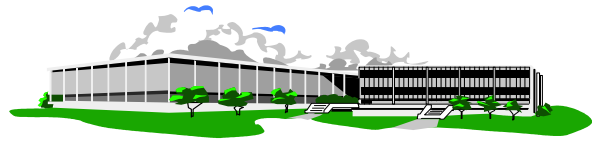


U.S. Army-Baylor University Doctoral Program in Physical Therapy

Clinical Education Handbook

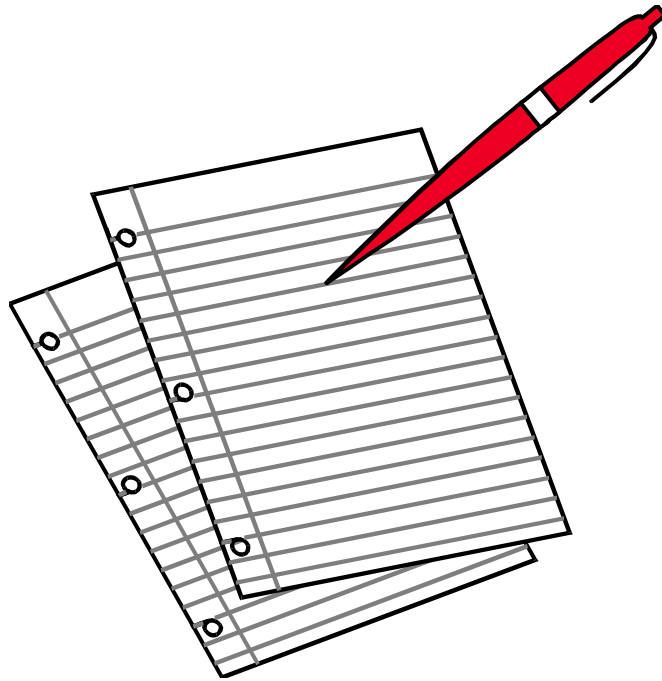


U.S. Army Medical Department
Center and School
Fort Sam Houston, Texas

TABLE OF CONTENTS

Academic Program.....	3
History	4
Philosophy Statement	5
Mission and Terminal Learning Objectives.....	6
Glossary of Terms.....	10
Academic Faculty	11
Curriculum.....	13
First Semester	13
Second Semester	13
Third Semester.....	13
Fourth Semester	14
Fifth Semester.....	14
Clinical Education.....	15
Texas Consortium for Physical Therapy Clinical Education.....	16
Clinical Assignments	16
Responsibilities of the DCE.....	17
Responsibilities of the Student	18
Responsibilities of the CID/CI.....	20
Grievances.....	2
1	
Evaluation	
Clinical Grading Criteria	23
General Information.....	23
First Clinical Rotation.....	27
Second Clinical Rotation	28
Internship	29
Performance Summary.....	32
Student Evaluation Forms.....	32
Professional	
Behaviors.....	32
Guidelines for Effective Formative Evaluation.....	33
APPENDIX A.....	35

ACADEMIC PROGRAM



HISTORY

The long and proud tradition of physical therapy education in the United States Army was born of necessity. No rehabilitation services, civilian or military, existed to meet the needs of American soldiers when we entered World War I. After a quick study of European rehabilitation systems, Army Surgeon General Gorgas consolidated the use of various physical modalities under the term "physiotherapy." His Reconstruction Aide training program was conducted at civilian higher education facilities across the country. The enthusiastic "120-day wonders", who graduated from these emergency programs, would later form the nucleus of the American Physical Therapy Association.

The Army Medical Department recognized the need for a formalized physical therapy course of instruction during the early 1920s. Such a course began in the fall of 1922 at Walter Reed General Hospital. The course, only four months long at that time, went through numerous changes in length and content in the following two decades. The program received its first accreditation in 1928. The students were civilians and worked as civilians in military hospitals after graduation.

In 1942, therapists were granted relative military rank and graduates could apply for commissions upon program completion. Enlisted women were also allowed to become students and then receive a commission. World War II increased the need for therapists, and from 1942 through 1946, the Army course (26 weeks in length) was run concurrently, on a quarterly basis, at not only Walter Reed, but at other locations which included Fort Sam Houston, TX; Hot Springs, AR; Brigham City, UT; and White Sulphur Springs, WV.

After the war the need for therapists declined and the training of new therapists was suspended. The physical therapists already on active duty were included in the newly established Women's Medical Specialist Corps (WMSC) in 1947. The program was restarted in 1948 at which time the trainees were commissioned as second lieutenants during their schooling. The coursework was moved to its current location at Fort Sam Houston, TX. Male therapists were accepted into the Corps in 1955 and the name of the Corps was changed to the Army Medical Specialist Corps (AMSC).

In 1971 Baylor University and the Army joined together to establish an entry-level Master's degree program. Curriculum changes reflected the evolving role of the profession in the Army. Prior to the early 1970s, physical therapists worked in a prescriptive environment during peacetime. Then, once again, a major change occurred. After the Vietnam conflict, the Army had too few orthopedic surgeons to manage huge troop populations with neuromusculoskeletal problems. Based on our performance record, and the way in which we had met the expanded scope of practice required in Korea and Vietnam, physical therapists were identified as "physician extenders," credentialed to evaluate and treat neuromusculoskeletal patients without physician referral. Army physical therapists have functioned in direct access for more than 20 years. Not one lawsuit has stemmed from this expanded role, attesting to its success in the eyes of patients and physicians. The U.S. Army-Baylor University Graduate Program in Physical Therapy is tasked, therefore, to prepare the student for entry-level

competence in all traditional physical therapy skills as well as to emphasize those skills needed as part of the neuromusculoskeletal evaluation process. Students are commissioned in the Army Medical Specialist Corps, Navy Medical Service Corps, the Air Force Biomedical Sciences Corps, or the Public Health Service usually at the rank of second lieutenant or ensign. The Navy joined the program in 1987, the Air Force in 1990, and the Public Health Service in 1994. Upon successful completion of all graduation requirements, the students receive the Doctor of Physical Therapy (D.P.T.) degree upon successful completion of the Baylor University curriculum.

The program was re-accredited in 1998 for 8 years by the Commission on Accreditation for Physical Therapy Education.

PHILOSOPHY STATEMENT

This program fosters clinical and professional excellence in physical therapy and lifelong pursuit of continued professional development. Physical Therapy is a dynamic profession with an established theoretical base grounded in research, and widespread clinical applications, particularly in the preservation, development, and restoration of maximum physical function. Physical therapists seek to prevent injury, impairments, functional limitations, and disability; to maintain and promote fitness, health and quality of life; and to ensure availability, accessibility and excellence in the delivery of physical therapy services. As essential participants in the health care delivery system, physical therapists assume leadership roles in prevention and health maintenance programs, and in professional and community organizations.

Through a rigorous selection process, our students are well qualified for the demands of the curriculum and the profession. They are mature, adult learners who are self-motivated, people oriented, open minded, independent, flexible, and versatile. Our students are committed to become competent physical therapists in the Uniformed Services and in the health care delivery system of the United States following active duty. We strive to provide our students with one of the best professional preparations in the nation.

Members of the faculty embrace the learning process as active participants and are exemplary professional role models. Faculty members teach the basic sciences and a conceptual framework in the applied sciences to enable the learner to synthesize information and develop problem-solving skills. While recognizing individual differences among students in both rate and ability to learn, the faculty member designs meaningful learning experiences and adjusts teaching strategies to meet the needs of each student, whether in the classroom, practical exercises, or tutorial sessions. Faculty members participate in continuing professional development including clinical practice, service, and scholarly activity.

The scope of our program includes three distinct, but interrelated arenas -- academic, professional, and military. The intense and challenging curriculum provides academic self-enrichment and the development of professional behaviors and competencies. The demands of the curriculum, coupled with the nature of the military are both stimulating and challenging for

the incoming student. Our faculty recognizes the unique nature of the program and its potential impact on the learning environment. Our faculty accepts responsibility for actively assisting the student's adjustment to this unique interrelationship.

