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Overview of the Program

The University of Michigan-Flint Neurologic Residency Program at the University of Michigan Health System is dedicated to foster the resident in gaining expertise in neurologic practice by providing the highest level of training to the resident through didactic and clinical education, patient care, opportunities in clinical research and leadership development. The goal of the residency program is to prepare graduates who will become an evidence-based clinician in advanced practice in neurologic physical therapy.

The residency curriculum includes clinical and didactic components both of which are based on the APTA’s Description of Specialty Practice in Neurology (DSP). The DSP details what a Neurologic Clinical Specialist is expected to know, and it forms the basis for the American Board of Physical Therapy Specialists (ABPTS) Neurologic Clinical Specialist (NCS) exam. Mentored clinical experiences occur across a broad range of neurologic clinical practice settings and are facilitated by an ABPTS certified clinical specialist. The didactic component of the residency curriculum is delivered fully online and taught by University of Michigan – Flint Physical Therapy Department faculty. Upon completion of didactic coursework, the resident earns a Clinical Certificate in Neurologic Physical Therapy from the University of Michigan. Coursework can also be applied to PhD studies in the University of Michigan – Flint PhD in Physical Therapy program. In addition to coursework and clinical practice, residents develop leadership skills through service, advocacy, teaching, and research activities.

The University of Michigan-Flint Neurologic Residency Program at University of Michigan Health System is the result of a collaborative partnership between University of Michigan-Flint (UM-F) and the University of Michigan Health System (UMHS). The Coordinator of the Residency is responsible for all internal and external activities related to the program, ongoing program evaluation, and monitoring the outcomes of the program. The Clinical Coordinator of the Residency Program is a member of the UMHS and an ABPTS certified neurologic clinical specialist. The Clinical Coordinator facilitates the communication between the UM-F and UMHS campuses and the delivery of quality mentoring experience for residents enrolled in the program. Faculty meetings, on site visits, and sharing of teaching outcomes and resources are scheduled regularly and the Neurologic Physical Therapy Residency Organization page in Blackboard is utilized to assist the collaboration of faculty at the UM-F and UMHS campuses.

Our program policies and procedures reflect the collaborative partnership between UM-Flint and UMHS. Policies and procedures are reviewed on an ongoing basis and are available on the residency organization page, in the Neurologic Physical Therapy Advanced Practicum Blackboard course shell, and in the Resident Handbook.
Faculty and Staff of the UM-Flint Neurologic Post-Professional Program

James Creps, PT, DScPT, OCS, CMPT
Assistant Professor and Associate Director of Post-Professional Education Non-Degree Programs

Dr. Creps graduated from the Medical College of Ohio's School of Physical Therapy in 1984, received an Advanced Master’s Degree in Orthopedic Physical Therapy in 2000, and a Doctor of Science degree in Physical Therapy in 2009. He's an ABPTS certified Orthopedic Clinical Specialist and a certified Manual Physical Therapist through the North American Institute of Orthopedic Manual Therapy. In his capacity as the Associate Director of Post-Professional Non-Degree Programs, Dr. Creps is responsible for the administration of all of the University of Michigan-Flint's Certificate and Residency Programs, including the Neurologic Physical Therapy Residency Program.

Contact Information
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Phone: 810.762.3373

Mary Roberts, PT, DPT, NCS
Director and Coordinator of Neurologic Residency Program

Dr. Roberts has a doctoral degree in Physical Therapy from Northwestern University. Dr. Roberts is a board certified Neurologic Clinical Specialist. Her clinical and research experience has focused primarily on neurologic rehabilitation with an emphasis on postural control, motor control and advancements in neurological recovery via use of technology. Mary is the clinical mentor for the MedRehab Canton clinical rotation site and assists with the development of the neurological rehabilitation. Her professional associations include the American Physical Therapy Association (APTA) and Section for Neurology. Mary has been working for the University of Michigan since 2007.

Contact Information
E-mail: mpietsch@med.umich.edu
Phone: 734-844-2020
Christina Wixson, BA

Program Coordinator, Post-Professional Programs Mrs. Wixson is the Program Coordinator for all post-professional degree and non-degree programs. She joined the University of Michigan – Flint Physical Therapy Department in November of 2008. Christina holds a BA in Organizational Communications from the University of Michigan-Flint. Mrs. Wixson works closely with the Associate Director of Post-Professional Non-Degree Programs and the Residency Coordinator and provides student support.

Contact Information
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Phone: 810.762.3373

University of Michigan-Flint

Mission Statement
The University of Michigan-Flint is a comprehensive urban university of diverse learners and scholars committed to advancing our local and global communities. In the University of Michigan tradition, we value excellence in teaching, learning and scholarship; student centeredness; and engaged citizenship. Through personal attention and dedicated faculty and staff, our students become leaders and best in their fields, professions and communities.

Core Values
The University’s 2011-2016 strategic plan sets forth priorities to fulfill the University’s three pillars of excellence in teaching, learning and scholarship, student centeredness, and engaged citizenship including the following:

- Priority #1 – Enhance the quality and breadth of academic programs and be a school of first choice
- Priority #2 – Foster a culture in which faculty are supported in pursuing disciplinary and interdisciplinary teaching, scholarship, and creative activity, and expand faculty professional development
- Priority #4 – Expand participation in civic engagement, experiential learning, and service learning
- Priority #5 – Fulfill our student mission as we serve a growing and increasingly diverse student population
- Priority #6 – Cultivate a campus climate that embraces diverse social identities and perspectives.

The mission statement and 2011-2016 strategic plan of the University of Michigan-Flint guides the goals and objectives associated with the Neurologic Physical Therapy Residency Program.
Accreditation Status
The University of Michigan-Flint is fully accredited by the Higher Learning Commission of the North Central Accreditation of Colleges and Schools. Accreditation was renewed in 2010. The American Board of Physical Therapy Residency and Fellowship Education (ABPTRFE) is the accrediting body of the American Physical Therapy Association for physical therapy residency programs in the United States. The Neurologic Residency accreditation was approved on November 30th, 2016 and will remain accredited until November 2021.

Academic Integrity
Intellectual integrity is the most fundamental value of an academic community. Students and faculty alike are expected to uphold the highest standards of honesty and integrity in their scholarship. No departure from the highest standards of intellectual integrity, whether by cheating, plagiarism, fabrication, falsification, or aiding and abetting dishonesty by another person, can be tolerated in a community of scholars. Such transgressions may result in action ranging from reduced grade or failure of a course, to expulsion from the University or revocation of degree.

It is the responsibility of all students and faculty to know the policies on academic integrity in the instructional units at the University of Michigan-Flint. Information about these policies and the appeals process is available from the appropriate administrative office of the instructional units: in the College of Arts and Sciences, the Office of the Dean of the College of Arts and Sciences; in the School of Education and Human Services, the Office of the Dean of the School of Education and Human Services; in the School of Management, the Office of the Dean of the School of Management; in the School of Health Professions and Studies, the Office of the Dean of the School of Health Professions and Studies and for graduate students, the Office of the Dean of Graduate Programs.

Departments and programs within these instructional units may have specific policies and procedures which further delineate academic integrity. In such cases students are bound by the University policy on academic integrity as well as these department or program policies.

Neurologic Residency Program

Mission Statement
The University of Michigan-Flint Neurologic Residency Program at University of Michigan Health System is dedicated to foster the resident in gaining expertise in neurologic practice by providing the highest level of training to the resident through didactic and clinical education, patient care, opportunities in clinical research and leadership development.
**Goals & Objectives**

**Goal #1.** Support the mission of the University of Michigan-Flint to achieve excellence in patient care, education, research, and leadership in neurologic practice by sharing the expertise of the faculty to new physical therapy graduates or general practitioners.

**Objectives**

a. The residency program will provide education focusing on evidence-based and patient-centered care in all elements of the patient/client management model as described in the APTA’s Guide to Physical Therapist Practice

b. The residency program will lead to competencies in advanced neurologic practice across the continuum of care, including the neurologic ICU, inpatient acute care, inpatient rehabilitation, vestibular rehabilitation, and outpatient settings

c. The faculty will provide clinical mentoring to residents at selected clinical sites within the University of Michigan Health System

**Goal #2.** Develop a Neurologic Residency that meets the credentialing criteria by the American Physical Therapy Association.

**Objectives:**

a. The program will recruit qualified physical therapy residents who desire to pursue advanced practice in neurologic physical therapy.

b. The program will support the faculty in receiving continuing education and training in areas relevant to teaching, mentoring, and advanced practice in neurologic physical therapy.

c. The faculty will evaluate the program performance according to the credentialing requirements of APTA, and develop appropriate strategies to improve program outcomes through formal and informal discussion at regularly scheduled and other face to face meetings.

**Goal #3.** Provide the post-professional education in advanced practice that integrates the current best evidence about neurologic physical therapy and foundational sciences in neurologic rehabilitation.

**Objectives:**

a. The program curriculum, including didactic courses and clinical mentoring, will address all areas of the Description of Specialty Practice in Neurologic Physical Therapy.

b. The faculty will provide additional instruction as needed based on the findings obtained through the evaluation of the resident’s performance and learning outcomes.

**Goal #4.** Graduate physical therapy residents who will demonstrate competencies in advanced neurologic practice as evidenced by attainment of neurologic specialist recognition.

**Objectives:**

a. The program curriculum will prepare the resident to sit for and pass the Neurologic Clinical Specialist examination on the first attempt after graduation

b. The faculty will mentor the resident in professionalism, advocacy, leadership,
professional development, and other scholarly activities, and provide opportunities for the resident to participate in professional meetings at the regional, state, or national levels.

**Resident Goals and Objectives**

The goals and objectives of the resident-in-training are as follows:

**Goal #1:** The residents will demonstrate clinical expertise for advanced practice in neurologic physical therapy.

**Objectives:** At the end of the program, the residents will be able to:

a. Complete all written, oral, and practical examinations in the didactic and clinical components of the residency successfully in good academic standing (GPA = B and above).

b. Attain advanced knowledge and skills in clinical reasoning and evidence-based practice to prepare the resident in passing the Neurologic Clinical Specialist examination on the first attempt after graduation.

c. Provide efficient and effective patient-centered care consistent with the Neurologic Physical Therapy Description of Specialty Practice.

d. Evaluate the ethical and legal considerations that impact neurologic physical therapy.

e. Conduct a systematic search of literature and critically appraise the literature to inform evidence-based practice for patients/clients.

f. Select appropriate and evidence-based outcome measures in complex clinical cases and incorporate the exam findings to develop the treatment plan, ongoing reassessment of patient progress, and in the discharge planning process.

g. Observe at specialty clinics and multidisciplinary management for patients with neurologic diseases and disorders.

**Goal #2:** The residents will demonstrate advocacy, leadership, and service in the profession.

**Objectives:** At the end of the program, the residents will be able to:

a. Become an active member in the APTA and the APTA Section on Neurology.

b. Participate in an advocacy activity that impacts the health care for patients with neurologic diseases and disorders at the local, state, or national level.

c. Create a knowledge translation proposal that explores strategies for implementing evidence-based practice and advanced practice at a clinical setting, or at the local, state, or national level.

d. Develop a quality improvement project, including peer review, utilization review, and the development and implementation of performance improvement processes within the health care setting.

e. Become a certified basic and/or advanced Clinical Instructor training through the APTA to prepare for future clinical education and mentoring of professional DPT students.

**Goal #3:** The resident will demonstrate competency in clinical research, teaching and learning.
Objectives: At the end of the program, the residents will be able to:

a. Complete a case report or other scholarly products to present at a national, state or local professional meetings or conferences.

b. Develop an education module on a topic related to advanced practice in neurologic physical therapy to an interdisciplinary team of healthcare professionals, physical therapy students, clinical mentors, and/or other physical therapists.

