DEPARTMENT OF PHYSICAL THERAPY

Entry-Level Doctor of Physical Therapy Program

CLINICAL EDUCATION HANDBOOK

Students are required to read the enclosed information and sign a form stating that they have read and will abide by the following policies and guidelines to complete their coursework in the Loma Linda University DPT program.

Rev. 10-9-24

Clinical Education Handbook
Table of Contents

Table of Contents 2

University Principles of Education 5
University Mission
University Vision
University Core Values
SAHP Mission
SAHP Vision
SAHP Purpose
Department of Physical Therapy Clinical Education Mission

Entry Level Doctor Physical Therapy Program 6
Program Objectives, Outcomes 6
Objectives of Clinical Education 6

Section 1: General Policies 7
Academic Considerations 7
International Long Clinical Experiences (LCE) 7
Professional Behavior Expectations 7
Legal & Ethical Practice 8
Essential Functions 8

Section 2: Clinical Education Policies 9
Assignment of Clinical Education Experiences 9
Student Communication with Clinical Facilities and Program 10
- Unauthorized, authorized communication 10
- Critical communication 11
- Contact Information for Program Director and Directors of Clinical Education 11

Responsibilities of the University and Program 12
Rights, Privileges and Responsibilities of the Clinical Education Site 12
- Clinical Site, Clinical Education Faculty (CEF), Expectations of CEF 12
- CEF development, Responsibilities of the Clinical Education Site 13
- Rights, and Privileges of the CEF 13

Communication between Clinical Facility and Academic Program 14
- Schedule of Communication between the DCE and SCCE/CI 14
- Student Accommodations 14
- Feedback from Clinical Education Faculty to Program 14
- Feedback from Program and Student to Clinical Education Faculty 14
- Complaints 15

Assessment of Student Learning In Clinical Setting 15
- Short Clinical Experience: Procedure 15
- Long Clinical Experience: Procedure 16

Criteria and Procedures for Assigning Final Grades to Clinical Experiences 17

Section 3: Student Rights and Responsibilities **19**
Student Rights and Access to Benefits 19
Student Responsibilities 19
Health Policies 19
Cardio-Pulmonary Resuscitation (CPR) 19
Background Check 19
Student Clinical Education Resources: Online and Printed resources and Materials 20
Biographical Information 20
Confidentiality and Protected Information 20
Timeline for Student Responsibilities 21
Prior to SCE/LCE 21
Prior to or during the SCE/LCE 21
At the completion of the SCE/LCE 23

Appendices

Appendix One **24**

Tab. 1 APTA Core Documents:
APTA Core Values
Code of Ethics
Guide for Professional Conduct
Standards of Ethical Conduct for the Physical Therapist Assistant
Guide for Conduct of the Physical Therapist Assistant

Tab. 2 Dress Code

Tab. 3 Procedure for Evaluating Fitness for Duty - School of Allied Health Professions Policy

Tab. 4 Risk Management Letter/Health Plan

Tab. 5 Sexual Harassment Policy - Loma Linda University Policy

Tab. 6 Identification and Supervision of Physical Therapy, Physical Therapy Assistant Students

Tab. 7 Essential Functions for PT/PTA students

Tab. 8 Medicare Reimbursement and Student Services - APTA Chart *(rev. 10-15-13)*

Appendix Two **25**

Tab. 9 Course descriptions, APTA CPI 3.0

Tab.10 Year-at-a-Glance

Tab.11 Grading Policy-Clinical Experiences

Tab.12 Standards for Satisfactory Completion of Long Clinical Experiences and Short Clinical Experiences

12B. Specific Objectives for Short Clinical Experience
12C. Specific Objectives for Long Clinical Experience.

Tab.13 Student Signature Page **26**

UNIVERSITY PRINCIPLES OF EDUCATION

University Mission

The mission of Loma Linda University Health is to continue the healing ministry of Jesus Christ, "to make man whole," in a setting of advancing medical science and to provide a stimulating clinical and research environment for the education of physicians, nurses, and other health professionals.

University Vision

Transforming lives through education, healthcare, and research.

University Core Values

The University affirms these values as central to its view of education: Compassion, Wholeness, Integrity, Teamwork, Humility, Justice, and Excellence.

SAHP Mission

Loma Linda University School of Allied Health Professions is committed to creating a globally recognized, world-class learning environment where students are taught in the manner of Christ.

SAHP Vision

We envision an environment that enables learners to lead, to heal, to serve, to touch the world in a way that transforms lives.

SAHP Purpose

To prepare our graduates to be employees of choice for premier organizations around the world, by providing them with practical learning experiences through partnerships with those open to sharing our vision.

Department of Physical Therapy Clinical Education Mission:

As part of a faith-based and diverse institution, we strive to improve the human movement experience and quality of life by advancing physical therapy practice through education, scholarship, and professional service.

ENTRY-LEVEL DOCTOR OF PHYSICAL THERAPY PROGRAM

Clinical Education is a critical component of Physical Therapy Education. Like most healthcare and allied health professions, it is dynamic in nature. Professional task forces and special interest groups continue to provide input to develop models of clinical assessment which are more and more efficient and valid in representing student performance and program outcomes.

Program Objectives:
As part of a Seventh-day Adventist professional school within Loma Linda University, the Department of Physical Therapy is committed to inspiring our students and faculty to achieve academic excellence, live a life of service, appreciate diversity, and pursue lifelong learning.

Goal It is the goal of the entry-level Doctor of Physical Therapy Program, hereafter referred to as the Program, to graduate students who:

SG1: demonstrate entry-level knowledge and clinical skills appropriate for physical therapy practice.

SG2: demonstrate an understanding of using evidence-based practice to guide clinical decision making.

SG3: demonstrate effective verbal and non-verbal communication relating to physical therapy practice.

Outcomes

SO1: 100% of students will have a rating scale anchor descriptor of Entry Level performance [5] or above for all 12 criteria on the APTA Clinical Performance Instrument (3.0) by the end of their third long clinical experience. (SG1)

SO2: 100% of students will earn a passing grade for all clinical courses. (SG1, SG2).

SO3: 100% of students will earn a passing grade for all 3 research track courses. (SG2, SG3)

Objectives of Clinical Experiences
1. To provide students with clinical supervision by experienced, licensed physical therapists in an environment representative of the physical therapy scope of practice.
2. To provide students with opportunities for physical therapy practice with patients/clients in interdisciplinary learning environments to apply the knowledge and experiences gained in the classroom and laboratories.
3. To provide a setting in which the clinical performance of the student may be evaluated in order to determine readiness to enter the Profession at the completion of the Program.
4. To expose students to clinical education models, and roles and responsibilities of clinical educators.

Section 1: GENERAL POLICIES

ACADEMIC CONSIDERATIONS

Each student's record is reviewed quarterly by the Program faculty. Promotion is contingent on satisfactory academic and professional performance and on factors related to aptitude, proficiency, and responsiveness to the established aims of the school and of the profession. As an indication of satisfactory academic performance, the student is expected to maintain the following minimum grade point average: associate programs - 2.0; doctoral degree programs - 3.0.

INTERNATIONAL CLINICAL EXPERIENCES

All clinical experiences are to be completed within the United States of America. Facilities that are in the USA Commonwealth will be considered on a case-by-case basis by the Department of Physical Therapy Clinical Education Committee.

PROFESSIONAL BEHAVIOR EXPECTATIONS

- As an indication of satisfactory professional behavior, students are expected to demonstrate attributes, characteristics, and behaviors that while not explicitly part of the professional core of knowledge and technical skills but are nevertheless required for success in the Profession. Students are guests in the clinical facilities and are expected to conduct themselves in a professional manner in actions, behavior, attire, and appearance, in accordance with the facilities' standards and University's policies and expectations. They are expected to carry out assignments safely and competently according to procedures demonstrated in class and/or the clinic. If the student feels a procedure is unsafe, contraindicated, or if they are not prepared to perform it safely, they must report this to their Clinical Instructor (CI). A patient should not receive treatment until the physical therapist or physical therapist student has done an initial evaluation.

Student behavior reflects on the School of Allied Health Professions, Loma Linda University students are expected to follow ethical and professional standards of the School and University. They must follow the Program's dress code unless directed otherwise by their Director of Clinical Education (DCE) (see Dress Code in Appendix One).

One other behavior has to do with attendance and tardiness. Tardiness is **NOT** acceptable behavior and will influence the student's evaluation in a negative manner.

The APTA has identified behaviors [Core Values] that are integral to the administration of physical therapy services. These behaviors are described below.

Accountability
Accountability is active acceptance of the responsibility for the diverse roles, obligations, and actions of the physical therapist and physical therapist assistant including self-regulation and other behaviors that positively influence patient and client outcomes, the profession, and the health needs of society.

Altruism
Altruism is the primary regard for or devotion to the interest of patients and clients, thus assuming the responsibility of placing the needs of patients and clients ahead of the physical therapist's or physical therapist assistant's self-interest.

Collaboration
Collaboration is working together with patients and clients, families, communities, and professionals in

health and other fields to achieve shared goals. Collaboration within the physical therapist-physical therapist assistant team is working together, within each partner's respective role, to achieve optimal physical therapist services and outcomes for patients and clients.

Compassion and Caring

Compassion is the desire to identify with or sense something of another's experience, a precursor of caring. Caring is the concern, empathy, and consideration for the needs and values of others.

Duty

Duty is the commitment to meeting one's obligations to provide effective physical therapist services to individual patients and clients, to serve the profession, and to positively influence the health of society.

Excellence

Excellence in the provision of physical therapist services occurs when the physical therapist and physical therapist assistant consistently use current knowledge and skills while understanding personal limits, integrate the patient or client perspective, embrace advancement, and challenge mediocrity.

Integrity

Integrity is the steadfast adherence to high ethical principles or standards; truthfulness, fairness, doing what you say you will do, and "speaking forth" about why you do what you do.

Social Responsibility

Social responsibility is the promotion of a mutual trust between the physical therapist assistant, as a member of the profession, and the larger public that necessitates responding to societal needs for health and wellness.

Reference:
CORE VALUES FOR THE PHYSICAL THERAPIST AND PHYSICAL THERAPIST ASSISTANT
HOD P06-19-48-55[Amended: HOD P06-18-25-33; Initial HOD P05-07-19-19;] [Previously Titled: Core Values: for the Physical Therapist] [Position]
American Physical Therapy Association. Core Values for the Physical Therapist and Physical Therapist Assistant. 9/20/19. Accessed 7/6/2021. https://www.apta.org/apta-and-you/leadership-and-governance/policies/core-values-for-the-physical-therapist-and-physical-therapist-assistant

LEGAL AND ETHICAL PRACTICE

A description of professional behavior would not be complete without the *Code of Ethics* adopted by the American Physical Therapy Association, hereafter referred to as the Association, considered binding on physical therapists who are members of the Association. Student membership in this Association is required by the Department of Department of Physical Therapy for both physical therapist and physical therapist assistant students. (See Appendix One for the Physical Therapist *Code of Ethics* and the *Guide for Professional Conduct* and the *Standards of Ethical Conduct for the Physical Therapist Assistant* and *Guide for Conduct of the Affiliate Member.*

ESSENTIAL FUNCTIONS

The practice of physical therapy is unique and requires the professional to possess skills and physical abilities that would allow effective participation in the didactic as well as clinical components of the education. These Essential Functions are delineated in program-specific documents found in Appendix One.

Section 2: CLINICAL EDUCATION POLICIES

ASSIGNMENT OF CLINICAL EDUCATION EXPERIENCES

"All clinical assignments will be made by the Director of Clinical Education (DCE) or a designee. Because of the limited number of local facilities, assignments cannot be made based on the student's family/marital status or personal preference. Although the department tries to accommodate the student's preference, the student agrees to accept the clinical assignments made by the department at any of the affiliated facilities, whether local or out of state." *LLU 2023-2024 Catalog: Entry-level DPT Program-Clinical experiences.*

The Department of Physical Therapy uses a lottery system for student selection of pre-arranged clinical slots. Students also have the option of placing a Special Request for a site which is not a pre-arranged clinical slot. This may be an existing or new contract. The DCE will make the decision as to whether a contract with a new site is pursued on the student's behalf.

The *School of Allied Health Professions Policy Handbook* provides guidelines for clinical assignments when a question of fitness for duty or accommodation occurs, such as medical conditions, emotional instability, pregnancy, or incompetent immunological systems (See Appendix One).

Required Clinical Experiences:
Supervised clinical experiences are obtained in a variety of settings, and at different times. There are two full-time short clinical experiences (SCE) occurring at the end of the first year and the second year respectively. There are three full-time long clinical experiences (LCE) occurring in the final year of the Program.

Program	**SCE settings**	Length	**LCE settings**	Length
DPT	One Outpatient Orthopedic One Inpatient	One 4-week One 4-week	One Outpatient Orthopedic One Inpatient One Elective (any setting)	One 12-weeks One 11-weeks One 10-weeks

Each clinical experience should average 40 hours per week. Occasionally, the Clinical Education Committee may approve collaboration with a clinical facility that can only provide a minimum of 35 hours per week. The DPT student must satisfactorily pass all five clinical experiences to qualify for completion of the Program. If a clinical experience occurs in two or more settings, a minimum of 75% of time spent in one setting is required to classify it as that setting.

General goals for clinical education experiences

- To provide learning experiences for students in a wide variety of patient types and clinical settings representing a broad cross-section of current physical therapy specialties and practice.
- To prepare the student as a generalist in the Profession, equipped to add specialization to a broad and solid foundation as entry-level professionals in any practice arena.

General guidelines

- Students **may not** attend two SCE's or two LCE's at the same facility/setting.

- Students may attend the same facility for an SCE and a LCE once. However, this is not recommended as a variety of settings and clinical sites increases the breadth of clinical education, likely enhancing the student's readiness to be a generalist clinician.

- Students are NOT assigned to a SCE or an LCE in a facility where there is any potential for conflict of interest. This may include but not be limited to a facility where a relative, or significant other is employed as a PT, PTA, or in an administrative position over the physical therapy department. Potential conflicts of interest will be reviewed by the Clinical Education Committee as needed.

- Students are NOT assigned to facilities where they are either currently employed or have been employed in the last 5 years. Students will be held accountable for revealing such information to their DCE prior to the assignments. Failure to reveal this information will lead to disciplinary action by the Department of Physical Therapy Clinical Education Committee and may result in dismissal from the Program.

- Students are NOT to engage in fraternization with their CI or other staff at the facility during the time of the clinical experience.

STUDENT COMMUNICATION WITH CLINICAL FACILITIES AND PROGRAM

Unauthorized Contact

Under **no circumstance** is a student, parent, family member or friend of a student **to contact** a Facility Director, Site Coordinator of Clinical Education (SCCE), Clinical Instructor (CI) or other staff in any facility with which LLU SAHP holds a clinical affiliation agreement **for any reason without specific permission of the appropriate DCE**. **All communication to request placement for a clinical experience with facilities must be done by the DCE**. A student will not be placed in a facility if there is evidence that any person other than the DCE has contacted the facility to request clinical placement.

If a student makes unauthorized contact with a clinical facility, disciplinary action(s) will be taken which may include but are not limited to:

- Deferment of the clinical experience to a later time.
- Removal from the Program due to unprofessional and unethical behavior.
  Disciplinary action will be decided upon by the Clinical Education Committee and presented in writing to the student.

Authorized Contact

If a student is interested in a facility that is **not on the current contract list**, the student must discuss a Special Request for placement with the respective DCE. **Limited authorization may be granted for the student to make an initial inquiry to collect information regarding possible interest at the clinical site in accepting students in general for clinical education and gaining contact information to refer to the DCE. A typical scenario for authorized inquiry would be as follows:**

Hello, my name is ______ and I'm a DPT/PTA student at Loma Linda University. Does your facility currently take students for clinical experiences?
***If YES:** Will you please give me the name and contact information (email/phone) of the person responsible for organizing clinical experiences so that I can share it with my Director of Clinical Education?*
***If No:** Is there a possibility that this facility would consider taking a student for a clinical experience?*
***If YES:** Will you please give me the name and contact information (email/phone) of the person responsible for organizing clinical experiences so that I can share it with my Director of Clinical Education?*
***If NO:** Thank you for your time.*

Required Contact

Unless directed otherwise by the DCE, each **student is required to contact the SCCE/CI for final details at least six weeks prior** to the beginning of any clinical experience.

Critical Communication

In an emergency the student must:

- Notify the SCCE, CI, or Supervisor at the facility of the clinical experience.
- Notify the DCE or Program Director.

If the student is ill or unable to go to the clinic facility as assigned for any reason the student must:

- Call the CI or SCCE prior to the start time that day.
- Call the DCE or Program Office Secretary informing them of the absence on the same day as the absence. Report all serious illnesses to the LLU Risk Management Student Insurance Claims Examiner – James Mendez 909-558-1000 ext. 58113. The general office extension is 14010.
- Arrange for "make-up" time with the SCCE/CI and DCE.
- A physician's note is required for absences of three or more consecutive business days or ER visits and must be given to the SCCE, CI, and DCE.
- In the event of injury to a patient or the student, the student must:
  - Report the incident to the CI and SCCE immediately and to the Program DCE.
  - The DCE will report any incident that involves injury to a patient to the LLU Risk Management Liability/Casualty Manager, 909-558-1000 ext. 14010.

If time is lost from the clinical experiences or the experience was postponed due to a serious medical condition:

- **The student should give both the SCCE/CI and the DCE a physician's note** before he/she can either return to the clinical facility or start the postponed clinical experience.

If unexpected clinical problems develop:

- For patient-related problems (e.g., treatment protocols, scheduling issues, incidents involving patients, institutional procedures), the student should communicate first with the CI to identify the problem and work together to resolve the situation.
- If the problem persists, the student will consult with the SCCE and the DCE.
- For interpersonal problems with the CI or other staff, the student may contact the DCE for help in addressing the problem. If the student is not able to solve the problem within the clinic, the DCE shall be contacted for consultation.

Contact	DPT Short Clinical Experiences	DPT Long Clinical Experiences
Director of Clinical Education	**Henry A. Garcia** W: 909 558-4632 x 47332/follow prompts Email: HGarcia@llu.edu	**Theresa Joseph** W: 909-558-7744 W: 909-558-4632 x 87444/follow prompts Email: TJoseph@llu.edu
Program Director	**Larry Chinnock** W: 909-558-4632 x 47251/follow prompts Email: lchinnock@llu.edu	**Larry Chinnock** W: 909-558-4632 x47251 Email: lchinnock@llu.edu

RESPONSIBILITIES OF THE UNIVERSITY AND PROGRAM

Students remain under the jurisdiction of the University during clinical experiences. This includes but is not limited to:

- Requiring students to register for the clinical experience. Registered students are therefore covered by a health insurance and liability insurance plan. *(Please refer to the letter from Risk Management in Appendix One).*
- Requiring that each student has an annual background check.
- Providing students with an identification badge and name tags.
- Providing a primary point of contact, i.e., the DCE or designee, for student assignment and planning for participation in and monitoring while on the clinical experience.
- Requiring all students have completed required health screens.
- Requiring all students to abide by the policies and procedures of the clinical site while at the site and using its facilities. Providing final grade assignments for clinical experience.

RIGHTS, PRIVILEGES, AND RESPONSIBILITIES OF THE CLINICAL EDUCATION SITE

Clinical Site

The clinical site is an environment in which physical therapy rendered is typical of the scope of practice. Loma Linda University (the University) negotiates legal affiliation agreements with each clinical facility or group whereby the students have access to clinical experiences. These contracts may vary slightly between each facility and organization but have the same basic premise of agreement.

Clinical Education Faculty (CEF)

The Clinical Education Faculty are the Site Coordinator of Clinical Education (SCCE) & Clinical Instructor (CI). The SCCE is the primary contact for the Program and coordinates and manages the student's learning experience in the clinical setting. The DCE relies on the SCCE to assign the student to the CI with consideration for achieving the most successful outcome. The SCCE maintains the Clinical Site Information Form (CSIF) which may be a source to the Program to provide current background and qualifications of the CI and general information related to the site.

Clinical Education Faculty are expected to:

- Comply with regulations for practice as identified by the professional organization and governing agencies.
- Have a minimum of one year of clinical experience if acting in the role of primary Clinical Instructor.
- Provide student orientation to setting and communicate expectations and responsibilities early in the clinical experience.
- Provide ongoing constructive feedback of student performance with consideration of student's learning style, and needs, which stimulates collaborative learning.
- Evaluate the student according to the guidelines and tools provided by the program and complete documentation in accordance with the identified schedule.
- Communicate with the Program DCE in a timely manner regarding student issues.
- Provide clinical education learning experiences within a safe environment, with a caseload which is representative of the physical therapy scope of practice and allows the student to practice skills learned in the Program.
- Demonstrate ongoing desire and skill in providing clinical instruction to students and continuing professional development.

Clinical Education Faculty Development
The CI is a licensed physical therapist with a minimum of one year of clinical experience. The Program strongly encourages the ongoing pursuit of continuing education for SCCEs and CIs. The Program recognizes that in some clinical sites, the same individual may serve as SCCE and CI. SCCEs and CIs who remain current in their area of practice, knowledgeable regarding healthcare trends and avidly utilize resources for professional and personal development possess an advantage in being more effective teachers. In addition to participation in local PT clinical education forums, the Clinical Education faculty may benefit from reviewing APTA guidelines for development at:

https://www.apta.org/search?q=development+of+clinical+education+programs
https://www.apta.org/for-educators/assessments/pt-cpi [scroll down to hyperlink addressing appropriate trainee]

Responsibilities of the Clinical Education Site administration includes the following:
- Provide suitable clinical learning experiences as prescribed by the Program curriculum and objectives.
- Designate appropriate personnel to coordinate the student's clinical learning experience. This designation shall be called the Clinical Education Supervisor or Site Coordinator of Clinical Education (SCCE).
- Provide all equipment and supplies needed for clinical instruction at the clinical site.
- Provide necessary emergency care or first aid required by an accident occurring at the facility.