Education is an active, continuous, cooperative process between the teacher and learner and must meet both the needs of the learner and the objectives of the teacher. Learning is a developmental process in which the learner is responsible for the acquisition and synthesis of knowledge. Ideally learning should take place at an individualized rate. To facilitate the learning process, the faculty must guide the development of the student in a positive and non-threatening manner. The faculty ensures that the learning process is logical and the material presented is well sequenced, evidence-based and can be assimilated within the time allotted. The faculty makes every effort to help each student succeed.

MISSION AND TERMINAL LEARNING OBJECTIVES

COURSE: U.S. Army-Baylor University Doctoral Program in Physical Therapy, 6H-65B.

MISSION: To produce active duty physical therapists for the United States Uniformed Services - Army, Navy, Air Force, and Public Health. Uniformed service therapists are generalist practitioners who may be assigned across the continuum of care in a variety of practice settings. However, the majority of therapists are working in a primary care role with an emphasis in examination and intervention for patients with neuromusculoskeletal problems. The program provides students with the knowledge, skills, problem-solving ability, duties, responsibilities, and ethics to deliver quality physical therapy patient care and provides those concepts, principles, methods and role models, which will stimulate the continuous personal and professional growth of these physical therapy officers. Students are commissioned in the Army Medical Specialist Corps, the Navy Medical Service Corps, the Air Force Biomedical Science Corps, or the Public Health Service. Area of Concentration (AOC) for which trained: Physical Therapist, Army (65B), Air Force (AFSC: 9231), Navy (1873-P), Public Health Service (10).

TERMINAL LEARNING OBJECTIVES: The overall objective of the Program is to produce competent clinicians for the practice of physical therapy. The course is designed to meet this objective through a sequenced regional approach. The body of knowledge that comprises the practice of physical therapy is presented by major regions. To successfully complete this course of instruction, the student must meet didactic standards and demonstrate clinical competencies commensurate with established entry-level criteria. The following terminal objectives describe the basic cognitive, affective, and psychomotor requirements students must accomplish.

1. Given a real or simulated patient, or patient care situation in the practice of physical therapy,

evaluate an individual seeking services, document, and interpret the results of the evaluation.

- a. Gather relevant subjective data and history through patient interview, chart review, questioning techniques, and observation.
 - b. Conduct an appropriate physical examination.
 - c. Select effective and efficient evaluative measures.
 - d. Analyze data in an ongoing manner to support or eliminate working diagnoses.
 - e. Differentiate between normal and abnormal functions and structures to formulate working diagnoses.
 - f. Determine the existence of environmental barriers to patient function.
 - g. Participate in screening programs designed to identify potential related to physical therapy.
2. Plan an appropriate treatment program based on an accurate interpretation of the evaluation.
- a. Establish long and short-term goals.
 - b. Develop a plan to meet long and short-term goals.
 - c. Establish criteria for judging effectiveness of the plan.
 - d. Relate concepts of pathophysiology to long and short-term goals to develop a relevant plan of action.
 - e. Demonstrate an understanding of the physical therapy ramifications of the medical and surgical management of the patient.
 - f. Design programs to promote long-term wellness and prevent secondary disabilities.
3. Execute the treatment, assess its efficacy, and modify the treatment, as indicated, to reach desired goals.
- a. Apply therapeutic procedures safely and effectively.
 - b. Interpret the patient's responses to treatment.
 - c. Interpret and respond appropriately to changes in the physiological state.
 - d. Change the plan of action based on the patient's response to treatment.
 - e. Recommend modifications in the patient's environment to improve function.
 - f. Select those components of the physical therapy plan that can be delegated to appropriate support personnel.
4. Educate patients, families, and other health care professionals in theories and techniques related to the practice of physical therapy.
- a. Design, implement, and evaluate individual patient education programs.
 - b. Design, conduct, and evaluate in-service educational programs for peers, subordinates, other health care providers, and members of the community.
 - c. Design and deliver injury prevention and health promotions programs.
5. Communicate with peers, subordinates, supervisors, patients, patients' families, and other health team members in an ethical manner using verbal, written, and non-verbal

communication appropriate to the situation and the people involved.

- a. Utilize appropriate verbal and non-verbal communication skills in all professional interaction.
 - b. Respect individual socioeconomic, cultural, and religious differences.
 - c. Recognize and respond appropriately to reactions of patients and their families to illness, disability, and death.
 - d. Recognize and respond to one's own reaction to illness, disability, and death.
 - e. Utilize effective and efficient written communication.
 - f. Interact effectively with other health professionals to improve the quality of health care.
 - g. Make formal presentations complete with audiovisual aids.
6. Demonstrate an understanding of the privileges, responsibilities, and goals of the organizations and association of the physical therapy profession.
- a. Adhere to the Code of Ethics of the American Physical Therapy Association (APTA).
 - b. Adhere to expected standards of behavior as a military officer.
 - c. Appreciate the role and function of the APTA.
 - d. Appreciate the need for continued education and professional development.
 - e. Adhere to the legal requirements of the practice environment.
 - f. Interact in a manner that reflects a positive image of the profession.
 - g. Identify current issues in the health care delivery system and propose alternative solutions.
 - h. Integrate concepts of continuous quality improvement into all patient care activities.
7. Participate in an individual or group research project as related to physical therapy practice.
- a. Critically analyze published research.
 - b. Conduct research on a previously approved proposal.
 - c. Statistically analyze data collected during research, working with a consultant when necessary
 - d. Develop a research proposal
 - e. Provide an oral report and defense of research findings.
 - f. Provide a written report of the research findings in a publishable format and submit for publication.
8. Utilize appropriate management strategies in the operation of a section of a physical therapy department.
- a. Determine equipment needs.
 - b. Determine staffing needs.
 - c. Supervise physical therapy assistants, technicians, and support personnel.
 - d. Coordinate section activities with other departmental sections and departments within the facility.
 - e. Establish standard operating procedures for the section.

- f. Participate in quality control and improvement.
- g. Function effectively within the organizational structure.
- h. Design, implement, and evaluate cost effective physical therapy services.

GLOSSARY OF TERMS

DCE (Director of Clinical Education)

The DCE's (formerly the ACCE) primary function is to provide comprehensive planning and direction for the clinical education program within the entry-level degree professional curriculum, mission and goals of the academic institution, professional and regional accreditation standards, and generally accepted norms in higher education. The DCE coordinates the administration of the clinical education program, in association with the academic and clinical faculty and students. S/he, also, relates the student's clinical education to the curriculum and evaluates the student's progress in integrating academic and clinical experiences. This individual serves as a liaison between the University and clinical rotation sites and is responsible for clinical site selection, development, and evaluation.

Additional responsibilities include planning, developing, implementing, and evaluating course content in the areas of expertise such as education, health care systems, or procedures. The DCE participates in curriculum development of the entry-level graduate degree program in physical therapy.

CID (Clinical Internship Director)

The CID (formerly the CCCE) is the individual at each clinical education center who coordinates and arranges the clinical education of the physical therapy student and who communicates with the DCE and faculty at the educational institution. This individual is responsible for ensuring student supervision and a well-rounded clinical experience.

CI (Clinical Instructor)

The CI is the physical therapist who is responsible for the direct instruction, supervision, and grading of the physical therapy student in the clinical education setting.

CLINICAL EDUCATION

Clinical education is the method through which students are provided with clinically based, pre-planned learning activities. This clinical education should require analytical thinking, problem solving, treatment design, and application on actual patients to insure that the student is able to function at the professional entry level. It is considered an integral part of the curriculum.