Program Curriculum
Courses PTP 677 (4 credit hour), PTP 678 (4 credit hour), PTP 679 (4 credit hour), PTP 777 (3 credit hour), PTP 774 (1 credit hour), PTP 778 (2 credit hour) and PTP 802 (6 credit hour) make up the didactic component of the neurologic physical therapy residency. These are post-professional graduate level courses that are only open to individuals who have obtained the DPT degree. The development of the curricular content in these courses was completed by referencing the American Board of Physical Therapy Specialties Neurologic Description of Specialty Practice (DSP) and Neurologic Physical Therapy Residency Curriculum by the Neurology Section of the American Physical Therapy Association. The skills and didactic knowledge described as requirements for advanced clinical practice are included in the curricular modules and care has been taken to ensure that an understandable transition between CAPTE standards for entry-level knowledge and skills and those referenced in the DSP has been made. PTP 802 is the course number for the Advanced Practicum component of the residency experience. This course is the vehicle that is used to coordinate the resident’s clinical mentoring experience and clinically relevant leadership, education, and research activities. The Advanced Practicum begins in the first semester of the first year and proceeds through the entire residency experience. It is designed so that congruency between the didactic and clinical components of the residency experience is ensured. Residents must hold a license to practice Physical Therapy in order to be eligible to enroll for this course.

Courses related to diseases and disorders encountered in neurologic physical therapy practice and those related to physical therapy examination, evaluation, and intervention are taught in sequence so that the resident has the opportunity to build upon previous didactic knowledge as they move towards advanced clinical practice. This allows the resident to have base line knowledge as their clinical practice exposure becomes more complex. Finally, the case study coursework, as well as the course on neurologic physical therapy practice in today’s health care system, ensure that the resident has the opportunity to have a broader perspective on how this new knowledge fits into the larger framework of advanced clinical practice and leadership in the profession.

The residency program is designed for a 12 month completion. The sequence of courses is shown below.
<table>
<thead>
<tr>
<th>Semester</th>
<th>Course Number</th>
<th>Course</th>
<th>Credit Hour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winter 201X</td>
<td>PTP 802</td>
<td>Advanced Practicum in Neurologic PT</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>PTP 678</td>
<td>Evidence Based Examination &amp; Outcomes in Neurologic Practice</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>PTP 774</td>
<td>Health Policy and Practice Administration in Advanced Practice</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>PTP 778</td>
<td>Health Policy and Practice Administration in Neurologic Physical Therapy</td>
<td>2</td>
</tr>
<tr>
<td>Spring-Summer 201X</td>
<td>PTP 802</td>
<td>Advanced Practicum in Neurologic PT</td>
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<tr>
<td></td>
<td>PTP 679</td>
<td>Evidence Based Plan of Care in Neurologic Practice</td>
<td>4</td>
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<tr>
<td>Fall 201X</td>
<td>PTP 802</td>
<td>Advanced Practicum in Neurologic PT</td>
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<tr>
<td></td>
<td>PTP 677</td>
<td>Advances in Neuroscience, Neurologic Diseases &amp; Disorders</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>PTP 777</td>
<td>Case Studies in Neurologic Physical Therapy</td>
<td>3</td>
</tr>
</tbody>
</table>

**Residency Experience**

**Environment**
Clinical practice locations for the neurologic residency will differ based on the employment agreement and learning needs of the resident. The types of clients treated at the facilities will reflect those listed in the Description of Specialty Practice in Neurology. Residents will have access to the client’s medical records, the expertise of physical therapy clinical specialists and other allied professionals (nursing, OT) as well as contact with the specialty and referring physicians.

**Schedule**
The resident engages in clinical practice based on the employment contract. During clinical practice, the resident will receive a minimum of 100 hours of mentoring during patient examination or intervention sessions. A minimum of an additional 50 hours of non-patient care mentoring will take place during the residency. Other mentorship will occur via synchronous and asynchronous communication with didactic and clinical faculty to include, but not limited
to review of patient cases, review of literature relevant to the patient cases, and discussion of clinical reasoning relative to various neurologic patient cases.

**Leadership Experience**
The resident is expected to provide leadership by example for the use of evidence based physical therapy practice. The resident is required to complete specific leadership activities as defined in the Advanced Practicum coursework. Examples of these leadership activities include performing educational presentations for peers, assisting with didactic and/or clinical education in the t-DPT and professional DPT program, submission of scholarly writing to a neurologic publication, and participation in statewide and national PT meetings and conferences as able.

**Cost and Compensation**
The cost for participating in the neurologic certificate and residency program is equivalent to the cost per credit hour at the University of Michigan-Flint for instate and out of state students. Residents may be eligible for scholarships to cover the cost of courses in the curriculum. Residents are paid a single monthly stipend of $3392.00.

**Professional Development Opportunities**
The resident will have access to all teleconferences and webinars offered through the University of Michigan-Flint’s Post Professional Program and may participate in the sponsored APTA CI credentialing courses. The resident will have access to the APTA professionalism modules and other courses through the APTA Learning Center. The resident will be encouraged to participate in an online knowledge translation learning circle with other residents in the Post Professional Certificate and Residency courses at the University of Michigan-Flint. Residents will be encouraged to attend state and national PT meetings of the profession and to participate as a presenter at these meetings.

**Resident Initial Competence and Safety within the Clinical Setting**

**CONFIDENTIALITY OF MEDICAL RECORDS AND PERSONAL INFORMATION**
All medical records and personal information of patients are kept strictly confidential following all policies and procedures of the University of Michigan Health System (UMHS) and the University of Michigan-Flint (UM-Flint). Any paper documentation of the above mentioned information must remove patient-identifiable data in compliance with the HIPAA regulations, and will be kept in a locked storage by the Coordinator of Neurologic Residency for up to 3 years. When deemed appropriate, these records will be destroyed confidentially by shredding. The UMHS utilizes the Electronic Medical System (EMS) for patient documentation which requires secured login using authorized credentials through the intranet. In addition, residents must follow all UMHS and UM-Flint policies and procedures related to nondisclosure of confidential information, including employee personal records, patient records, release of information, confidentiality of information transmitted via Fax machine, and third party concurrent medical record review. The residency program, its faculty/staff and residents must comply with the HIPAA regulations.
PATIENT RIGHTS AND ORGANIZATIONAL ETHICS
Patients at the UMHS are made aware of their rights in various formats, including signs posted throughout the facility, Notice of Privacy Practices automatically printed on patient’s first outpatient visit, and the Informed Consent process that explains the treatment or procedure a patient is facing. Consent must be obtained prior to any significant invasive treatment or procedure, and when there is a need to document the patient’s response to physical therapy treatments using audio-video recording. These consent forms must be approved by the UMHS in compliance with the HIPAA regulations. The patient’s understanding and consent are documented. The residents and faculty providing treatments to the patient must follow the UMHS policies and procedures in obtaining the consent from the patient, and documenting the consent or refusal accordingly.

The Institutional Review Boards of the UMHS (IRBMED) review and grant permission to all clinical research of human subjects conducted at the University of Michigan. Residents and faculty participating in clinical studies involving human subjects must comply with the IRBMED requirements. Prior to conducting a clinical study, residents and faculty must obtain the approval from the IRBMED, and obtain the written or verbal informed consent as required by the IRBMED from participating patients or legal guardians. All consent forms and procedures must comply with HIPAA regulations.

RESIDENT INITIAL COMPETENCY AND SAFETY
Initial competence of each resident is evaluated based on the information contained in their application files to the Residency, including academic records, past work experience, physical therapy licensure in the state of Michigan, statement of purpose, and letters of recommendation. Additionally, during the interview at the UM-Flint and the UMHS as required in the program admission process, the applicants to the Neurologic Residency will be presented with clinical scenarios of neurologic cases and provided the opportunities to discuss how they would manage these scenarios. This process will allow the faculty to assess the Residency applicant’s baseline knowledge and clinical reasoning skills with neurologic patients.

Upon matriculation into the residency, each resident first completes an orientation to the organization and to the work unit prior to beginning patient care. Physical therapy licensure in the state of Michigan is verified again by the employer at UMHS during this initial orientation. To determine the initial competence and safety in patient care, the clinical faculty will assess the resident at the beginning of a rotation (Week 1-2 during Acute Care/ICU; Week 1-2 during Inpatient Rehabilitation; Week 1 during Vestibular Rehabilitation; Week 1-2 during Outpatient Rehabilitation) using the graded Live Patient Examination form (passing score > 80%). Based on the initial evaluation, the faculty will meet with the residents to develop a learning plan to identify areas in need of improvement.

Additional forms of assessment used to determine clinical competency and safety are completed throughout the residency and include, but are not limited to: Clinical Mentoring Log (completed weekly), Residency Mentoring Forms (completed weekly), Formative and
Summative Assessment (completed at 6 and 12 months of the Residency), Live Patient Examination after the Mid-Term of each rotation (Week 6-8 at Acute Care/ICU; Week 10-11 at Inpatient Rehabilitation; Week 4 at Vestibular Rehabilitation; Week 4-6 at Outpatient Rehabilitation), and Resident Self-Assessment Survey (completed at 0, 6, and 12 months of the Residency). These forms with instructions are provided in Appendix C.

The residents submit the electronic copies of completed forms to the PTP 802 Advanced Practicum course shell in the UM-Flint Blackboard website through secured login. The results of these assessment are shared among the residency faculty through informal face-to-face communication, phone calls, or emails, and formal discussion at regularly scheduled faculty meetings or emergency meetings if deemed necessary.

**American Physical Therapy Association References and Resources**

In addition to the guidance provided by the University of Michigan – Flint Mission Statement, the American Physical Therapy Association provides guidelines for physical therapy residency programs which are incorporated into the framework of the neurologic physical therapy residency program. The following information on residency programs is available on the APTA website. This information was current as of November 2014.

**Residency Program Curriculum**

If the curriculum of the residency program is in an area or a portion of an area where American Board of Physical Therapy Specialties (ABPTS) specialist certification exists, the curriculum must reflect the entire spectrum of the current ABPTS Descriptions of Specialty Practice (DSP). If the curriculum of the residency or fellowship program is not in an area where ABPTS specialist certification exists, the curriculum must reflect the use of an analysis of practice using validated process. The validated analysis of practice must be approved by ABPTRFE prior to establishing the Program curriculum. See the definition for "Analysis of Practice" in ABPTRFE Accreditation Handbook for requirements related to conducting an analysis of practice for the purpose of developing a new residency or fellowship practice area. Please note that ABPTRFE approval of an analysis of practice and residency program is not formal recognition of a specialty area as defined by APTA. In addition, ABPTRFE recognition does not guarantee recognition by ABPTS and ABPTS retains its authority to require additional work and documentation should a petition to establish a specialty area be filed with ABPTS.

**Clinical Practice Time**

“The amount of time devoted to clinical practice should be determined according to what is necessary to achieve the program's curricular outcomes.”
**Clinical Residency and ABPTS Specialist Certification**

“Applicants must submit evidence of successful completion of an APTA-accredited post professional clinical residency in their respective specialty. Applicants who are currently enrolled in APTA-accredited clinical residencies (or are enrolled in a residency program who has submitted an accreditation application to ABPTRE no later than March 1, 2014) may apply for the specialist certification examination in the appropriate specialty area prior to completion of the clinical residency. These applicants will be conditionally approved to sit for the examination, as long as they meet all other eligibility requirements, pending submission of evidence of successful completion of the APTA-accredited clinical residency to APTA’s Specialists Certification Program. To verify your residency program’s credentialing status, please visit [www.abptrfe.org](http://www.abptrfe.org).” (Minimum Eligibility Requirements and General Information for All Physical Therapist Specialist Certification Examinations. [http://www.abpts.org/uploadedFiles/ABPTSorg/Specialist_Certification/About_Certification/SpecCertMinimumCriteria.pdf](http://www.abpts.org/uploadedFiles/ABPTSorg/Specialist_Certification/About_Certification/SpecCertMinimumCriteria.pdf). Accessed November 12, 2014).

