Please Reply by **April 15, 2018** by emailing Dawn Roller and Kelly Pogemiller at DPTUHart@hartford.edu or fax: 860-768-4474

| Facility: ________________________________________________ |
| Center Coordinator of Clinical Education: _______________  Email Address: ______________________ |
| Telephone Number: __________________________  Fax Number: __________________________ |

Our facility will participate in **University of Hartford** clinical education experiences in **2019**. ____ Yes (complete the info below)  ____ No

<table>
<thead>
<tr>
<th>Clinical Experience Information</th>
<th>Clinical Site Availability</th>
<th>Setting for this experience (please circle all that apply)</th>
<th>Patient Populations (please circle all that apply)</th>
</tr>
</thead>
</table>
| **Clinical Education I**      | Number of Students: __________  
Reserved for U of Hartford: ___ Yes ___ No  
Supervisory Model (Student : CI): __________________________ |
Multiple Sites Available: ___ Yes ___ No  
Placement Location (city/state): __________________________ |
|                               | Inpatient Acute  
Inpatient Subacute  
LTACH  
Outpatient  
Home Health  
School Based  
Other/Comments: __________________________ |
|                               | Orthopedic/Sports  
Cardiopulmonary  
Neuromuscular  
Pediatrics  
Geriatrics  
Other: __________________________ |

| **Clinical Education II**     | Number of Students: __________  
Reserved for U of Hartford: ___ Yes ___ No  
Supervisory Model (Student : CI): __________________________ |
Multiple Sites Available: ___ Yes ___ No  
Placement Location (city/state): __________________________ |
|                               | Inpatient Acute  
Inpatient Subacute  
LTACH  
Outpatient  
Home Health  
School Based  
Other/Comments: __________________________ |
|                               | Orthopedic/Sports  
Cardiopulmonary  
Neuromuscular  
Pediatrics  
Geriatrics  
Other: __________________________ |

| **Clinical Education III**    | Number of Students: __________  
Reserved for U of Hartford: ___ Yes ___ No  
Supervisory Model (Student : CI): __________________________ |
Multiple Sites Available: ___ Yes ___ No  
Placement Location (city/state): __________________________ |
|                               | Inpatient Acute  
Inpatient Subacute  
LTACH  
Outpatient  
Home Health  
School Based  
Other/Comments: __________________________ |
|                               | Orthopedic/Sports  
Cardiopulmonary  
Neuromuscular  
Pediatrics  
Geriatrics  
Other: __________________________ |
Clinical Site Information Update

Please update your facility information if anything has changed over the past year:

*I have updated the Clinical Site Information Form (CSIF) in the past year, please see _____ PTCSIF web or _____ Electronic/Paper Version

Facility Name: ____________________________________________________________
Address:  ____________________________________________________________
___________________________________________________________
Phone #:  ____________________________________________________________
Fax #:       ____________________________________________________________
Website address:   ____________________________________________________________

Please note below the site requirements students must complete prior to coming to your facility:

Background check: ___ Yes ___ No                           Finger printing: ___ Yes ___ No
Background check type, timeframe for completion:

School to facilitate completion
Facility to facilitate completion

Drug screen: ___ Yes ___ No
Drug screen type, timeframe for completion: 
School to facilitate completion
Facility to facilitate completion

Flu vaccine: ___ Yes ___ No

TB Test: ___ Yes ___ No
If yes, please identify timeframe for completion: _______

One step
Two step

Other site requirements: ___ Yes ___ No
If yes, please describe: _______________________________________________________________________

Do you have any housing suggestions or offer any assistance with housing? ___ Yes ___ No
If yes, please describe: _______________________________________________________________________

Please rate the ease of using this form?

_________ Excellent __________ Very Good __________ Good __________ Fair __________ Poor

_________ Prefer electronic form ________ Prefer paper form ________ No preference on form type

Comments: __________________________________________________________________________________________

Thank you for your continued support of our Clinical Education Program. Please return this completed form as soon as possible to:
University of Hartford, Physical Therapy Program, 200 Bloomfield Ave D 410, West Hartford, CT 06117
Attn: Dawn Roller or Kelly Pogemiller, DPTUHart@hartford.edu
Or call 860-768-5181/860-768-5405