Rights and Privileges of the Clinical Education Faculty (CI/SCCE)
University Standard: The standard affiliation agreement signed by the facility and the University outlines rights and privileges of the clinical education faculty including but not limited to:
- The right to designate the individual from their staff who will coordinate the student's clinical learning experience at the facility.
- The right to receive assignments of only students who have satisfactorily completed the prerequisite didactic portion of the curriculum.
- The right to recommend withdrawal, and/or exclude, any student from its premises.

Program Standard: The faculty and staff of the Program recognize the contribution of CEF. With the goal of fostering a mutual relationship of professional development, several additional rights and privileges have been extended to them:
- Clinical education faculty are offered attendance to LLU PT hosted continuing education courses at a discounted rate.
- The Program provides documented verification of hours earned towards CEU credit (consistent with the licensing board criteria) for providing clinical instruction to the students.
- The Program provides sponsorship to several clinical education faculty to the APTA Clinical Instructor credentialing courses annually.
- Clinical education faculty have increased access to professional forums such as CEF and CEF-IACCC combined meetings via announcements and facilitated processes made by the Program. These forums offer additional opportunities for individual input to the development of the Profession as well as personal professional growth.
- Clinical education faculty have a right to provide feedback to the Program regarding program development and community perspectives related to the PT scope of practice.

COMMUNICATION BETWEEN CLINICAL FACILITY AND ACADEMIC PROGRAM

Schedule of Communication between the DCE and SCCE/CI:

- The DCE/designee sends an annual request form in March to the SCCE requesting a commitment to provide specific clinical experiences for the following year or to defer until slots are requested by the DCE as needed. Upon assignment of a student to a specific slot offered, a confirmation notice is sent to the SCCE. Best efforts are made to complete the assignment and confirmation process 10-12 weeks prior to the start of the clinical experience.
- Approximately 6-8 weeks prior to the start of the clinical experience, a standard student information packet is sent to the SCCE. ***The Program expects the SCCE to use care in sharing the student's personal information on a "need to know" only basis*.**
- The student contacts the SCCE at least 6 weeks prior to the start of the clinical experience to introduce self and to discover specific expectations for practice at the site. The student then completes any additional requirements.
- If an offered clinical slot is not assigned to a student, the DCE/designee sends a letter of cancellation to the SCCE 4 weeks before the start date.
- For LCEs, the DCE or faculty designee contacts the SCCE and/or CI 2-4 weeks prior to the midterm to schedule a midterm performance review session. The SCCE/CI is expected to contact the DCE for resolution of problems at any time during the clinical experience as needed.
- The student is responsible for returning the required completed documents to the DCE at the end of the clinical experience. The CI is expected to complete the documentation by the final day of the clinical experience.
- The Program provides documented verification of hours earned towards CEU credit (consistent with the licensing board criteria) for providing clinical instruction to the students. These are sent to the clinical site approximately 1-2 weeks after the clinical experience.
- **Student *Accommodations:* Learning accommodations in the didactic portion of the curriculum do not automatically apply to the clinical education portion of the program. They must be requested by the student and assessed individually.** Students who have been granted accommodations and wish to use those accommodations for clinical education should notify the DCE in writing at least two weeks in advance of clinical assignment ("Pick date") for each specific course. If accommodations for the clinical education portion of the curriculum are requested by the student and granted, the scheduling of subsequent clinical experiences may be impacted. If a student is granted approval by the school for accommodations or needs special supervision, the DCE discusses these needs with the SCCE prior to confirmation of the clinical experience. If special needs are discovered or become necessary while in the clinic, the SCCE/CI is to notify the DCE immediately.

Feedback

Feedback from the Clinical Education Faculty to the Program includes the following:

- During the midterm visit of long clinical experiences and at the end of both short and long clinical experiences. Feedback regarding the Program's preparation of the student for practice in the specific setting is discussed and documented.
- Completion of a brief survey regarding the Program's functions and processes at the end of the Long Clinical Experiences approximately every two years.
- During Community Advisory Council meetings and more detailed surveys distributed at other intervals as deemed necessary by the Program DCEs and Program Director.

Feedback from the Program and Student to the SCCE/CI includes the following:

- Students are expected to give formal feedback to the DCE and the CEF regarding the clinical experience via the Physical Therapist Student Evaluation of Experience and Clinical Instruction forms. The DCE

may choose to follow up on information provided via this tool at the time of the midterm visit or otherwise as appropriate.

- During the LCE midterm visit/review, the DCE or faculty designee observes the clinical environment and provides feedback which may enhance the teaching/learning experience.
- The Program provides, as deemed appropriate, general announcements and information regarding the University and Program to clinical education faculty via either written, verbal, or online communications.
- The DCE or designee presents information accumulated through SIG meetings such as the IACCC-CEF annual meeting.
- The DCE obtains information regarding the post-professional educational needs of the CIs via course evaluation surveys at Program-sponsored continuing education events. Assessment and development of educational opportunities are communicated to the CEF via email and the University website.

Complaints

Outside Complaints or Grievance Procedures

The Doctor of Physical Therapy Program at Loma Linda University values comments and concerns from the outside public, regarding the behavior of our students. We strive to graduate competent, compassionate, and ethical students.

Any grievance made will be responded to and dealt with in a timely and appropriate manner.

Procedures and Responsibilities

Complaints can be made in writing through email or anonymously over the phone.

The Chair of the Department of Physical Therapy will manage the complaint and respond in a timely manner. Depending on the gravity of the complaint, a committee may be created to hear the complaint and a vote taken to decide the student's standing in the Doctor of Physical Therapy Program. Legal counsel will be consulted when deemed appropriate.

Responsible Party: Chair of the Department of Physical Therapy, Dr. Larry Chinnock at lchinnock@llu.edu 909-558-4632 Ext. 47251

Students with Complaints regarding the clinical experience should contact the Director of Clinical Education and follow-up with the Program Director or Associate Program Director for additional response as needed for resolution.

ASSESSMENT OF STUDENT LEARNING IN CLINICAL SETTING

Short Clinical Experience (SCE)

Student performance during the SCE is evaluated using a Short Clinical Evaluation Form. This form allows the Clinical Instructor (CI) to assess the student's clinical skills and for the student to conduct a self-assessment of their basic PT skills relevant to the clinical experience. Students receive guidance from the DCE on how to use this tool and are expected to work with the CI to set performance goals for self-reflection and development.

Any changes or updates to this process will be detailed in the course syllabus

The SCE Evaluation tool includes two components:

CI assessment of the student's clinical performance.

Student's self-assessment of performance and evaluation of clinical experience.

Although a formative assessment at the midpoint is not performed during SCE, the CI is encouraged and expected to provide feedback as needed during the clinical experience. A formal evaluation with CI and student including a

documented narrative summary at the end of the SCE is expected.

Procedure for Final Assessment of SCE

1. Evaluation of student by the CI includes documentation using the *SCE Evaluation Form*.
2. Student Self-Assessment using the *SCE Evaluation Form*.
3. Interviews by academic faculty with the CI and the student if needed.
4. Timely submission of other program assignments (see course syllabus)

[See Appendix 2, TAB 12B, or individual course outline for specific learning objectives and Program Standard for Successful Completion of each SCE experience].

Long Clinical Experiences (LCE)

Assessment tool:
APTA Physical Therapist Clinical Performance Instrument (APTA CPI, version 3.0):
The tool contains 12 criteria which are used to assess student performance at the midterm and final evaluations by the Clinical Instructor as well as self- assessment by the student.

The student receives instructions in, and practices use of the assessment tool prior to attending the clinical experience. These instructions, links to the APTA training, and practice exercises are maintained in Canvas Clinical Orientation resource and LCE courses

Clinical Instructors and SCCEs receive letters of instruction prior to the start of the experience which include links to the APTA training site as well as the website[https://www.apta.org/for-educators/assessments/pt-cpi]for accessing the assessment tool.
While it is recommended that both complete the training, it is required for all CIs. Vendor support may be accessed at email: cpi@apta.org; Phone: 703-706-8582

Midterm reviews: The DCE assigns key academic faculty to each student for review of the student's performance with the student and CI at the midterm. Completion of the CPI just prior to the midterm meeting is highly encouraged to allow timely faculty review and more meaningful and efficient discussion as well as problem solving as needed. Faculty are not expected to be present for the final assessment. The CI, student and SCCE (if desired) assess and provide final documentation using the tool. The DCE is notified by faculty, student or CEF of any need for post midterm follow- up by the DCE.
In addition to the summative discussion and documentation of the student's performance presented at midterm and final evaluation periods, the Program highly recommends that the CI provides additional student feedback as needed to foster ongoing professional development.

Procedures for Final Assessment of LCE**:**

1. Evaluation of student by the CI (includes documentation using the APTA CPI.
2. Student Self-Assessment using the APTA CPI.
3. Student submission of other program assignments (see Course outline and CI letter of Instruction)
4. Documentation of midterm reviews by academic faculty with the CI and the student.

[See Appendix 2, TAB 12C, or individual course outline for specific learning objectives and Program Standard for Successful Completion of each LCE experience].

CRITERIA AND PROCEDURES
FOR ASSIGNING FINAL GRADES TO CLINICAL EXPERIENCES

All Short Clinical Experiences must be completed successfully before proceeding on to a Long Clinical Experience. (See course syllabi for details of program progression)

Grading and Intervention (The Entire DPT Grading Policy may be found in Appendix Two).

The following include resources for grading of clinical experiences:

1. Physical Therapist Clinical Performance Instrument (CPI) or the SCE Evaluation Form.
2. Interviews conducted by academic faculty reviewers with the Site Coordinator of Clinical Education (SCCE), Clinical Instructor (CI), and the student.
3. Student's *Self-Assessment* using *the Clinical Performance Instrument - or SCE Evaluation Form.*
4. Documentation of assignments as indicated in the Course Syllabus/Outline.

Students are expected to demonstrate attributes, characteristics, and behaviors that are not explicitly part of the professional core of knowledge and technical skills but are nevertheless required for success in the profession. The APTA has identified behaviors [Core Values/Values-based behavior] that are integral to the satisfactory completion of a clinical experience. The CEC will reference these APTA sources to substantiate the decision for grading as deemed necessary.

Each student is expected to receive a satisfactory rating by the end of each clinical experience. Each rotation is independent of the others and must be satisfactorily completed.

<u>Challenges with meeting expectations</u>
If the clinical faculty (SCCE/CI) finds that the student is not meeting the requirements or expectations for the clinical experience, SCCE/CI should contact the DCE to develop an agreeable plan of action for successful completion. The student is also encouraged to contact the DCE in this regard. Periodic review and specific feedback from the CEF should be provided to the student and the DCE. If the problem remains unresolved, the Loma Linda University PT Program Clinical Education Committee (CEC) will review the case and provide recommendation which may include actions up to immediate termination of the clinical experience. A clinical facility has the right to terminate an experience at the discretion of the CEF and/or administration. Errors in safety and/or judgment and unprofessional behavior may be grounds for the student to be removed from the facility. A student who terminates any clinical experience without prior consultation and approval from the Director of Clinical Education (DCE) will be automatically referred to the Clinical Education Committee (CEC). The CEC will make a final decision regarding the student's program progression, which may include disciplinary action and could result in an "Unsatisfactory" grade for the clinical experience.

The Clinical Instructor does not determine the final grade for clinical experiences. The CI is only responsible for providing a documented assessment of the student's performance while in the clinic using the appropriate tool. The DCE and CEC will provide the final grade by incorporating additional resources as appropriate.

The *Program Clinical Education Committee* is comprised of the following: DCEs from PT and PTA Programs, Program Directors of PT and PTA, and Academic Faculty who perform PT Midterm reviews, as representation of the PT faculty. The CEC has the right to obtain additional input from other faculty in assessing the overall student performance and assigning the grade.

Timely submission of clinical documents to the DCE by the student is critical to facilitate timely review and grade assignment. See course syllabi. If the student fails to complete and submit the required documents by the deadline stated in the course syllabi, an **"Unsatisfactory" (U) grade will be submitted. A "U" grade entered under this condition must be remediated by submission of completed documents and re-registration for**

the clinical experience.

Scholastic Disqualification Policy

The Program has a policy regarding disqualification based on scholastic performance throughout the program. "If a student receives a grade of "Fail" or "Unsatisfactory" in two courses, didactic or clinical, the student will have disqualified themselves from the program.

Section 3: STUDENT RIGHTS AND RESPONSIBILITIES

STUDENT RIGHTS AND ACCESS TO BENEFITS
These resources are detailed in the University Student Handbook as well as the Student Handbook for the Physical Therapy program.

STUDENT RESPONSIBILITIES
This section contains the individual responsibilities for the DPT student as they relate to the clinical setting. Compliance with these policies and responsibilities is necessary for satisfactory completion of each SCE and LCE.

Health Policies - All students must have the following on file with the DCE or designee:

> **TB test** - (Tuberculosis Screen)
> Documentation of the TB test must be current within 1 year prior to starting a clinical experience. Some clinical sites may require a two-step test or a test within a shorter time. If the TB test is positive, a copy of the chest x-ray report must be on file.
>
> **Hepatitis B Vaccine** - Documentation for 3 vaccinations or a report of a positive antibody titer.
>
> **MMR -** mumps, measles, and rubella vaccine) - Documentation of immunization or a report of a positive antibody titer.
>
> **TDAP** - Tetanus, Diphtheria and Pertussis. Documentation of inoculation within the last ten years.
>
> **Varicella (chicken pox)** - Proof of a positive varicella titer or a series of two injections. Some clinical sites require a titer.
>
> **Seasonal Flu** - Documentation of influenza vaccine for current flu season, October-March.
>
> **Site Specific** - There may be other additional health records that are required by some clinical facilities. The student is to consult with the DCE or designee for any specific requirements. Facilities may require titers for Hepatitis B, MMR, and Varicella (chicken pox), proof of COVID 19 vaccination. Pre-clinical or random drug testing or physical examinations may also be required, as well as required site-specific testing.

Cardio-Pulmonary Resuscitation (CPR)
The student must carry a current BLS CPR certification for the Health Care Worker (for adult, child, and infant) issued from the **American Heart Association** when in the clinic and a copy should be on file in the Program's clinical education office.

Background Check
Background checks are currently part of registration preceding the student's enrollment into the Program and an updated background check is completed just prior to the end of the second year in the Program. This is to ensure that background checks are not more than 12 months old when the student begins a clinical experience. The background check is completed via the student portal of the University and accessed by an administratively designated individual in the school.

As per the website "The background package has been designed to meet the clinical placement requirements for all Loma Linda University medical programs and their associated clinical placement facilities." Some clinical facilities may require additional background checks done by the student or fingerprinting through their own

vendor, at the student's expense.

The student is advised that while the result of background checks may allow entrance to particular clinical sites during the course of the program, there is no guarantee that this would allow satisfactory completion of the application for licensure. Each background check for application for state licensure is assessed individually by the state's own licensing body.

Student Clinical Education Resources:
Students access resources for orientation and training through program and course-specific Canvas courses, department resources on Canvas (Clinical Education Resource Archives (CERA), and the EXXAT.com database. Information regarding aspects of the professional organization (APTA) as it relates to student experiences in the clinic, clinical site information and contact personnel, feedback from previous students, Instructions and guidelines on preparation for the clinical environment, instructions for use of the CPI, as well as assignments to be completed while on the clinical experience are accessed on these sites. Instructions for use of these resources are presented to the students during Orientation to Clinical Education sessions by the DCE and support staff.

Students have access to view their rotation placement process using the web application: EXXAT.com.

Additionally, students are able to review lectures and exercises in which they participated during Orientation sessions which are maintained on Canvas. These include topics such as Conflict Management, Decision Making styles and how these impact clinical interactions, professionalism, professional behaviors, HIPAA, as well as expectations of the clinic for student participation in the clinic. .

Biographical Information
The *Profile page* found on *EXXAT.com* allows the student to provide their biographical information and includes the student's history of clinical experiences, their professional interests, learning objectives and expectations of upcoming clinical experiences. A subsection in this electronic page allows a student to upload a resume which may be specific to a particular clinical experience/clinical site. This information is crucial for both the DCE and the clinical education faculty. It is sent to each student's clinical experiences sites.

- The biographical/profile page is available online in EXXAT.
- Each student must complete the profile page by the date given.
- The student is responsible for updating and keeping current all information on the EXXAT student profile page.

Confidentiality and Protected Information
The Department of Physical Therapy recognizes that information which promotes effective student education and patient/client care may be shared with appropriate individuals. Reasonable care is expected in the dissemination and use of this information in arranging clinical experiences. Students document acknowledgement of this sharing of information with the Program.

Students receive instruction in the basics of Health Information Portability and Accountability Act (HIPAA), OSHA for the healthcare setting early in the program, but it is reasonable to expect some clinical sites to include additional training during their orientation.

Policies regarding patient/client rights within the clinical setting are established by that institution and should allow patient/clients the right to refuse to participate in clinical education. Students are expected to adhere to these policies while at the clinical site.

TIMELINE OF STUDENT RESPONSIBILITIES

Prior to the SCE/LCE the Student Will:

- Attend all **Clinical Orientation classes** per program.
- Submit documentation of all **health requirements and other compliance items on EXXAT as directed by the DCE/designee**
- Complete Student **Profile/Biographical page on EXXAT as instructed by DCE**.

- Access all **pertinent information** needed for SCE/LCE from the DCE/designee in a timely manner. Respond to emails in a timely fashion to ensure sufficient time for a successful on-boarding process.

- **Contact the facility SCCE/CI as directed by the DCE,** to confirm placement and obtain information any additional requirements, such as work schedule, directions to the facility, dress code, and for proper communication.

- Failure to complete and/or submit requirements on time may be subject to disciplinary action up to and including a fee assignment or deferral of attendance to the current clinical experience.

Prior to and/or during the SCE/LCE the student will:

- **Make arrangements for reliable transportation to the clinical facility.**
  The student is responsible for housing as well as transportation to and from the facility, whether by his/her own transportation, carpooling, or public transportation. Students may expect to travel up to 60 minutes from residence to attend some clinical experiences. Some sites may offer stipends, but this is a privilege and not a right to be expected. Any hours lost due to absences and/or tardiness because of transportation trouble may need to be made up.

- **Arrive on time each day.**
  Each student must clarify the work schedule with the SCCE/CI prior to starting the clinical experience. Clinic hours may vary throughout the clinical experience. Students are required to complete an average of 40 hours per week with a minimum of 35 hours per week. The student is not to request an alternative work schedule with the facility. Exceptions to the assigned work schedule must be negotiated by the DCE.

- **Notify the SCCE/CI if student expects to be late.**

- **Notify the SCCE/CI and DCE if absent for any length of time.**
  Both the CI and the DCE must be notified and given the reason for the absence. The DCE will determine if the absence may be excused. **A maximum of one day for Short Clinical Experiences and two days only for Long Clinical Experiences will be allowed for illnesses per clinical experience**. Absences beyond the stated days above must be made up at the discretion of the CI in conjunction with the DCE. The absences are for emergencies only. These are not personal days.
  Request personal days in writing to the DCE prior to the clinical experience. The DCE will consult with the SCCE/CI to determine if the request can be approved. If approved, the student may still need to make up any days lost.

- **Dress professionally and abide by the dress code of the academic program and the clinical facility.**
  (See Appendix One for Dress Code) The student must clarify any questions regarding the dress code with the SCCE/CI prior to starting the clinical experience. If there are any questions about the appropriateness of the attire, a lab coat should be worn.

- **Wear the name badge provided by the Program** and any additional identification required by the clinical facility.

- **Introduce self to the patient and clinical or hospital staff as a PT student, using full name.** Acknowledge the patients' right to refuse treatment.

- **Prepare adequately for the clinical experience, including case studies, in-services, and any other additional assigned "homework".** The clinical experience should NOT be considered a VACATION from school, but an advanced learning experience. Students are expected to complete all assignments given by the SCCE/CI and to prepare for in-services in a timely manner.

- Complete all required assignments as per course syllabi.

- **Student is required to have access to EXXAT, CANVAS, any Internet programs used by the school while in the clinic.**

- **Take responsibility for his/her clinical learning experience**.
  Make good use of "free time" by reading information pertaining to the clinical setting, preparing for his/her in-service, or with the permission of the CI, observe other clinicians and healthcare professionals involved with patient care.

- **Abide by the safety policy of the facility.**
  Safety policies should be covered during the student orientation of each facility. If safety policies are not covered the student is required to seek out this information.

- **Practice in a safe manner and adhere to legal and ethical standards**.
  Under no circumstance is the student to treat a patient without a physical therapist in the building. If the physical therapist has stepped out of the building for any reason, the student is not to start or continue treatment of any patient, even if directed to do so by the CI. If this situation occurs the DCE should be notified immediately.

  The student should be very careful to use safe techniques when treating patients. Good body mechanics are important and should be practiced in all situations.

  The student should inform the DCE regarding any serious problems encountered during the clinical experience, such as errors in practice, unethical, or illegal practices. Problems that involve the CI and/or problems with a patient or patient's family member should be reported to the SCCE and the DCE.

- **Discuss the use of the evaluation forms for SCE and the CPI for LCE with the CI at the beginning of the experience.** Complete the student's version of the evaluation documents and discuss CIs assessment and feedback (at midterm for LCE) and at final for SCE and LCE. Both the student and the CI should be proactive in the completing documentation of all assessments, but it is the student's responsibility for timely completion and submission.