US Army-Baylor University Graduate Program In Physical Therapy

Full Time Academic Faculty

COL Josef H. Moore, USA
Program Director

PhD., University of Virginia, 1997
MED., University of Louisville, 1987
B.H.S., University of Kentucky, 1984
ATC, 1997; SCS, 1997

COL Thomas G. Sutlive, USA
Scheduling Officer

Ph.D., Virginia Commonwealth Univ., 1999
M.P.T., US Army-Baylor University, 1987
B.A. William & Mary University, 1985
OCS, 1995

LTC Joseph Molloy, USA
Quality Assurance Officer

Ph.D., Auburn University, 2003
MPT., U.S. Army-Baylor University, 1992
B.S., United States Military Academy, 1984
SCS, 1998

LTC Scott Shaffer, USA
Executive Officer

PhD, University of Kentucky, 2007
MPT., U.S. Army-Baylor University, 1992
B.S., Nebraska Wesleyan University, 1986
OCS, 1997; ECS, 2002

Maj John Childs, USAF
Research Director

PhD, University of Pittsburgh, 2003
MBA, University of Arizona, 2000
MPT, U.S. Army-Baylor University, 1996
BS, US Air Force Academy, 1994
OCS 2001, FAAOMPT 2002

MAJ Stephen Goffar, USA
Director of Clinical Education

PhD, University of Hawaii, 2005
MPT, US Army-Baylor University, 1996
AB, Ripon College, 1989
OCS, 2001

MAJ Deydre Teyhen, USA
Lab Director, Center for PT
Research

PhD, University of Texas, 2004
MPT, US Army-Baylor University, 1995
BA, Ohio Wesleyan University, 1993
OCS, 2001

Dr. Douglas S. Christie
Chief, A&P Branch
Physiologist

Ph.D., UTHSC-SA, 1984
B.S.N., UTHSC-SA, 1979
B.S., Southwest Texas State Univ., 1974

Dr. George B. Kemper
Anatomist/Neurophysiologist

Ph.D., University of Kansas Med Center, 1979
M.S., NW Missouri State University, 1973
B.S., NW Missouri State University, 1971

Curriculum (Baylor University Credits)

Curriculum

The five-semester curriculum includes outlined academic courses and clinical experiences, a research project, and a comprehensive oral examination.

Semester I

PT 6120	Evidenced Based Practice I
PT 6150	Introduction to Therapeutic Intervention
PT 6231	Clinical Pathophysiology
PT 6240	Clinical Medicine I
PT 6310	Anatomy I
PT 6330	Neuromuscular Physiology
PT 6400	Physical Therapy Fundamentals
PT 6470	Research Methods I
PT 6501	Musculoskeletal Physical Therapy I – Lower Member
Total	24 sem. hrs

Semester II

PT 6104	Diagnostic Imaging and Procedures
PT 6121	Evidenced Based Practice II
PT 6151	Pharmacology for Physical Therapists
PT 6153	Orthotic and Prosthetic Interventions
PT 6241	Clinical Medicine II
PT 6252	Physical Agent Interventions
PT 6332	Physiology of The Oxygen Delivery System
PT 6402	Musculoskeletal Physical Therapy II – Spine
PT 6403	Musculoskeletal Physical Therapy III – Upper Member
PT 6411	Anatomy II
Total	24 sem. hrs

Semester III

PT 6107	Emerging Topics in Physical Therapy
PT 6122	Evidenced Based Practice III
PT 6142	Clinical Medicine III
PT 6206	Cardiopulmonary Physical Therapy
PT 6212	Neuroanatomy
PT 6313	Neuroscience
PT 6405	Neuromuscular Physical Therapy
PT 6760	Physical Therapy Practice I
Total	21 sem. hrs

Semester IV

PT 6123	Evidenced Based Practice IV
PT 6181	Physical Therapy in Deployed Environments
PT 6182	Injury Control and Prevention
PT 6208	Lifespan Physical Therapy
PT 6209	Primary Care Musculoskeletal Physical Therapy
PT 6254	Advanced Joint Manipulative Interventions
PT 6280	Executive Skills for Physical Therapists
PT 6371	Research Methods II
PT 6761	Physical Therapy Practice II
Total	21 sem. hrs

Fifth Semester

PT 6V98	Physical Therapy Internship
Total	30 sem. Hrs

Program Total: 120 Sem Hrs

CLINICAL EDUCATION



Texas Consortium for Physical Therapy Clinical Education

The coordination of physical therapy clinical education among eleven Texas universities is the primary function of the Texas Consortium for Physical Therapy Clinical Education, of which the U.S. Army-Baylor University Doctoral Program in Physical Therapy is a member. The Consortium provides guidance in the development and maintenance of clinical education sites. All potential facilities should be visited and evaluated by a Consortium member. Once a facility is established as an active clinical site, pertinent information about the facility and its personnel is required. This information is updated regularly so that current records are available for DCEs, students, and the APTA Commission on Accreditation.

Clinical Assignments

The U.S. Army-Baylor University Doctoral Program in Physical Therapy sends out clinical requests to military and civilian facilities on the mailing date established each year by the members of the Texas Consortium for Physical Therapy Clinical Education. The responses received from the Clinical Internship Director (CIDs) then determine the list of available clinical facilities and the types of learning experiences offered at each facility. This list is provided to the students early in the second semester for their review. Students may request specific clinical sites to fulfill their clinical experience requirements in acute care, neuromusculoskeletal evaluation/orthopaedic care, and rehabilitation. It is not uncommon for students to be assigned to at least one facility outside of the San Antonio area. In addition, each student will have at least one clinical rotation in a military or federal facility. They are encouraged to refer to the clinical site files to review the Clinical Site Information Forms (CSIF) and prior students' facility evaluations in order to aid them in the decision making process. Although the DCE will take these requests into consideration, greatest emphasis will be placed on the individual educational needs of each student when making the clinical assignments. Occasionally, however, these clinical rotations must be changed on the basis of students' personal, academic and/or clinical needs or for reasons integral to the clinical site.

Responsibilities of the Director of Clinical Education (DCE)

1. Certify eligibility of students for training and education.
2. Provide students with information about the clinical rotation site.
3. Schedule the clinical rotation for individual students.
4. Provide all clinical sites to which students have been assigned with the name of each student affiliate, student contact information, and length and dates of the clinical rotation.
5. Provide the CID/clinical instructor (CI) with information about the physical therapy curriculum and educational goals.
6. Provide the CID/CI with information about level of training of individual student affiliates to assist the CI in planning learning experiences for students. (See “Curriculum”, p.13 of this handout.)
7. Notify the clinical site as soon as possible prior to the start date in the event of change or cancellation of the assignment.
8. Maintain communication with the CID/CI and provide assistance with planning learning experiences, monitoring, evaluating, and counseling students throughout the clinical rotation.
9. Provide the clinical site with a clinical evaluation tool necessary to evaluate students.
10. Make clinical on-site visits, or exchange information by letter or telephone, to review student progress during the full-time clinical rotation.
12. Require students to abide by the rules, regulations, and policies of the clinical site while assigned to that facility.
13. Maintain current Clinical Site Information Forms (no more than 2-3 years old) and request updates from affiliating health care facilities biannually.
14. Establish, maintain, and review clinical site agreements annually.

Student Responsibilities for Each Clinical Rotation

1. Be prompt; when possible, familiarize yourself with the travel route to the facility **prior** to your first day.
2. Determine the facility dress code prior to your arrival. Dress appropriately and act in a professional manner. Discourteous behavior in the clinical setting is inexcusable.
3. Contact the clinic 2-3 weeks prior to the rotation to confirm your arrival.
4. **Bring your Clinical Assessment Book (CAB).** Familiarize yourself with the CAB prior to the clinical rotation to select skills you want to fulfill and those that you must fulfill. Review the CAB with your CI on the first day of your rotation. Remember, completion of the CAB is **your** responsibility. You are also responsible for the timely completion of any projects or assignments made by your clinical instructor.
5. Review the facility's emergency procedures within the first two days of the clinical rotation.
6. Maintain close **communication** with your clinical instructor. Discuss your learning style and feedback preference with your clinical instructor and be prepared to share **written goals** and expectations for the rotation.
7. Respect the rights and dignity of the patients and your co-workers at all times.
8. Use spare time constructively. Ask about resources available to you. Resources may include a medical library, journals, observing in other disciplines, observing other patient treatments, etc.
9. Respect the knowledge and experience of the clinical instructors. Offer suggestions or alternatives in a tactful manner, but do not "challenge" the knowledge of the clinical instructor.
10. Take as active a role as possible in evaluating and treating patients. You are there to gain experience, but remember to relax and have fun as well.
11. Accept feedback and constructive criticism in a positive manner. Identify your own strengths and weaknesses. Always demonstrate a positive learning attitude and take the initiative to seek out additional learning opportunities.
12. Adhere to all policies and procedures of the clinical facility and all policies of our program related to clinical education.
13. Remember safety first. Safety awareness is crucial to successful clinical performance.