**APTA Oath**

“GUIDELINES: PROFESSIONAL OATH FOR PHYSICAL THERAPISTS HOD G06-04-23-19
[Initial HOD 06-00-32-12] [Previously titled: Oath for Physical Therapists] [Guideline]

Whereas, the Code of Ethics, Guide for Professional Conduct, and Standards of Practice set forth principles and guidelines for professional behaviors;

Whereas, the profession has defined core values of accountability, altruism, compassion/caring, excellence, integrity, professional duty, and social responsibility;

Whereas, it is the responsibility of all academic and clinical faculty, clinical instructors, and professional mentors to actively promote to physical therapist students the importance of professionalism;

Whereas, an oath serves to enhance the commitment of the physical therapist professional to the patient, client, and themselves; and

Resolved, that the American Physical Therapy Association supports the use of a professional oath for students in accredited physical therapist education programs and for licensed physical therapists.”

American Board of Physical Therapy Specialties

References

The American Board of Physical Therapy Specialties (ABPTS) offers board-certification in eight specialty areas of physical therapy: Cardiovascular and Pulmonary, Clinical Electrophysiology, Geriatrics, Neurology, Orthopedics, Pediatrics, Sports, and Women's Health.

Mission Statement

“ABPTS’ mission is to improve public health by enhancing clinical excellence in physical therapy practice through credentialing clinical specialists.”


Specialist Certification

“The American Physical Therapy Association (APTA), a national professional organization representing more than 80,000 members throughout the United States, established the specialist certification program in 1978. Specialization is the process by which a physical therapist builds on a broad base of professional education and practice to develop a greater depth of knowledge and skills related to a particular area of practice. Clinical specialization in physical therapy responds to a specific area of patient need and requires knowledge, skill, and experience exceeding that of the physical therapist at entry to the profession and unique to the specialized area of practice........ ....The specialist certification program was established to provide formal recognition for physical therapists with advanced clinical knowledge, experience, and skills in a special area of practice and to assist consumers and the health care community in identifying these physical therapists.”  (Specialist Certification. http://www.abpts.org/Certification/ Accessed November 12, 2014)

Resources at the University of Michigan-Flint

Email Account

Your email address will be your uniqname@umflint.edu. Your email will be accessible at https://email.umflint.edu. As a student in the post-professional program at the University of Michigan-Flint you are expected to check your University email daily. This is to ensure that you are up to date with the most recent information that your instructors have to offer as this is the primary means of communication for the University and the faculty.

For more email information please visit: http://www.umflint.edu/advising/transfer_next_steps.htm
Office of Registrar
http://www.umflint.edu/registrar/welcome-office-registrar

Blackboard
https://bb.umflint.edu
Blackboard is the medium that will be used throughout the program to deliver your curriculum. It is a very good idea that you take the time to get familiar with this program. A sign-in page will appear. Enter your username and password to sign into Blackboard. Your username is the same as your Uniqname.

Office of Extended Learning (OEL)
The Office of Extended Learning (OEL) provides support for Blackboard. If you have questions about the use of Blackboard, please contact OEL directly for expert assistance.

Email
olhelp@umflint.edu

Office Location
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Student Resource
http://www.umflint.edu/node/1758

Residency Policies and Procedures

(Created in collaboration with The University of Michigan Health System Fall 2012; revised May 2015)

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Section 1: Patient and Client Care

CONFIDENTIALITY AND SECURITY OF HEALTH INFORMATION

How do I maintain the confidentiality and security of patient information?
Patient information is protected under UMHS and UM-Flint policies, Michigan laws and regulations, and professional ethical standards. Additional rules put in place by federal law under the Health Insurance Portability and Accountability Act (HIPAA), specifically govern the use, disclosure, access and safety of protected health information (PHI) related to our patients. Among other things, these rules impose new administrative requirements and consequences if we fail to adequately protect the information in all its forms (including verbal discussion, paper and electronic media).

What is protected health information (PHI)?
PHI is a HIPAA term for any information that can be linked to a specific patient about the patient’s health, health care or payment for health care services. PHI can be a patient’s complete medical record billing information, or simply the patient’s name, address, date of birth, date of service, or the fact they are a patient of ours.

When may I access PHI?
You may access PHI if you need the information to perform your job relating to the care of a patient. Accessing PHI for any other reason, including concern for a co-worker or relative or to determine whether an employee who has called in sick is actually ill or to check the
demographics page for address, birthday or contact information is strictly forbidden and will result in disciplinary sanctions up to and including discharge from employment.

What does “need to know” mean?
Need to know means that you may access or disclose PHI to a UMHS faculty, staff member or trainee only what he or she needs to know to perform his or her job. For example, you should not discuss seeing a co-worker’s relative or a celebrity in the Hospital. Need to know is important, however, this should never interfere with providing the best possible care to a patient. For example, never withhold PHI from a coworker who is co-managing a patient if the information might be relevant to that patient’s diagnosis or treatment. In the context of the Neurologic residency program, it is not appropriate to use any distinguishing patient information in the completion of an assignment unless permission has been granted by the patient.

PLEASE NOTE: Access to PHI is logged, and it can be audited. Access audits are undertaken when there is a report of inappropriate access, when requested by any patient, employee or staff member who believes their privacy rights have been violated, or when requested by an employee’s supervisor. When an audit reveals inappropriate access, disciplinary action will be initiated, up to and including discharge from employment.

What is the “minimum necessary" PHI I should access?
When you have determined that you have a need to know, you must still use or disclose only the minimum amount of PHI necessary to do your work. It is not appropriate to access or provide more PHI than needed. Minimum necessary does not apply to the information needed to treat our patients, so PHI can and should be used for treatment. Make sure that printed reports do not contain social security numbers, and think carefully before including other information that could put patients at risk for identity disclosure and theft.

May I discuss PHI with the patient's family and friends?
Discussion of PHI with a patient’s family and friends may or may not be appropriate, depending on the situation and the patient’s circumstances. Detailed information on disclosures to family and friends, as it relates to the Neurologic residency, is available online at http://www.med.umich.edu/u/hipaa/faqfamily.htm

May we give PHI to outside organizations that request it?
PHI may be disclosed if the request for information comes from a health care provider or health plan that is part of the patient’s treatment (remember, minimum necessary does not apply to treatment), or when the information is necessary for payment purposes, or is part of regular business operations of the Hospital or Health Center. In any event, be sure to verify the identity of the requesting individual or organization.

When may I access information about myself or my family members?
In the University of Michigan system, if your work authorizes access to CareWeb, you may access your own records and the records of your children until a child’s 11th birthday. After a
child turns 11, parental access is obtained through the child’s physician or the HIM Release of Information Unit.

To access the records of a spouse, family members or friends for purposes other than your job, you must have a signed authorization from the person granting access. This authorization must be placed on file with Medical Information Services in order to be valid. It is recommended that you also keep a copy of this signed authorization. Accessing information without authorization is subject to disciplinary action up to and including discharge, regardless of the reason. Using CareWeb to find a co-worker’s birthday or when a baby was born is unauthorized access.

**May I e-mail PHI?**

E-mail between UMHS workforce members should be sent within the GroupWise system. If you must send e-mail to a non-GroupWise user, such as many U-M Campus employees, follow the minimum necessary principle. When exchanging e-mail with patients, use the required disclaimer: “Electronic Mail is not secure, may not be read every day, and should not be used for urgent or sensitive issues.”

Email sent outside GroupWise is email that is sent or forwarded by any mechanism to an electronic mail box outside GroupWise. There are a number of ways to accomplish this, and in some cases it will be difficult for a user to know whether or not this is happening.

More information is available regarding communications containing PHI is available online at: [http://www.med.umich.edu/i/policies/umh/01-04-357.htm](http://www.med.umich.edu/i/policies/umh/01-04-357.htm)

FAQs on this topic are available at: [http://www.med.umich.edu/u/hipaa/faqemail.htm](http://www.med.umich.edu/u/hipaa/faqemail.htm)

**What can I do to protect PHI in general?**

- When sharing patient-related information, keep your voice level down, and avoid discussing it in public areas, such as corridors, elevators and the cafeteria.
- Dispose of all paper containing PHI by shredding or discarding in blue secure recycle bins. For disposal of non-paper PHI waste (ePHI on CD-ROMs, radiographs, portable hard-drive devices, etc.), call the Maintenance Call Center at 936-5054.
- Keep patient-related information from the view of other patients and visitors. In cases where patient safety may require patient identifiers in public areas, contact the Compliance Office at: [http://www.med.umich.edu/compliance/index.htm](http://www.med.umich.edu/compliance/index.htm) to determine whether it is appropriate to do so.
- Do not give patients their medical records to carry from one area to another.
- Where can I turn with PHI confidentiality and security questions?
- Ask your supervisor, who will know your unit’s specific practices.
- Review privacy/security information at: [http://www.med.umich.edu/u/compliance/area/privacy/index.htm](http://www.med.umich.edu/u/compliance/area/privacy/index.htm)
- Email questions to HIPAA-Inquiries@med.umich.edu.
PATIENT PROTECTION: RIGHTS AND ORGANIZATIONAL ETHICS

How do our mission and values assist our commitment to patients and families first?
We have an obligation to provide - and patients have a right to expect:

- Considerate and respectful care
- Information regarding their diagnosis and treatment
- Involvement in decisions about their own care
- Participation in ethical issues and questions
- Privacy and confidentiality
- Access to protective services
- The opportunity to consent to, or decline, participation in research studies
- Resolution of complaints
- To be informed of hospital charges and payment methods
- Appropriate assessment and management of pain

How patients are made aware of their rights?

- Signs are posted throughout the facility listing patient rights.
- The Patient Rights and Responsibilities brochure is available in all patient areas.
- The Guide to Guest Services lists patient’s rights in all inpatient units.
- Notice of Privacy Practices automatically printed on patient’s first outpatient visit.

How can patients have their concerns heard and what is the process for resolution?
It is every employee’s responsibility to attempt to resolve patient concerns at the point of origin in a timely and reasonable manner. However, it is appropriate to refer patients and family members to the Office of Clinical Safety (formerly Patient Relations) when:

- The staff providing the care, treatment or services are unable to resolve the patient/family concern at the point of delivery.
- The patient/family concern involves multiple areas.
- The Office of Clinical Safety can be contacted in one of the following ways:
  - Walk-in: University Hospital, Room UH 2B228 (Monday through Friday, 8 a.m. - 12 p.m. & 1-5 p.m.).
  - Phone: Call (734) 936-4330 or toll-free (877) 285-7788.
  - After hours, weekends & holidays: Call (734) 936-4000 and ask to have a House Manager or Administrator-on-Call paged.
  - Online: Fill out the secure, confidential form that is available online at https://www.med.umich.edu/secure/patrel/feedbackform.htm

How and when do patients give informed consent to receive medical treatments and procedures?
The Informed Consent process involves an explanation of the treatment or procedure a patient is facing — including foreseeable risks, potential benefits, possible consequences of refusal and
alternatives; providing an opportunity for questions and information-gathering; and allowing
the patient to make a choice. Consent is obtained prior to any significant invasive treatment or
procedure. The patient’s understanding and consent are documented.

Completed consent forms must be faxed into CareWeb, Imaged Documents by the unit/clinic
where the consent is obtained. When the consent is obtained in the inpatient setting the paper
copy should be placed in the medical record under the tab, —Reports & Procedures.