- **Communicate openly with CI regarding learning opportunities, questions or differences between CI and student, and learning style and format of feedback.** If the CI and student are not able to **resolve a conflict,** the SCCE/DCE should be notified for assistance.

- **Attend Midterm Review and Reflection Forums for feedback and clarifications where applicable and as directed by DCE.**

At the completion of the Clinical Experience the student will:

- **Submit all required course materials on CANVAS and EXXAT as directed by DCE.**
- **Complete Course Survey at the end of the second year for SCEs and at the end of the final year for LCEs.**
- **Attend Program focus groups to provide overall feedback at the end of the final LCE.**

Appendix One

Tab. 1 APTA Core Documents:
APTA Core Values
Code of Ethics
Guide for Professional Conduct
Standards of Ethical Conduct for the Physical Therapist Assistant
Guide for Conduct of the Physical Therapist Assistant

Tab. 2 Dress Code

Tab. 3 Procedure for Evaluating Fitness for Duty - School of Allied Health Professions Policy

Tab. 4 Risk Management Letter/health plan

Tab. 5 Sexual Harassment Policy - Loma Linda University Policy

Tab. 6 Identification and Supervision of Physical Therapy, Physical Therapy Assistant Students

Tab. 7 Essential Functions for PT/PTA students

Tab. 8 Medicare Reimbursement and Student Services - APTA Chart

Appendix Two

Tab. 9 Course descriptions, APTA CPI 3.0

Tab.10 Year-at-a-Glance

Tab.11 Grading Policy-Clinical Experiences

Tab.12 Standards for Satisfactory Completion of Long Clinical Experiences and Short Clinical Experiences

12B. Specific Objectives for Short Clinical Experience
12C. Specific Objectives for Long Clinical Experience.

Tab.13 Student Signature Page

Code of Ethics for the Physical Therapist

Code of Ethics for the Physical Therapist HOD S06-19-47-67 [Amended HOD S06-09-07-12; HOD S06-00-12-23; HOD 06-91-05-05; HOD 06-87-11-17; HOD 06-81-06-18; HOD 06-78-06-08; HOD 06-78-06-07; HOD 06-77-18-30; HOD 06-77-17-27; Initial HOD 06-73-13-24] [Standard]

Preamble

The Code of Ethics for the Physical Therapist (Code of Ethics) delineates the ethical obligations of all physical therapists as determined by the House of Delegates of the American Physical Therapy Association (APTA). The purposes of this Code of Ethics are to:

1. Define the ethical principles that form the foundation of physical therapist practice in patient and client management, consultation, education, research, and administration.
2. Provide standards of behavior and performance that form the basis of professional accountability to the public.
3. Provide guidance for physical therapists facing ethical challenges, regardless of their professional roles and responsibilities.
4. Educate physical therapists, students, other health care professionals, regulators, and the public regarding the core values, ethical principles, and standards that guide the professional conduct of the physical therapist.
5. Establish the standards by which the American Physical Therapy Association can determine if a physical therapist has engaged in unethical conduct.

No code of ethics is exhaustive, nor can it address every situation. Physical therapists are encouraged to seek additional advice or consultation in instances where the guidance of the Code of Ethics may not be definitive.

This Code of Ethics is built upon the five roles of the physical therapist (management of patients and clients, consultation, education, research, and administration), the core values of the profession, and the multiple realms of ethical action (individual, organizational, and societal). Physical therapist practice is guided by a set of seven core values: accountability, altruism, compassion/caring, excellence, integrity, professional duty, and social responsibility. Throughout the document the primary core values that support specific principles are indicated in parentheses. Unless a specific role is indicated in the principle, the duties and obligations being delineated pertain to the five roles of the physical therapist. Fundamental to the Code of Ethics is the special obligation of physical therapists to empower, educate, and enable those with impairments, activity limitations, participation restrictions, and disabilities to facilitate greater independence, health, wellness, and enhanced quality of life.

Principles

Principle #1: *Physical therapists shall respect the inherent dignity and rights of all individuals. (Core Values: Compassion, Integrity)*

1A. Physical therapists shall act in a respectful manner toward each person regardless of age, gender, race, nationality, religion, ethnicity, social or economic status, sexual orientation, health condition, or disability.

1B. Physical therapists shall recognize their personal biases and shall not discriminate against others in physical therapist practice, consultation, education, research, and administration.

Principle #2: *Physical therapists shall be trustworthy and compassionate in addressing the rights and needs of patients and clients. (Core Values: Altruism, Compassion, Professional Duty)*

2A. Physical therapists shall adhere to the core values of the profession and shall act in the best interests of patients and clients over the interests of the physical therapist.
2B. Physical therapists shall provide physical therapist services with compassionate and caring behaviors that incorporate the individual and cultural differences of patients and clients.
2C. Physical therapists shall provide the information necessary to allow patients or their surrogates to make informed decisions about physical therapist care or participation in clinical research.
2D. Physical therapists shall collaborate with patients and clients to empower them in decisions about their health care.
2E. Physical therapists shall protect confidential patient and client information and may disclose confidential information to appropriate authorities only when allowed or as required by law.

Principle #3: *Physical therapists shall be accountable for making sound professional judgments. 2 (Core Values: Excellence, Integrity)*

3A. Physical therapists shall demonstrate independent and objective professional judgment in the patient's or client's best interest in all practice settings.
3B. Physical therapists shall demonstrate professional judgment informed by professional standards, evidence (including current literature and established best practice), practitioner experience, and patient and client values.
3C. Physical therapists shall make judgments within their scope of practice and level of expertise and shall communicate with, collaborate with, or refer to peers or other health care professionals when necessary.
3D. Physical therapists shall not engage in conflicts of interest that interfere with professional judgment.
3E. Physical therapists shall provide appropriate direction of and communication with physical therapist assistants and support personnel.

Principle #4: *Physical therapists shall demonstrate integrity in their relationships with patients and clients, families, colleagues, students, research participants, other health care providers, employers, payers, and the public. (Core Value: Integrity)*

4A. Physical therapists shall provide truthful, accurate, and relevant information and shall not make misleading representations.
4B. Physical therapists shall not exploit persons over whom they have supervisory, evaluative or other authority (eg, patients/clients, students, supervisees, research participants, or employees).
4C. Physical therapists shall not engage in any sexual relationship with any of their patients and clients, supervisees, or students.
4D. Physical therapists shall not harass anyone verbally, physically, emotionally, or sexually.
4E. Physical therapists shall discourage misconduct by physical therapists, physical therapist assistants, and other health care professionals and, when appropriate, report illegal or unethical acts, including verbal, physical, emotional, or sexual

harassment, to an appropriate authority with jurisdiction over the conduct.

4F. Physical therapists shall report suspected cases of abuse involving children or vulnerable adults to the appropriate authority, subject to law.

Principle #5: *Physical therapists shall fulfill their legal and professional obligations. (Core Values: Professional Duty, Accountability)*

5A. Physical therapists shall comply with applicable local, state, and federal laws and regulations.

5B. Physical therapists shall have primary responsibility for supervision of physical therapist assistants and support personnel.

5C. Physical therapists involved in research shall abide by accepted standards governing protection of research participants.

5D. Physical therapists shall encourage colleagues with physical, psychological, or substance-related impairments that may adversely impact their professional responsibilities to seek assistance or counsel.

5E. Physical therapists who have knowledge that a colleague is unable to perform their professional responsibilities with reasonable skill and safety shall report this information to the appropriate authority.

5F. Physical therapists shall provide notice and information about alternatives for obtaining care in the event the physical therapist terminates the provider relationship while the patient or client continues to need physical therapist services.

Principle #6: *Physical therapists shall enhance their expertise through the lifelong acquisition and refinement of knowledge, skills, abilities, and professional behaviors. (Core Value: Excellence)*

6A. Physical therapists shall achieve and maintain professional competence.

6B. Physical therapists shall take responsibility for their professional development based on critical self-assessment and reflection on changes in physical therapist practice, education, health care delivery, and technology.

6C. Physical therapists shall evaluate the strength of evidence and applicability of content presented during professional development activities before integrating the content or techniques into practice.

6D. Physical therapists shall cultivate practice environments that support professional development, lifelong learning, and excellence.

Principle #7: *Physical therapists shall promote organizational behaviors and business practices that benefit patients and clients and society. (Core Values: Integrity, Accountability)*

7A. Physical therapists shall promote practice environments that support autonomous and accountable professional judgments.

7B. Physical therapists shall seek remuneration as is deserved and reasonable for physical therapist services.

7C. Physical therapists shall not accept gifts or other considerations that influence or give an appearance of influencing their professional judgment.

7D. Physical therapists shall fully disclose any financial interest they have in products or services that they recommend to patients and clients.

7E. Physical therapists shall be aware of charges and shall ensure that documentation and coding for physical therapist services accurately reflect the nature and extent of the services provided.

7F. Physical therapists shall refrain from employment arrangements, or other arrangements, that prevent physical therapists from fulfilling professional obligations to patients and clients.

Principle #8: *Physical therapists shall participate in efforts to meet the health needs of people locally, nationally, or globally. (Core Value: Social Responsibility)*

8A. Physical therapists shall provide pro bono physical therapist services or support organizations that meet the health needs of people who are economically disadvantaged, uninsured, and underinsured.

8B. Physical therapists shall advocate to reduce health disparities and health care inequities, improve access to health care services, and address the health, wellness, and preventive health care needs of people.

8C. Physical therapists shall be responsible stewards of health care resources and shall avoid overutilization or under-utilization of physical therapist services.

8D. Physical therapists shall educate members of the public about the benefits of physical therapy and the unique role of the physical therapist.

Effective June 2019

For more information, go to www.apta.org/ethics.

APTA Guide for Professional Conduct

Purpose

The APTA Guide for Professional Conduct (Guide) is intended to serve physical therapists in interpreting the Code of Ethics for the Physical Therapist (Code of Ethics) of the American Physical Therapy Association (APTA) in matters of professional conduct. The APTA House of Delegates in June of 2009 adopted a revised Code of Ethics, which became effective July 1, 2010.

The Guide provides a framework by which physical therapists may determine the propriety of their conduct. It also is intended to guide the professional development of physical therapist students. The Code of Ethics and the Guide apply to all physical therapists. These guidelines are subject to change as the dynamics of the profession change, and as new patterns of health care delivery are developed and accepted by the professional community and the public.

Interpreting Ethical Principles

The interpretations expressed in this Guide reflect the opinions, decisions, and advice of the APTA Ethics and Judicial Committee (EJC). The interpretations are set forth according to topic. These interpretations are intended to assist a physical therapist in applying general ethical principles to specific situations. They address some but not all topics addressed in the principles and should not be considered inclusive of all situations that could evolve.

This Guide is subject to change, and the Ethics and Judicial Committee will monitor and revise the Guide to address additional topics and principles when and as needed.

Preamble to the Code of Ethics

The Preamble states as follows:

> The Code of Ethics for the Physical Therapist (Code of Ethics) delineates the ethical obligations of all physical therapists as determined by the House of Delegates of the American Physical Therapy Association (APTA). The purposes of this Code of Ethics are to:
>
> 1. Define the ethical principles that form the foundation of physical therapist practice in patient/client management, consultation, education, research, and administration.
> 2. Provide standards of behavior and performance that form the basis of professional accountability to the public.
> 3. Provide guidance for physical therapists facing ethical challenges, regardless of their professional roles and responsibilities. APTA Guide for Professional Conduct
> 4. Educate physical therapists, students, other health care professionals, regulators, and the public regarding the core values, ethical principles, and standards that guide the professional conduct of the physical therapist.
> 5. Establish the standards by which the American Physical Therapy Association can determine if a physical therapist has engaged in unethical conduct.

> No code of ethics is exhaustive nor can it address every situation. Physical therapists are encouraged to seek additional advice or consultation in instances where the guidance of the Code of Ethics may not be definitive.
>
> This Code of Ethics is built upon the five roles of the physical therapist (management of patients/clients, consultation, education, research, and administration), the core values of the profession, and the multiple realms of ethical action (individual, organizational, and societal). Physical therapist practice is guided by a set of seven core values: accountability, altruism, compassion/caring, excellence, integrity, professional duty, and social responsibility. Throughout the document the primary core values that support specific principles are indicated in parentheses. Unless a specific role is indicated in the principle, the duties and obligations being delineated pertain to the five roles of the physical therapist. Fundamental to the Code of Ethics is the special obligation of physical therapists to empower, educate, and enable those with impairments, activity limitations, participation restrictions, and disabilities to facilitate greater independence, health, wellness, and enhanced quality of life.

Interpretation: Upon the Code of Ethics for the Physical Therapist being amended effective July 1, 2010, all the lettered principles in the Code of Ethics contain the word "shall" and are mandatory ethical obligations. The language contained in the Code of Ethics is intended to better explain and further clarify existing ethical obligations. These ethical obligations predate the revised Code of Ethics. Although various words have changed, many of the obligations are the same. Consequently, the addition of the word "shall" reinforces and clarifies existing ethical obligations. A significant reason that the Code of Ethics was revised was to provide physical therapists with a document that was clear enough to be read on its own without the need to seek extensive additional interpretation.

The Preamble states that "[n]o Code of Ethics is exhaustive nor can it address every situation." The Preamble also states that physical therapists "are encouraged to seek additional advice or consultation in instances in which the guidance of the Code may not be definitive." Potential sources for advice and counsel include third parties and the myriad resources available on the APTA website. Inherent in a physical therapist's ethical decision-making process is the examination of his or her unique set of facts relative to the Code of Ethics. APTA Guide for Professional Conduct

Topics

Respect

Principle 1A states as follows:

> 1A. Physical therapists shall act in a respectful manner toward each person regardless of age, gender, race, nationality, religion, ethnicity, social or economic status, sexual orientation, health condition, or disability.
>
> Interpretation: Principle 1A addresses the display of respect toward others. Unfortunately, there is no universal consensus about what respect looks like in every situation. For example, direct eye contact is viewed as respectful and courteous in some cultures and inappropriate in others. It is up to the individual to assess the appropriateness of behavior in various situations.

Altruism

Principle 2A states as follows:

> 2A. Physical therapists shall adhere to the core values of the profession and shall act in the best interests of patients/clients over the interests of the physical therapist.
>
> Interpretation: Principle 2A reminds physical therapists to adhere to the profession's core values and act in the best interest of patients and clients over the interests of the physical therapist. Often this is done without thought, but, sometimes, especially at the end of the day when the physical therapist is fatigued and ready to go home, it is a conscious decision. For example, the physical therapist may need to make a decision between leaving on time and staying at work longer to see a patient who was 15 minutes late for an appointment.

Patient Autonomy

Principle 2C states as follows:

> 2C. Physical therapists shall provide the information necessary to allow patients or their surrogates to make informed decisions about physical therapy care or participation in clinical research.
>
> **Interpretation:** Principle 2C requires the physical therapist to respect patient autonomy. To do so, he or she shall communicate to the patient or client the findings of the physical therapist examination, evaluation, diagnosis, and prognosis. The physical therapist shall use sound professional judgment in informing the patient or client of any substantial risks of the recommended examination and intervention and shall collaborate with the individual to establish the goals of treatment and the plan of care. Ultimately, the physical therapist shall respect the individual's right to make decisions regarding the recommended plan of care, including consent, modification, or refusal.

Professional Judgment

Principles 3, 3A, and 3B state as follows:

> 3: Physical therapists shall be accountable for making sound professional judgments. (Core Values: Excellence, Integrity)
>
> 3A. Physical therapists shall demonstrate independent and objective professional judgment in the patient's/client's best interest in all practice settings.
>
> 3B. Physical therapists shall demonstrate professional judgment informed by professional standards, evidence (including current literature and established best practice), practitioner experience, and patient/client values.
>
> Interpretation: Principles 3, 3A, and 3B state that it is the physical therapist's obligation to exercise sound professional judgment, based upon his or her knowledge, skill, training, and

experience. Principle 3B further describes the physical therapist's judgment as being informed by 3 elements of evidence-based practice.

With regard to the patient and client management role, once a physical therapist accepts an individual for physical therapy services he or she shall be responsible for: the examination, evaluation, and diagnosis of that individual; the prognosis and intervention; reexamination and modification of the plan of care; and the maintenance of adequate records, including progress reports. The physical therapist shall establish the plan of care and shall provide and/or supervise and direct the appropriate interventions. Regardless of practice setting, the physical therapist has primary responsibility for the physical therapy care of a patient or client and shall make independent judgments regarding that care consistent with accepted professional standards.

If the diagnostic process reveals findings that are outside the scope of the physical therapist's knowledge, experience, or expertise or that indicate the need for care outside the scope of physical therapy, the physical therapist shall so inform the patient or client and shall refer the individual to an appropriate practitioner.

The physical therapist shall determine when a patient or client will no longer benefit from physical therapist services. When the physical therapist's judgment is that a patient will receive negligible benefit from physical therapist services, the physical therapist shall not provide or continue to provide such services if the primary reason for doing so is to further the financial self-interest of the physical therapist or his or her employer. The physical therapist shall avoid overutilization of physical therapist services. See Principle 8C.

Supervision

Principle 3E states as follows:

3E. Physical therapists shall provide appropriate direction of and communication with physical therapist assistants and support personnel.

Interpretation: Principle 3E describes an additional circumstance in which sound professional judgment is required; namely, through the appropriate direction of and communication with physical therapist assistants and support personnel. Further information on supervision via applicable local, state, and federal laws and regulations (including state practice acts and administrative codes) is available. Information on supervision via APTA policies and resources is also available on the APTA website. See Principles 5A and 5B.

Integrity in Relationships

Principle 4 states as follows:

4. Physical therapists shall demonstrate integrity in their relationships with patients/clients, families, colleagues, students, research participants, other health care providers, employers, payers, and the public. (Core Value: Integrity)

Interpretation: Principle 4 addresses the need for integrity in relationships. This is not limited to relationships with patients and clients but includes everyone physical therapists come into contact with professionally. For example, demonstrating integrity could encompass working collaboratively with the health care team and taking responsibility for one's role as a member of that team.

Reporting

Principle 4C states as follows:

4C. Physical therapists shall discourage misconduct by health care professionals and report illegal or unethical acts to the relevant authority, when appropriate.

Interpretation: Physical therapists shall seek to discourage misconduct by health care professionals. Discouraging misconduct can be accomplished through a number of mechanisms. The following is not an exhaustive list:

- Do not engage in misconduct; instead, set a good example for health care professionals and others working in their immediate environment.
- Encourage or recommend to the appropriate individuals that health care and other professionals, such as legal counsel, conduct regular (such as annual) training that addresses federal and state law requirements, such as billing, best practices, harassment, and security and privacy; as such training can educate health care professionals on what to do and not to do.
- Encourage or recommend to the appropriate individuals other types of training that are not law based, such as bystander training.
- Assist in creating a culture that is positive and civil to all.
- If in a management position, think about promotion and hiring decisions and how they can impact the organization.
- Access professional association resources when considering best practices.
- Revisit policies and procedures each year to remain current.

Many other mechanisms may exist to discourage misconduct. The physical therapist should be creative, open-minded, fair, and impartial in considering how to best meet this ethical obligation. Doing so can actively foster an environment in which misconduct does not occur. The main focus when thinking about misconduct is creating an action plan on prevention. Consider that reporting may never make the alleged victim whole or undo the misconduct.

If misconduct has not been prevented, then reporting issues must be considered. This ethical obligation states that the physical therapist reports to the "relevant authority, when appropriate." Before examining the meaning of these words it is important to note that reporting intersects with corporate policies and legal obligations. It is beyond the scope of this interpretation to provide legal advice regarding laws and policies; however, an analysis of reporting cannot end with understanding one's ethical obligations. One may need to seek advice of legal counsel who will take into consideration laws and policies and seek to discover the facts and circumstances.

With respect to ethical obligations, the term "when appropriate" is a fact-based decision and will be impacted by requirements of the law. If a law requires the physical therapist to take an action, then, of course, it is appropriate to do so. If there is no legal requirement and no corporate policy, then the physical therapist must consider what is appropriate given the facts and situation. It may not be appropriate if the physical therapist does not know what occurred, or because there is no legal requirement to act and the physical therapist does not want to assume legal responsibility, or because the matter is being resolved internally. There are many different reasons that something may or may not be appropriate.

If the physical therapist has determined that it is appropriate to report, the ethical obligation requires him or her to consider what entity or person is the "relevant authority." Relevant authority can be a supervisor, human resources, an attorney, the Equal Employment Opportunities Commission, the licensing board, the Better Business Bureau, Office of the Insurance Commissioner, the Medicare hotline, the Office of the Inspector General hotline, the US Department of Health & Human Services, an institution using their internal grievance procedures, the Office of Civil Rights, or another federal agency, state agency, city or local agency, or a state or federal court, among others.

Once the physical therapist has decided to report, he or she must be mindful that reporting does not end his or her involvement, which can include office, regulatory, and/or legal proceedings. In this context, the physical therapist may be asked to be a witness, to testify, or to provide written information.

Sexual Harassment

Principe 4F states as follows:

> 4F. Physical Therapists shall not harass anyone verbally, physically, emotionally, or sexually.

Interpretation: As noted in the House of Delegates policy titled Sexual Harassment, "[m]embers of the association have an obligation to comply with applicable legal prohibitions against sexual harassment…." This statement is in line with Principle 4F that prohibits physical therapists from harassing anyone verbally, physically, emotionally, or sexually. While the principle is clear, it is important for APTA to restate this point, namely that physical therapists shall not harass anyone, period. The association has zero tolerance for any form of harassment, specifically including sexual harassment.

Exploitation

Principle 4E states as follows:

> 4E. Physical therapists shall not engage in any sexual relationship with any of their patient/clients, supervisees or students.