14. Notify the DCE of any absences or schedule changes during the clinical rotation (PT Branch: 210-221-7513/8410).
15. Promptly return the completed Progress Report, Master List, Clinical Instructor Evaluation of Student Performance, and [Student Evaluation of Clinical Education Experience](#) (SECEE) forms at the conclusion of the rotation. A midterm Progress Report must be prepared and turned into the DCE midway through the rotation.
16. Notify the DCE or midterm visiting faculty member of your inservice topic. Complete and submit a Minimum Data Set during the acute care and orthopedic experiences and Critically Appraised Topic (CAT) during the rehabilitation experience. These must be submitted to the appropriate faculty member within the prescribed deadlines.
17. Complete the Professional Behaviors Self-Assessment and discuss it with your CI prior to the conclusion of your internship.

Responsibilities of the CID/ CI

1. Designate a member of its staff as clinical instructor.
2. Provide appropriate facilities, equipment, and supplies in order to provide supervised clinical experience in the program.
3. Advise the Director of Clinical Education (DCE) of any changes in personnel, operations, or policies that may affect the clinical rotation. Ensure the [Clinical Site Information Form](#) is updated bi-annually and submitted to the DCE.
4. Be prepared for the student's arrival.
5. Orient the student to the policies and procedures of the clinic.
6. Insure familiarity of the clinical instructors with the Clinical Assessment Book (CAB) .
7. Review the CAB with the student within the first two days of the clinical rotation in order to familiarize yourself with the requirements established for the student and to help set goals for the rotation.
8. Provide informal feedback sessions frequently throughout the clinical rotation.
9. Provide formal feedback and review of the CAB at least during the mid-term and final evaluations, although a weekly review is highly recommended. Provide classroom and counseling space on a scheduled basis.
10. Provide adequate supervision of the student and a good learning environment. Structure the learning experiences, interact directly with the student, and adjust workload to the student's needs.
11. Serve as a role model and demonstrate a positive attitude toward students. Challenge students to utilize skills and resources available.
12. Maintain ethical standards. A physical therapist must always be present when a student is in the clinic. A student should not treat patients if only a physical therapist assistant or aide is in the clinic or on the premises.
13. Respect the rights and dignity of the student. Provide a private setting for evaluation and feedback sessions.
14. Ensure that all clinical instructors demonstrate a desire to be life long learners by remaining current in the field of physical therapy (i.e. Continuing Education Courses etc.).

V. GRIEVANCE:

A. The program will receive and be open to the merits of any complaint made against the program by interested parties including, but not limited to, current or former students, program faculty or staff, patients, research subjects or their families.

B. Student complaints involving grades, evaluations, unfair treatment or other situations will be handled within the Program using the student and faculty chain of command with the Program Director mediating and gathering facts regarding the complaint.

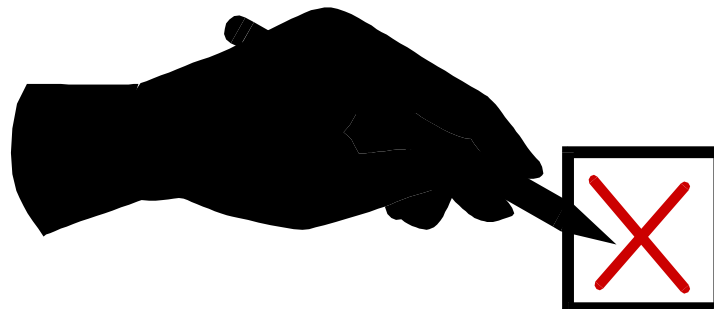
C. If the Program Director is the object of the complaint, the Chief of the Department of Medical Science will attempt to resolve the dispute. If the complaint is unresolved, the Dean of the Academy of Health Sciences will be notified.

D. Complaints from within the Program that cannot be handled using the Army Medical Department Center and School chain of command may also be referred to the Army Medical Department Center and School and Fort Sam Houston Inspector General Office to obtain legal counsel.

E. Complaints against the Program from outside agencies or non-enrolled individuals will be investigated by the Program Director in an attempt to resolve the complaint. The Chief of the Department of Medical Science will be notified of external complaints against the program and will advise the Program Director on all matters related to the complaint. If the situation remains unresolved, the Dean of the Academy of Health Sciences will be notified.

F. The Program will keep a record on file in the Program Director's office for ten years of all complaints made and the outcome of each complaint. Secured files will be maintained in the Program Director's office.

EVALUATION



Clinical Grading Criteria

General Information

1. All clinical rotations are graded on a **PASS/FAIL** basis. The final decision as to whether or not a student passes or fails a clinical rotation resides with the DCE of the U.S. Army-Baylor University Doctoral PT Program. If the student fulfills all of the requirements to pass a given clinical rotation (as specified in the passing criteria for each rotation later in this section), a passing grade will be awarded to the student by the DCE. If the student does not complete the requirements for passing a clinical rotation, then the DCE will confer with the Program Director to determine an appropriate course of action. This may include, but is not limited to the following:

- a. No action required. A grade of “PASS” is awarded.
- b. Re-teach and re-test the deficient skill(s), as applicable, in the academic environment with the expectation that the deficiency will be resolved in a subsequent clinical rotation.
- c. * Assign the grade of “INCOMPLETE”. (See “First”, “Second” and “Internship Rotation” subheadings for additional information.)
- d. Require an additional clinical rotation.
- e. Extend the clinical rotation (applies to the third clinical experience only, due to scheduling sequence of the clinical rotations).
- f. ** Convene a Physical Therapy Faculty Board.
- g. *** Assign the grade of “FAIL”
- h. Recommend the student be relieved from the Program.

* If a student should receive an **INCOMPLETE** during the first clinical rotations, s/he must resolve the deficiency(ies) that resulted in this grade and fulfill all of the requirements to pass the subsequent clinical rotation. If a student should receive an **INCOMPLETE** during the Internship rotation, s/he must resolve the deficiency(ies) during an extension of this rotation, not to exceed 8 weeks. The actual length of time in which the student has to resolve the deficiency(ies) will be determined by the DCE and Program Director and/or the recommendations of the Physical Therapy Faculty Board. Failure to do so will result in a drop from the Baylor Program and the case may then be referred to an Academic Board convened by the AMEDD Center and School for consideration for drop from the U.S. Army Academy of Health Sciences Program.

** A Physical Therapy Faculty Board (PTFB) is chaired by the Program Director and members include the academic faculty. The PTFB is a fact-finding forum designed to gather information and look at all aspects of the situation prior to rendering a decision. As such, the CI or other knowledgeable individuals may be in attendance. Possible Faculty Board decisions range from no action to relief from the program. For additional information on Faculty Boards, please refer to the SEP.

*** If a student should FAIL a clinical rotation, s/he will be dropped from the Baylor Program and the case may then be referred to a Faculty Board convened by the AMEDD Center and School for consideration for drop from the U.S. Army Academy of Health Sciences Program.