For information on faxing into —Imaged Documents  go to:
http://www.med.umich.edu/mcit/carewebwe/help/Legal&Consents.htm

Refusals should be documented on the Patient’s Release Form for Refusal of Blood or
Treatment available online at: http://www.med.umich.edu/i/policies/umh/releaseform.html

For more information, refer to the Informed Consent Policy available online at:
http://www.med.umich.edu/i/policies/umh/62-10-001.html

What if a patient cannot provide consent?
For minors or patients incapable of giving consent, consent may be obtained from a parent,
guardian or other individual with legal authority for medical decision making. In the event of a
medical emergency, when consent cannot be reasonably obtained, the physician may make a
judgment as to the patient’s likely wishes. Prior directives will have precedence in such cases.
Under certain circumstance, such as admission to the Emergency Department, there is an
implied consent for treatment.

What about consent related to blood products?
Blood products (red cells, platelets, plasma or cryoprecipitate) require a separate consent form.
The —Consent or Refusal Form for Blood Transfusion  is located on the back of the —Request
and Consent to Medical, Surgical, Radiological or Other Procedures  form. It can be used in
conjunction with a procedure/surgery or as a stand- alone form.

What resources are available for those dealing with ethical issues?
Ethical concerns are addressed by individual practitioners, multidisciplinary teams or by referral
to the Adult or Neurologic Ethics Committees. Ethics Committee members serve as consultants
on ethical/bioethical issues. An Ethics/Bioethics consult is needed when an individual is seeking
advice on ethical, moral or philosophical problems and issues related to the provision of patient
care.

Who can discuss help for financial or cost-of-care issues with patients?
Representatives from:

•  Patient Accounts 936-6939
•  Admissions and Business Services 936-6929
•  Professional Fee Billing 647-5225
•  Cancer Center Financial Counselor 647-8663
What is an advanced directive?
An advance directive is a legal document signed by a competent adult giving direction to health care providers about who can speak for them when they are deemed to be unable to speak for themselves and to express their choices for treatment in certain medical, surgical, and behavioral health circumstances. Legal Advance Directives in Michigan are limited to Durable Powers of Attorney for Health Care (DPOA-HC) and Do Not Resuscitate (DNR) declarations. A DNR declaration for non-hospital settings is different from a Do Not Attempt Resuscitation (DNAR) Order described in UMHHC policy 62-010-003 Patient Care Orders. DNAR Orders are written for hospital inpatients.

For more information, refer to the Advance Directives Policy available online at: [http://www.med.umich.edu/i/policies/umh/03-07-010.html](http://www.med.umich.edu/i/policies/umh/03-07-010.html)

At which point in the care experience are patients asked whether they have -- or wish to initiate -- an Advance Directive?
As required by federal and state law, competent adult patients 18 and older will be asked, when they are admitted as an inpatient, whether they have an advance directive. In ambulatory care settings, patients will be asked about their advance directives, when warranted in ambulatory care settings. Conversations around advance directives should take place at every inpatient episode of care, during new patient exams, during annual physicals, and prior to planned procedures and/or hospitalizations. Patients will be offered information in both settings - inpatient and ambulatory care. This is to be done in a sensitive manner, with regard to cultural and religious beliefs. Under Michigan law, neither the hospital staff nor the patient’s family members or presumptive heirs may act as a witness to the patient’s signature on an advance directive.

What resources are available to assist patients with advance directives?
We provide patients, family members and the public with booklets, and online information on advance directives. Representatives from Social Work (764-3140) are trained to discuss them with patients and families. Members of the adult and neurologic ethics committees assist with difficult situations.

What is meant by “No Code“?
No Code, also referred to as Do Not Attempt Resuscitation (DNAR), is an indicator of patients who do NOT wish to be resuscitated in the event their heart stops or they cannot breathe on their own (cardiac or respiratory arrest). In these cases, cardiopulmonary resuscitation (CPR) is not initiated (the arrest team is not called). A No Code/DNAR order must be written only by the patient’s attending physician, House Officer, Nurse Practitioner or Physician Assistant responsible for the patient’s care after consultation with the attending physician. A verbal order cannot be accepted. The order is written only after discussion with, and consent from, the patient - or an advocate/guardian (where applicable) if the patient is not competent. The written order should be accompanied by a note in the patient’s medical history describing involvement of the treatment team and patient and family in the decision.
Do Not Resuscitate (DNR) declarations are legal documents intended to be used ONLY in non-hospital settings. They are different from an inpatient DNAR Order, as described above.

**What assistance is there for possible victims of abuse and neglect?**
There are numerous resources available at the Abuse Hurts website located at: [http://www.med.umich.edu/i/abusehurts](http://www.med.umich.edu/i/abusehurts)
An Abuse Consultation Team (ACT) is in place to provide consultation on assessment, reporting and intervention in suspected cases of child abuse, sexual assault, elder/vulnerable adult abuse and domestic violence. The team also provides consultation about legal or confidentiality issues related to these issues. You may contact the team at 763-0215.

**What are the “red flags” to help identify possible abuse and neglect?**
Certain symptoms, injuries, behaviors and histories are indicators, or red flags, for abuse. If a patient exhibits these indicators, clinicians should explore the possibility of abuse more carefully. There is a formal inpatient screening process for abuse and neglect that includes specific questions for clinicians to ask patients. A yes response to questions such as those on the Functional Health Pattern Assessment Form (sampled below) should trigger a special consultation by the Social Work department.

- Are you afraid of anyone close to you?
- Have you ever been hit, slapped, kicked, pushed, shoved or otherwise physically hurt by your partner or someone close to you?
- Are you frequently upset, ashamed or embarrassed by someone close to you?
- Has anyone forced you to have sexual activities?
- Online resources include:
  - Red flags for domestic violence located at: [http://www.med.umich.edu/i/abusehurts/dvflags.htm](http://www.med.umich.edu/i/abusehurts/dvflags.htm)
  - Red flags for vulnerable adult abuse located at: [http://www.med.umich.edu/i/abusehurts/vaaflags.htm](http://www.med.umich.edu/i/abusehurts/vaaflags.htm)
  - Red flags for child abuse located at: [http://www.med.umich.edu/i/abusehurts/childflags.htm](http://www.med.umich.edu/i/abusehurts/childflags.htm)

If you, or a co-worker, is experiencing abuse at home or at work, contact the Employee Assistance Program at [http://www.med.umich.edu/mworks/eap/](http://www.med.umich.edu/mworks/eap/)

**Protection of Patient Rights Involved with Human Subject Research**
The resident must successfully complete the University of Michigan Program for Education and Evaluation in Responsible Research and Scholarship (PEERRS) training in the first semester and will comply with all University of Michigan policies and procedures related to human subjects research. Compliance with these policies and procedures are embedded in all assignments related to human subject research with the residency program.
PATIENT SAFETY

What is done to keep patient care at UMHHC as safe as possible?
UMHHC is committed to, and responsible for, providing a safe environment for patients, staff and visitors. You can read the UMHS Commitment to Safety available online at:
http://www.med.umich.edu/i/safety/commitment.htm

An institutional Patient Safety Program is in place to improve patient care and reduce mortality and morbidity. It identifies and analyzes high-risk processes and known adverse events that could have or did cause preventable patient injury or an impairment of patient safety. With the results, patient safety groups are developing risk-reduction strategies and other measures to enhance safety.

It is the policy of the UMHHC that all employees, faculty and staff, contract staff, residents, volunteers, patients, parents, legal guardians and visitors have the right to speak up to identify uncomfortable situations, confusion about the care provided or to be provided, or issues where real or perceived safety concerns are identified. This information is reported through an established chain of command.

More patient safety resources are available online at the UMHS Safety Central website at:
http://www.med.umich.edu/i/safety/patient.htm

What are the key principles guiding the Patient Safety program?
• A focus on process improvement, and the implementation of checks and balances to reduce the risk of error in the complex patient-care environment.
• A non-punitive, trusting environment where errors, adverse consequences of care and—near misses can be reported confidentially.
• All events, or potential events, that compromise patient or staff safety also provide opportunities to learn and identify ways to prevent future occurrences.
• Patient safety is everyone’s responsibility. Each employee plays a critical role in identifying, reporting and resolving conditions that may pose a potential hazard to patients and/or staff.
• New information or changes in process resulting from analysis will be communicated to staff in a timely manner.
• How do I report a safety concern?
• As an employee of UMHHC, there are several avenues available to you for addressing concerns related to the safety and quality of patient care, violation of University or UMHS policies or procedures, or breaches in privacy or security. More information on how to address concerns is available online at:
http://www.med.umich.edu/i/quality/action/quality_care_concerns.html
Section 2. Administration and Human Resources

REVIEW AND ASSESSMENT OF PROGRAM POLICIES AND PROCEDURES
Policies and procedures for the Neurologic Physical Therapy Residency Program will be reviewed on an ongoing basis and formally assessed approved at least annually.

ADMISSION POLICIES AND PROCEDURES
The residency admission process represents a collaboration between University of Michigan-Flint and UMHS including components from each institution as outlined below:

1. Residents apply online through RF-PTCAS.
   a. Complete online application
   b. Submit required documentation
      i. Official transcript from an accredited institution applicant must have a minimum 3.0 GPA in physical therapy degree
      ii. Current physical therapy license or registration as required in the state in which the applicant resides and practices
      iii. Current CPR Card
      iv. Two letters of recommendation from currently practicing Physical Therapists
      v. Curriculum vitae
      vi. Statement of Purpose with description of patient population in specialty area
   c. After application is completed, the Office of Graduate Programs review for admission into Graduate Programs. Upon admission into Graduate Programs, the applicant file is forwarded to the PT Department for faculty review and admission determination.
      i. Primary source verification of PT license
      ii. Review official transcript to confirm minimum academic requirement is met (3.0 GPA in PT degree)
      iii. Review documentation of current professional liability insurance coverage
      iv. Review letters of recommendation
      v. Review Statement of Purpose to confirm goal congruency between the applicant and the residency program.

2. University of Michigan – Flint Admission status
   a. Denial
      1. Does not successfully meet all criteria
   b. Standard admission
      i. Successfully meets all criteria
   c. Conditional admission
      i. Completes majority of admission requirements but has the following outstanding
         1) Official transcript with DPT posted
         2) PT License (licensing application in process with state Board of Physical Therapy Licensure)
3. **University of Michigan Health System Admission**
   Once an applicant to the University of Michigan-Flint Residency Program has been accepted and has selected University of Michigan Health System (UMHS) as the location for their clinical work, they will be required to have an onsite interview with the unit supervisors from the locations the resident will be treating patients and optionally with the Lead Coordinator for Clinical Residencies at UMHS. If an onsite interview is going to provide hardships due to travel, timing/availability, or scheduling, an interview via web meetings such as Skype, Blackboard, Blue Jeans, or Face Time will be provided.

   Acceptance to the UMHS clinical portion of the UM-Flint Residency Program is based on the application material and the interview. Once accepted, the applicant will be considered Allied Health Residents within the UMHS system, and is required to apply for a non-posted position at UMHHS to initiate their residency. Possession of a Michigan Physical Therapy license and proof of professional liability coverage is a requirement of acceptance to the clinical portion of the residency.

4. **No transfer of credit is allow at the UM-Flint Residency Program.** Once admitted into the program, the resident must enroll in all didactic courses and the Advanced Practicum course throughout the 12-month residency program.

**ORIENTATION TO THE RESIDENCY**
The resident receives orientation to the Physical Therapy Residency Program through a series of activities including:

- **Welcome Package Letter from UM-Flint**
  - Mailed to the resident immediately after the Graduate Programs admissions letter has been sent
  - Contains information to assist the resident in accessing the UM-Flint website, the PTD Post-Professional Student Handbook, course registration procedures, the Blackboard Orientation for Online Students, and additional resources for online learning

- **Blackboard Orientation for Online Students**
  - An online course designed to assist UM-Flint Post-Professional students and residents gain familiarity with the skills required for successful use of technology for online coursework
  - Available 6 weeks prior to the beginning of the first semester

- **Orientation to Advanced Practicum**
  - Blackboard Collaborate web-based, real time computer conference session between the Resident and the Residency Coordinator during the first week of the Fall Semester, Year 1; see Orientation Checklist in the Residency Handbook posted to the corresponding UM Flint PTD Post-Professional Education residency web page.
Orientation with Coordinator of Residency Program for completion of the orientation checklist. It is highly recommend that the orientation is completed face-to-face.

