |
|  | |  | | | |  | | | | | |  | |  | |
| Current Address: | | |  | | | | | | | | | | | |
| City: |  | | | | | |  | State: |  |  | Zip: | |  | |

*APTA members*: certificates will be sent to your address on file at APTA. Please verify your address is correct by visiting <http://www.apta.org/apta/profile/MyProfile.aspx> and update as needed. **Then confirm by completing the address fields above.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Professional Designation: | PT | PTA | Non-PT Provider – (if yes, please specify): |  |

|  |  |
| --- | --- |
| Date graduated from an accredited PT/PTA Program: |  |

Highest earned degree:

|  |  |  |
| --- | --- | --- |
| Associate Degree (AA/AS) |  | Professional Doctorate (DPT) |
| Baccalaureate/Certificate |  | Post-professional Transition DPT (DPT) |
| Professional Master's (MPT/MSPT) |  | Post-professional Doctorate (PhD/EdD/ScD) |

|  |  |
| --- | --- |
| Number of years working as a clinician: |  |
|  |  |
| Number of years supervising students: |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Number of students supervised in the last 5 years: | 0 | 1-2 | 3-5 | 6-10 | 11-20 | More than 20 |

|  |  |  |
| --- | --- | --- |
| State(s) in which licensed: |  | **NOTE:** Attach a copy of license for state(s) in which you work |

|  |  |  |
| --- | --- | --- |
| Do you grant permission for APTA to release your contact information for **research** purposes? | Yes | No |
| Do you grant permission for APTA to release your contact information for **marketing** purposes? | Yes | No |

|  |  |
| --- | --- |
| If necessary, specify any special accommodations you require to complete this program: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Employer** | **City/State** | **Zip Code** | **Dates** |
|  |  |  | From:       To: |

**To be completed by participant's direct supervisor (e.g., Department Head/Senior Staff/CCCE/Program Director)**

|  |  |  |
| --- | --- | --- |
| **1.** Applicant demonstrates clinical competence, professional skills, and ethical behavior in clinical practice and/or teaching. | Yes | No |
| **2.** Applicant demonstrates the maturity and professionalism to serve as a CI. | Yes | No |
| **3.** Applicant has demonstrated a willingness to work with students by pursuing learning experiences to develop knowledge and skills in the clinical/academic setting. | Yes | No |
| **4.** Applicant demonstrates a systematic approach to patient/client care and/or job responsibilities. | Yes | No |
| **5.** Applicant uses critical thinking in the delivery of health services or managing job responsibilities. | Yes | No |
| **6.** Applicant provides rationale, including evidence, for decision making in patient/client care. | Yes | No |
| **7.** Applicant demonstrates appropriate time management skills. | Yes | No |
| **8.** Applicant represents the profession positively by assuming responsibility for professional self-development. | Yes | No |
| **9.** Applicant interacts effectively with patients, colleagues, and other health professionals to achieve identified goals. | Yes | No |

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| Participant’s Signature (electronic acceptable) |  | Date |