2. Grading is based on the student's progress as recorded in Clinical Assessment Book (CAB) . Please refer to the CAB for a complete set of instructions guiding its use. The faculty has identified a **minimum** skill set for each clinical rotation that the students should be able to perform at that point in their education. (Each minimum skill set is outlined under the individual clinical rotation headings later in this section.) CIs are encouraged to review the CAB with students at the beginning of the clinical rotation to identify those skills that can be developed along with any additional learning opportunities that are unique to that facility.
3. Skills outlined in the CAB are categorized as either “Entry-Level” or “Site Specific”. The faculty of the U.S. Army-Baylor University Graduate Program in Physical Therapy has designated the following as **Entry-Level** skills:

1- 12	Professional Practice and Patient Management
13- 23	Patient Management
24- 29	Practice Management

The **Site-Specific** skills consist of the following:

SS1	Prosthetic Management
SS2	Self –Care and Home Management
SS3	Environmental/Home/Work Barrieres
SS4	Community/Work reintegration
SS5	Neuromotor Development
SS6	Wound Care and Debridement
SS7	Prosthetic Training
SS8	Airway Clearance
SS9	Functional Training- Work and Environment
SS10	Site Specific:_____

4. These skills are rated by the CI and student throughout the clinical rotation. A skill may be graded in one of six ways:
 - a. **“4” STUDENT HAS EXCEEDED ENTRY-LEVEL PERFORMANCE**
Place a “4” in the box opposite the CI rating if the student is competent, safe and independent in the delivery of patient care. The student is exceeding entry-level performance at this facility.
 - b. **“3” STUDENT HAS MET ENTRY-LEVEL PERFORMANCE**
Place a “3” in the box opposite the CI rating if the student is competent, and safe in the delivery of patient care, but still requires minimal guidance from the CI and/or needs more patient exposure. The student performs at entry-level at this facility.
 - c. **“2” STUDENT NEEDS EXPERIENCE TO MEET ENTRY-LEVEL**
Write “2” in the box opposite the CI rating if the student requires moderate guidance (instruction or supervision) from the CI. The CI is physically present at the student’s

side during most patient encounters.

***Note:** This is the minimal grade accepted as “passing” for either the first or second clinical rotation. A grade of “2” is considered a “failing” grade by the end of the Internship.

- d. **“1” STUDENT NEEDS IMPROVEMENT TO MEET ENTRY-LEVEL**
Write “1” in the box opposite the CI rating if the student is struggling, constantly requires guidance and assistance from the CI to complete skills. This is a “failing” grade. All “1s” **require a comment** describing why the performance needs improvement or is not yet independent.
 - e. **“0” STUDENT PERFORMANCE IS UNACCEPTABLE**
Write “0” in the box opposite the CI rating if the student’s performance is unsatisfactory and/or unsafe despite repeated attempts by the CI to correct the deficiencies. **CI must call the DCE immediately and document reasons/incident(s) by which the student earned this rating.**
 - f. **STUDENT HAS NOT BEEN WORKING ON KEY INDICATOR**
Leave blank if there has been “no opportunity to perform” or this is not a skill that can be addressed at this facility.
5. In keeping with the philosophy of the CAB, a “2” reflects that a student is performing a skill safely and competently, but needs more experience. It is the expectation of the faculty at the U.S. Army-Baylor University Doctoral PT Program that some students are likely to need additional experience in some skills after the first and possibly second clinical rotation. However, if a **final** rating of “2” is awarded, which when viewed in the context of the entire Progress Report may be suggestive of substandard practice, the DCE will confer with the Program Director to consider the appropriate action to be taken. (See paragraph 1).
 6. Philosophy for use of the “1” is consistent across all clinical rotations, but during the second rotation and internship, “1s” will be viewed more critically. A “1” is not meant to be punitive, but instead, is meant to indicate only that the student has not yet met minimal competency standards for a new graduate physical therapist. However, it is the interpretation of the faculty that a “1” in any skill may give cause for concern, particularly in Skills 1-13, since most of these involve affective and safety-related behaviors. For this reason, we ask that when a student is performing at an “1” level at midterm, or later, in any skill, the CI inform the DCE immediately. The CI is required to **document** the deficiencies in the student’s performance and the DCE will review these concerns with other faculty members. The DCE will, in turn, provide suggestions to the student and/or clinical instructor, or determine if any alternative course of action must be taken. If the necessary patients with appropriate pathologies continue to be available, the CI will use these suggestions throughout the remainder of the clinical rotation to re-teach and re-test the skills in question. If the student has one or more outstanding “1s” at the conclusion of any one of the clinical rotations or internship, a Physical Therapy Faculty Board may be convened to consider appropriate action.
 7. Approval of a skill at a previous clinical rotation means that the student met entry-level criteria for *that* facility at *that* time. The CI may “challenge” the student to re-demonstrate mastery of the skill that was previously approved. (Refer to the CAB for instructions describing and

guiding the use of a “challenge”.) The faculty at the U.S. Army-Baylor University Doctoral PT Program encourage the use of the “1” and the “challenge”. The “1” and the challenge are the perfect tools to bring the gravity of the situation to the student's attention. The earlier in the clinical rotation that these tools are used, the better. Most students resolve “1s” and challenges before completing the clinical rotation in which they were given. This resolution is much more difficult if the clinical instructor waits until after the midterm to take action. When using these tools, however, it is important to keep the DCE informed. Most problems are not "show-stoppers" when addressed early but become much more difficult to resolve if we just "wait and see."

8. An additional advantage to appropriate liberal use of the “1” and the “challenge, and communicating their use with the DCE, is that the DCE can identify trends that could point to a problem within the curriculum. Such trend identification is possible only with frequent, open, and honest communication among all those who are charged with providing and monitoring clinical instruction.
9. A “0” (representing unacceptable performance) is of serious concern to the faculty and must be brought to the **immediate** attention of the DCE by the student’s CI. As in the case of a “0”, the CI is **required to document** the deficiencies in the student’s performance and the DCE will review these concerns with other faculty members. The DCE will in turn provide suggestions to the student and/or clinical instructor, or determine if any alternative course of action must be taken. If the necessary patients with appropriate pathologies continue to be available, the CI will use these suggestions throughout the remainder of the clinical rotation to re-teach and re-test the skills in question. Depending on the circumstances a Physical Therapy Faculty Board may be convened during the period of the clinical rotation. If a “0” has not been resolved by the conclusion of the clinical rotation, a PTFB will be convened to consider appropriate action. Possible faculty decisions include, but are not limited to the following:
 - a. Re-teach and re-test the deficient skill(s), as applicable, in the academic environment with the expectation that the deficiency will be resolved in a subsequent clinical rotation.
 - b. Assign the grade of “INCOMPLETE”. (See “First”, “Second” and “Internship” subheadings for additional information.)
 - c. Require an additional clinical rotation.
 - d. Extend the clinical rotation (applies to the third clinical experience only, due to scheduling sequence of the clinical rotations).
 - e. Assign the grade of “FAIL”
 - f. Recommend the student be relieved from the Program.
10. A brief narrative summary is required on the Progress Report that is returned to the Academy. The narrative may be used as a "fine-line" discriminator regarding clinical performance. If specific statements or incidents noted in the narrative summary and/or verbal report by the clinical instructor are in conflict with the grades in the CAB, the

differences will be resolved between the CI and DCE, or by a faculty evaluation of the reports.

11. **The student, not the clinical instructor**, has the primary responsibility for meeting the clinical rotation criteria. Clinical instructors will provide supervision, instruction, and assistance in planning learning experiences, but the students must actively seek learning experiences and make the instructors aware of the skills on which they need to work.