**UMHS Employee Orientation**
- Each UMHS allied health resident participates in an institutional orientation called "Michigan Traditions and Values" (MTV) before the work assignment begins. This activity is provided through the UMHS MLearning department. Topics include:
  - Mission, Vision, Values and Goals
  - Service Excellence
  - Patient and Family-Centered Care
  - Diversity and Cultural Competency
  - Employee Engagement
  - Lean Management
  - UMHS Mandatories
  - The MTV activity, once completed can be found on the residents MLearning Transcript.

Orientation to Residency UMHS Neurologic Clinical Practice Rotations
- Departmental orientations include topics such as:
  - ✔ Departmental organization and goals, and alignment with UMHS mission
  - ✔ Unit and scope of services
  - ✔ Unit/building fire/safety procedures
  - ✔ Major areas of responsibility, expectations, standards and competencies
  - ✔ All policies that affect employees including parking, smoking, dress code, key requests, etc.

**CLINICAL RETENTION**
The resident must abide by all UMHS employment policies and procedures and perform in a manner that is consistent with the UMHS Physical Therapy job description (see **Appendix D**). In addition, the resident must achieve a score > 80% on the graded Live Patient Examination/Interventions Evaluation at the end of each clinical rotation, and on the graded Summative/Formative Assessment at 6-month and 12-month of the Residency. If the clinical mentors or residency faculty have concerns about the resident’s performance in clinical competency during a rotation, an emergency meeting will take place via phone, online, or face to face to determine the appropriate steps to improve the resident’s performance.

**CLINICAL REMEDIATION**
The resident’s remediation plan is determined on an individual basis and follows these procedures. If the resident earns the grade of less than 80% on the Live Patient Examination/Intervention Evaluation that is scheduled after the Mid-Term of a rotation, or on
the Formative/Summative Assessment at 6-month and 12-month of the Residency, a remediation plan is warranted and will take place before reassessment. The plan for the rotations outside Vestibular Rehabilitation shall include:

1. Week 1 of the remediation plan
   a. Resident to provide self-reflection and self-evaluation of the assessment items needing improvement.
   b. Resident to develop and submit a written remediation plan to clinical mentor/evaluator and Coordinator of Residency.

2. Weeks 2-3 of the remediation plan
   a. Weekly meeting with clinical Mentor/Evaluator and Coordinator of Residency to discuss plan for improvement, performance, and progress toward goals.

3. Week 4 of the remediation plan
   a. Reassessment using the Live Patient Examination form
   b. The criteria for successful completion of the remediation plan is a score ≥80% or greater on a retake of the Live Patient Examination.

ACADEMIC RETENTION
Each semester, enrollment and completion of course work are confirmed
1. Appropriate clinical certificate courses taken and successfully completed
2. Academic deficiencies are identified
   a. Email is generated and sent to the resident with a request to contact the residency clinical coordinator to discuss.
   b. Plan is created and implemented to address the challenges the resident faces.

Resident must improve their academic standing in the semester following the academic shortage. Failure to do so may result in:
1. Academic probation
2. Dismissal

ACADEMIC PROBATION
A resident whose cumulative GPA falls below a B (3.0 on a 4.0 point scale, or 84-86.9% out of 100%), or receives a course grade below a C (2.0 on a 4.0 point scale, or 74-76.9% out of 100%) in a given semester or half semester will be placed on academic probation for the following semester or half semester of enrollment. Grades of C- and below are considered failing grades. During the probationary semester, the resident will not be awarded a graduate degree or certificate and cannot transfer credit to a PTD Post-Professional Education Program, be advanced to candidacy, or be allowed to change his or her program (i.e., dual degree, degree level, etc.). Upon the recommendation of the Associate Director for Post-Professional Education Degree and Non-degree Programs, and with the consent of Graduate Programs, a resident may be given an opportunity to correct the scholastic and/or academic deficiency. Graduate programs may also require residents to achieve minimum grades in the overall program of study and/or in particular courses.
A resident on probation when last enrolled in the PTD Post-Professional Education Program who wishes to be reinstated or change fields or degree level, must petition the PTD Post-Professional Education Program and Graduate Programs to modify the conditions of academic standing or discipline. The petition should: provide reasons for the poor academic record; explain how conditions that produced this poor performance have changed; and present specific plans for improvement. The PTD Post-Professional Education Program must approve the petition before a resident can be reinstated.

A resident may be required to withdraw or be dismissed. A resident whose cumulative GPA falls below a B (3.0 on a 4.0 point scale, or 84-86.9% out of 100%), who is not making satisfactory progress toward the degree, or who is failing to demonstrate an ability to succeed in his or her plan of studies, may be denied permission to register, required to withdraw, or dismissed from the program. Time limits for achieving candidacy, completing the program/degree doctorate are defined in this document.

**ACADEMIC REMEDIATION**
Residents who are challenged with the rigors of this program are given the opportunity to request a temporary withdrawal from the program.

1. Resident submits formal request for temporary withdrawal
   a. Request must include
      i. Reasons for challenges
      ii. Areas of challenge must be clearly outlined
      iii. Draft plan to re-enter the program
2. Request is reviewed by entire faculty for determination
   a. Timely review is required (5 business day response)
   b. Associate Director must approve request and plan to return

**ACADEMIC APPEAL PROCESS**
Residents to which the academic discipline policy is applied have a right of appeal to the Director of the Physical Therapy Department. The appeal to the Director must be written on the Physical Therapy Department Academic Standards Appeal Form (Appendix E). The appeal form must be received by the Director no later than 5 business days after the resident has received written confirmation of the faculty’s decision. During the departmental and school appeal processes the resident may not be enrolled in courses for which the resident has not successfully completed the prerequisite courses.

- The resident must specify the basis for the appeal on the PT Department Academic Standards Appeal form that is submitted to the Director.
- All evidence relevant to the appeal claim must be presented to the Director prior to or at the time of the appeal hearing. The Department Director is best able to make an informed decision only if all evidence pertinent to the case is presented before or during the departmental appeal hearing.
Upon receipt of notification of appeal, the Director shall in a timely manner hear the appeal if any of the following conditions exist:

- The decision is in violation of established departmental, school or university policies or procedures.
- New evidence is presented which bears upon the validity of the faculty’s decision.

Following appeal to the PT Department Director, the resident may seek further appeal to the Student Appeals Committee of the School of Health Professions and Studies (SHPS).

- If pursuing an appeal at the SHPS level, the resident should contact the Dean’s Office for a copy of the policy and procedures relative to the appeals.
- The decision of the Student Appeals Committee of the School of Health Professions and Studies shall be final.

**TERMINATION FROM PROGRAM**

A resident who withdraws from the academic portion of the Residency, the Physical Therapy Department (PTD) Post-Professional Graduate Program, or is dismissed from the program for academic reasons, is officially discontinued from the program by the PTD, Office of Graduate Programs and the Registrar’s Office of the University of Michigan-Flint (UM-Flint). Similarly, a resident who is not on an approved leave of absence and who does not maintain registration through a semester will be considered to have withdrawn and will be discontinued from the graduate program. As an employee of the UMHS, the resident is subject to all of the rules of employment of the organization, including the standard probationary period. A resident can be terminated from the Residency program if she or he fails to fulfill obligations within the UMHS as a physical therapist, or does not comply with the Academic Standards policy of the PTD at UM-Flint. Funding commitments made at the time of admission expire when a resident is discontinued from the program. A resident should consult with the faculty advisor and the Associate Director of Post-Professional Non-Degree Programs before deciding to withdraw from a Residency program. The employment status of a resident at the UMHS is terminated when a resident’s enrollment at the PTD Post-Professional Graduate Program ends.

**UMHS PROBATIONARY PERIOD**

The first 6 months of residency is a probationary period, unless an evaluation is not completed by the fourth month of the residency (UMPNC Agreement, paragraph 232). Upon satisfactory completion of the probationary period or if no evaluation is completed before the end of the fourth month, the individual acquires regular status as resident with the UM-Flint.

During the probationary period it is important to determine whether the individual continues service with the department and the UMHS. If the individual is not meeting the requirements of the job, corrective action should be taken prior to completion of the probationary period. Primary counsel regarding the any unsatisfactory performances is first managed by the clinical
mentor as well as the unit supervisors. Counsel and assistance in handling of this situation are available from the Human Resources Department at UMHS and within the policies and procedures of the UM-Flint Neurologic Residency.

**Nondiscrimination**
The University of Michigan, as an equal opportunity/affirmative action employer, complies with all applicable federal and state laws regarding nondiscrimination and affirmative action, including Title IX of the Education Amendments of 1972 and Section 504 of the Rehabilitation Act of 1973. The University of Michigan is committed to a policy of nondiscrimination and equal opportunity for all persons regardless of race, sex*, color, religion, creed, national origin or ancestry, age, marital status, sexual orientation, disability, or Vietnam-era veteran status in employment, educational programs and activities, and admissions. Inquiries or complaints may be addressed to the Senior Director for Institutional Equity and Title IX/Section 504 Coordinator, Office for Institutional Equity, 2072 Administrative Services Building, Ann Arbor, Michigan 48109-1432, 734-763-0235, TTY 734-647-1388. For other University of Michigan information call 734-764-1817.

* Includes discrimination based on gender identity and gender expression.

**Grievance Procedures**

I. Policy
A resident will be afforded the opportunity to file a grievance on matters associated with the resident’s relationship with the University or to enter into a dispute resolution process to facilitate resolving misunderstandings and maintain positive work relationships. An allegation that a resident’s rights under this policy have been violated also will be subject to review under the grievance procedure. (This procedure is not available for resolving disputes or concerns regarding the University’s Benefit Plans. A separate procedure, administered by the Benefits Office, exists for those matters.)

II. Regulations
A. Pre-Grievance Counseling
Representatives of Human Resources and Affirmative Action (i.e. Staff Human Resources, Mediation Services, Health System Human Resources, Flint and Dearborn Human Resources), and, in situations when unlawful discrimination is alleged, a representative of the HR/AA Office of Institutional Equity, will be available to counsel Residents who believe they have a grievance.

The role of the counselor is to help the grievant identify the source of the problem and provide the grievant with information concerning University resources, policies and Standard Practice Guides, as well as information about protective state and federal laws and regulations which may have a bearing on the potential grievance.

B. Informal Resolution
The University will make a good faith effort to seek informal resolution of a problem brought to the attention of a Human Resources representative, through discussion and communication.
with the department or unit involved and with appropriate University officials. Residents and supervisory personnel are expected to consult with the appropriate offices and consider the option of mediation or other dispute resolution mechanisms before proceeding with the formal grievance process.

Efforts will be made to protect the privacy of persons involved to the extent possible. Informal avenues for University Residents to discuss work-related conflicts and resolve disputes are available from Human Resources. Specialized assistance using a trained mediator is available (see SPG 201.09). The use of any of these services will not deny a grievant continuing access to the prescribed grievance procedures.

Staff at Dearborn and Flint and within the Health Systems have access to the Informal Resolution option and may have other dispute resolution mechanisms available. Check with the appropriate HR/AA office.

C. Grievance Procedure
The Grievance Procedure is a three step management review process whereby Residents may address matters associated with their employment in accordance with the procedures set forth in this Standard Practice Guide. The process begins generally with a conversation between the resident and his/her supervisor (step 1). If not resolved there, step 2 in the process is for the Resident to submit his/her concerns in writing to the next level of supervision, the residency director. The final step, if needed, is the University Review Committee (see Procedures and item 6 below).