Interpretation: The statement is clear—sexual relationships with their patients or clients, supervisees, or students are prohibited. This component of Principle 4 is consistent with Principle 4B, which states:

Physical therapists shall not exploit persons over whom they have supervisory, evaluative, or other authority (eg, patients and clients, students, supervisees, research participants, or employees).

Consider this excerpt from the EJC Opinion titled Topic: Sexual Relationships With Patients or Former Patients:

> A physical therapist stands in a relationship of trust to each patient and has an ethical obligation to act in the patient's best interest and to avoid any exploitation or abuse of the patient. Thus, if a physical therapist has natural feelings of attraction toward a patient, he or she must sublimate those feelings in order to avoid sexual exploitation of the patient.
>
> One's ethical decision making process should focus on whether the patient or client, supervisee, or student is being exploited. In this context, questions have been asked about whether one can have a sexual relationship once the patient or client relationship ends. To this question, the EJC has opined as follows:
>
> The Committee does not believe it feasible to establish any bright-line rule for when, if ever, initiation of a romantic/sexual relationship with a former patient would be ethically permissible.
>
> The Committee imagines that in some cases a romantic/sexual relationship would not offend…if initiated with a former patient soon after the termination of treatment, while in others such a relationship might never be appropriate.

Colleague Impairment

Principle 5D and 5E state as follows:

5D. Physical therapists shall encourage colleagues with physical, psychological, or substance-related impairments that may adversely impact their professional responsibilities to seek assistance or counsel.

5E. Physical therapists who have knowledge that a colleague is unable to perform their professional responsibilities with reasonable skill and safety shall report the information to the appropriate authority.

Interpretation: The central tenet of Principles 5D and 5E is that inaction is not an option for a physical therapist when faced with the circumstances described. Principle 5D states that a physical therapist shall encourage colleagues to seek assistance or counsel while Principle 5E addresses reporting information to the appropriate authority.

5D and 5E both require a factual determination. This may be challenging in the sense that the physical therapist might not know or easily be able to determine whether someone in fact has a physical, psychological, or substance-related impairment. In addition, it might be difficult to

determine whether such impairment may be adversely affecting his or her professional responsibilities.

Moreover, once the physical therapist does make these determinations, the obligation under 5D centers not on reporting, but on encouraging the colleague to seek assistance, while the obligation under 5E does focus on reporting. But note that 5E discusses reporting when a colleague is unable to perform; whereas, 5D discusses encouraging colleagues to seek assistance when the impairment may adversely affect their professional responsibilities. So, 5D discusses something that may be affecting performance, while 5E addresses a situation in which someone clearly is unable to perform. The 2 situations are distinct. In addition, it is important to note that 5E does not mandate to whom the physical therapist reports; it provides discretion to determine the appropriate authority.

The EJC Opinion titled: Topic: Preserving Confidences; Physical Therapist's Reporting Obligation With Respect to Unethical, Incompetent, or Illegal Acts provides further information on the complexities of reporting.

Professional Competence

Principle 6A states as follows:

6A. Physical therapists shall achieve and maintain professional competence.

Interpretation: 6A requires the physical therapist to maintain professional competence within his or her scope of practice throughout their career. Maintaining competence is an ongoing process of self-assessment, identification of strengths and weaknesses, acquisition of knowledge and skills based on that assessment, and reflection on and reassessment of performance, knowledge, and skills. Numerous factors including practice setting, types of patients and clients, personal interests, and the addition of new evidence to practice will influence the depth and breadth of professional competence in a given area of practice. Additional resources on continuing competence are available on the APTA website.

Professional Growth

Principle 6D states as follows:

6D. Physical therapists shall cultivate practice environments that support professional development, lifelong learning, and excellence.

Interpretation: 6D elaborates on the physical therapist's obligations to foster an environment conducive to professional growth, even when not supported by the organization. The essential idea is that this is the physical therapist's responsibility, whether or not the employer provides support.

Charges and Coding

Principle 7E states as follows:

> 7E. Physical therapists shall be aware of charges and shall ensure that documentation and coding for physical therapy services accurately reflect the nature and extent of the services provided.
>
> Interpretation: Principle 7E provides that the physical therapist must make sure that the process of documentation and coding accurately captures the charges for services performed. Additional resources on Documentation and Coding and Billing are available on the APTA website.

Pro Bono Services

Principle 8A states as follows:

> 8A. Physical therapists shall provide pro bono physical therapist services or support organizations that meet the health needs of people who are economically disadvantaged, uninsured, and underinsured.
>
> Interpretation: The key word in Principle 8A is "or." If a physical therapist is unable to provide pro bono services, then he or she can fulfill ethical obligations by supporting organizations that meet the health needs of people who are economically disadvantaged, uninsured, or underinsured. In addition, physical therapists may review the House of Delegates guidelines titled Guidelines: Pro Bono Physical Therapist Services and Organizational Support. Additional resources on pro bono physical therapist services are available on the APTA website.
>
> 8A also addresses supporting organizations to meet health needs. The principle does not specify the type of support that is required. Physical therapists may express support through volunteerism, financial contributions, advocacy, education, or simply promoting their work in conversations with colleagues.
>
> *Issued by the Ethics and Judicial Committee*
> *American Physical Therapy Association*
> *October 1981*
> *Last Amended March 2019*

Standards of Ethical Conduct for the Physical Therapist Assistant **HOD S06-19-47-68** [Amended HOD S06-09-20-18; HOD S06-00-13-24; HOD 06-91-06-07; Initial HOD 06- 82-04-08] [Standard]

Preamble

The Standards of Ethical Conduct for the Physical Therapist Assistant (Standards of Ethical Conduct) delineate the ethical obligations of all physical therapist assistants as determined by the House of Delegates of the American Physical Therapy Association (APTA). The Standards of Ethical Conduct provide a foundation for conduct to which all physical therapist assistants shall adhere. Fundamental to the Standards of Ethical Conduct is the special obligation of physical therapist assistants to enable patients and clients to achieve greater independence, health and wellness, and enhanced quality of life.
No document that delineates ethical standards can address every situation. Physical therapist assistants are encouraged to seek additional advice or consultation in instances where the guidance of the Standards of Ethical Conduct may not be definitive.

Standards

Standard #1: Physical therapist assistants shall respect the inherent dignity, and rights, of all individuals.

1A. Physical therapist assistants shall act in a respectful manner toward each person regardless of age, gender, race, nationality, religion, ethnicity, social or economic status, sexual orientation, health condition, or disability.
1B. Physical therapist assistants shall recognize their personal biases and shall not discriminate against others in the provision of physical therapist services.

Standard #2: Physical therapist assistants shall be trustworthy and compassionate in addressing the rights and needs of patients and clients.

2A. Physical therapist assistants shall act in the best interests of patients and clients over the interests of the physical therapist assistant.
2B. Physical therapist assistants shall provide physical therapist interventions with compassionate and caring behaviors that incorporate the individual and cultural differences of patients and clients.
2C. Physical therapist assistants shall provide patients and clients with information regarding the interventions they provide.
2D. Physical therapist assistants shall protect confidential patient and client information and, in collaboration with the physical therapist, may disclose confidential information to appropriate authorities only when allowed or as required by law.

Standard #3: Physical therapist assistants shall make sound decisions in collaboration with the physical therapist and within the boundaries established by laws and regulations.

3A. Physical therapist assistants shall make objective decisions in the patient's or client's best interest in all practice settings.
3B. Physical therapist assistants shall be guided by information about best practice regarding physical therapist interventions.
3C. Physical therapist assistants shall make decisions based upon their level of competence and consistent with patient and client values.

3D. Physical therapist assistants shall not engage in conflicts of interest that interfere with making sound decisions.
3E. Physical therapist assistants shall provide physical therapist services under the direction and supervision of a physical therapist and shall communicate with the physical therapist when patient or client status requires modifications to the established plan of care.

Standard #4: Physical therapist assistants shall demonstrate integrity in their relationships with patients and clients, families, colleagues, students, research participants, other health care providers, employers, payers, and the public.

4A. Physical therapist assistants shall provide truthful, accurate, and relevant information and shall not make misleading representations.
4B. Physical therapist assistants shall not exploit persons over whom they have supervisory, evaluative or other authority (e.g, patients and clients, students, supervisees, research participants, or employees).
4C. Physical therapist assistants shall not engage in any sexual relationship with any of their patients and clients, supervisees, or students.
4D. Physical therapist assistants shall not harass anyone verbally, physically, emotionally, or sexually.
4E. Physical therapist assistants shall discourage misconduct by physical therapists, physical therapist assistants, and other health care professionals and, when appropriate, report illegal or unethical acts, including verbal, physical, emotional, or sexual harassment, to an appropriate authority with jurisdiction over the conduct.
4F. Physical therapist assistants shall report suspected cases of abuse involving children or vulnerable adults to the appropriate authority, subject to law.

Standard #5: Physical therapist assistants shall fulfill their legal and ethical obligations.

5A. Physical therapist assistants shall comply with applicable local, state, and federal laws and regulations.
5B. Physical therapist assistants shall support the supervisory role of the physical therapist to ensure quality care and promote patient and client safety.
5C. Physical therapist assistants involved in research shall abide by accepted standards governing protection of research participants.
5D. Physical therapist assistants shall encourage colleagues with physical, psychological, or substance-related impairments that may adversely impact their professional responsibilities to seek assistance or counsel.
5E. Physical therapist assistants who have knowledge that a colleague is unable to perform their professional responsibilities with reasonable skill and safety shall report this information to the appropriate authority.

Standard #6: Physical therapist assistants shall enhance their competence through the lifelong acquisition and refinement of knowledge, skills, and abilities.

6A. Physical therapist assistants shall achieve and maintain clinical competence.
6B. Physical therapist assistants shall engage in lifelong learning consistent with changes in their roles and responsibilities and advances in the practice of physical therapy.
6C. Physical therapist assistants shall support practice environments that support career development and lifelong learning.

Standard #7: Physical therapist assistants shall support organizational behaviors and business practices that benefit patients and clients and society.

7A. Physical therapist assistants shall promote work environments that support ethical and accountable decision-making.
7B. Physical therapist assistants shall not accept gifts or other considerations that influence or give an appearance of influencing their decisions.
7C. Physical therapist assistants shall fully disclose any financial interest they have in products or services that they recommend to patients and clients.
7D. Physical therapist assistants shall ensure that documentation for their interventions accurately reflects the nature and extent of the services provided.
7E. Physical therapist assistants shall refrain from employment arrangements, or other arrangements, that prevent physical therapist assistants from fulfilling ethical obligations to patients and clients

Standard #8: Physical therapist assistants shall participate in efforts to meet the health needs of people locally, nationally, or globally.

8A. Physical therapist assistants shall support organizations that meet the health needs of people who are economically disadvantaged, uninsured, and underinsured.
8B. Physical therapist assistants shall advocate for people with impairments, activity limitations, participation restrictions, and disabilities in order to promote their participation in community and society.
8C. Physical therapist assistants shall be responsible stewards of health care resources by collaborating with physical therapists in order to avoid overutilization or underutilization of physical therapist services.
8D. Physical therapist assistants shall educate members of the public about the benefits of physical therapy.

Effective June 2019
For more information, go to www.apta.org/ethics.

APTA Guide for Conduct of the Physical Therapist Assistant

Purpose

The APTA Guide for Conduct of the Physical Therapist Assistant (Guide) is intended to serve physical therapist assistants in interpreting the Standards of Ethical Conduct for the Physical Therapist Assistant (Standards of Ethical Conduct) of the American Physical Therapy Association (APTA). The APTA House of Delegates in June of 2009 adopted the revised Standards of Ethical Conduct, which became effective July 1, 2010.

The Guide provides a framework by which physical therapist assistants may determine the propriety of their conduct. It also is intended to guide the development of physical therapist assistant students. The Standards of Ethical Conduct and the Guide apply to all physical therapist assistants. These guidelines are subject to change as the dynamics of the profession change and as new patterns of health care delivery are developed and accepted by the professional community and the public.

Interpreting the Standards of Ethical Conduct

The interpretations expressed in this Guide reflect the opinions, decisions, and advice of the Ethics and Judicial Committee (EJC). The interpretations are set forth according to topic. These interpretations are intended to assist a physical therapist assistant in applying general ethical standards to specific situations. They address some but not all topics addressed in the Standards of Ethical Conduct and should not be considered inclusive of all situations that could evolve.

This Guide is subject to change, and the Ethics and Judicial Committee will monitor and revise the Guide to address additional topics and standards when and as needed.

Preamble to the Standards of Ethical Conduct

The Preamble states as follows:

The Standards of Ethical Conduct for the Physical Therapist Assistant (Standards of Ethical Conduct) delineate the ethical obligations of all physical therapist assistants as determined by the House of Delegates of the American Physical Therapy Association (APTA). The Standards of Ethical Conduct provide a foundation for conduct to which all physical therapist assistants shall adhere. Fundamental to the Standards of Ethical Conduct is the special obligation of physical therapist assistants to enable patients/clients to achieve greater independence, health and wellness, and enhanced quality of life. No document that delineates ethical standards can address every situation. Physical therapist assistants are encouraged to seek advice or consultation in instances where the guidance of the Standards of Ethical Conduct may not be definitive.

Interpretation: Upon the Standards of Ethical Conduct for the Physical Therapist Assistant being amended effective July 1, 2010, all the lettered standards contain the word “shall” and are mandatory ethical obligations. The language contained in the Standards of Ethical Conduct is intended to better explain and further clarify existing ethical obligations. These ethical obligations predate the revised Standards of Ethical Conduct. Although various words have changed, many of the obligations are the same. Consequently, the addition of the word “shall” serves to reinforce and clarify existing ethical obligations. A significant reason that the Standards of Ethical Conduct were revised was to provide

physical therapist assistants with a document that was clear enough to be read on its own without the need to seek extensive additional interpretation.

The Preamble states that “[n]o document that delineates ethical standards can address every situation.” The Preamble also states that physical therapist assistants “are encouraged to seek additional advice or consultation in instances where the guidance of the Standards of Ethical Conduct may not be definitive.” Potential sources for advice or counsel include third parties and the myriad resources available on the APTA website. Inherent in a physical therapist assistant’s ethical decision-making process is the examination of his or her unique set of facts relative to the Standards of Ethical Conduct.

Topics

Respect

Standard 1A states as follows:

> 1A. Physical therapist assistants shall act in a respectful manner toward each person regardless of age, gender, race, nationality, religion, ethnicity, social or economic status, sexual orientation, health condition, or disability.

Interpretation: Standard 1A addresses the display of respect toward others. Unfortunately, there is no universal consensus about what respect looks like in every situation. For example, direct eye contact is viewed as respectful and courteous in some cultures and inappropriate in others. It is up to the individual to assess the appropriateness of behavior in various situations.

Altruism

Standard 2A states as follows:

> 2A. Physical therapist assistants shall act in the best interests of patients/clients over the interests of the physical therapist assistant.

Interpretation: Standard 2A addresses acting in the best interest of patients and clients over the interests of the physical therapist assistant. Often this is done without thought, but, sometimes, especially at the end of the day when the clinician is fatigued and ready to go home, it is a conscious decision. For example, the physical therapist assistant may need to make a decision between leaving on time and staying at work longer to see a patient who was 15 minutes late for an appointment.

Sound Decisions

Standard 3C states as follows:

> 3C. Physical therapist assistants shall make decisions based upon their level of competence and consistent with patient/client values.

Interpretation: To fulfill 3C, the physical therapist assistant must be knowledgeable about his or her legal scope of work as well as level of competence. As a physical therapist assistant gains experience and additional knowledge, there may be areas of physical therapy interventions in which he or she displays advanced skills. At the same time, other previously gained knowledge and skill may be lost due to lack of

use. To make sound decisions, the physical therapist assistant must be able to self-reflect on his or her current level of competence.

Supervision

Standard 3E states as follows:

> 3E. Physical therapist assistants shall provide physical therapy services under the direction and supervision of a physical therapist and shall communicate with the physical therapist when patient/client status requires modifications to the established plan of care.

Interpretation: Standard 3E goes beyond simply stating that the physical therapist assistant operates under the supervision of the physical therapist. Although a physical therapist retains responsibility for the patient or client throughout the episode of care, this standard requires the physical therapist assistant to take action by communicating with the supervising physical therapist when changes in the individual's status indicate that modifications to the plan of care may be needed. Further information on supervision via APTA policies and resources is available on the APTA website.

Integrity in Relationships

Standard 4 states as follows:

> 4. Physical therapist assistants shall demonstrate integrity in their relationships with patients/clients, families, colleagues, students, other health care providers, employers, payers, and the public.

Interpretation: Standard 4 addresses the need for integrity in relationships. This is not limited to relationships with patients and clients but includes everyone physical therapist assistants come into contact with in the normal provision of physical therapist services. For example, demonstrating integrity could encompass working collaboratively with the health care team and taking responsibility for one's role as a member of that team.

Reporting

Standard 4C states as follows:

> 4C. Physical therapist assistants shall discourage misconduct by health care professionals and report illegal or unethical acts to the relevant authority, when appropriate.

Interpretation: Physical therapist assistants shall seek to discourage misconduct by health care professionals. Discouraging misconduct can be accomplished through a number of mechanisms. The following is not an exhaustive list:

- Do not engage in misconduct; instead, set a good example for health care professionals and others working in their immediate environment.
- Encourage or recommend to the appropriate individuals that health care and other professionals, such as legal counsel, conduct regular (such as annual) training that addresses federal and state law requirements, such as billing, best practices, harassment, and security and privacy; as such training can educate health care professionals on what to do and not to do.
- Encourage or recommend to the appropriate individuals other types of training that are

not law based, such as bystander training.
- Assist in creating a culture that is positive and civil to all.
- If in a management position, consider how promotion and hiring decisions can impact the organization.
- Access professional association resources when considering best practices.
- Revisit policies and procedures each year to remain current.

Many other mechanisms may exist to discourage misconduct. The physical therapist assistant should be creative, open-minded, fair, and impartial in considering how to best meet this ethical obligation. Doing so can actively foster an environment in which misconduct does not occur. The main focus when thinking about misconduct is creating an action plan on prevention. Consider that reporting may never make the alleged victim whole or undo the misconduct.

If misconduct has not been prevented, then reporting issues must be considered. This ethical obligation states that the physical therapist assistant reports to the "relevant authority, when appropriate." Before examining the meaning of these words it is important to note that reporting intersects with corporate policies and legal obligations. It is beyond the scope of this interpretation to provide legal advice regarding laws and policies; however, an analysis of reporting cannot end with understanding one's ethical obligations. One may need to seek advice of legal counsel who will take into consideration laws and policies and seek to discover the facts and circumstances.

With respect to ethical obligations, the term "when appropriate" is a fact-based decision and will be impacted by requirements of the law. If a law requires the physical therapist assistant to take an action, then, of course, it is appropriate to do so. If there is no legal requirement and no corporate policy, then the physical therapist assistant must consider what is appropriate given the facts and situation. It may not be appropriate if the physical therapist does not know what occurred, or because there is no legal requirement to act and the physical therapist assistant does not want to assume legal responsibility, or because the matter is being resolved internally. There are many different reasons that something may or may not be appropriate.

If the physical therapist assistant has determined that it is appropriate to report, the ethical obligation requires him or her to consider what entity or person is the "relevant authority." Relevant authority can be a supervisor, human resources, an attorney, the Equal Employment Opportunities Commission, the licensing board, the Better Business Bureau, Office of the Insurance Commissioner, the Medicare hotline, the Office of the Inspector General hotline, the US Department of Health and Human Services, an institution using their internal grievance procedures, the Office of Civil Rights, or another federal, state, city, or local agency, or a state or federal court, among others.

Once the physical therapist assistant has decided to report, he or she must be mindful that reporting does not end his or her involvement, which can include office, regulatory, and/or legal proceedings. In this context, the physical therapist assistant may be asked to be a witness, to testify, or to provide written information.

Sexual Harassment

Standard 4F states as follows:

> 4F. Physical therapist assistants shall not harass anyone verbally, physically, emotionally, or sexually.

Interpretation: As noted in the House of Delegates policy titled "Sexual Harassment," "[m]embers of the association have an obligation to comply with applicable legal prohibitions against sexual harassment…." This statement is in line with Standard 4F that prohibits physical therapist assistants from harassing anyone verbally, physically, emotionally, or sexually. While the standard is clear, it is important for APTA to restate this point, namely that physical therapist assistants shall not harass anyone, period. The association has zero tolerance for any form of harassment, specifically including sexual harassment.

Exploitation

Standard 4E states as follows:

> 4E. Physical therapist assistants shall not engage in any sexual relationship with any of their patients/clients, supervisees, or students.

Interpretation: The statement is clear—sexual relationships with their patients or clients, supervisees, or students are prohibited. This component of Standard 4 is consistent with Standard 4B, which states:

> 4B. Physical therapist assistants shall not exploit persons over whom they have supervisory, evaluative, or other authority (eg, patients and clients, students, supervisees, research participants, or employees).
>
> Consider this excerpt from the EJC Opinion titled Topic: Sexual Relationships With Patients or Former Patients (modified for physical therapist assistants):
>
> A physical therapist [assistant] stands in a relationship of trust to each patient and has an ethical obligation to act in the patient's best interest and to avoid any exploitation or abuse of the patient. Thus, if a physical therapist [assistant] has natural feelings of attraction toward a patient, he or she must sublimate those feelings in order to avoid sexual exploitation of the patient.
>
> One's ethical decision making process should focus on whether the patient or client, supervisee, or student is being exploited. In this context, questions have been asked about whether one can have a sexual relationship once the patient or client relationship ends. To this question, the EJC has opined as follows:
>
> The Committee does not believe it feasible to establish any bright-line rule for when, if ever, initiation of a romantic/sexual relationship with a former patient would be ethically permissible.
>
> The Committee imagines that in some cases a romantic/sexual relationship would not offend ... if initiated with a former patient soon after the termination of treatment, while in others such a relationship might never be appropriate.