First Clinical Rotation

1. Prior to the first clinical rotation, the students have completed two semesters of coursework. (Please refer to the list of courses described earlier in this handbook.) Therefore, the clinical experiences offered for this clinical rotation consist of neuromusculoskeletal evaluation/orthopaedic care or acute care.
2. Students must meet or exceed the following criteria in order to pass this rotation:
 - a. The following CAB Skills must be addressed and receive a **final** rating of “4”, “3”, or “2”:
 - 1) Skills 1-12:
 - **All 12** skills must be rated by the CI
 - 2) Skills 13- 23
 - **8** of these **11** skills must be rated by the CI
 - 3) Skills 24- 29
 - **4** of these **6** skills must be rated by the CI
 - 4) Site-Specific Skills (SS!- SS10)
 - a) At least **1** site-specific skill must receive a **final** rating of “4” or “3”
 - b) If only one skill has been addressed during this clinical rotation, a final rating of “2” for that skill could result in either an “Incomplete” or “Failure” for this rotation*
 - c) Skill SS10 is a “User Defined Site-Specific Skill”. In this instance, the CI at a given facility has the ability to annotate a physical therapy skill that is not otherwise defined in the CAB. In order for the student to receive credit for this skill, the CI and student must perform the following:
 - (1) Clearly annotate the skill
 - (2) Prepare **objectives** applicable to the skill
 - (3) Obtain **approval** from the **DCE**
 - b. Completion of an Inservice
 - 1) Completion of an inservice is required for each clinical rotation.

- 2) The topic and format for the inservice must be approved by the CID and/or CI of the given facility.
3. An “incomplete” or “failing” grade *may* be awarded by the faculty for the first clinical rotation if:
 - a. The student fails to complete the requirements listed in 2.a., 2.b., and 2.c. OR
 - b. The student receives a **final** rating of “1” or “0” in any skill OR
 - c. The student receives a **final** rating of “2” in numerous skills, which when viewed in the context of the entire Progress Report, is suggestive of substandard practice.

Second Clinical Rotation

1. The students have completed all didactic coursework prior to this clinical rotation. Therefore, the clinical experiences offered for this rotation may consist of acute care neuromusculoskeletal evaluation/orthopaedic care, and rehabilitation (neurologic or pediatric).
2. The students will continue to be graded using the CAB. Requirements for passing the **Second Clinical Rotation** are listed below:
 - a. The following CAB Skills must be addressed and receive a **final** rating of “4”, “3”, or “2”:
 - 1) Skills 1-12
 - **All 12** skills must be **approved** by the CI, even though they may have been approved during the first clinical rotation.
 - 2) Skills 13- 23
 - **All** of these **11** skills must be rated by the CI by the conclusion of the second rotation. Those skills that were approved in the first clinical rotation, do not have to be re-approved, but are subject to being “challenged” at the discretion of the CI.
 - 3) Skills 24- 29
 - **All** of these **6** skills must be rated by the CI by the conclusion of the second clinical rotation. Those skills that were approved in the first rotation, do not have to be re-approved, but are subject to being “challenged” at the discretion of the CI.
 - 4) Site-Specific Skills (SS1- SS10)
 - a) Unless **2** or more site-specific skills were approved prior to the start of this clinical rotation, then at least **1** site-specific skill must receive a **final** rating of “4” or “3” during this rotation. (Therefore, by the

conclusion of the 2nd clinical rotation, a **total of 2** site-specific skills must be completed, but seeking out additional learning opportunities is highly encouraged.)

- b) Skill SS10 is a “User Defined Site-Specific Skill”. In this instance, the CI at a given facility has the ability to annotate a physical therapy skill that is not otherwise defined in the CAB. In order for the student to receive credit for this skill, the CI and student must perform the following:
 - (1) Clearly annotate the skill
 - (2) Prepare **objectives** applicable to the skill
 - (3) Obtain **approval** from the **DCE**
 - b. Completion of an Inservice: (See “First Clinical Rotation”)
3. An “incomplete” or “failing” grade *may* be awarded by the faculty for the second clinical rotation if:
- a. The student fails to complete the requirements listed in 2.a., 2.b., and (2.c. or 2.d.)
OR
 - b. The student receives a **final** rating of “1” or “0” in any skill OR
 - c. The student receives a **final** rating of “2” in numerous skills, which when viewed in the context of the entire Progress Report, is suggestive of substandard practice.

Internship

1. The students have completed all didactic coursework prior to the Internship. Therefore, this nine month clinical experiences consists of a wide breadth of areas designed to develop, enhance and expand the clinical knowledge base that is expected of a doctoral trained physical therapist. Interns are expected to have rotations in outpatient and inpatient Physical Therapy Clinics, as well as the specialty clinics, i.e. Orthopaedics, Radiology, Family Practice, Emergency Room, and Occupational Therapy as available.
2. Requirements for passing the Internship are listed below:
 - a. The following CAB Skills must be addressed and receive a **final** rating of “4” or “3”:
 - 1) Skills 1-12
 - **All 12** skills must be **completed/approved** by the CI, even though they were approved during the first and/or second clinical rotations.
 - 2) Skills 13- 23
 - **All** of these skills must be **completed/approved** by the conclusion of the Internship. If they were approved in the first or second rotation, they do not have to be re-approved, but they are subject to

being “challenged” at the discretion of the CI.

3) Skills 24- 29

- **All** of these skills must be **completed/approved** by the conclusion of the Internship.

4) Site-Specific Skills (SS1- SS10)

a) Unless **3** or more site-specific skills have been completed prior to the start of this clinical rotation, at least **1** site-specific skill must receive a **final** rating of “4” or “3” during this rotation. (Therefore, by the conclusion of the Internship, a **total of 3** site-specific skills must be completed, but seeking out additional learning opportunities is highly encouraged.)

b) Skill SS10 is a “User Defined Site-Specific Skill”. In this instance, the CI at a given facility has the ability to annotate a physical therapy skill that is not otherwise defined in the PT MACS. In order for the student to receive credit for this skill, the CI and student must perform the following:

1. Clearly annotate the skill
2. Prepare **objectives** applicable to the skill
3. Obtain **approval** from the **ACCE**

b. Completion of an in-service with-in the first eight weeks. This in-service will be instructional in nature and cover Critically Appraised Topics (CAT). The intention is to educate the clinical staff on the use of a CAT and to begin a CAT Bank for the clinic.

c. A total of 4 CATs must be submitted to the Intern’s Academic Advisor. The first CAT is due at the time of the CAT in-service. The remainder are due at the end of every month thereafter, for the next six months.

d. Collection and analysis of a Minimum Data Set. This requirements and topics for the MDS assignment will be as determined by the Research Director.

e. Primary Care: there are two parts to this deliverable: 1) a case study, written in and expanded SOAP note format accompanying a Power Point presentation that would be suitable to present at Grand Rounds. 2) a take home examination.

f. The Intern will complete the Professional Abilities Self-assessment Tool and share the results with his/her CI during the second half of the clinical rotation. (See Appendix A). This tool was initially administered to the students upon entry into the Army-Baylor program and periodically thereafter to provide continuous feedback with respect to their performance. Although this tool is designed for self-assessment purposes, the expectation is that the students will have achieved entry-level performance on all 10 Professional Abilities prior to graduation. If the CI is

under the impression that a student has not achieved entry-level performance in one or more of these Professional Abilities, s/he is asked to bring this to the attention of the DCE.

- g. **Executive Skills:** This is a deliverable that spans the length of the Internship. The Intern will develop a portfolio with all written requirements for this project. These requirements should be reviewed, but not graded, by the CID/CI prior to submission for review by faculty. The portfolio will be graded as pass/fail and a passing grade is required for graduation. Projects within the portfolio will be a health promotions project, a budgeting project, a clinic performance improvement plan, and a personal professional development plan.
 - h. **During the Internship,** the student will complete the Professional Abilities Self-assessment Tool and share the results with his/her CI during the second half of the clinical rotation. (See Appendix A). This tool was initially administered to the students upon entry into the Army-Baylor program and periodically thereafter to provide continuous feedback with respect to their performance. Although this tool is designed for self-assessment purposes, the expectation is that the students will have achieved entry-level performance on all 10 Professional Abilities prior to graduation. If the CI is under the impression that a student has not achieved entry-level performance in one or more of these Professional Abilities, s/he is asked to bring this to the attention of the DCE.
3. An “incomplete” or “failing” grade *may* be awarded by the faculty for the Internship if:
- a. The student fails to complete the requirements listed in 2.a through 2.g, OR
 - b. The student receives a **final** rating of “**2**”, “**1**” or “**0**” in any CAB skill.

