

**CREDENTIALED CLINICAL INSTRUCTOR PROGRAM (CCIP): Level 2**

**Participant Dossier**

**Each participant must complete and submit this form electronically to receive CEU credit and the Level II credential.**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Participant Name: | | |  | | | | |  | Date of Birth: | |  | |
|  | | |  | | | | |  |  | |  | |
| E-Mail Address: | | |  | | | | |  | Phone: | |  | |
|  | | |  | | | | |  |  | |  | |
| 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): |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Type of Entry-Level Degree: |  |  | Date graduated from an accredited PT 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) |

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| --- | --- | --- | --- | --- |
| Are you certified as a clinical specialist by APTA? | No | Yes | If yes, indicate type: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| APTA Membership # |  |  | Date of last membership renewal: |  |

|  |  |
| --- | --- |
| Date of completion of APTA Clinical Instructor Credentialing Program (CCIP) Level 1: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Location of completed CCIP Level 1: |  |  | State: |  |

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| --- | --- | --- | --- | --- |
| Did you complete the CCIP Level 1 using a different name? | No | Yes | If yes, indicate name: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you require special accommodations to complete this program? | No | Yes | If yes, please specify: |  |

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

**Employment History/Practice Setting for the past 5 years (please list most recent employer first)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Employer** | **City/State** | **Job Description** | **Dates (MM/YYYY)** |
|  |  |  | From:       To: |
|  |  |  | From:       To: |
|  |  |  | From:       To: |

In the past 5 years, describe the frequency of time spent in each of the following areas.

**1: Never 2: Rarely 3: Occasionally 4: Often**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Diversity Of Case Mix** | **Rating** | **Patient Lifespan** | **Rating** | **Continuum Of Care** | **Rating** |
| Musculoskeletal |  | 0-12 years |  | Critical care, ICU, Acute |  |
| Neuromuscular |  | 13-21 years |  | SNF/ECF/Sub-acute |  |
| Cardiopulmonary |  | 22-65 years |  | Rehabilitation |  |
| Integumentary |  | over 65 years |  | Ambulatory/Outpatient |  |
| Other (GI, GU, Renal, Metabolic, Endocrine) |  |  |  | Home Health/Hospice |  |
|  | | | | Wellness/Fitness/Industry |  |

**Clinical Education History**

Indicate your current and past education roles for the last 5 years: (Check all that apply)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ACCE/DCE | CCCE | CI | Faculty | Adjunct Faculty | Other: |

|  |  |  |
| --- | --- | --- |
| How many students have you supervised in clinical practice the last 5 years? | students | |
| How many part-time students have you supervised in clinical practice in the last 5 years? | students | |
| If you are an educator or a CCCE, how many students have you supervised or overseen in the last 5 years? | students | |
| Have you been actively involved in student learning and education since receiving your CCIP Level I credential? | Yes | No |

**Participant Self-Assessment**

**Mentoring Roles – Indicate your level of expertise in the following areas: (check the appropriate column for each item)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Area** | **Inexperienced** | **Experienced** | **Highly Experienced** |
| Academic Teaching (classroom lecture, lab) |  |  |  |
| Clinical Teaching (in-services, journal club, mentoring, instruction) |  |  |  |
| Clinical Supervision of PT students |  |  |  |
| Direction/Supervision of PTAs and Aides |  |  |  |
| Clinical Management (supervision, development, and evaluation of staff and personnel) |  |  |  |
| Use of Information Technology |  |  |  |

**Practice Roles – Indicate your level of expertise in the following areas:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Area** | **Inexperienced** | **Experienced** | **Highly Experienced** |
| Clinical Curriculum |  |  |  |
| Professionalism |  |  |  |
| Reflection and Clinical Reasoning |  |  |  |
| Patient/Client Management Model |  |  |  |
| Interprofessional Collaborative Care |  |  |  |
| Advocacy |  |  |  |
| Novice to Master Clinician Continuum |  |  |  |

|  |  |  |
| --- | --- | --- |
| Do you have access to APTA electronic resources (e.g., PTNow, APTA website, Article Search, Professional Development)? | Yes | No |

|  |  |  |
| --- | --- | --- |
| Are you willing to review pre-course reading assignments, complete 3 sections of the APTA Professionalism Module (Introduction, Sections 1 and 4 with assessments), participate in a 2-day instructional program, and satisfactorily complete an assessment center and a professional development plan? | Yes | No |

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

**Participant's signature indicates approval to release this information for purposes of this participant dossier.**

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