Colleague Impairment

Standard 5D and 5E state as follows:

> 5D. Physical therapist assistants shall encourage colleagues with physical, psychological, or substance-related impairments that may adversely impact their professional responsibilities to seek assistance or counsel.

> 5E. Physical therapist assistants who have knowledge that a colleague is unable to perform their professional responsibilities with reasonable skill and safety shall report this information to the appropriate authority.

Interpretation: The central tenet of Standard 5D and 5E is that inaction is not an option for a physical therapist assistant when faced with the circumstances described. Standard 5D states that a physical therapist assistant shall encourage colleagues to seek assistance or counsel while Standard 5E addresses reporting information to the appropriate authority.

5D and 5E both require a factual determination on the physical therapist assistant's part. This may be challenging in the sense that the physical therapist assistant might not know or easily be able to determine whether someone in fact has a physical, psychological, or substance-related impairment. In addition, it might be difficult to determine whether such impairment may be adversely affecting someone's work responsibilities.

Moreover, once the physical therapist assistant does make these determinations, the obligation under 5D centers not on reporting, but on encouraging the colleague to seek assistance, while the obligation under 5E does focus on reporting. But note that 5E discusses reporting when a colleague is unable to perform; whereas, 5D discusses encouraging colleagues to seek assistance when the impairment may adversely affect their professional responsibilities. So, 5D discusses something that may be affecting performance, whereas 5E addresses a situation in which someone clearly is unable to perform. The 2 situations are distinct. In addition, it is important to note that 5E does not mandate to whom the physical therapist assistant reports; it provides discretion to determine the appropriate authority.

The EJC Opinion titled Topic: Preserving Confidences; Physical Therapist's Reporting Obligation With Respect to Unethical, Incompetent, or Illegal Acts provides further information on the complexities of reporting.

Clinical Competence

Standard 6A states as follows:

> 6A. Physical therapist assistants shall achieve and maintain clinical competence.

Interpretation: 6A should cause physical therapist assistants to reflect on their current level of clinical competence, to identify and address gaps in clinical competence, and to commit to the maintenance of clinical competence throughout their career. The supervising physical therapist can be a valuable partner in identifying areas of knowledge and skill that the physical therapist assistant needs for clinical competence and to meet the needs of the individual physical therapist, which may vary according to areas of interest and expertise. Further, the physical therapist assistant may request that the physical therapist serve as a mentor to assist him or her in acquiring the needed knowledge and skills. Additional resources on Continuing Competence are available on the APTA website.

Lifelong Learning

Standard 6C states as follows:

> 6C. Physical therapist assistants shall support practice environments that support career development and lifelong learning.

Interpretation: 6C points out the physical therapist assistant's obligation to support an environment conducive to career development and learning. The essential idea here is that the physical therapist assistant encourages and contributes to his or her career development and lifelong learning, whether or not the employer provides support.

Organizational and Business Practices

Standard 7 states as follows:

> 7. Physical therapist assistants shall support organizational behaviors and business practices that benefit patients/clients and society.

Interpretation: Standard 7 reflects a shift in the Standards of Ethical Conduct. One criticism of the former version was that it addressed primarily face-to-face clinical practice settings. Accordingly, Standard 7 addresses ethical obligations in organizational and business practices on both patient and client and societal levels.

Documenting Interventions

Standard 7D states as follows:

> 7D. Physical therapist assistants shall ensure that documentation for their interventions accurately reflects the nature and extent of the services provided.

Interpretation: 7D addresses the need for physical therapist assistants to make sure that they thoroughly and accurately document the interventions they provide to patients and clients and document related data collected from the patient or client. The focus of this Standard is on ensuring documentation of the services rendered, including the nature and extent of such services.

Support - Health Needs

Standard 8A states as follows:

> 8A. Physical therapist assistants shall support organizations that meet the health needs of people who are economically disadvantaged, uninsured, and underinsured.

Interpretation: 8A addresses the issue of support for those least likely to be able to afford physical therapist services. The standard does not specify the type of support that is required. Physical therapist assistants may express support through volunteerism, financial contributions, advocacy, education, or simply promoting their work in conversations with colleagues. When providing such services, including *pro bono* services, physical therapist assistants must comply with applicable laws, and as such work under the direction and supervision of a physical therapist. Additional resources on *pro bono* services are available on the APTA website.

Issued by the Ethics and Judicial Committee
American Physical Therapy Association
October 1981
Last Amended March 20

LOMA LINDA UNIVERSITY SCHOOL OF ALLIED HEALTH PROFESSIONS
Department of Physical Therapy PTA & DPT Programs
Professional Appearance Standards

Students in the program are expected to present an appearance consistent with the highest professional standards in healthcare and with the mission and philosophy of Loma Linda University. These standards apply during scheduled school hours in classrooms, laboratories, chapel, and in all facilities used for physical therapy education purposes, including clinics and off-campus assignments. Clinical sites affiliating with Loma Linda University may prescribe additional codes of dress for students in training. Alternate dress codes during laboratory sessions will be outlined by the course instructors.

In essence, a professional appearance is defined as modest, neat, clean, and conservative in style.

- Men
    - Dress slacks or long pants such as chinos or khakis
    - Shirts: neatly pressed and with collars
    - Scrub sets may be worn as an alternative (see below)
- Women
    - Dresses/skirts must approximate or fall below the knees
    - Dress slacks or long pants such as chinos or khakis
    - Blouses/tops: modesty required; no exposed mid-riffs, low-cut necklines and skin-tight clothing
    - Scrub sets may be worn as an alternative (see below)
- Scrub sets for men or women
    - Scrubs must be neat, clean and in a solid color
    - Scrub top and pants must be the same color
    - A black polo shirt with departmental logo may be paired with scrub pants
    - A plain T-shirt (long or short-sleeved) with a crew or V-neck may be worn under the scrub top and must be tucked in at the waist.
- Shoes: clean, good condition; no flip-flops

- The following items are considered inappropriate for professional attire:
    - T-shirts worn as outer garments
    - Visible undergarments
    - Denim clothing of any color
    - Shorts
    - Halter tops, tank tops, midriffs, or "spaghetti" straps
    - Sweat pants, leggings (aka: yoga pants)
    - Hats, caps, beanies, or hoods of sweatshirts worn indoors
- Extreme hairstyles are not acceptable for men or women:
    - Men: Hair must be clean, neat, and not fall below the collar. Mustaches and beards must be closely trimmed. Women: Hair must be clean, neat; long hair may need to be tied back.

- Jewelry, if worn, must be conservative. Rings, if worn, should be low-profile and limited to one finger per hand. Ear ornaments, if worn by women, are limited to simple studs in the earlobe, one per ear, and should not drop below the bottom of the earlobe. Men may not wear ear ornaments. Rings or ornaments in other anatomical sites are not acceptable.

- Nails must be closely trimmed. Nail polish, if worn, should be a subdued tone.

- Excessive makeup and strong fragrances are not appropriate.

- Any display of words, pictures, and symbols must be consistent with Christian principles and be sensitive to others' views. If found offensive, tattoos must remain covered while in program, at the discretion of faculty.

I have read the Professional Appearance Standards and I agree to observe them.
Student Signature ____Date _______________ ***Revised 2018-12-12***

Procedure for Evaluating An Individual's Fitness For Duty And Accommodating An Individual's Clinical Assignment.

Evaluation of an individual's fitness for duty will be performed by the clinical coordinator in the following areas:

A. Competence
    1. Medical condition resulting in incompetence
    2. Emotional instability to perform assigned tasks

B. Ability to perform routine duties
    1. Inability to perform regular duties, assuming "reasonable accommodations" have been offered for the disability
    2. Susceptible to varicella zoster virus, rubella or measles

C. Compliance with established guidelines and procedures
    1. Refusal to follow guidelines
    2. Unable to comprehend guidelines

The clinical coordinator makes accommodations for a student from a clinical experience perspective on a case-by-case basis. Decisions for exemption for more than one clinical session will be made in consultation with the student's physician and appropriate University faculty/administrators, including the chairperson of the University Communicable Disease and AIDS Committee. The following conditions require consideration when assigning a student to clients with communicable disease.

A. Confirmed pregnancy
    1. The risk of transmission of HIV infection to pregnant health care workers is not known to be greater than the risk to those not pregnant.
    2. The risk of transmission of other pathogens such as cytomegalovirus from clients with AIDS to pregnant health care workers is unknown but is thought to be low to nonexistent.
    3. If, however, due to personal concerns related to protection of the fetus, pregnant students, in consultation with the clinical coordinator, may be excluded by caring for clients infected with known communicable diseases or blood borne pathogens.

B. Incompetent Immunological Systems

    Students with diagnosed immunological deficiencies are at an increased risk for developing opportunistic infections. In consultation with the clinical coordinator, these students may request exclusion from caring for clients with known communicable diseases or blood-borne pathogens.

C. Infections

    Any student with a communicable infectious process could further compromise an already incompetent immunological system, such as a client who is neutrophic from chemotherapy, an AIDS client, or other immune-compromised client; thus, a student may, in consultation with the clinical coordinator, request a change in assignment.

From the School of Allied Health Professions Policy Handbook, p. 5 and 6.

Loma Linda University

Department of Risk Management

Loma Linda, California 92350
(909) 558-4386
FAX: (909) 558-4775

To Whom It May Concern:

RE: Student Health Plan & Risk Management Programs

The purpose of this letter is to outline and clarify the protection afforded to students and/or employees under the various insurance and risk management programs in effect at Loma Linda University. All coverage descriptions are subject to the limits of liability, exclusions, conditions, and other terms of the actual insurance or self-insurance program in effect.

Professional Liability – The primary professional liability exposures at Loma Linda University are funded through a self-insurance trust program established at Bank of America, Chicago, Illinois. Excess coverage is provided through University Insurance Company of Vermont, policy number XS-1014. Professional liability coverage applies to both employees and students. Employees are only covered while functioning within the course and scope of their duties as employees of Loma Linda University. Students are covered while enrolled in a formal training program offered by Loma Linda University, but only for such student's legal liability resulting from the performance of or failure to perform duties relating to the training program.

Student Health Plan – All full time students at Loma Linda University enrolled in any regular educational program are covered by the Student Health Plan. This program provides accident and sickness benefits while enrolled. Coverage under the Student Health Plan also applies to any student while participating in clinical rotations sponsored by Loma Linda University.

Workers' Compensation – In accordance with the California State Labor Code, Loma Linda University is self-insured for the Workers' Compensation exposures of its *employees*. Loma Linda has been granted a Certificate of Consent to Self-Insure, #1095, by the Department of Industrial Relations of the State of California, and provides statutory workers' compensation benefits to all *employees* who sustain job-related injuries or illnesses. Benefits under this program include all necessary medical care, temporary disability benefits, and long-term benefits in accordance with the State Labor Code. Students are generally not considered employees for purposes of workers' compensation coverage.

Sincerely,

Raul E. Castillo
Risk Manager

(updated 06/06/05)

Theresa Joseph, P.T, DPT, MBA, NCS, CCM
Director of Clinical Education,
Entry-Level DPT Program,
(909) 558-7744, fax: (909)558-0459;
tjoseph@llu.edu

School of Allied Health Professions, Loma Linda University
Physical Therapy Program

Memo

TO: PT Student

FROM: Theresa Joseph

CC:

Date: 07/2023

Re: Risk management and student health

Contact for Risk Management is (909) 558-1000 ext. 58113

If you should need medical attention while away from campus on a clinical rotation contact the representative, James Mendez, at that number for insurance approval. Provide him with receipts for services rendered.

Student Health contact is (909) 558-1000 ext. 88770

The DCE must also be notified of all illnesses which necessitate absences from the clinic or visits to the doctor.

Loma Linda University Health

Anti-Discrimination & Sexual Misconduct Title IX

"Loma Linda University and its affiliated educational sites adheres to all federal, state, and local civil rights laws prohibiting discrimination and harassment in employment and education…" See link for more https://llu.edu/about-llu/policies/sex-discrimination-sexual-misconduct-title-ix

Loma Linda University
Department of Physical Therapy
Physical Therapist Program

Identification and Supervision of Physical Therapist Students

The faculty of the DPT Program at Loma Linda University have formalized the policy regarding requirements of supervision and documentation for our students which reflects both legal and ethical mandates. A description of what constitutes legal supervision is excerpted below from the "California Code of Regulations".

16 CCR § 1398.37

§ 1398.37. Identification and Supervision of Physical Therapist Students Defined.

(a) When rendering physical therapy services as part of academic training, a physical therapy student shall only be identified as a "physical therapist student." When rendering physical therapy services, the required identification shall be clearly visible and include his or her name and working title in at least 18-point type.

(b) The "clinical instructor" or the "supervisor" shall be the physical therapist supervising the physical therapist student while practicing physical therapy.

(c) The supervising physical therapist shall provide on-site supervision of the assigned patient care rendered by the physical therapist student.

(d) The physical therapist student shall document each treatment in the patient record, along with his or her signature. The clinical instructor or supervising physical therapist shall countersign with his or her first initial and last name all entries in the patient's record on the same day as patient related tasks were provided by the physical therapist student.

Note: Authority cited: Section 2615, Business and Professions Code. Reference: Section 2633.7, Business and Professions Code.

HISTORY

1. New section filed 4-16-79; effective thirtieth day thereafter (Register 79, No. 16).

2. Amendment filed 6-29-83; effective thirtieth day thereafter (Register 83, No. 27).

3. Amendment of section heading, section and Note filed 12-23-2002; operative 1-22-2003 (Register 2002, No. 52).

4. Change without regulatory effect amending section heading, section and Note filed 9-21-2015 pursuant to section 100, title 1, California Code of Regulations (Register 2015, No. 39).

5. Change without regulatory effect amending Note filed 7-6-2017 pursuant to section 100, title 1, California Code of Regulations (Register 2017, No. 27).

This database is current through 5/24/19 Register 2019, No. 21
16 CCR § 1398.37, 16 CA ADC § 1398.37

Loma Linda University
Department of Physical Therapy
Physical Therapist Assistant Program

Identification and Supervision of Physical Therapist Assistant Students

The faculty of the Physical Therapist Assistant Program at Loma Linda University have formalized the policy regarding requirements of supervision and documentation for our students which reflects both legal and ethical mandates. A description of what constitutes legal supervision is excerpted below form “California Code of Regulations”.

16 CCR § 1398.52

§ 1398.52. Identification and Supervision of Physical Therapist Assistant Students Defined.

(a) A physical therapist assistant student is an unlicensed person rendering physical therapy services as part of academic training pursuant to section 2650.1 of the Code and shall only be identified as a “physical therapist assistant student.” When rendering physical therapy services, the required identification shall be clearly visible and include his or her name and working title in at least 18-point type.

(b) The physical therapist assistant student shall be supervised by a physical therapist supervisor. A physical therapist assistant under the supervision of a physical therapist supervisor may perform as a clinical instructor of the physical therapist assistant student when rendering physical therapy services.

(c) A physical therapist supervisor shall provide on-site supervision of the assigned patient care rendered by the physical therapist assistant student.

(d) The physical therapist assistant student shall document each treatment in the patient record, along with his or her signature. The clinical instructor shall countersign with his or her first initial and last name in the patient's record on the same day as patient related tasks were provided by the physical therapist assistant student. The supervising physical therapist shall conduct a weekly case conference and document it in the patient record.

Note: Authority cited: Section 2615, Business and Professions Code. Reference: Section 2633.7, Business and Professions Code.

HISTORY

1. New section filed 12-23-2002; operative 1-22-2003 (Register 2002, No. 52).

2. Change without regulatory effect amending section heading, section and Note filed 9-21-2015 pursuant to section 100, title 1, California Code of Regulations (Register 2015, No. 39).

3. Change without regulatory effect amending Note filed 7-6-2017 pursuant to section 100, title 1, California Code of Regulations (Register 2017, No. 27).

This database is current through 5/24/19 Register 2019, No. 21

16 CCR § 1398.52, 16 CA ADC § 1398.52

Essential Functions
Doctor of Physical Therapy Program
Department of Physical Therapy
School of Allied Health Professions
Loma Linda University

Based on the philosophy of the Department of Physical Therapy in the School of Allied Health Professions, the intent of the professional program is to educate competent generalist physical therapists who can evaluate, manage, and treat the general population of acute and rehabilitation clients in current health care settings. Enrolled students are expected to complete the academic and clinical requirements of the professional DPT program.

The following "essential functions" specify those attributes that the faculty consider necessary for completing the professional education enabling each graduate to subsequently enter clinical practice. The Department of Physical Therapy, School of Allied Health Professions will consider for admission any qualified applicant who demonstrates the ability to perform or to learn to perform the "essential functions" specified in this document. Applicants are not required to disclose the nature of any disability(ies) to the physical therapy department; however, any applicant with questions about these "essential functions" is strongly encouraged to discuss the issue with the program director prior to the interview process. If appropriate, and upon the request of the applicant/student, reasonable accommodations may be provided.

Certain chronic or recurrent illnesses and problems that interfere with patient care or safety may be incompatible with physical therapy training or clinical practice. Other illnesses may lead to a high likelihood of student absenteeism and should be carefully considered. Deficiencies in knowledge, judgment, integrity, character, or professional attitude or demeanor which may jeopardize patient care may be grounds for course/rotation failure and possible dismissal from the program.

The purpose of this document is to delineate the cognitive, affective and psychomotor skills deemed essential for completion of this program and to perform as a competent generalist physical therapist.

ESSENTIAL FUNCTIONS REQUIRED TO GRADUATE AS A PHYSICAL THERAPIST
Students are required to apply essential functions to all patients without bias

Cognitive Learning Skills
The student must demonstrate the ability to:
1. Receive, interpret, remember, reproduce and use information in the cognitive, psychomotor, and affective domains of learning to solve problems, evaluate work, and generate new ways of processing or categorizing similar information listed in course objectives.
2. Perform a physical therapy evaluation of a patient's posture and movement including analysis of physiological, biomechanical, behavioral, and environmental factors in a timely manner, consistent with the acceptable norms of clinical settings.
3. Use evaluation data to formulate and execute a plan of physical therapy management in a timely manner, appropriate to the problems identified consistent with acceptable norms of clinical settings.
4. Reassess and revise plans as needed for effective and efficient management of physical therapy problems, in a timely manner and consistent with the acceptable norms of clinical settings.

Psychomotor Skills

The student must demonstrate the following skills.

1. Locomotion ability to:
   1. Get to lecture, lab and clinical locations, and move within rooms as needed for changing groups, partners and work stations.
   2. Physically maneuver in required clinical settings, to accomplish assigned tasks.
   3. Move quickly in an emergency situation to protect the patient (eg. from falling).
2. Manual tasks:
   1. Maneuver another person's body parts to effectively perform evaluation techniques.
   2. Manipulate common tools used for screening tests of the cranial nerves, sensation, range of motion, blood pressure, e.g., cotton balls, safety pins, goniometers, Q-tips, sphygmomanometer.
   3. Safely and effectively guide, facilitate, inhibit, and resist movement and motor patterns through physical facilitation and inhibition techniques (including ability to give time urgent verbal feedback).
   4. Manipulate another person's body in transfers, gait, positioning, exercise, and mobilization techniques. (Lifting weights between 10-100+ lbs)
   5. Manipulate evaluation and treatment equipment safely and accurately apply to clients.
   6. Manipulate bolsters, pillows, plinths, mats, gait assistive devices, and other supports or chairs to aid in positioning, moving, or treating a patient effectively. (Lifting, pushing/pulling weights between 10-100 lbs)
   7. Competently perform and supervise cardiopulmonary resuscitation (C.P.R.) Using guidelines issued by the American Heart Association or the American Red Cross.
3. Small motor/hand skills:
   1. Legibly record thoughts for written assignments and tests.
   2. Legibly record/document evaluations, patient care notes, referrals, etc. in standard medical charts in hospital/clinical settings in a timely manner and consistent with the acceptable norms of clinical settings.
   3. Detect changes in an individual's muscle tone, skin quality, joint play, kinesthesia, and temperature to gather accurate objective evaluative information in a timely manner and sense that individual's response to environmental changes and treatment.
   4. Safely apply and adjust the dials or controls of therapeutic modalities
   5. Safely and effectively position hands and apply mobilization techniques
   6. Use a telephone
4. Visual acuity to:
   1. Read written and illustrated material in the English language, in the form of lecture handouts, textbooks, literature and patient's chart.
   2. Observe active demonstrations in the classroom.
   3. Visualize training videos, projected slides/overheads, X-ray pictures, and notes written on a blackboard/whiteboard.
   4. Receive visual information from clients, e.g., movement, posture, body mechanics, and gait necessary for comparison to normal standards for purposes of evaluation of movement dysfunctions.
   5. Receive visual information from treatment environment, e.g., dials on modalities and monitors, assistive devices, furniture, flooring, structures, etc.
   6. Receive visual clues as to the patient's tolerance of the intervention procedures. These may include facial grimaces, muscle twitching, withdrawal etc.

5. Auditory acuity to:
    1. Hear lectures and discussion in an academic and clinical setting.
    2. Distinguish between normal and abnormal breathing, lung and heart sounds using a stethoscope.
6. Communication:
    1. Effectively communicate information and safety concerns with other students, teachers, patients, peers, staff and personnel by asking questions, giving information, explaining conditions and procedures, or teaching home programs. These all need to be done in a timely manner and within the acceptable norms of academic and clinical settings.
    2. Receive and interpret written communication in both academic and clinical settings in a timely manner.
    3. Receive and send verbal communication in life threatening situations in a timely manner within the acceptable norms of clinical settings.
    4. Physical Therapy education presents exceptional challenges in the volume and breadth of required reading and the necessity to impart information to others. Students must be able to communicate quickly, effectively and efficiently in oral and written English with all members of the health care team.
7. Self care:
    1. Maintain general good health and self care in order to not jeopardize the health and safety of self and individuals with whom one interacts in the academic and clinical settings.
    2. Arrange transportation and living accommodations to foster timely reporting to the classroom and clinical assignments.