Overall Performance Summary

The Overall Performance Summary is a five-page document consisting of two major areas: Performance Summary, and Narrative Comments. The narrative comments section addresses the broad areas of professional practice, patient management, practice management and overall performance of the student. It must be completed at both midterm and again at the conclusion of the clinical rotation. The Narrative Comments section is provided so that there is a line of communication and documentation on the students progress. This section is used as a

way to document and support the decisions of the CID/CI. It can be used by the DCE, Program Director and/or the PTFB as part of the decision process in a course of action that require remediation.

Student Evaluation Forms

The student is required to complete an evaluation form ([SECEE](#) - Student Evaluation of Clinical Education Experience) prior to leaving each clinical site. The student should discuss this completed form with the CI unless the student expresses a hesitancy to do so. If the form is not reviewed by the CI prior to the student's departure, the DCE will mail a copy back to the facility.

Professional Behaviors/Generic Abilities

The faculty of the U.S. Army-Baylor University Doctoral Program in Physical Therapy believes that entry-level competency not only includes clinical proficiency, but also embodies the ten professional behaviors commonly referred to as the 'generic abilities'. Our students are introduced to these behaviors on day one of the program and the emphasis remains paramount for the duration of the program. Clinical instructors are encouraged to routinely discuss and assess the student's progress in each of these professional behaviors. If it is the opinion of the CI

that a student is performing unsatisfactorily in any of the following areas, please contact the ACCE as soon as possible.

- 1) Commitment to Learning
The ability to self-assess, self-correct, and self-direct to identify needs and sources learning, and to continually seek new knowledge and understanding.
- 2) Interpersonal Skills
The ability to interact effectively with patients, families, colleagues, other health care professionals, and the community to deal effectively with cultural and ethnic diversity issues.
- 3) Communication Skills
The ability to communicate effectively (i.e. speaking, body language, reading, writing, listening) for varied audiences and purposes.
- 4) Effective Use of Time
The ability to obtain the maximum benefit from a minimum investment in time and resources.
- 5) Use of Constructive Feedback
The ability to identify sources and seek out feed back and to effectively use and provide feedback for improving personal interaction.
- 6) Problem Solving
The ability to recognize and define problems, analyze data, develop and implement solutions, and evaluate outcomes.
- 7) Professionalism
The ability to exhibit appropriate professional conduct and to represent the profession effectively.
- 8) Responsibility
The ability to fulfill commitments and to be accountable for actions and outcomes.
- 9) Critical Thinking
The ability to question logically; to identify, generate, and evaluate elements of logical argument; to recognize and differentiate facts, illusions, assumptions, and hidden assumptions; and to distinguish the relevant from the irrelevant.
- 10) Stress Management
The ability to identify sources of stress and to develop effective coping behaviors.

Guidelines for Effective Formative Evaluation

Counseling sessions or conferences in which students are provided a formative evaluation should be:

INDIVIDUALIZED

Tell each student how he or she is doing rather than spending time discussing how "most" students do, or even comparing this student's performance with that of a group.

GOAL-RELATED

Focus the discussion of the student's progress toward clearly specified performance objectives. Be sure the student understands what those objectives are and how his/her performance is being judged.

DIAGNOSTIC

Identify specific strengths and weaknesses rather than simply making global comments about overall performance. Anecdotal comments or examples often help to clarify. When problems arise in mastery of complex skills, work with the student to analyze his/her performance to figure out where the difficulty lies.

REMEDIAL

Before the session ends, try to work out with the student a practical plan for future activity that will help to maintain present strengths and remedy weaknesses.

COLLEGIAL

Collaborate with the student in reaching conclusions and planning future action; listen, be flexible, give the student time to put his/her thoughts into words. Recognize that the student knows things about himself/herself you do not. Both your verbal and nonverbal behavior, and the setting in which you meet with the student, will have an important influence on your success.

POSITIVE

Be sure to mention the things that the student is doing right. You may also need to identify errors, but be certain that is NOT the only thing you do.

LIBERATING

Help the student learn to assess his/her own performance and to want to do so.

TIMELY

Try to arrange your schedule so that advising can be done soon after the events that need to be discussed. Plan some conferences early so there is still time to carry out the remedial plan you and the student develop. Remember several short sessions carried out at a time when they seem really relevant and fresh may be more valuable than a long, formal session scheduled at some arbitrary time.

RECIPROCAL

Use these conferences to get ideas about your own strengths and weaknesses as an instructor. Remember that if a student is having problems, you may need to make changes in what you are doing in order to help him/her to improve.

APPENDIX A

Student Professional Abilities Assessment¹ US Army-Baylor University Doctoral Program in Physical Therapy

Student Name _____

Date _____

Clinical Facility _____ Clinical Instructor _____ Clinical Rotation 1 2 3

Directions: 1. Read the description of each professional ability

2. Become familiar with the behavioral criteria described in each of the levels.
3. Self-assess your performance continually, relative to the professional abilities, using the behavioral criteria.
4. In the seventh week of the clinical experience, complete this form.
 - a) Using a highlighter pen, highlight all criteria that describes behaviors you demonstrate in Beginning, Developing or Entry Level professional abilities.
 - b) Give at least one specific example of a time when you demonstrated a behavior from the highest level highlighted.
 - c) Place an “x” along the visual analog scale to indicate the level at which you primarily function in each ability. This should be based on your highlighted areas, the specific example and feedback from your CI.
 - d) Set goals and an action plan to meet those goals.
 - e) Give the completed assessment to your CI on the Monday of the final week of your clinical rotation.
5. Share your self assessment with your CI, specifically seeking his/her feedback during your final counseling.
6. Sign and return to your faculty advisor and discuss at your next counseling session.

¹ Adapted from University of Wisconsin-La Crosse

1. COMMITMENT TO LEARNING: The ability to self-assess, self-correct, and self-direct; to identify needs and sources of learning; and to continually seek new knowledge and understanding.		
Beginning Level Behaviors: Identifies problems; formulates appropriate questions; identifies and locates appropriate resources; demonstrates a positive attitude/motivation toward learning; offers own thoughts and ideas; identifies need for further information.	Developing Level Behaviors: Prioritizes information needs; analyzes and subdivides large questions into components; seeks out professional literature; sets personal and professional goals; identifies own learning needs based on previous experiences; plans and presents an in-service, or research or case study; welcomes and/or seeks new learning opportunities.	Entry Level Behaviors: Applies new information and re-evaluates performance; accepts that there may be more than one answer to a problem; recognizes the need to and is able to verify solutions to problems; reads articles critically and understands the limits of application to professional practice; researches and studies where knowledge base is lacking.
Specific Example:		Place and “x” on the visual analog scale <hr/> B D E
2. INTERPERSONAL SKILLS: The ability to interact effectively with patients; families; colleagues; other health professionals; and community and to deal effectively with cultural and ethnic diversity issues.		
Beginning Level Behaviors: Maintains professional demeanor in all clinical interactions; demonstrates interest in patients as individuals; respects cultural and personal differences of others; in non-judgmental about patients’ lifestyles; communicates with others in a respectful, confident manner; respects personal space of patients and others; maintains confidentiality in all clinical interactions; demonstrates acceptance of limited knowledge and experience.	Developing Level Behaviors: Recognizes impact on non-verbal communication and modifies accordingly; assumes responsibility for own actions; motivates others to achieve; establishes trust; seeks to gain knowledge and input from others; respects role of support staff.	Entry Level Behaviors: Listens to patient but reflects back to original concern; works effectively with challenging patients; responds effectively to unexpected experiences; talks about difficult issues with sensitivity and objectivity; delegates to others as needed; approaches others to discuss differences in opinion; accommodates differences in learning styles.
Specific Example:		Place and “x” on the visual analog scale <hr/> B D E