1. Time Standards
   Time limits set forth for filing and appealing grievances, must be strictly followed by the grievant. Mutually agreeable adjustments in the time period for holding a review meeting and in issuing an answer may be made due to the unavailability of a necessary party. The grievance is considered settled on the basis of the last answer if the grievant fails to appear at a scheduled review meeting or does not appeal on a timely basis. When both parties in a formal grievance process request it, the time clock on the grievance procedure may be stopped for a time period satisfactory to both parties to allow for a good faith attempt to resolve the conflict or disagreement through mediation.

2. Modification
   The progression from Steps 1 through 3 (see attached procedures) may be modified by the University by reducing the number of steps for grievance resolution where the origin of the grievance, the operational unit involved, or the content and scope of the grievance makes that progression impractical. In addition, at the option of the grievant, the grievance may begin at a level above the supervisor involved if the grievance alleges unlawful discrimination by such supervisor.

3. Assistance in Review Meetings
An Resident may select any individual (except an Resident who is included in a University collective bargaining unit or the grievant’s immediate supervisor) to assist in the review meetings at Steps 2 and 3. If the assistant is a University Resident, the assistant will not lose time or pay for attending meetings held during the assistant’s normal working hours.

4. No Loss of Time or Pay
An Resident’s attendance at a grievance review meeting held during normal residency hours shall be with pay per the stipend agreement. Any other time spent in formulating or preparing a grievance shall be done outside the regular work schedule and shall be without compensation.

5. Discipline Grievances
Grievances concerning discharge, disciplinary layoff, a written reprimand in lieu of a disciplinary layoff, alleged sex harassment or alleged unlawful discrimination will begin at Step 3.

6. University Grievance Review Committee
The University Grievance Review Committee includes the head of the aggrieved Resident’s operating unit, or a designated representative, who is responsible for the answer; an appropriate Director of Human Resources or a designated representative, who will preside and is responsible for conducting the review; and an resident not employed in the vice presidential or vice chancellor area in which the aggrieved resident works, who will be selected by the aggrieved resident from a panel appointed by the Vice Presidents and Vice Chancellors. When unlawful discrimination is alleged, the committee will also include an HR/AA representative of the Office of Institutional Equity.

The conduct of the meeting is prescribed by the University. The Resident will have an opportunity to present all relevant information to the University Review Committee during the meeting. The Committee will consider this information in formulating its response. Participants should not expect that witnesses will be called, testimony taken or that the proceedings will be recorded electronically.

The University Grievance Review Committee may explore the context in which the grievance occurred and consider other remedies. When one or more members of the committee do not agree with the grievance answer proposed by the operating unit, the member(s) may present concerns to the appropriate Executive Officer or designee for review.

7. Limits on Financial Reimbursement
Except as otherwise specifically provided, University liability for back wages or other financial reimbursement is limited to the period of 30 calendar days prior to the University’s knowledge of the facts brought to the University’s attention through this procedure.
D. Cooperation/Non-Retaliation
These procedures are designed to provide a fair internal mechanism for resolving disputes of Residents. The success of these procedures depends upon willingness of all members of the University community to participate when asked and to participate truthfully. An appeal under this procedure will not cause any reflection on the individual’s status as an resident nor will it affect future residency, compensation or work assignments. Retaliation against a resident who participates in the grievance or any informal resolution process is prohibited. A resident who penalizes or retaliates against another resident may be subject to corrective action.

RESPONSIBILITY ACTION
Seek pre-grievance counseling, and consider informal resolution.
Human Resources advises the Resident concerning University policies, practices, options and resources for mediation, Standard Practice Guides, and protective laws and regulations.

Work to informally resolve a grievance. In no event shall this effort void the time limits established in the procedure outlined in the Standard Practice Guide, except when parties choose to participate in mediation, per SPG 201.09.

Resident (Step 1) Within 15 calendar days (30 calendar days if the grievant works with a representative of HR/AA or the Office of Institutional Equity to informally resolve a grievance) of knowledge of the facts giving rise to the grievance, discuss grievance with immediate supervisor, or consistent with II.C.2. above, and at the option of the grievant, at a level above the supervisor involved if an allegation of unlawful discrimination against the supervisor Resident should clearly inform the supervisor they consider the discussion the 1st step of the grievance process. Supervisor Reply orally to Resident within three mutual working days from date of discussion. At this step supervisors are strongly encouraged to use informal dispute resolution to resolve problems.

Resident (Step 2) If not satisfied with oral answer, may appeal in writing to Department Head.

Complete Grievance Form 39707. Obtain advice as needed from appropriate Human Resources Office.

Present Grievance Form 39707 to Department Head (or equivalent level of supervisor) or his/her designated representative within seven calendar days following an unsatisfactory answer. If no answer is received within the time limit of three (3) mutual working days from date of discussion, the grievant may appeal at any time within seven calendar days after the due date.

Department Head Upon receipt of written appeal:

Notify Human Resources representative and send copy of grievance.
Schedule review meeting and hear oral presentation of grievance within seven calendar days of receipt of written grievance.

Provide resident with a written response to grievance within seven calendar days of review meeting.

Resident (Step 3) If not satisfied with the answer, appeals to the University Grievance Review Committee within 14 calendar days after receipt of Step 2 answer. If no Step 2 answer is received within seven calendar days of review meeting, may appeal to the University Review Committee within 14 calendar days of the due date (grievance involving lost time, discipline or discharge begins at Step 3 and must be filed within the time limits set forth for a Step 1 grievance).

Present Grievance Form 39707 (including Step 2 answer) to the University Grievance Review Committee.

Presider of University Upon receipt of written appeal, schedule review meeting.

Grievance Review Committee within 30 calendar days of receipt of written grievance.

University Grievance Review the record and hear the presentation of the grievance.

Review Committee Meet and consult as necessary. Issue answer to the grievance.

Presider of University Assure that written response to grievance is issued within 60 days.

Grievance Review Committee days from date of hearing (30 days when the grievant is appealing a discharge, a lost time disciplinary action, or alleged unlawful discrimination).

Member(s) of the University If not in agreement with the proposed answer, submit the matter Grievance Review Committee to the appropriate Executive Officer.

Executive Officer Review the record, determine whether the proposed answer requires reconsideration or direct the University Grievance Review Committee to issue the answer.

Head of Operating Unit If findings include the conclusion that a representative of the University with supervisory responsibility violated University policy, consider corrective action as provided in SPG 201.12.

No further appeal is available under this policy.

Procedures are issued by Human Resources and Affirmative Action Administration, and HR/AA retains the authority to revise them as necessary. Inquiries should be directed to HR/AA.
MALPRACTICE AND HEALTH INSURANCE
Statement of Medical Professional Liability Insurance:
For University of Michigan-Flint Residents Enrolled in the Physical Therapy Program, The University of Michigan self-insures its Medical Professional Liability Insurance exposures. This program includes coverage for all enrolled residents while acting within the scope of University sponsored activities, including course-required activity to complete their clinical certificate and residency. The University’s self-insurance program is permanently funded, non-cancelable and provides limits in excess of $1,000,000 each occurrence and $3,000,000 annual aggregate.

For questions, please contact the following:
Chip Hartke, Underwriter
The University of Michigan
Risk Management Department
Argus II Building
400 S. Fourth Street
Ann Arbor, MI 48103-4816
Office: (734) 764-2200
Fax: (734) 763-2043
E-mail: ehartke@umich.edu

UMHS Allied Health Residents are eligible for medical benefits. The costs of the benefits are scheduled according to the base salary of the resident. Residents are currently paid a stipend of $3392.00 per month for 30 hours a week of clinical work and 10 hours a week of didactic work; part time salaries are pro-rated from this amount based on the number of hours worked per week. Below is the cost schedule for Allied Health Residents which is under the category of Professional Specialist for HR benefits program. Residents sign up for these benefits through UMHS HR department.

Benefits Program: Professional Specialist
<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Your 2015 Monthly Deduction</th>
<th>University 2015 Monthly Contribution</th>
<th>2015 Total Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>U-M Premier Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You Only</td>
<td>$ 41.00</td>
<td>$ 485.00</td>
<td>$ 526.00</td>
</tr>
<tr>
<td>You + Adult</td>
<td>$ 229.00</td>
<td>$ 823.00</td>
<td>$ 1,052.00</td>
</tr>
<tr>
<td>You + Adult + Children</td>
<td>$ 334.00</td>
<td>$ 1,117.00</td>
<td>$ 1,451.00</td>
</tr>
<tr>
<td>You + Child</td>
<td>$ 145.00</td>
<td>$ 780.00</td>
<td>$ 925.00</td>
</tr>
<tr>
<td>You + Children</td>
<td>$ 145.00</td>
<td>$ 780.00</td>
<td>$ 925.00</td>
</tr>
<tr>
<td><strong>BCBS of Michigan Community Blue PPO</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You Only</td>
<td>$ 130.00</td>
<td>$ 485.00</td>
<td>$ 615.00</td>
</tr>
<tr>
<td>You + Adult</td>
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<td>$ 823.00</td>
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<tr>
<td>You + Adult + Children</td>
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<td>$ 1,117.00</td>
<td>$ 1,697.00</td>
</tr>
<tr>
<td>You + Child</td>
<td>$ 302.00</td>
<td>$ 780.00</td>
<td>$ 1,082.00</td>
</tr>
<tr>
<td><strong>Comprehensive Major Medical</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>You Only</td>
<td>$ 0.00</td>
<td>$ 482.00</td>
<td>$ 482.00</td>
</tr>
<tr>
<td>You + Adult</td>
<td>$ 141.00</td>
<td>$ 823.00</td>
<td>$ 964.00</td>
</tr>
<tr>
<td>You + Adult + Children</td>
<td>$ 213.00</td>
<td>$ 1,117.00</td>
<td>$ 1,330.00</td>
</tr>
<tr>
<td>You + Child</td>
<td>$ 68.00</td>
<td>$ 780.00</td>
<td>$ 848.00</td>
</tr>
<tr>
<td>You + Children</td>
<td>$ 68.00</td>
<td>$ 780.00</td>
<td>$ 848.00</td>
</tr>
<tr>
<td><strong>Health Alliance Plan</strong></td>
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<td></td>
</tr>
<tr>
<td>You Only</td>
<td>$ 133.00</td>
<td>$ 485.00</td>
<td>$ 618.00</td>
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<tr>
<td>You + Adult</td>
<td>$ 413.00</td>
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<tr>
<td>You + Child</td>
<td>$ 307.00</td>
<td>$ 780.00</td>
<td>$ 1,087.00</td>
</tr>
<tr>
<td>You + Children</td>
<td>$ 307.00</td>
<td>$ 780.00</td>
<td>$ 1,087.00</td>
</tr>
</tbody>
</table>
**TIME OFF**

UMHS Allied Health Residents are allotted 10 paid days off for a 12 month and 15 paid days off for an 18 month clinical residency program, not including holidays. Allied Health Residents are paid for the following observed holidays:

- Labor Day
- Thanksgiving Day
- Friday after Thanksgiving (only if the resident is working in an outpatient clinic at that time)
- Christmas Day
- New Year’s Day
- Memorial Day
- Fourth of July

Should an allied health resident require more than the above stated time off for any reasons during their residency, including remediation or leaves of absence, the UMHS Lead Coordinator for Clinical Residencies will review the circumstances around this excess. The UMHS Lead Coordinator for Clinical Residencies will require the resident to either (1) add time to the end of their clinical residency to make up for remediation or leaves of absence for up to a maximum of 20 days, (2) dismiss the resident for the remainder of the clinical residency with the option to return to the clinical residency during the following cycle.

**PROGRAM COMPLIANCE WITH ACCREDITATION CRITERIA**

The University of Michigan-Flint is actively pursuing ABPTRFE accredited physical therapy residencies in multiple specialty areas. As part of this initiative, the faculty and staff review the most updated versions of the ABPTRFE Evaluative Criteria as they become available and are published on the website. This process is used both proactively for developing residencies and retroactively for accredited residencies to ensure that all programs maintain compliance with the accreditation requirements of the ABPTRFE.

