

**CREDENTIALED CLINICAL INSTRUCTOR PROGRAM (CCIP)**

**Participant Dossier**

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

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| --- | --- | --- | --- | --- |
| 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: |       |

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

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| --- | --- | --- |
| 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)**

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| --- | --- | --- |
| **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 |