Affective learning skills

The student must be able to:

1. Demonstrate respect to all people, including students, teachers, patients and medical personnel, without showing bias or preference on the grounds of age, race, gender, sexual preference, disease, mental status, lifestyle, opinions or personal values.
2. Demonstrate appropriate affective behaviors and mental attitudes in order not to jeopardize the emotional, physical, mental, and behavioral safety of clients and other individuals with whom one interacts in the academic and clinical settings and to be in compliance with the ethical standards of the American Physical Therapy Association.
3. Sustain the mental and emotional rigors of a demanding educational program in physical therapy which includes academic and clinical components that occur within set time constraints, and often concurrently.
4. Acknowledge and respect individual values and opinions in order to foster harmonious working relationships with colleagues, peers, and patients/clients.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C5-15-12
Baltimore, Maryland 21244-1850

December 20, 2019

Sharmila Sandhu	Kara Gainer	Sarah Warren
AOTA	APTA	ASHA
Director	Director	Director
Regulatory Affairs	Regulatory Affairs	Health Care Policy

Dear Ms. Sandhu, Ms. Gainer, and Ms. Warren:

We wanted to thank each of you and each of your respective organizations' representatives for meeting with us at the Centers for Medicare & Medicaid Services (CMS) on December 11, 2018, and for explaining your concerns regarding the hospital Conditions of Participation (CoPs), CMS Inpatient Rehabilitation Facility (IRF) payment and coverage policies, and the provision of rehabilitative services to patients by therapy students in hospitals (including IRFs).

As you stated in your letter and at the meeting, hospitals and IRFs provide critical training grounds for the future therapy workforce and these settings offer unique opportunities for students to see diverse patients and respond to various clinical challenges. We agree with this view and believe that practical clinical training in hospitals is essential for educating and providing not only future therapists, but also future physicians, nurses, pharmacists, advanced practice providers, and other professionals responsible for providing quality patient care. Therefore, to clarify our position on this subject, CMS has not changed its policy with regard to the CoPs and the provision of healthcare services by students in hospitals, including therapy students providing rehabilitative services in hospitals and IRFs.

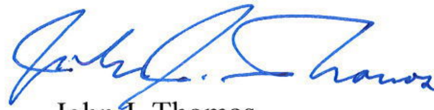
Regarding the Medicare hospital CoPs, and specifically the Rehabilitation Services CoP at 42 CFR 482.56, no requirements or interpretive guidance exist that prohibit students (including, but not limited to, therapy students, medical students, nursing students, and other allied health students) from providing patient care services as part of their respective training programs. Under §482.56, the director of a hospital's rehabilitation services "must have the necessary knowledge, experience, and capabilities to properly supervise and administer the services" and must ensure that the services are "organized and staffed to ensure the health and safety of patients." The director's responsibilities would extend to all therapy students providing services to patients in the hospital as part of their training program.

Regarding the IRF intensive rehabilitation therapy program requirement in 42 CFR 412.622(a)(3)(ii), CMS's current policy does not prohibit the therapy services furnished by a therapy student under the appropriate supervision of a qualified therapist or therapy assistant from counting toward the intensive rehabilitation therapy program. However, IRFs provide a very intensive hospital level of rehabilitation therapy to some of the most vulnerable patients. To ensure the health and safety of this vulnerable population, CMS expects that all student therapy services will be provided by students under the supervision of a licensed therapist allowed by the hospital to provide such services.

Additionally, the CoPs at §§482.11, 482.12, and 482.22 hold the hospital responsible for the health and safety of patients through compliance with all federal, state, and local laws related to the health and safety of patients; ensuring that the medical staff is accountable to the governing body for the quality of care provided to patients; and having an organized medical staff that is responsible for the quality of medical care provided to patients by the hospital. By extension, any students providing services and care to patients within the hospital as part of a training program, their supervisory faculty, and any hospital staff acting as student preceptors would be subject to these levels of oversight within the hospital's organizational structure as well as any standards and requirements established by their respective training programs and by national organizations such as yours.

Sincerely,

Laurence D. Wilson
Director
Chronic Care Policy Group



John J. Thomas
Director
Clinical Standards Group

Recommended Skilled Nursing Facility Therapy Student Supervision Guidelines
Submitted to CMS by the American Physical Therapy Association (APTA)
During the Comment Period for the FY 2012 SNF PPS Final Rule

Please note: These suggested guidelines would be in addition to the student supervision guidelines outlined in the RAI MDS 3.0 Manual and all relevant Federal Regulations.

- The amount of supervision must be appropriate to the student's level of knowledge, experience, and competence.
- Students who have been approved by the supervising therapist or assistant to practice independently in selected patient/client situations can perform those selected patient/client services specified by the supervising therapist/assistant.
- The supervising therapist/assistant must be physically present in the facility and immediately available to provide observation, guidance, and feedback as needed when the student is providing services.
- When the supervising therapist /assistant has cleared the student to perform medically necessary patient/client services and the student provides the appropriate level of services, the services will be counted on the MDS as skilled therapy minutes.
- The supervising therapist/assistant is required to review and co-sign all students' patient/client documentation for all levels of clinical experience and retains full responsibility for the care of the patient/client.
- Therapist assistants can provide instruction and supervision to therapy assistant students so long as the therapist assistant is properly supervised by the therapist.

These changes as well as other changes regarding MDS 3.0 will take effect October 1, 2011. If you have questions regarding this provision or other provisions within MDS 3.0, please contact the APTA at advocacy@apta.org or at 800.999.2782 ext. 8533.

APTA

American Physical Therapy Association

Last Updated: 10/15/13
Contact: advocacy@apta.org

Chart: Supervision of Students Under Medicare

Practice Setting	PT Student Part A	PT Student Part B	PTA Student Part A	PTA Student Part B
PT in Private Practice	N/A	X1	N/A	X1
Certified Rehabilitation Agency	N/A	X1	N/A	X1
Comprehensive Outpatient Rehabilitation Facility	N/A	X1	N/A	X1
Skilled Nursing Facility	Y1	X1	Y2	X1
Hospital	Y3	X1	Y3	X1
Home Health Agency	NAR	X1	NAR	X1
Inpatient Rehabilitation Agency	Y4	N/A	Y4	N/A

Key
Y: Reimbursable
X: Not Reimbursable
N/A: Not Applicable
NAR: Not Addressed in Regulation. Please defer to state law.

Y1: Reimbursable: Therapy students are not required to be in line-of-sight of the professional supervising therapist/assistant (**Federal Register**, August 8, 2011). Within individual facilities, supervising therapists/assistants must make the determination as to whether or not a student is ready to treat patients without line-of-sight supervision. Additionally all state and professional practice guidelines for student supervision must be followed. Time may be coded on the MDS when the therapist provides skilled services and direction to a student who is participating in the provision of therapy. All time that the student spends with patients should be documented.

Medicare Part B—The following criteria must be met in order for services provided by a student to be billed by the long-term care facility:

- The qualified professional is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.
- The practitioner is not engaged in treating another patient or doing other tasks at the same time.
- The qualified professional is the person responsible for the services and, as such, signs all documentation. (A student may, of course, also sign but it is not necessary because the Part B payment is for the clinician's service, not for the student's services.)

(RAI Version 3.0 Manual, October 2011)

Individual Therapy:
When a therapy student is involved with the treatment of a resident, the minutes may be coded as individual therapy when only one resident is being treated by the therapy student and supervising therapist/assistant (Medicare A and Medicare B). The supervising therapist/assistant shall not be engaged in any other activity or treatment when the resident is receiving therapy under Medicare B. However, for those residents whose stay is covered under Medicare A, the supervising therapist/assistant shall not be treating or supervising other individuals **and** he/she is able to immediately intervene/assist the student as needed.

Example: A speech therapy graduate student treats Mr. A for 30 minutes. Mr. A.'s therapy is covered under the Medicare Part A benefit. The supervising speech-language pathologist is not treating any patients at this time but is not in the room with the student or Mr. A. Mr. A.'s therapy may be coded as 30 minutes of individual therapy on the MDS.

Concurrent Therapy:
When a therapy student is involved with the treatment, and one of the following occurs, the minutes may be coded as concurrent therapy:

- The therapy student is treating one resident and the supervising therapist/assistant is treating another resident, and both residents are in line of sight of the therapist/assistant or student providing their therapy; or
- The therapy student is treating 2 residents, **regardless of payer source**, both of whom are in line-of-sight of the therapy student, and the therapist is not treating any residents and not supervising other individuals; or
- The therapy student is not treating any residents and the supervising therapist/assistant is treating 2 residents at the same time, regardless of payer source, both of whom are in line-of-sight.

Medicare Part B: The treatment of two or more residents who may or may not be performing the same or similar activity, regardless of payer source, at the same time is documented as group treatment.

Example: An Occupational Therapist provides therapy to Mr. K. for 60 minutes. An occupational therapy graduate student, who is supervised by the occupational therapist, is treating Mr. R. at the same time for the same 60 minutes but Mr. K. and Mr. R. are not doing the same or similar activities. Both Mr. K. and Mr. R's stays are covered under the Medicare Part A benefit. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:

- Mr. K. received concurrent therapy for 60 minutes.
- Mr. R. received concurrent therapy for 60 minutes.

Group Therapy:
When a therapy student is involved with group therapy treatment, and one of the following occurs, the minutes may be coded as group therapy:

- The therapy student is providing the group treatment and the supervising therapist/assistant is not treating any residents and is not supervising other individuals (students or residents); or
- The supervising therapist/assistant is providing the group treatment and the therapy student is not providing treatment to any resident. In this case, the student is simply assisting the supervising therapist.

Medicare Part B: The treatment of 2 or more individuals simultaneously, regardless of payer source, who may or may not be performing the same activity.

When a therapy student is involved with group therapy treatment, and one of the following occurs, the minutes may be coded as group therapy:

- The therapy student is providing group treatment and the supervising therapist/assistant is not engaged in any other activity or treatment; or

- The supervising therapist/assistant is providing group treatment and the therapy student is not providing treatment to any resident.

Documentation: APTA recommends that the physical therapist co-sign the note of the physical therapist student and state the level of supervision that the PT determined was appropriate for the student and how/if the therapist was involved in the patient's care.

Y2: Reimbursable: The minutes of student services count on the Minimum Data Set. Medicare no longer requires that the PT/PTA provide line-of-sight supervision of physical therapist assistant (PTA) student services. Rather, the supervising PT/PTA now has the authority to determine the appropriate level of supervision for the student, as appropriate within their state scope of practice. See **Y1.**

Documentation: APTA recommends that the physical therapist and assistant should co-sign the note of physical therapist assistant student and state the level of appropriate supervision used. Also, the documentation should reflect the requirements as indicated for individual therapy, concurrent therapy, and group therapy in **Y1.**

Y3: This is not specifically addressed in the regulations, therefore, please defer to state law and standards of professional practice. Additionally, the Part A hospital diagnosis related group (DRG) payment system is similar to that of a skilled nursing facility (SNF) and Medicare has indicated very limited and restrictive requirements for student services in the SNF setting.

Documentation: Please refer to documentation guidance provided under **Y1**

Y4: This is not specifically addressed in the regulations, therefore, please defer to state law and standards of professional practice. Additionally, the inpatient rehabilitation facility payment system is similar to that of a skilled nursing facility (SNF) and Medicare has indicated very limited and restrictive requirements for student services in the SNF setting.

X1: B. Therapy Students

1. General
Only the services of the therapist can be billed and paid under Medicare Part B. However, a student may participate in the delivery of the services if the therapist is directing the service, making the judgment, responsible for the treatment and present in the room guiding the student in service delivery.

EXAMPLES:
Therapists may bill and be paid for the provision of services in the following scenarios:

- The qualified practitioner is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.
- The qualified practitioner is present in the room guiding the student in service delivery when the therapy student and the therapy assistant student are participating in the provision of services, and the practitioner is not engaged in treating another patient or doing other tasks at the same time.
- The qualified practitioner is responsible for the services and as such, signs all documentation. (A student may, of course, also sign but it is not necessary since the Part B payment is for the clinician's service, not for the student's services).

2. Therapy Assistants as Clinical Instructors

Physical therapist assistants and occupational therapy assistants are not precluded from serving as clinical instructors for therapy students, while providing services within their scope of work and performed under the direction and supervision of a licensed physical or occupational therapist to a Medicare beneficiary.

Documentation: APTA recommends that the physical therapist or physical therapist assistant complete documentation.

Compliance Matters: Supervision Requirements for PTAs and Physical Therapy Students

A brief primer on what to ask and where to seek answers.

Column

Date: Tuesday, May 1, 2018
Author: Sharita Jennings, JD

Supervision requirements for physical therapist assistants (PTAs) and physical therapy students (both physical therapist and PTA students) depend on such factors as the policies of individual payers and insurers, state practice act provisions, and the setting in which physical therapy is being provided. Let's simplify this situation by looking at some key issues.

Levels of Supervision

It is the responsibility of the physical therapist (PT) alone to evaluate and assess patients, develop a plan of care, and oversee provision of services. PTAs and physical therapy students play important roles in carrying out the plan of care, however. Supervision rules are meant to ensure that patients and clients always are receiving the safest and most effective care. Depending on the setting, practitioner, and applicable state laws, 1 of 3 types of supervision will apply to PTs and the PTAs and students they supervise.

General. This is the least restrictive type of supervision. It requires only that the PT be available for direction and supervision by telephone or another form of telecommunication during the procedure in question; the PT need not be onsite.

Direct. This type of supervision requires the PT to be physically present at the facility and immediately available for in-room direction and supervision. The PT must have direct contact with the patient or client for the duration of each visit—defined as all encounters with that patient or client within a 24-hour period.

Direct personal. This is the highest level of supervision. The PT must be physically present in the room and immediately available to direct and supervise tasks related to patient and client management, and must provide continuous direction and supervision throughout the time these tasks are performed.

Factors to Consider

To determine the required level of supervision of PTAs and students, PTs should ask themselves these questions:

- What does the state practice act say about supervision of PTAs and students?
- When Medicare patients are involved, what are Medicare's regulations regarding PTAs and students?
- When a commercial insurer is involved, what are that payer's policies regarding PTAs and students?
- In what type of practice setting are the physical therapist services being provided?

State practice acts. State practice acts typically define the scope of practice of PTs and the scope of work of PTAs and physical therapy students. It's the PT's go-to document, therefore, for determining supervision requirements. Links to all state practice acts are available on APTA's website. (See "Resources" on page 10.)

Be advised, however, that not all state practice acts address supervision of either PTAs or physical therapy students, while some acts address PTAs but not students. Here's what do in these situations:

- If the state practice act is silent on supervision of students but *does* contain policies on PTA supervision, apply the rules of PTA supervision to physical therapy students.
- If the state practice act addresses *neither* supervision of PTAs *nor* supervision of physical therapy students, look to the supervision requirements of the payer policy. For example, if the individual who is receiving services has health insurance from Blue Cross, consult that company's policies regarding supervision of PTAs and students. If the person is a Medicare or Medicaid patient, check that agency's billing policy.

Medicare provisions. Again, if the state practice act is *silent* on supervision requirements, turn to Medicare's billing guidelines to determine the needed level of supervision for PTAs and students in providing services to Medicare beneficiaries. Medicare dictates general supervision of PTAs in all settings other than private practice, in which direct supervision is required. In some settings, however, Medicare stipulates additional requirements even under general supervision. For instance, when a PTA provides services to a patient in a standalone clinic (defined by Medicare as "a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients"), rehabilitation agency, or public health agency, the supervising PT must make an onsite visit at least once every 30 days.

Medicare states that PTs may not bill for services provided by physical therapy students, because they are not licensed practitioners. Students may help PTs provide billed services, however, and PTs may physically guide students through the provision of a billed service. PTs, therefore, need to exercise their best judgment in such situations. Medicare offers these scenarios as guidance for appropriately billing Part B services:

- The PT is present and in the room for the entire session. The student participates in the delivery of services only when the PT is directing the service, exercising skilled judgment, and is the party responsible for assessment and treatment of the patient or client.
- The PT is present in the room, guiding the student in service delivery whenever the student is participating in its provision. The PT is at no time engaged in treating other patients or performing any other tasks.

The PT is the responsible party and, as such, signs all documentation. (A physical therapy student also may sign, but the student's signature is unnecessary.)

PTAs and physical therapy students cannot bill for their services under Medicare or any other payer. The supervising PT, rather, must bill for all services under his or her National Provider Identifier issued by the Centers for Medicare and Medicaid Services.

(A note on payment for services provided by PTAs: Medicare and commercial insurers currently reimburse for services rendered by PTAs at the same rate as they do those furnished by PTs. Beginning in 2022, however, services provided by PTAs will be reimbursed at 85% of the Medicare physician fee schedule rate that applies to those rendered by PTs. At this writing, this upcoming change has no bearing on supervision rules for PTAs.)

Commercial insurers. PTs treating patients or clients whose health care is covered by a commercial insurance plan must closely read the contract with the insurer to ensure that they meet supervision policies covering PTAs and students. Commercial insurers typically defer to Medicare guidelines, but it's important to check with the insurer to be certain.

Who Signs?

The answer to this question is simple. Because the PT is responsible for drafting the plan of care and supervising all procedures carried out under it, the PT must review and sign all care notes and the plan of care itself.

PTAs and students may draft notes on the care they've provided under the appropriate level of supervision. The supervising PT then must authorize and sign that documentation.

As with all supervision rules, the PT should check the state practice act and agreements with participating insurers to determine if more-stringent rules on signatures apply to any given situation.

Sharita Jennings, JD*, is senior regulatory specialist at APTA.*

Resources

Levels of Supervision (APTA House of Delegates Position)

- House Policy: Levels of Supervision

State Practice Acts

- FSBPT Licensing Authorities Contact Information

Report to Congress: Standards for Supervision of Physical Therapist Assistants (Under Medicare)

- www.cms.gov/medicare/billing/therapyservices/downloads/61004ptartc.pdf

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Author(s)

Sharita Jennings, JD

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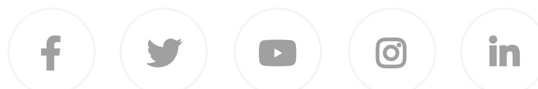

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About APTA | Work at APTA

Loma Linda University Entry-level Doctor of Physical Therapy
Curriculum with Course Descriptions

PHTH 501. Neurology I. 3 Units.
Physical therapy management of individuals with balance and vestibular disorders resulting in impairments, functional limitations, and disabilities. Emphasizes application and integration of theoretical constructs, evidence-based practice, examination, evaluation, diagnosis, prognosis, intervention, and outcome measurements.

PHTH 502. Neurology II. 3 Units.
Physical therapy management of individuals with neurological disorders (including stroke, traumatic brain injury, multiple sclerosis, Parkinson's disease) resulting in impairments, functional limitations, and disabilities. Emphasizes application and integration of theoretical constructs, evidence-based practice, examination, evaluation, diagnosis, prognosis, intervention, and outcomes measurement.

PHTH 503. Neurology III. 3 Units.
Physical therapy management of individuals with spinal cord injury, Guillain-Barre Syndrome, and Amyotrophic Lateral Sclerosis resulting in impairments, functional limitations, and disabilities. Emphasizes application and integration of theoretical constructs, evidenced-based practice, examination, evaluation, diagnosis, prognosis, intervention, and outcomes measurement.

PHTH 504. Neurology IV. 1 Unit.
Capstone experience assessing critical thinking and clinical application of previously learned content supporting neurologic physical therapy practice.

PHTH 505. Integrated Clinical Experience. 1 Unit.
A year-long course that provides the students—assisted by faculty and clinical therapist—experience with mock and real patients. Emphasis is on critical thinking related to assessment, safety, and treatment progression. Course incorporates didactic education into practical application.

PHTH 506. Exercise Physiology. 3 Units.
Addresses physiologic, metabolic, circulatory, and structural adaptations, responses, and interactions that occur during acute and chronic exercise. Includes body fat analysis and risk of disease in the obese client. Applies tests and measures to concepts and applications of exercise prescriptions.

PHTH 508. PT Communication and Documentation. 2 Units.
Introduces principles and dynamics of professional verbal and written communication, including use of electronic health records and the ICF model. Emphasizes skills required in a clinical setting for effective communication with third-party payors, health-care professionals, and patients. Includes quality and legal considerations in documentation of evaluations, progress notes, daily notes, discharge summaries, and letters of justification.

PHTH 509. Biophysical Agents. 3 Units.
Fundamental principles, physiological effects, and application techniques in the use of biophysical agents, including thermotherapy, cryotherapy, hydrotherapy, ultrasound, and electrotherapy procedures. Manual modalities, including massage techniques, myofascial and trigger point release. Lecture and laboratory.

PHTH 510. Kinesiology. 3 Units.
Fundamental principles of joint and muscle structure and function related to the development of treatment strategies for the physical therapist. Analyzes and applies the biomechanics of normal and pathological movement of the human body. Functional anatomy of the musculoskeletal system, including palpatory techniques for bone, ligament, and muscle.

PHTH 511. Clinical Orthopaedics. 2 Units.
Addresses the physical therapist's management of patients with functional impairments stemming from orthopaedic pathologies in all body regions. Introduces patient/client management; including, examinations, evaluations, diagnoses, prognoses, interventions, and outcomes. Emphasizes postoperative rehabilitation to enhance outcomes following orthopaedic procedures.