**ABPTRFE COMPLAINT PROCESS**

Any person who believes that this residency program is not in compliance with ABPTRFE criteria may turn to the American Board of Physical Therapy Residency and Fellowship Education (ABPTRFE) to log a complaint using the process described below.


File a Complaint

Any person may submit a complaint to ABPTRFE if he/she has reason to believe that a program with unqualified accreditation is not in substantial compliance with the Rules of Practice and Procedure, that a program with probationary accreditation does not merit probationary accreditation under Rule 9.5, or that an accredited program has not complied with its program agreement.
A complaint submitted under this Rule must be filed with APTA staff on the prescribed form.

Initial Review of Complaint
The APTA staff will review any complaint submitted under Rule 18.1 to determine whether the complaint relates to the program’s compliance with the program agreement, its compliance with the Rules of Practice and Procedure or, if applicable, its qualifying for probationary accreditation under Rule 9.5.

If the determination is negative, the staff shall so advise the complainant.

Compliance with Program Agreement
If APTA staff determines that a complaint relates to the program’s compliance with the program agreement and that the program has failed to comply with the obligations imposed by the program agreement, APTA may administratively withdraw the program’s accreditation pursuant to Rule 9.8.

ABPTRFE Processing
If APTA staff determines that a complaint relates to a program’s compliance with the Rules of Practice and Procedure or, if applicable, its qualifying for probationary accreditation under Rule 9.5, then the staff shall forward the complaint to ABPTRFE for processing in accordance with Rule 13.

Notification
ABPTRFE will notify the complainant if APTA administratively withdraws the program’s accreditation under Rule 9.8, if ABPTRFE changes an accreditation to a probationary accreditation under Rule 13.5, or if ABPTRFE withdraws accreditation under Rule 13.6.

If ABPTRFE chooses not to take adverse action under Rule 13.5 or Rule 13.6, it will notify the complainant.

UM-Flint Services and Support

Availability/Accessibility to Educational Advising and Counseling
The University of Michigan-Flint’s Physical Therapy Department offers students both educational advising and counseling via email, phone, office hours and video conferencing.

Available Support Staff and Services
The resident has access to the Assistant Director for Post-Professional Education Non-Degree Programs, the Residency Coordinator, the Lead Coordinator for Clinical Residencies at UMHS,
Clinical Mentors, Clinical Faculty, and the UM Flint Program Coordinator for Post-Professional Programs for assistance throughout the program.

**Educational Resources and Methods of Access**

1. **Resources**
   1) Blackboard Course Management System [www.bb.umflint.edu](http://www.bb.umflint.edu)
   2) Neurologic Physical Therapy Clinical Certificate Program curriculum
   3) UM-Flint Physical Therapy Department research lab facilities including neurologic body weight support system and treadmill, GaitRite walkway system, VICON motion analysis system, AccuGait portable force plate, and two AMTI-O-R-6-5 force plates
   4) Resources for research at UMHS including the Center for Statistical Consultation and Research and the Michigan Institute for Clinical & Health Research
   5) University of Michigan Filelocker Secure Temporary File Storage [http://filelocker.umflint.edu](http://filelocker.umflint.edu)
   6) Go-Pro video camera
   8) University of Michigan Inter-library loan [http://libguides.umflint.edu/ill](http://libguides.umflint.edu/ill)
   9) Taubman Medical Library [http://www.lib.umich.edu/taubman-health-sciences-library](http://www.lib.umich.edu/taubman-health-sciences-library)
   10) UMHS Grand Rounds and Clinic In-services

2. **Access to Educational Resources**
   1) For the didactic portion of the residency, residents are enrolled in the five course Neurologic Physical Therapy Clinical Certificate Program curriculum; courses are presented in an online format via the Blackboard course management system. Residents may access course materials and asynchronous learning activities at any time. Synchronous class meetings are held for all courses using Blackboard Collaborate computer conferencing sessions. Residents receive orientation to the Blackboard system prior to beginning the first semester in the program.
   2) Faculty and residents have access to the UM-Flint research labs by coordinating with the UM-Flint PTD Director of Research and to UMHS research resources through the assistance of clinical mentors and Lead Coordinator for Clinical Residencies.
   3) Residents are provided access to the University of Michigan Filelocker Secure Temporary File Storage through the Blackboard course shells for the Neurologic Physical Therapy Clinical Certificate Program curriculum. The Filelocker system is designed to allow large data files to be uploaded to a secure temporary site.
   4) The resident is provided with access to a Go-Pro video camera for video assignments. Video files can then be submitted to the instructor using the UM Filelocker system.
   5) All residents have full access to the University of Michigan and University of Michigan-Flint libraries. At the time of admission to the program, each resident is given a UMID number which enables them to access the electronic library and utilize the Taubman Medical Library.
   6) All residents attend the clinical lectures presented by the UMHS clinical faculty.
7) All residents participate in journal clubs and may attend the Grand Rounds (optional) at UMHS.
8) All residents attend the Department of Physical Rehabilitation in-services (required and optional).
9) All residents have access to personal computers located at the UMHS facilities

**Information Technology Service (ITS)**
The ITS department is available to help with all needs regarding on campus technology. The following guide will help with any questions with setting up a new account at The University of Michigan – Flint: [http://www.umflint.edu/its/documentation/studentguide.pdf](http://www.umflint.edu/its/documentation/studentguide.pdf)

**Office of Extended Learning**
The Office of Extended Learning ([http://www.umflint.edu/oel/](http://www.umflint.edu/oel/)) is a resource provided to all of University of Michigan-Flint students. It provides learning opportunities outside the traditional, face-to-face classroom experience. Outside of the online and mixed mode academic courses, professional development courses and workshops are also available.

The Office of Extended Learning also provides technology and online instructional support for UM-Flint faculty.

Student Help Guides are available at: [http://www.umflint.edu/node/1758](http://www.umflint.edu/node/1758)

**Counseling Services**
Counseling Services are provided to all University of Michigan-Flint students through the Student Development Center.

Contact Information:
Please call (810) 762-3456

**Accessibility Services**
Accessibility Services provides a supportive environment that enables students with disabilities the opportunity to develop to their maximum academic and personal potential. Students with documented disabilities may request modifications, accommodations, or auxiliary aids enabling them to participate in and benefit from all postsecondary educational programs and activities. The Accessibility Services Coordinator serves as a resource for students to assist them in adapting to the university, and educates the student about his/her role as a self-advocate in the accommodation process.

**Non-Discrimination Policy**
The University of Michigan, as an equal opportunity/affirmative action employer, complies with all applicable federal and state laws regarding nondiscrimination and affirmative action. The University of Michigan is committed to a policy of equal opportunity for all persons and does
not discriminate on the basis of race, color, national origin, age, marital status, sex, sexual orientation, gender identity, gender expression, disability, religion, height, weight or veteran status in employment, educational programs and activities, and admissions. Inquiries or complaints may be addressed to the Senior Director for Institutional Equity and Title IX/Section 504/ADA Coordinator, Office of Institutional Equity, 2072 Administrative Services Building, Ann Arbor, Michigan 48109-1432, 734-763-0235, TTY 734-647-1388. For other University of Michigan information call 734-764-1817.

**Student Loan Deferment Information**

Students may have loan deferment options while undergoing a residency or fellowship physical therapy program. Information regarding student loan deferment during residency can be found at ABPTRFE website:

“For information regarding federal loans, please review the [Federal Student Loan Forgiveness Opportunities for Physical Therapists](http://www.abptrfe.org/). Information regarding forbearance and deferment can be found on the [Department of Education website](http://www.ed.gov/).”

With respect to loans from private lenders, contact them and see what options they offer. Bear in mind that upon residency completion, you may receive a certificate from the program. In addition, should you sit for and pass the board certification exam through the [American Board of Physical Therapy Specialties (ABPTS)](http://www.abpts.org/), you will earn credentials following your residency training. Some private loan lenders may require you to verify either, or both.”

Appendix A: Neurologic Residency Orientation Checklist

NEUROLOGIC RESIDENCY ORIENTATION CHECKLIST

RESIDENT NAME:
REVIEWER NAME/INITIAL:

PHYSICAL THERAPY DEPARTMENT

- ORGANIZATIONAL STRUCTURE
- MISSION AND STRATEGIC PLAN
- POST-PROFESSIONAL PHYSICAL THERAPY EDUCATION NON-DEGREE PROGRAMS
  CLINICAL CERTIFICATES AND RESIDENCIES
- ACADEMIC STANDARDS AND INTEGRITY

RESIDENCY PROGRAMS

- PROGRAM MISSION
- PROGRAM GOALS/OBJECTIVES
- RESIDENT GOALS/OBJECTIVES
- CURRICULUM: CLINICAL AND DIDACTIC COMPONENTS
- CURRICULUM FLOW CHART
- ABPTRFE CRITERIA
- METHODS OF PROGRAM EVALUATION
## RESIDENCY EXPERIENCE

- ENVIRONMENT
- SCHEDULE
- CLINICAL MENTORING
- EVALUATION OF RESIDENT’S ADVANCING CLINICAL COMPETENCE
- ROLE OF THE RESIDENCY COORDINATOR
- POLICIES AND PROCEDURES
- COST AND COMPENSATION
- PROFESSIONAL DEVELOPMENT
- TEACHING AND RESEARCH
- ABPTS GRIEVANCE POLICY AND PROCEDURE

## STUDENT SERVICES AND UNIVERSITY SUPPORT

- EDUCATIONAL ADVISING AND COUNSELING
- INFORMATION TECHNOLOGY SERVICES (ITS)
- OFFICE OF EXTENDED LEARNING (OEL)
- ACCESSIBILITY SERVICES
- LIBRARY
- CENTER FOR STATISTICAL CONSULTATION AND RESEARCH
- MICHIGAN INSTITUTE FOR CLINICAL & HEALTH RESEARCH

## RESOURCES

- E-MAIL ACCOUNT
- CLASS REGISTRATION
- BLACKBOARD ACCESS
- ORIENTATION TO BLACKBOARD COURSE
- ORIENTATION TO BLACKBOARD ADVANCED PRACTICUM COURSE SHELL
- ORIENTATION TO BLACKBOARD RESIDENCY ORGANIZATION “ROOM”
Appendix B: Online Orientation Class

Welcome to the University of Michigan-Flint’s Post-Professional Neurologic Clinical Residency Program! We are happy to have you join us in this important and exciting journey. Graduate Programs will be sending you your University of Michigan-Flint Student ID (UMID) if they haven’t already. Below are some first steps to take to get you started. Please note that this document includes ‘snapshots’ from our actual website. This should assist you in seeing exactly what you should see!

Visit our website www.umflint.edu

In the upper right-hand corner of the webpage, you will see a “My” icon. Click on “My” to open a menu. Select ‘My UM-Flint’. Scroll down and Select “Blackboard”.

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[Website screenshot and navigation menu]

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Blackboard is the medium that will be used throughout the program to deliver your curriculum. It is a very good idea that you take the time to get familiar with this program.

A sign-in page will appear. Enter your username and password to sign into Blackboard. Your username is the same as your Uniqname.

Upon signing in, you are required to complete the Blackboard Orientation for Online Students. This will take approximately 1 hour. Make sure to get comfortable and avoid distractions.
Appendix C: Residency Forms

Form 1: Clinical Mentoring Log Sheet

**Purpose:** The clinical mentor and the resident use this form to track the number of medical diagnoses and patients seen, and the discussion on patient management during the one-on-one mentoring hours at each rotation.

**Use:** The resident will submit the completed form electronically via secured login to the Advanced Practicum course on Blackboard. The resident is to keep a signed paper copy in his or her binder. Blank copy of this form is available at the Advanced Practicum course shell on Blackboard. This form **MUST** be completed during the mentoring hours.

