



**CREDENTIALLED CLINICAL INSTRUCTOR PROGRAM (CCIP)**

**Participant Dossier**

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

Participant Name: \_\_\_\_\_ DOB: \_\_\_\_\_

APTA ID Number: \_\_\_\_\_ (nonmembers leave blank)

APTA members, certificates will be sent to your address on file at APTA. Please verify that your address is correct by visiting <http://www.apta.org/apta/profile/MyProfile.aspx> and update as needed. **Then confirm your address by completing the fields below.**

Current Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Professional Designation:  PT  PTA  Non-PT Provider – (if yes, please specify): \_\_\_\_\_

Date graduated from an accredited PT/PTA 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)

Number of years working as a clinician: \_\_\_\_\_

Number of years supervising students: \_\_\_\_\_

Number of students supervised in the last 5 years:  0  1-2  3-5  6-10  11-20  More than 20

State(s) in which licensed: \_\_\_\_\_  
 (Please provide a copy of your state practice license)

Do you grant permission for APTA to release your contact information for **research** purposes?  Yes  No

Do you grant permission for APTA to release your contact information for **marketing** purposes?  Yes  No

If necessary, please specify any special accommodations you require to complete this program: \_\_\_\_\_

Employer	City/State	Zip Code	Dates
			From:      To:

**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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Applicant demonstrates the maturity and professionalism to serve as a CI.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. 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
4. Applicant demonstrates a systematic approach to patient/client care and/or job responsibilities.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Applicant uses critical thinking in the delivery of health services or managing job responsibilities.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Applicant provides rationale, including evidence, for decision making in patient/client care.	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Applicant demonstrates appropriate time management skills.	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Applicant represents the profession positively by assuming responsibility for professional self-development.	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Applicant interacts effectively with patients, colleagues, and other health professionals to achieve identified goals.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Participant's Signature (electronic acceptable) \_\_\_\_\_

Signature & Title of Director Supervisor (electronic acceptable) \_\_\_\_\_