PHTH 512. Clinical Psychiatry. 2 Units.
Introduces mental and personality disorders. Reviews abnormal behaviors commonly found in a clinical setting.

PHTH 513. Therapeutic Procedures. 3 Units.
Blood pressure determination and aseptic techniques. Principles and utilization of posture and body mechanics. Selection and use of wheelchairs, ambulation aids, and other equipment. Progressive planning toward complete activities of daily living.

PHTH 514. Manual Muscle Testing. 3 Units.
Methods of evaluating muscle strength and function using specific and gross manual muscle tests. Integrates manual muscle testing with other aspects of patient care. Live patient demonstrations and discussion regarding each patient. Lecture, demonstration, and laboratory.

PHTH 516. Histology. 2 Units.
Surveys fundamental tissues (epithelial, connective, muscle, and nervous) and the histopathology of selected diseases, including changes in bone and cartilage.

PHTH 517. Movement Science. 2 Units.
An integrative approach to movement impairment and neuromuscular approaches in the evaluation and management of musculoskeletal pain syndromes. Identifies clinical reasoning and examination of movement patterns. Extensive laboratory practice with patient/case studies.

PHTH 518. Aspects of Health Promotion. 2 Units.
Dynamics of physical therapy involvement in health promotion for the individual and the community. Factors in the promotion of a healthful lifestyle, including cardiovascular enhancement, stress reduction and coping mechanisms, nutritional awareness, weight management, and substance control. Students design and implement community-based health education program.

PHTH 519. Locomotion Studies. 3 Units.
Basic and advanced observational analysis of normal and abnormal human locomotion in adults. Compares differences in gait impairments at each joint and at different stance/swing phases. Use of assessment tools and clinical reasoning in the attributes and interventions of normal and abnormal gait characteristics. Basic pathological and soft tissue impairments to gait cycle. Correlates energy expenditure to gait.

PHTH 521A. Orthopaedics 1A. 3 Units.
Discusses physical therapy examination, evaluation, and interventions relevant to the clinical management of musculoskeletal conditions of the upper extremities. Presents instruction related to orthopaedic physical therapy interventions—including joint mobilization, hand splinting, and other selected manual techniques for specific upper extremity musculoskeletal conditions. Utilizes lecture, laboratory, and case studies to develop and integrate these concepts.

PHTH 521B. Orthopaedics 1B. 3 Units.
Students further develop concepts of examination, differential diagnosis, prognosis, and interventions that are expanded to patients with musculoskeletal conditions of the lower extremities. Utilizes lecture, laboratory, and case studies to develop and integrate these concepts.

PHTH 522. Orthopaedics II. 3 Units.
Evidence-based theory of spinal examination, evaluation, and physical therapy intervention. Expanded principles of functional anatomy, tissue and joint biomechanics, pathology, and treatment. Differentiates causes of neck and head pain—including temporomandibular joint disorders, myofascial pain dysfunctions, and cervicogenic headaches.

PHTH 523. Orthopaedics III. 3 Units.
Evidence-based theory of lumbopelvic, lumbar and thoracic spine examination, evaluation, and physical therapy intervention. Expanded principles of functional anatomy, tissue and joint biomechanics, pathology, and treatment. Differentiates etiology of lumbar, lumbopelvic, and thoracic pain.

PHTH 525. General Medicine. 3 Units.
An understanding of medical and surgical disorders for the physical therapist. Basic pathology and/or etiology and clinical manifestations. Medical treatment for conditions within selected specialties of: endocrinology, arthritis, oncology, and integumentary management.

PHTH 526A. Cardiopulmonary I. 3 Units.
Anatomy and physiology of the cardiovascular system as applied to patient management. Physical therapy management of patients diagnosed with cardiac diseases and complications. Identifies disease processes, including definition, etiology, pathophysiology, clinical presentation, and the clinical course of cardiac conditions. Analyzes and examines ECGs of various forms with basic interpretation. Includes lecture and laboratory.

PHTH 526B. Cardiopulmonary II. 3 Units.
Normal anatomy and physiology of the pulmonary system as applied to physical therapy management. Medical and physical therapy management of patients diagnosed with pulmonary diseases and complications. Analyzes arterial blood gases in a systematic manner and relates findings to the disease and ventilatory process. Discusses PFTs for obstructive and restrictive diseases. Includes lecture and laboratory.

PHTH 528. Therapeutic Exercise I. 3 Units.
Introduces basic exercise techniques used in the practice of physical therapy. Techniques include, ROM, stretching/flexibility, joint mobilization, muscle performance (including strength, power, and endurance), and aquatic rehabilitation.

PHTH 530. Therapeutic Exercise II. 3 Units.
Formulation and implementation of exercise prescriptions based on impairments and protocols. Opportunities to design treatment progressions for the extremities. Emphasizes spinal stabilization approaches for the axial skeleton.

PHTH 534. Soft Tissue Techniques. 2 Units.
Physical therapy evaluation and treatment-planning strategies for individuals with orthopedic dysfunction primarily related to soft tissue injury resulting in pathology, impairments, functional limitations, and disabilities. Emphasizes laboratory hands-on application and integration of theoretical constructs, evidenced-based practice, examination, evaluation, intervention, and measurement of outcomes.

PHTH 539. Integrative Physiology. 4 Units.
Physiology of the human body, including integumentary, skeletal, muscular, neuronal, cardiovascular, respiratory, endocrine, digestive, urinary, and reproductive physiology.

PHTH 540. Concepts of Acute Care. 2 Units.
Presents procedures, equipment, lines and tubes, medications, and treatments used while treating adult and pediatric patients in the acute care setting. Covers ICU, NICU, and CCU using current research on mobilization and improving function. Identifies roles of multidisciplinary team members managing critical care patients.

PHTH 555. Medical Screening. 2 Units.
Emphasizes information gathering from history taking, review of systems, and directed questioning—combined with a focused examination to establish a working diagnosis. Emphasizes clinical pattern recognition for both musculoskeletal and nonmusculoskeletal disorders. Students learn strategies to differentiate between musculoskeletal and nonmusculoskeletal disorders. Highlights knowledge and skills related to screening for medical pathology.

PHTH 557. Pediatrics I. 3 Units.
Examines typical sequential human development observed throughout prenatal, infant, toddler, and childhood periods, in the context of physical therapy; and provides an introduction to atypical development. Emphasizes observation of motor development and learning, and identification and documentation of movement for both the typically and atypically developing child.

PHTH 558. Pediatrics II. 3 Units.
Discussion, demonstration and practice of physical therapy assessment and treatment of pediatric clients with developmental disabilities. Select diagnoses will be studied including cerebral palsy, spina bifida, muscular dystrophy and torticollis, as well as other common impairments. Specific treatment interventions will be practiced including pediatric NDT, sensory processing, orthotic assessment, positioning and handling for the treatment of the pediatric client.

PHTH 559. Geriatrics. 2 Units.
Overview of the normal and pathological changes seen during the aging process as related to physical therapy. Includes theories and demographics of aging, physiological and psychosocial changes, principles of geriatric rehabilitation, pharmacology, orthopedic considerations, fall risk, and fall prevention.

PHTH 561. Physical Therapy Administration. 4 Units.
Principles of organization and administration in health-care delivery. Multidisciplinary approach to patient management and patient-therapist relations. Administration of physical therapy services. Professionalism, medicolegal considerations, supervision and training of support personnel. Departmental design and budgetary considerations.

PHTH 563. Research I. 2 Units.
Introduction to research methods and measurement principles, applied to assessing and interpreting information sources to support patient/client management decisions fundamental to evidence-based practice.

PHTH 564. Research II. 1 Unit.
Assessment and interpretation of information sources, evaluating outcomes related to a specific clinical question for purpose of writing an evidenced-based practice literature review.

PHTH 565. Research III. 1 Unit.
Assessment and interpretation of information sources, evaluating outcomes related to a specific clinical question for purpose of developing professional poster and oral presentations.

PHTH 566. Pathology. 4 Units.
Fundamental mechanisms of disease, including cell injury, inflammation, repair, fluid disorders, neoplasms; developmental, genetic, pediatric, immune, infectious, physical, dietary, blood, vascular, and heart diseases.

PHTH 568. Integrative Neuroanatomy. 4 Units.
Basic anatomy and function of the central, peripheral, and autonomic nervous systems and related structures. Gross anatomy of the brain and spinal cord. Functional consideration of cranial nerves, tracks, and nuclei of major systems. Lecture, slides, and laboratory with specimens, models, and exercises.

PHTH 569. Clinical Neurology. 2 Units.
Introduces the practice of neurologic physical therapy. Emphasizes neurologic disorders routinely encountered by physical therapists and their clinical manifestations. Presents components of the neurologic physical therapy examination.

PHTH 571. Short Clinical Experience I. 2 Units.
Four-week, forty clock hours per week, supervised short clinical experience (SCE) that introduces students to a variety of physical therapy practice settings, and allows them to begin applying and utilizing physical therapy clinical and professional skills learned during the first year of the DPT curriculum.

PHTH 572. Short Clinical Experience II. 2 Units.
A four-week, forty clock hours per week, clinical education experience. Students apply and practice knowledge and skills learned in general medicine, neurologic, orthopedics, and preventive care/wellness as they relate to patients across the life span. Supervision by a licensed physical therapist. Includes direct patient care, as well as possible participation in specific site team conferences, demonstrations, special assignments, and observation.

PHTH 575. Orthopaedics IV. 1 Unit.
A three-quarter course that integrates examination procedures taught in the orthopaedic curriculum. Culminates in a comprehensive laboratory practical that includes the five elements of patient/client management, as described in the Guide to Physical Therapy Practice: examination, evaluation, diagnosis, prognosis, and intervention.

PHTH 586. Orthotics and Prosthetics. 2 Units.
Clinical reasoning in the attributes and interventions of normal and abnormal gait characteristics based on the field of orthotics and prosthetics. Instruction with various types of orthotics and prosthetics in order to collaborate with O&P clinicians and patients in locomotion rehabilitation.

PHTH 587. Pharmacology. 2 Units.
Introduction to general principles of pharmacology, including actions of commonly used medications on physiological processes related to physical therapy.

PHTH 595. Clinical Imaging. 3 Units.
Covers the various types of imaging used in clinical practice. Educates the future practitioner on the strong and weak points of each type of imaging, what that type of imaging is used for, and how the process is completed start to finish. Covers conventional x-ray, CAT scan, MRI, and MSK ultrasound. Laboratory portion familiarizes the student with MSK ultrasound, including its application and the general interpretation of the image produced.

PHTH 596. Orthopaedics V. 3 Units.
Presents the newest evidenced-based clinical evaluation and treatment applications over the spectrum of the patient population in the field of physical therapy. Emphasizes the specialized area of orthopedic physical therapy.

PHTH 597. Specialized Interventions in Physical Therapy. 2 Units.
Provides advanced study opportunities to pursue, in greater depth, various topics related to current trends in physical therapy and development of advanced clinical skills, where appropriate. Topics include: women's/men's health, lymphedema, wound care, and other specialized areas in physical therapy.

PHTH 701. Long Clinical Experience I. 5 Units.
Twelve-week, full-time (40 hours/week average) clinical education assignment for D.P.T. students completed in an affiliated clinic with an emphasis in any of a variety of settings including: acute care, outpatient orthopedics, neurological rehabilitation, geriatrics, pediatrics, sports medicine, and preventive care/wellness.

PHTH 702. Long Clinical Experience II. 5 Units.
Eleven-week, full-time (40 hours/week average) clinical education assignment for D.P.T. students completed in an affiliated clinic with an emphasis in any of a variety of settings including: acute care, outpatient orthopedics, neurological rehabilitation, geriatrics, pediatrics, sports medicine, and preventive care/wellness. This is the second of three required affiliations in the final year of the program.

PHTH 703. Long Clinical Experience III. 5 Units.
Ten-week, full-time (40 hours/week average) clinical education assignment for DPT students completed in an affiliated clinic with an emphasis in any of a variety of settings including: acute care, outpatient orthopedics, neurological rehabilitation, geriatrics, pediatrics, sports medicine, and preventive care/wellness. This is the final of three required affiliations in the final year of the program.

AHCJ 510. Human Gross Anatomy. 9 Units.
Gross anatomy of the musculoskeletal system, with emphasis on spatial orientation, joint structure, skeletal muscle origins, insertions, actions, nerves, and blood supply. A cadaver-based course.

AHCJ 705. Infectious Disease and the Health Care Provider. 1 Unit.
Current issues related to infectious diseases, with emphasis on principles of epidemiology and etiology of HIV/AIDS. Disease pathology and modes of transmission as compared to hepatitis, tuberculosis, and influenza. Development of ethical response to psychosocial, economic, and legal concerns. Strategies and programs for education, prevention, and identification of resources. Impact on health-care workers; risk factors and precautions for blood-borne pathogens.

AHCJ 721. Wholeness Portfolio I. 1 Unit.
Students continue developing a portfolio that illustrates the potential graduate's ability to meet the student learning outcomes set by Loma Linda University—including wholeness, Christ-centered values, commitment to discovery and lifelong learning, effective communication, embracing and serving a diverse world, and collaboration.

AHCJ 722. Wholeness Portfolio II. 1 Unit.
Students continue developing a portfolio that illustrates the potential graduate's ability to meet the student learning outcomes set by Loma Linda University—including wholeness, Christ-centered values, commitment to discovery and lifelong learning, effective communication, embracing and serving a diverse world, and collaboration.

RELE 707. Ethics for Allied Health Professionals. 2 Units.
Ethical issues, cases, and principles in the contemporary practice of allied health professionals. Christian and philosophical resources for ethical decision making.

RELR 775. Whole Person Care. 2 Units.
Integrates psychosocial and spiritual care in the clinical setting.

RELT 718. Adventist Heritage and Health. 2 Units.
Studies the fundamental beliefs and values that led Seventh-day Adventists to become involved in health care, with particular emphasis on the spiritual story and principles leading to the founding of Loma Linda University.

RELT 740. World Religions and Human Health. 2,3 Units.
Studies of the history, beliefs, and practices of eight major world religions, with an emphasis on theological and ethical issues that are relevant to the practice of culturally competent health care. Gives attention to the interaction between specific religions and their cultures and to similarities, differences, and potential for understanding among religions. Third unit covers two additional world religions.

CPI3.0 links and resources

The first step to accessing the CPI is to open an account with the APTA. Membership is not required. The email address used to login to the account is used to link student and CI.

APTA CPI Support desk:
cpi@apta.org; Phone: 703-706-8582

APTA CI CPI 3.0 training course and use of CPI:
https://www.apta.org/for-educators/assessments/pt-cpi [Scroll down the page to find and access the hyperlink for CI/SCCE training and to access additional resources].

Or

open hyperlink below for direct access to training registration page for SCCE/CI
https://learningcenter.apta.org/p/CPI-3_CI-SCCE?_gl=1*qy8qvm*_ga*MTQxNTg5NDczMi4xNjUwMTgwNDQy*_ga_ZZJK74HXNR*MTY5NTMxMzA0NC4zMS4xLjE2OTUzMTM1MDkuNDkuMC4w&_ga=2.247900167.1046504564.1695243993-1415894732.1650180442

CPI3.0 Instructions-Paper Version:
https://www.apta.org/contentassets/b38cea3dbf7049a8b44d4cda452fbfc0/paper-version-of-pt-cpi-and-pta-cpi.pdf

APTA CPI login:
https://cpi.apta.org/login

DCE User guide:
https://aptacpistorage.blob.core.windows.net/orgid-2/apta-cpi-guides/DCE-ADCE_and_Admin_User_Guide.pdf

Adjunct Faculty User Guide
https://aptacpistorage.blob.core.windows.net/orgid-2/apta-cpi-guides/Adjunct_Faculty_User_Guide.pdf

Clinical Instructor User Guide:
https://aptacpistorage.blob.core.windows.net/orgid-2/apta-cpi-guides/Clinical_Instructor_User_Guide.pd

Site Coordinator Of Clinical Education User Guide:
https://aptacpistorage.blob.core.windows.net/orgid-2/apta-cpi-guides/SCCE_User_Guide.pdf

Student User guide:
https://aptacpistorage.blob.core.windows.net/orgid-2/apta-cpi-guides/PT-PTA_Student_User_Guide.pdf

LOMA LINDA UNIVERSITY

SCHOOL OF ALLIED HEALTH PROFESSIONS

DOCTOR OF PHYSICAL THERAPY – CLASS OF 2025

2022

SUMMER - 13 wks (June 20 - Sept 16)		AUTUMN - 12 wks (Sept 26 - Dec 16)
June 20-Aug 5 (7wks) AHCJ 510 Human Gross Anatomy [9 units]	**Aug 8 -- Sept 16** (6 wks) PHTH 505 Integrated Clinical Experience (1) PHTH 510 Kinesiology (3) PHTH 514 Manual Muscle Test (3) RELT 718 Adventist Heritage & Health (2) [9 units]	PHTH 505 ICE (0) PHTH 509 Biophysical Agents (3) PHTH 513 Therapeutic Procedures (3) PHTH 516 Histology (2) PHTH 539 Integrative Physiology (4) PHTH 563 Research I (2) AHCJ 705 Infectious Disease (1) AHCJ 721 Wholeness Portfolio I (1) RELR 775 Whole Person Care (2) [18 units]

2023

WINTER - 11 wks (Tues, Jan 3 - March 17)	SPRING - 13 wks (March 27 - June 23)	
PHTH 505 ICE (0) PHTH 508 PT Communication (2) PHTH 519 Locomotion Studies (3) PHTH 528 Therapeutic Exercise I (3) PHTH 564 Research II (1) PHTH 566 Pathology (4) AHCJ 721 Wholeness Portfolio I (0) RELE 707 Ethics for Allied Health (2) [15 units]	**March 27 – May 26 (9 wks)** PHTH 505 ICE (0) PHTH 506 Exercise Phys (3) PHTH 521A Orthopedics IA (3) PHTH 557 Pediatrics I (3) PHTH 565 Research III (1) PHTH 568 Integrative Neuroanatomy (4) PHTH 569 Clinical Neurology (2) PHTH 586 Orthotics & Prosthetics (2) AHCJ 721 Wholeness Port I (0) [18 units]	**May 29 – June 23** (4 wks) PHTH 571 Short Clinical Experience I (2) [2 unit]

2023

	SUMMER - 6 wks (Aug 7 - Sept 15)	AUTUMN - 12 wks (Sept 25 - Dec 15)
Vacation Anatomy TA (Optional Emp) June 26 – Aug 4 (6 wks)	PHTH 505 Integrated Clinical Experience (1) PHTH 511 Clinical Ortho (2) PHTH 512 Clin Psychiatry (2) PHTH 526A Cardiopulmonary (3) PHTH 587 Pharmacology (2) RELT 740 World Religions & Human Health (3) [13 units]	PHTH 501 Neurology I (3) PHTH 505 ICE (0) PHTH 521B Orthopedics IB (3) PHTH 525 General Medicine (3) PHTH 526B Cardiopulmonary II (3) PHTH 530 Therapeutic Exercise II (3) PHTH 575 Orthopedics IV (1) PHTH 595 Clinical Imaging (3) AHCJ 722 Wholeness Portfolio II (1) [20 units]

2024

WINTER - 11 wks (Tues, Jan 2 - March 15)	SPRING - 11 wks (March 25 – June 7)
PHTH 502 Neurology II (3) PHTH 505 ICE (0) PHTH 518 Aspects of Health Pro (2) PHTH 522 Orthopedics II (3) PHTH 534 Soft Tissue Techniques (2) PHTH 540 Concepts in Acute Care (2) PHTH 558 Pediatrics II (3) PHTH 575 Orthopedics IV (0) AHCJ 722 Wholeness Portfolio II (0) [15 units]	PHTH 503 Neurology III (3) PHTH 505 ICE (0) PHTH 517 Movement Science (2) PHTH 523 Orthopedics III (3) PHTH 555 Medical Screening (2) PHTH 559 Geriatrics (2) PHTH 561 PT Administration (4) PHTH 575 Orthopedics IV (0) PHTH 597 Specialized Interventions in PT (2) AHCJ 722 Wholeness Portfolio II (0) [18 units]

2024

SUMMER - 8 wks (June 17 – Aug 16)			AUTUMN – 12 wks (Sept 23–Dec 13)
June 17-July 12 (4 wks) PHTH 504 Neuro IV (1) PHTH 596 Ortho V (3) [4 units]	**July 22 – Aug 16** (4 wks) PHTH 572 Short Clinical Experience II (2) [2 units]	**Aug 19 – Wept 20** (5 wks) Vacation	PHTH 701 Long Clinical Experience I (5) [5 units]

2025

WINTER - 11 wks (Jan 6 - March 21)	SPRING - 11 wks (March 31 – June 13)
PHTH 702 Long Clinical Experience II (5) [5 units]	**March 31 – June 6 (10 wks)** PHTH 703 Long Clinical Experience III (5) **June 9-13 (1 wk) -** Graduation Preparation June 12 – White Coat Dedication Ceremony Graduation Ceremony: **June 15, 2025** [5 units]

