

AGREEMENT OF PARTICIPATION

APTA CLINICAL INSTRUCTOR EDUCATION AND CREDENTIALING PROGRAM

The Clinical Instructor Education and Credentialing Program is being offered by the **University of Central Arkansas Physical Therapy Program in Conway**. Successful completion of the didactic component of the curriculum and the accompanying Assessment Center (for PTs and PTAs only) will result in credentialing by the APTA as a Credentialed Clinical Instructor.

To be eligible for credentialing, the participant must:

- 1. Submit a fully completed Participant Dossier, signed Agreement of Participation, and Registration Fee prior to the beginning of the program.**
2. Attend each session of the program in its entirety and participate in all program activities.
3. Submit a completed Record of Attendance (evening format only) verifying attendance and participation in all sessions of the program.
4. Successfully complete each portion of the Assessment Center.

NOTE:

If any part of any session is missed, the participant must repeat the entire program to be eligible for CI Credentialing.

Only participants who have completed all program sessions will be permitted to sit for the Assessment Center.

I have read and understand the above policies and agree to abide by the conditions as stated.

Participant signature

Date

APTA CLINICAL INSTRUCTOR EDUCATION AND CREDENTIALING PROGRAM PARTICIPANT DOSSIER

*Each participant must complete this form and submit it with his/her registration form
PLEASE PRINT LEGIBLY [Please print your name the way you would like it to appear on your certificate(s)]*

1. Applicant Data

Name _____ Date of Birth _____

Current Address _____

City _____ State _____ Zip _____

Phone _____ FAX _____ E-Mail _____

Entry-Level Degree _____ Graduated from an accredited PT/PTA Program or other entry-level discipline MO/YR _____

Number of Years Supervising Students _____

Highest Earned Degree: Associate _____ Professional Doctorate (eg, DPT/AudD/PharmD) _____
 Baccalaureate _____ Postprofessional Master's _____
 Professional Master's _____ Postprofessional Doctorate (eg, PhD/EdD/ScD) _____

Number of Years as a Clinician _____ Professional Designation (eg, PT/PTA/OT/SLP/RN) _____

APTA Membership # (PT/PTA Only) _____ Membership Expiration Date ____/____/____(MM/DD/YY)
(Attach a copy of your current membership card)

Do you require any special accommodation to complete this program? Yes No If yes, specify _____

2. Employment History (List most recent first)

| Employer | City/State | Job Description | Dates | |
|----------|------------|-----------------|------------|----------|
| | | | From _____ | To _____ |
| | | | | |
| | | | | |
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3. **States in Which Licensed/Registered/Certified (IMPORTANT: Attach a copy of your license for the state in which you are currently working.)**

4. To be Completed by Participant's Direct Supervisor (eg, Department Head/Senior Staff/CCCE/Program Director)

| | |
|--|--|
| 1. Applicant demonstrates clinical competence, professional skills, and ethical behavior in clinical practice and/or teaching. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Applicant has at least 1 year of clinical experience (if yes, please go to #4). | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Applicant has less than 1 year of clinical experience but demonstrates the maturity, interest and professional behavior to become a CI. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Applicant has demonstrated a willingness to work with students by pursuing learning experiences to develop knowledge and skills in the clinical/academic setting. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Application demonstrates a systematic approach to patient care and/or job responsibilities. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Applicant uses critical thinking in the delivery of health services or managing job responsibilities. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Applicant provides rationale for decision making in patient care. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Applicant demonstrates appropriate time-management skills. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Applicant represents the profession positively by assuming responsibility for professional self-development. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Applicant interacts with patients, colleagues, and other health professionals to achieve identified goals. | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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

Participant's Signature

Name of Direct Supervisor (Please Print)

Signature of Direct Supervisor

Title

Date