

# 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 \_\_\_\_\_

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 _____

## 3. States in Which Licensed (**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 Signature \_\_\_\_\_

Date \_\_\_\_\_

Name of Direct Supervisor (Please Print) \_\_\_\_\_

Title \_\_\_\_\_

Signature of Direct Supervisor \_\_\_\_\_

Date \_\_\_\_\_