LOMA LINDA UNIVERSITY
SCHOOL OF ALLIED HEALTH PROFESSIONS

DOCTOR OF PHYSICAL THERAPY – CLASS OF 2026

2023–2024

SUMMER - 13 wks (June 19 - Sept 15)		AUTUMN - 12 wks (Sept 25 - Dec 15)	WINTER - 11 wks (Tues, Jan 2 - March 15)	SPRING - 13 wks (March 25 - June 21)	
June 19-Aug 4 (7wks) AHCJ 510 Human Gross Anatomy [9 units]	**Aug 7 -- Sept 15** (6 wks) PHTH 505 Integrated Clinical Experience (1) PHTH 510 Kinesiology (3) PHTH 514 Manual Muscle Test (3) RELT 718 Adventist Heritage & Health (2) [9 units]	PHTH 505 ICE (0) PHTH 509 Biophysical Agents (3) PHTH 513 Therapeutic Procedures (3) PHTH 516 Histology (2) PHTH 539 Integrative Physiology (4) PHTH 563 Research I (2) AHCJ 705 Infectious Disease (1) RELR 775 Whole Person Care (2) [17 units]	PHTH 505 ICE (0) PHTH 508 PT Communication (2) PHTH 511 Clinical Ortho (2) PHTH 519 Locomotion Studies (3) PHTH 528 Therapeutic Exercise I (3) PHTH 564 Research II (1) PHTH 566 Pathology (4) RELE 707 Ethics for Allied Health (2) [17 units]	**March 25 – May 24 (9 wks)** PHTH 505 ICE (0) PHTH 506 Exercise Phys (3) PHTH 521A Orthopedics IA (3) PHTH 525 General Medicine (3) PHTH 565 Research III (1) PHTH 568 Integrative Neuroanatomy (4) PHTH 569 Clinical Neurology (2) [16 units]	**May 27 – June 21** (4 wks) PHTH 571 Short Clinical Experience I (2) [2 unit]

2024–2025

	SUMMER - 6 wks (Aug 5 - Sept 13)	AUTUMN - 12 wks (Sept 23 - Dec 13)	WINTER - 11 wks (Jan 6 - March 21)	SPRING - 11 wks (March 31 – June 13)
Vacation Anatomy TA (Optional Emp) June 24 – Aug 2 (6 wks)	PHTH 505 Integrated Clinical Experience (1) PHTH 512 Clin Psychiatry (2) PHTH 526A Cardiopulmonary (3) PHTH 586 Orthotics & Prosthetics (2) PHTH 587 Pharmacology (2) RELT 740 World Religions & Human Health (3) [13 units]	PHTH 501 Neurology I (3) PHTH 505 ICE (0) PHTH 521B Orthopedics IB (3) PHTH 526B Cardiopulmonary II (3) PHTH 557 Pediatrics I (3) PHTH 575 Orthopedics IV (1) PHTH 595 Clinical Imaging (3) AHCJ 719 Wholeness Portfolio (1) [17 units]	PHTH 502 Neurology II (3) PHTH 505 ICE (0) PHTH 518 Aspects of Health Pro (2) PHTH 522 Orthopedics II (3) PHTH 530 Therapeutic Exercise II (3) PHTH 534 Soft Tissue Techniques (2) PHTH 540 Concepts in Acute Care (2) PHTH 558 Pediatrics II (3) PHTH 575 Orthopedics IV (0) AHCJ 719 Wholeness Portfolio (0) [18 units]	PHTH 503 Neurology III (3) PHTH 505 ICE (0) PHTH 517 Movement Science (2) PHTH 523 Orthopedics III (3) PHTH 555 Medical Screening (2) PHTH 559 Geriatrics (2) PHTH 561 PT Administration (4) PHTH 597 Specialized Interventions in PT (2) AHCJ 719 Wholeness Portfolio (0) [18 units]

2025–2026

SUMMER - 8 wks (June 23 – Aug 22)			AUTUMN – 12 wks (Sept 22–Dec 12)	WINTER - 11 wks (Jan 5 - March 20)	SPRING - 11 wks (March 30 – June 12)
June 23-July 18 (4 wks) PHTH 504 Neuro IV (1) PHTH 596 Ortho V (3) [4 units]	**July 28 – Aug 22** (4 wks) PHTH 572 Short Clinical Experience II (2) [2 units]	**Aug 25 – Sept 19** (4 wks) Vacation	PHTH 701 Long Clinical Experience I (5) [5 units]	PHTH 702 Long Clinical Experience II (5) [5 units]	**March 30 – June 5 (10 wks)** PHTH 703 Long Clinical Experience III (5) **June 8-12 (1 wk) -** Graduation Preparation June 11 – White Coat Dedication Ceremony Graduation Ceremony: **June 14, 2026** [5 units]

LOMA LINDA UNIVERSITY

SCHOOL OF ALLIED HEALTH PROFESSIONS

DOCTOR OF PHYSICAL THERAPY – CLASS OF 2027

2024

SUMMER - 13 wks (June 17 - Sept 13)

June 17-Aug 2 (7wks)

AHCJ 510 Human Gross Anatomy

[9 units]

Aug 5 -- Sept 13 (6 wks)

PHTH 505	Integrated Clinical Experience (1)
PHTH 510	Kinesiology (3)
PHTH 514	Manual Muscle Test (3)
PHTH 544	Professional Formation I (1)
RELT 718	Adventist Heritage & Health (2)

[10 units]

AUTUMN - 12 wks (Sept 23 - Dec 13)

PHTH 505	ICE (0)
PHTH 509	Biophysical Agents (3)
PHTH 513	Therapeutic Procedures (3)
PHTH 516	Histology (2)
PHTH 539	Integrative Physiology (4)
PHTH 544	Professional Formation I (0)
PHTH 563	Research I (2)
AHCJ 705	Infectious Disease (1)
RELR 775	Whole Person Care (2)

[17 units]

2025

WINTER - 11 wks (Jan 6 - March 21)

PHTH 505	ICE (0)
PHTH 508	PT Communication (2)
PHTH 511	Clinical Orthopedics (2)
PHTH 519	Locomotion Studies (3)
PHTH 528	Therapeutic Exercise I (3)
PHTH 544	Professional Formation I (0)
PHTH 564	Research II (1)
PHTH 566	Pathology (4)
RELE 707	Ethics for Allied Health (2)

[17 units]

SPRING - 13 wks (March 25 - June 21)

March 31 – May 30 (9 wks)

PHTH 505	ICE (0)
PHTH 506	Exercise Phys (3)
PHTH 521A	Orthopedics IA (3)
PHTH 525	General Medicine (3)
PHTH 544	Professional Formation I (0)
PHTH 565	Research III (1)
PHTH 568	Integrative Neuroanatomy (4)
PHTH 569	Clinical Neurology (2)

[16 units]

June 2-27 (4 wks)

PHTH 571 Short Clinical Experience I (2)

[2 unit]

2025

SUMMER - 6 wks (Aug 4 - Sept 12)

Vacation

Anatomy TA (Optional Emp)

June 30 – Aug 1 (6 wks)

PHTH 505	Integrated Clinical Experience (1)
PHTH 524	Psychosocial Aspects of Health Care (2)
PHTH 526A	Cardiopulmonary (3)
PHTH 554	Professional Formation II (1)
PHTH 586	Orthotics & Prosthetics (2)
PHTH 587	Pharmacology (2)
RELT 740	World Religions & Human Health (3)

[14 units]

AUTUMN - 12 wks (Sept 22 - Dec 12)

PHTH 501	Neurology I (3)
PHTH 505	ICE (0)
PHTH 521B	Orthopedics IB (3)
PHTH 526B	Cardiopulmonary II (3)
PHTH 554	Professional Formation II (0)
PHTH 557	Pediatrics I (3)
PHTH 575	Orthopedics IV (1)
PHTH 595	Clinical Imaging (3)
AHCJ 719	Wholeness Portfolio (1)

[17 units]

2026

WINTER - 11 wks (Jan 5 - March 20)

PHTH 502	Neurology II (3)
PHTH 505	ICE (0)
PHTH 518	Aspects of Health Pro (2)
PHTH 522	Orthopedics II (3)
PHTH 530	Therapeutic Exercise II (3)
PHTH 534	Soft Tissue Techniques (2)
PHTH 540	Concepts in Acute Care (2)
PHTH 554	Professional Formation II (0)
PHTH 558	Pediatrics II (3)
PHTH 575	Orthopedics IV (0)
AHCJ 719	Wholeness Portfolio (0)

[18 units]

SPRING - 11 wks (March 30 – June 12)

PHTH 503	Neurology III (3)
PHTH 505	ICE (0)
PHTH 517	Movement Science (2)
PHTH 523	Orthopedics III (3)
PHTH 554	Professional Formation II (0)
PHTH 555	Medical Screening (2)
PHTH 559	Geriatrics (2)
PHTH 561	PT Administration (2)
PHTH 597	Specialized Interventions in PT (2)
AHCJ 719	Wholeness Portfolio (0)

[16 units]

2026

SUMMER - 8 wks (June 22 – Aug 21)

June 22-July 17 (4 wks)

PHTH 504 Neuro IV (2)

PHTH 596 Ortho V (3)

[5 units]

July 27 – Aug 21 (4 wks)

PHTH 572 Short Clinical Experience II (2)

[2 units]

Aug 24-Sept 18 (4 wks)

Aug 24-Sept 4 (2 wks)

Sept 7-18 ACE Modules 1-3

AUTUMN – 12 wks (Sept 21–Dec 11)

PHTH 701 Long Clinical Experience I (5)

[5 units]

2027

WINTER - 11 wks (Jan 4 - March 19)

PHTH 702 Long Clinical Experience II (5)

[5 units]

SPRING - 11 wks (March 30 – June 12)

March 29 – June 4 (10 wks)

PHTH 703 Long Clinical Experience III (5)

June 7-11 (1 wk) - Graduation Preparation

June 10 – White Coat Dedication Ceremony

Graduation Ceremony: **June 13, 2027**

[5 units]

OPERATING POLICY

CATEGORY:	Academics	CODE:	A-8
		EFFECTIVE:	8/19/2013 8/6/2012
SUBJECT:	Grading- Clinical Experiences	REPLACE:	7/12/2021 8/19/2013 8/6/2012 8/3/2011
DEPARTMENT:	Physical Therapy	PAGE:	1 of 2
COORDINATOR:	DEPARTMENT CHAIR		

The sources of data listed below are used by the Director of Clinical Education (DCE) and Clinical Education Committee (CEC) in assigning a grade for a clinical experience. As the faculty representation for matters of clinical education experiences, the CEC has the right to and may obtain input from additional faculty members in assessing the overall student performance and assigning the grade. Data gathered from the following will inform the grading process:

1. Physical Therapist/Physical Therapist Assistant Clinical Performance Instrument (CPI) or the Short Clinical Experience Evaluation Form (for the DPT Program). Both the assessment by the Clinical Instructor as well as the student self-assessment will be reviewed.
2. Interviews conducted by academic faculty with the Site Coordinator for Clinical Education (SCCE), Clinical Instructor (CI) and the student.
3. Documentation of all required assignments as outlined in the Course Syllabus/Outline.

The CPI and the Short Clinical Experience Evaluation Form include criteria and rating scales/standards upon which the students' performance is represented. Space is also provided for each criterion where the CI could document narrative comments.

Students are expected to demonstrate attributes, characteristics and behaviors that are not explicitly part of the professional core of knowledge and technical skills but are nevertheless required for success in the profession. The APTA has identified behaviors [Core Values/Values-based behavior] that are integral to the satisfactory completion of a clinical experience. The CEC will reference these APTA sources to substantiate the decision for grading as deemed necessary.

The program has defined standards for each criterion which indicate satisfactory (S) completion of each specific clinical experience. (See *Standards for Satisfactory Completion of Long Clinical Experience* and *Standards for Satisfactory Completion of Short Clinical Experiences, and Standards for Satisfactory Completion of Clinical Experiences PTA*). The Clinical Instructor does not determine the final grade for the clinical experience but provides valuable assessment of student onsite performance in terms of each clinical criterion observed.

The clinical experiences are graded as Satisfactory (S), Unsatisfactory (U) and on rare occasions, Incomplete (I). In the very rare event that a course withdrawal occurs during the period allowed for significantly extenuating circumstances a Withdrawal (W) will be the designated transcript entry. Each student is expected to receive a satisfactory rating by the end of each clinical rotation. Each rotation is independent of the others and

must be satisfactorily completed. Errors in safety and/or judgment and unprofessional behavior may be grounds for the student to be removed from the facility.

If the clinical faculty (CI and SCCE) find that the student is not meeting the requirements or expectations for the clinical experience, the CI or SCCE should contact the DCE for more in-depth and collaborative assessment and development of a plan of action towards a more amenable outcome.

The following are examples of conditions presenting grounds for an Unsatisfactory (U) Grade:

1. The student terminates the clinical experience without authorization of DCE/CEC.

2. The student fails to attain Satisfactory Program Standards as assessed using the respective CPI/Short Clinical Experience Evaluation Form.

> *Note: failure to attain the standard for as few as one (1) criterion could result in an Unsatisfactory (U) grade. Performance scores which do not meet the standard are reviewed by the DCE in conjunction with the CEC in determining the final grade.*

3. The student fails to complete, with appropriate signatures and dates, and submit all required documents and assignments associated with the clinical experience by 5:00 p.m., on the MONDAY after the last scheduled date of the clinical rotation. The documents may include but are not limited to the CPI, Short Clinical Experience Evaluation Form, In-service / Project Report, and Reflection Paper ***A "U" grade entered under this condition may be remediated by submission of completed documents and re-registration.*** *(The tuition/fees would be calculated at half the price of the regular fees).*

4. The student commits an egregious offense e.g., stealing, sexual harassment, fraud, professional misconduct such as inappropriate public postings on public social networks such as Facebook ® and Twitter ®.

5. The student demonstrates practice which is significantly disruptive to the operation of the clinic, places patients at risk of injury and/or places the clinic and staff in a position of liability.

If a student receives an unsatisfactory grade on a clinical rotation for anything other than late submission of paperwork, the student will need to remediate the entire clinical experience prior to progressing to the next (more advanced) clinical experience or completing the program. Though the setting at the next clinical site may not be the same as the setting in which the Unsatisfactory grade was received, ultimately, the student will need to satisfactorily complete a clinical rotation in the same setting as the Unsatisfactory grade.

The following conditions may present grounds for an Incomplete (I) grade:

The student is unable to complete the clinical experience within the designated time frame due to, but not limited to unforeseen circumstances such as family death or lack of fitness for duty which may include injury, illness, and complicated pregnancy.

If a student receives an Incomplete (I) grade in a clinical experience the additional time must be completed in the same setting as the original. This period must be scheduled for no less than six weeks for Long Clinical Experience and no less than two weeks for return to the same clinical site and four weeks for a new clinical site in the case of the Short Clinical Experience in the DPT Program, The PTA Program requires the full six weeks in order to increase the potential for a satisfactory completion.

Loma Linda University Entry Level DPT Program

Standards for Satisfactory Completion of Short Clinical Experience

Students must complete the following to Complete SCE – 1 and progress to SCE - 2

1. Evaluation of student by the CI includes documentation using the *SCE Evaluation Form* marked at or above the second rating category stating **(“***can progress to next level”***)**
2. Student Self-Assessment using the *SCE Evaluation Form*
3. Interviews by academic faculty with the CI and the student if needed.
4. Timely submission of other program assignments (see course syllabus)

Students must complete the following to Complete SCE – 2 and progress to LCE - 1

5. Evaluation of student by the CI includes documentation using the *SCE Evaluation Form* marked at or above the second rating category stating **(“***can progress to next level”***)**
6. Student Self-Assessment using the *SCE Evaluation Form*
7. Interviews by academic faculty with the CI and the student if needed.
8. Timely submission of other program assignments (see course syllabus)

Loma Linda University Entry Level DPT Program
<u>Learning Objectives for Short Clinical Experiences</u>

At the end of the Short Clinical Experience (SCE) the student will be able to demonstrate Professional Behavior and Communication with few prompts or without prompts and will be able to perform basic PT skills with assistance or without assistance in the following areas, as indicated:

1. Professional Behavior: Punctual, dependable; appropriately dressed; shows initiative; DCE responsibility of own behavior; Protects patient privacy; respectful of authority; manages own time wisely. (7D1, 7D4, 7D5, 7D6, 7D14)
2. Communication: Communicate effectively with all stakeholders, including patients/clients, family members, caregivers, practitioners, inter-professional team members, consumers, payers, and policymakers. (7D7, 7D21)
3. Safety: Safe work area, patient safety, proper body mechanics, universal precautions, facilitated transfers. (7D33, 7D37)
4. Screening: General health, blood pressure, pulse oximetry, heart rate, pain, respiratory rate, limb girth, and sensation. (7D16, 7D34, 7D35)
5. Range of motion: Upper extremity, lower extremity, spine. (7D17, 7D18, 7D19 a-w, 7D35)
6. Manual Muscle Tests: Upper extremity, lower extremity. (7D17, 7D18, 7D19 a-w, 7D35)
7. Biophysical Agents: As indicated. (7D17, 7D18, 7D19 a-w, 7D35)
8. Gross ADL / Mobility: Transfer training, gait assessment. (7D17, 7D18, 7D19 a-w, 7D35)
9. Miscellaneous Skills: Orthopedic special tests, neurologic special tests. (7D17, 7D18, 7D19 a-w, 7D35)

Loma Linda University Entry Level DPT program
Standards for Satisfactory Completion of Long Clinical Experiences

The final grade for each clinical education experience is determined by the Director of Clinical Education (DCE) and the Clinical Education Committee (CEC), which is comprised of the of PT and PTA Program Directors, Department DCEs, and Midterm Faculty Reviewers.

The grade is determined based on the following resources:

1. Clinical Performance Instrument (both clinical instructor assessment and student self-assessments using the APTA CPI 3.0
2. Interviews by academic Faculty Midterm Reviewers with the clinical instructor (CI) and or site coordinator of clinical education (SCCE), and the student.
3. Completion of required assignments as outlined in the course syllabus/course outline including an In-Service, Case-Study, or Clinic Related Project as directed by the CI, and the APTA Physical Therapy Student Evaluation of Clinical Experience and Clinical Instruction (PTSECE) survey.

Rating Scale
The student's clinical performance is formerly evaluated during the midterm period and at the end of the experience using the CPI 3.0. However, clinical instructors are encouraged to provide ongoing feedback to the student on the student's progress to allow timely communication and intervention if needed.
The CPI is comprised of 12 Criteria. All of which should be addressed. Each student is expected to attempt to attain" Entry Level performance" as described by the APTA CPI Rating Scale anchors for each long clinical experience

Standards for passing according to the CPI Rating Scale anchors are:
First Long Clinical Experience (PT LCE I): The student should be at a minimum of *Advanced Intermediate Performance [4]* on all criteria.
Second Long Clinical Experience (PT LCE II): The student should be at a minimum of *Advanced Intermediate Performance [4]* on all criteria.
Third Long Clinical Experience (PT LCE III): The student should be at a minimum *of Entry-Level Performance [5]* on all criteria.

Each student is expected to attempt to attain" Entry Level" as described by the APTA CPI 3.0 Rating Scale Anchors descriptors for each Long Clinical Experience

Loma Linda University Entry Level DPT Program
Learning Objectives for Long Clinical experiences (LCE):

At the completion of the courses, **LCE I** and **LCE II,** the student will demonstrate a minimum "Advanced Intermediate Performance" as described by the Physical Therapy APTA CPI 3.0, on each of the 12 criteria.

Professionalism
1. Ethical Practice (7D1, 7D2, 7D3, 7D4, 7D5, 7D6, 7D14)
2. Legal Practice (7D1, 7D2, 7D3, 7D4, 7D5, 7D6, 7D14)
3. Professional Growth (7D13, 7D15)

Interpersonal
4. Communication. (7D7, 7D21)
5. Inclusivity. (7D8)

Technical/Procedural
6. Reasoning. (7D9, 7D10, 7D11, 7D34, 7D36, 7D40)
7. Examination, Evaluation and Diagnosis. (7D16, 7D17, 7D18, 7D19 a-w, 7D20, 7D22, 7D23, 7D34, 7D35, 7D40)
8. Plan of Care. (7D24, 7D26, 7D28, 7D30, 7D35, 7D36, 7D39, 7D40)
9. Interventions and Education (7D12, 7D27a-i, 7D34, 7D35)

Business
10. Documentation. (7D32, 7D38)
11. Financial Management and Fiscal Responsibility. (7D35, 7D36, 7D38, 7D40, 7D41, 7D42)

Responsibility
12. Guiding and Coordinating Support Staff (7D25**,** 7D29).

At the completion of the courses, **LCE III** the student will demonstrate a minimum of "Entry Level Performance" as described by the Physical Therapy APTA CPI 3.0, on each of the 12 criteria.

Professionalism
1. Ethical Practice (7D1, 7D2, 7D3, 7D4, 7D5, 7D6, 7D14)
2. Legal Practice (7D1, 7D2, 7D3, 7D4, 7D5, 7D6, 7D14)
3. Professional Growth (7D13, 7D15)

Interpersonal
4. Communication. (7D7, 7D21)
5. Inclusivity. (7D8)

Technical/Procedural
6. Reasoning. (7D9, 7D10, 7D11, 7D34, 7D36, 7D40)
7. Examination, Evaluation and Diagnosis. (7D16, 7D17, 7D18, 7D19 a-w, 7D20, 7D22, 7D23, 7D34, 7D35, 7D40)
8. Plan of Care. (7D24, 7D26, 7D28, 7D30, 7D35, 7D36, 7D39, 7D40)
9. Interventions and Education (7D12, 7D27a-i, 7D34, 7D35)

Business
10. Documentation. (7D32, 7D38)
11. Financial Management and Fiscal Responsibility. (7D35, 7D36, 7D38, 7D40, 7D41, 7D42)

Responsibility
12. Guiding and Coordinating Support Staff (7D25**,** 7D29).

Student Signature Page

By signing below, I acknowledge receipt of the Loma Linda University Department of Physical Therapy Clinical Education Handbook. I agree to follow the expectations and guidelines as outlined. I understand that the policies and procedures presented in the handbook are subject to change. I further understand that this handbook does not replace or nullify the contents of the School of Allied Health Professions Catalog or the Student Handbook.

Print Name

____

Signature | Date

____ | ___________________________