3. COMMUNICATION SKILLS: The ability to communicate effectively (i.e. speaking, body language, reading, writing, listening) for varied audiences and purposes.		
Beginning Level Behaviors: Demonstrates understanding of basic English (verbal and written); uses correct grammar, accurate spelling and expression; writes legibly; recognizes impact on non-verbal communication; listens actively; maintains eye contact.	Developing Level Behaviors: Utilizes non-verbal communication to augment verbal message; restates, reflects and clarifies message; collects necessary information from the patient interview.	Entry Level Behaviors: Modifies communication (verbal and written) to meet needs of different audiences; presents verbal or written message with logical organization and sequencing; maintains open and constructive communication; utilizes communication technology effectively; dictates clearly and concisely.
Specific Example:		Place and “x” on the visual analog scale <hr/> B D E
4. RESPONSIBILITY: The ability to fulfill commitments and to be accountable for actions and outcomes.		
Beginning Level Behaviors: Demonstrates dependability, demonstrates punctuality; follows through on commitments; recognizes own limits.	Developing Level Behaviors: Accepts responsibility for actions and outcomes; provides safe and secure environment for patients; offers and accepts help; completes projects without prompting.	Entry Level Behaviors: Directs patients to other health care professionals when needed; delegates as needed; encourages patient accountability.
Specific Example:		Place and “x” on the visual analog scale <hr/> B D E
5. PROFESSIONALISM: The ability to exhibit appropriate professional conduct and to represent the profession effectively.		
Beginning Level Behaviors: Abides by APTA Code of Ethics; demonstrates awareness of state licensure regulation; abides by facility policies and procedures; projects professional image; attends professional meetings; demonstrates honesty, compassion, courage and continuous regard for all.	Developing Level Behaviors: Identifies positive role models; discusses societal expectations of the profession; acts on moral commitment; involves other health care professionals in decision-making; seeks informed consent from patients.	Entry Level Behaviors: Demonstrates accountability for professional decisions; treats patients within scope of expertise; discusses role of physical therapy health care; keeps patient as priority.
Specific Example:		Place and “x” on the visual analog scale <hr/> B D E

6. USE OF CONSTRUCTIVE FEEDBACK: The ability to identify sources of and seek out feedback and to effectively use and provide feedback for improving personal interaction.		
Beginning Level Behaviors: Demonstrates active listening skills; actively seeks feedback and help; demonstrates a positive attitude toward feedback; critiques own performance; maintains two-way information.	Developing Level Behaviors: Assess own performance accurately; utilizes feedback when establishing pre-professional goals; provides constructive and timely feedback when establishing pre-professional goals; develops plan of action in response to feedback.	Entry Level Behaviors: Seeks feedback from clients; modifies feedback given to clients according to their learning styles; reconciles differences with sensitivity; considers multiple approaches when responding to feedback.
Specific Example:		Place and “x” on the visual analog scale _____ B D E
7. PROBLEM SOLVING: The ability to recognize and define problems, analyze data, develop and implement solutions, and evaluate outcomes.		
Beginning Level Behaviors: Recognizes problems; states problems clearly; describes known solutions to problem; identifies resources needed to develop solutions; begins to examine multiple solutions to problems.	Developing Level Behaviors: Prioritizes problems; identifies contributors to problems; considers consequences of possible solutions; consults with others to clarify problem.	Entry Level Behaviors: Implements solutions; reassesses solutions; evaluates outcomes; updates solutions to problems based on current research; accepts responsibility for implementation of solutions.
Specific Example:		Place and “x” on the visual analog scale _____ B D E
8. CRITICAL THINKING: The ability to question logically, generate and evaluate elements of logical argument; to recognize and differentiate facts, illusions, assumptions and hidden assumptions; and to distinguish the relevant from the irrelevant.		
Beginning Level Behaviors: Raises relevant question; considers all available information; states the results of scientific literature; recognizes “holes” in knowledge base; articulates ideas.	Developing Level Behaviors: Feels challenged to examine ideas; understands scientific method; formulates new ideas; seeks alternative ideas; formulates alternative hypotheses; critiques hypotheses and ideas.	Entry Level Behaviors: Exhibits openness to contradictory ideas; assesses issues raised by contradictory ideas; justifies solutions selected; determines effectiveness of applied solutions.
Specific Example:		Place and “x” on the visual analog scale _____ B D E
9. STRESS MANAGEMENT: The ability to identify sources of stress and to develop effective coping behaviors.		

<p>Beginning Level Behaviors: Recognizes own stressors or problems; recognizes distress or problems in others; seeks assistance as needed; maintains professional demeanor in all situations.</p>	<p>Developing Level Behaviors: Maintains balance between professional and personal life; demonstrates effective affective responses in all situations; accepts constructive feedback; establishes outlets to cope with stressors.</p>	<p>Entry Level Behaviors: Prioritizes multiple commitments; responds calmly to urgent situations; tolerates inconsistencies in health care environment.</p>
<p>Specific Example:</p>		<p>Place and “x” on the visual analog scale</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">B D E</p>
<p>10. EFFECTIVE USE OF TIME AND RESOURCES: The ability to obtain the maximum benefit from a minimum investment of time and resources.</p>		
<p>Beginning Level Behaviors: Focuses on tasks at hand without dwelling on past mistakes; recognizes own resource limitations; uses existing resources effectively; uses unscheduled time efficiently; completes assignments in timely fashion.</p>	<p>Developing Level Behaviors: Sets up own schedule; coordinates schedule with others; demonstrates flexibility; plans ahead.</p>	<p>Entry Level Behaviors: Sets priority and recognizes when needed; considers patient goals in context of patient clinic and third party resources; has ability to say “no”; performs multiple tasks simultaneously and delegate when appropriate; uses scheduled time with each patient efficiently.</p>
<p>Specific Example:</p>		<p>Place and “x” on the visual analog scale</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">B D E</p>
<p>Clinical Instructor comments regarding the student’s self-assessment and demonstration of Professional Abilities:</p>		

Clinical Instructor Signature _____ Date _____

Based on my Professional Abilities Assessment, I am setting the following goals:

To accomplish these goals, I will take the following specific actions:

Student Signature _____ Date _____

MODEL DPT INTERNSHIP EXPERIENCE

MONTH	1	2	3	4	5	6	7	8	9
Week 1	Orientation OC	OC	OC	OC	NR	IP	IP	PEDS WC	ERGO HAWC
Week 2	OC	OC	OC	OC	NR	IP	IP	PEDS OT	ERGO HAWC
Week 3	OC	OC	OC	OC	NR	IP	IP	HT IC	OC
Week 4	OC	OC	OC	OC	NR	IP	IP	HT IC	OC
EVALUATION	CAB	CAB	CAB	CAB	CAB	CAB	CAB	CAB	CAB
PROJECT	INSERVICE	CAT REVIEW	PORTFOLIO	INSERVICE	PORTFOLIO	Community Service	CAT REVIEW	INSERVICE	PORTFOLIO

OC = Out Patient PT

NR= Neuro/Rehab

IP= In Patient PT

PEDS PT

Ortho= Ortho Clinic (16)
 Rad= Radiology (16)
 ER= Emergency Room (16)
 PH= Pharmacology (8)
 IM = Internal Medicine (8)
 POD= Podiatry (8)
 EBP= Evidence Based Practice (72)

SP= Speech Therapy (4)
 OT= Occup Therapy (4)
 SW= Social Work (4)
 AC= Amputee Clinic (4)
 EBP= (16)

PC= Primary Care (8)
 ICU= Intensive Care Unit (8)
 ET= EMG/ NCV (16)
 EBP= (32)

WC= Wheel Chair Clinic (4)
 OT= Occup Therapy (4)
 EBP= (8)

MISC

CAB= Clinical Assessment Book
 ERGO= Work Hardening
 HAWC= Health & Wellness Center

HT= Hand (8)
 IC= Injury Control (8)
 CAT= Critical Appraisal of Topic