<table>
<thead>
<tr>
<th>Resident Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginning Date on:</td>
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<td>Ending Date on:</td>
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</table>

1:1 clinical mentoring/instruction from physical therapist clinical faculty while resident is treating patients

<table>
<thead>
<tr>
<th>Clinical faculty</th>
<th>Date</th>
<th>Time</th>
<th>Setting</th>
<th>Medical Diagnosis</th>
<th>Comments: Examination</th>
<th>Comments: Intervention</th>
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</table>
1:1 patient/client related planning/discussion/review of diagnostic tests, evaluation, plan of care, physical therapist clinical faculty treating patients, etc.

<table>
<thead>
<tr>
<th>Clinical Faculty</th>
<th>Date</th>
<th>Time</th>
<th>Topic</th>
<th>Comments: Planning/Discussion/Review</th>
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Clinical Faculty Name

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<th>Clinical Faculty Initials</th>
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Form 2: Resident Mentoring Form*

* Adapted from St. Catherine Rehabilitation Hospital Post-professional Residency in Geriatric Physical Therapy ICF Mentoring Tracking & Feedback Form, 2014

**Purpose:** This form is used during weekly one-on-one mentoring sessions. The resident completes Part I to prepare the faculty for observation of patient care. Part I provides the background information about the patient. The clinical faculty and the
resident use Part II to document the resident’s clinical reasoning in examination, evaluation, and intervention.

**Use:** The resident completes Part I and submit the form to the clinical faculty *prior to* the scheduled time for patient care. The resident and clinical faculty complete Part II *after* the patient care session and sign the form after discussion. The resident will submit the completed form electronically via secured login to the Advanced Practicum course in Blackboard. The resident keeps the signed paper copy in his or her binder. Blank copy of this form is available at the Advanced Practicum course shell in Blackboard.

- There are a total of 9 items in this evaluation.
- **The mentor must score items 1-7, and 9.**
- **Item #8 *Resident’s Goals for This Mentoring Session** is to help the resident identify learning goals for mentoring and is **NOT graded.**
- Each item is worth up to 2 points.
- **Interpretation:**
  - Passing raw score = 12 points (80%)
  - Good raw score = 13-14 points (80-90%)
  - Exceptional = 15-16 points (90-100%)

<table>
<thead>
<tr>
<th>Resident’s Name</th>
<th>Date of Mentoring Session</th>
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<table>
<thead>
<tr>
<th>Total Time of This Mentoring Session</th>
<th>Mentor’s Name</th>
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<table>
<thead>
<tr>
<th>Total Score</th>
<th>/16 points</th>
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<tr>
<td>Grade (Total Score/16 X 100%)</td>
<td>%</td>
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</table>

**Setting:** Acute/ICU ____ Inpatient ____ Vestibular ____ Outpatient ____

<table>
<thead>
<tr>
<th>Each item is worth a maximum of 2 points using the scoring criteria below:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unsatisfactory (US) = 0</strong></td>
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</tbody>
</table>
Part I. The resident will utilize this table to organize available patient’s data prior to the session.

1. Patient information

<table>
<thead>
<tr>
<th>Patient’s Age</th>
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</table>
## Medical Diagnosis

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## PT Diagnosis

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## PT Examination

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## PT Intervention

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## Additional Information

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### Score

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<th>0</th>
<th>1</th>
<th>2</th>
<th>Comments</th>
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</table>

2. **Complete the ICF diagram for this patient based on information available prior to the session. For each of the domains of Body Structure/Function, Activity, Participation, Personal and Environmental Factors, note facilitators/barriers to the desired outcomes.**

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<th>Score</th>
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<th>Comments</th>
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</table>

3. **Key Considerations from History:** (family/caregiver concerns, patient/client values and preference, previous intervention, current management including medications)

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<th>Comments</th>
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</thead>
</table>

49
Health Condition

- Body Structure/Function
  - 

- Activity
  - 

- Participation
  - 

- Personal Factors
  - 

- Environmental Factors
  - 
4. **Patient/Family Goals:** (Long term goals based on interview)

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<th>Score</th>
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5. **Session Goals:** (Short term goals for intervention session for the patient)

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<th>Comments</th>
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6. **Hypothesis for This Session:** (What tests and/or measures should be used and why? What intervention approaches should be used and why?)

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<th>Comments</th>
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</table>
7. **Outcome Measures Used:** (What outcome assessment tests and/or measures were used? How do you interpret the results of outcomes relate to the psychometric properties of the selected tests and/or measures, e.g. MCID? How do the outcome results correlate with progress toward patient’s goals?)

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<th>Score</th>
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<th>Comments</th>
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8. **Resident’s Goals for This Mentoring Session** (*this item is to help the resident set learning goals and is NOT graded):

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<th>Score</th>
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<th>Comments</th>
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**Part II.** The mentor and the resident will complete this section after discussion during the mentoring hours.

9. **Resident’s Reflection on Action:** (Did you feel prepared? If not, what was missing? What worked well? At what points did you hesitate? How did you resolve uncertainty? What do you think you need to work on in the future? How will you accomplish that?)

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<th>0</th>
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<th>Comments</th>
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Mentor Comments: (Summarize the resident’s performance; note areas of strength/progress and areas in need of improvement)

This Feedback Form Has Been Reviewed By

Resident Signature: _________________________ Date: ____________

Clinical Faculty Signature: _________________________ Date: ____________

Form 3: Live Patient Examination/Intervention Evaluation Form

Live Patient Examination/Intervention Session Evaluation Form

Purpose: The Live Patient Examination is used to provide the Resident with a formal written evaluation of clinical skills. The Live Patient Examination is completed at the beginning and after the mid-term of a rotation. This evaluation is completed for a total of 10 times in 12 months during residency.

Use: The resident will submit the completed form electronically via secured login to the Advanced Practicum course on Blackboard. The resident is to keep a signed paper copy in his or her binder. Blank copy of this form is available at the Advanced Practicum course shell on Blackboard.

- There are a total of 41 items in this evaluation. Each item is worth up to 2 points.
- Evaluators must rate at least 80% of items in each section and a total of 32 items in the entire evaluation.
- The results of the evaluation at the beginning of a rotation (Week 1-2 at Acute Care/ICU; Week 1-2 at Inpatient Rehabilitation; Week 1 during Vestibular Rehabilitation; Week 1-2 at Briarwood and Canton Outpatient Rehabilitation) are used to assess safety and assist with the development of the Learning Contract.
- The results of the evaluation at the end of the rotation are used to confirm clinical competency in the setting.
- The resident must achieve a total score ≥ 51 points (80%) in order pass the evaluation at the end of the rotation (Week 6-8 at Acute Care/ICU; Week 10-12 at Inpatient Rehabilitation; Week 4 at Vestibular Rehabilitation; Week 4-6 at Briarwood and Canton Outpatient Rehabilitation).
- Failure to pass the Live Patient Examination/Intervention at the end of the clinical rotation results in remediation (see Resident Handbook >> Policies & Procedures >> Clinical Remediation).

<table>
<thead>
<tr>
<th>Resident</th>
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<tbody>
<tr>
<td>Evaluator</td>
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<tr>
<td>Date</td>
</tr>
<tr>
<td>Diagnosis</td>
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<tr>
<td>Practice Setting</td>
</tr>
</tbody>
</table>

| Total Number of Items Assessed | 53 |
| Total Score (Sum of Part 1, 2, 3, and 4 Scores) |   |
| Total Score for Passing Live Patient Exam      | ≥200 points |

**Rate the resident’s competence using the 7-point scale below.** Write the number in the box next to each item. The mentor should consider the individual’s present skill level, relative to the competence of a master clinician. For each skill or activity, a physical therapist who is **competent at NCS level** demonstrates independent advanced and evidence based practice in neurologic physical therapy, exhibits high standards of professionalism, skills, knowledge, and comprehension of neurologic practice, and is able to effectively and accurately analyze, examine, synthesize, evaluate and intervene all aspects of neurologic patient care. The **master clinician** is someone who has developed that particular skill and would perform the skill consistently and at the highest level of standards with a variety of patients across diverse practice settings.

<table>
<thead>
<tr>
<th>Below entry-level</th>
<th>Competent at entry-level</th>
<th>Well-above entry-level</th>
<th>Slightly below NCS level</th>
<th>Competent at NCS level</th>
<th>Slightly below master clinician</th>
<th>Competent at master clinician</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
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</table>

**Score** | **Grading Criteria**
---|---
NA | Resident had no opportunity to demonstrate skill.
   | Skill or behavior not related to the setting.
1. Below entry-level | Critical safety concerns.  
   | Patient is at risk of injury.  
   | Requires verbal cues for appropriate and specific neurologic patient care 100% of the time.  
   | Unable to verbalize/demonstrate appropriate patient care skills.
2. Competent at entry-level | Capable of functioning without guidance or cues when managing patients with simple conditions and/or require 50-75% verbal cues for highly complex patient cases.  
   | Includes important tests and measures but may occasionally fail to select a key test.  
   | Demonstrates appropriate psychomotor skills but sometimes has difficulty performing complex techniques.  
   | Knows underlying rationale for selection of tests and measures and treatments, but cannot provide evidence 50-75% of them.  
   | Tends to be rule or “recipe” driven in selection of treatments.  
   | Consult with mentors to resolve unfamiliar or ambiguous situations.
3. Well-above entry-level | Requires cues for appropriate and specific neurologic patient care in highly complex cases 25-49% of the time.  
   | Consistently demonstrate proficiency at highly skilled examinations, interventions, and clinical reasoning and/or require cues 25-49% of the time.  
   | Able to verbalize clinical reasoning and evidence but requires moderate cues to apply concepts into practice for neurologic patient care 25-49% of the time.  
   | Able to function in unfamiliar or ambiguous situations.
<table>
<thead>
<tr>
<th>Skill or Activity (initial and date resident's level of performance)</th>
<th>Comments</th>
<th>Score</th>
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<tbody>
<tr>
<td>1. Establishes rapport and mutual respect with the patient/caregiver</td>
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<tr>
<td>2. Demonstrate effective and patient-centered communication; use active listening skills; use age-appropriate language; demonstrate culturally competent communication</td>
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<tr>
<td>3. Identify patient / caregiver concerns, needs, resources, and preferences</td>
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<td>4. Identify patient / caregiver goals</td>
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<tr>
<td>5. Obtain past medical / surgical history</td>
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<td>6. Obtain history of present illness / causes of injury</td>
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<td>7. Identify referring primary care provider or specialist clinician</td>
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<td>8. Identify previous / current physical therapy intervention</td>
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<td>9. Identify current multi-disciplinary interventions</td>
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<td>10. Identify current living environment, including architectural barriers</td>
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<td>11. Identify patient's wellness / health habits / learning style / communication preference</td>
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<td>12. Identify prior functional status</td>
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**Part 1: History and Review of Systems**

- Identifies patterns in patient data or responses based on past experiences with cues 25-49% of the time.
- Proficient and skilled in simple and complex tasks for skilled examinations, interventions, and clinical reasoning.
- Able to discuss evidence behind selection of tests and measures and/or interventions a majority of the time.
- Able to function in unfamiliar or ambiguous situations, but may occasionally consult others when patient information is complex, unfamiliar, or limited.

4. Slightly below NCS level
- Requires minimal cues for appropriate and specific neurologic patient care <25% of the time.
- Consistently demonstrate proficiency at highly skilled examinations, interventions, and clinical reasoning <25% of the time.
- Able to verbalize clinical reasoning and evidence as well as demonstrate appropriate skills for neurologic patient care <25% of the time.
- Capable of serving as a consultant or resource for others.

5. Competent at NCS level
- Exhibits high standards of professionalism, skills, knowledge, and comprehension of neurologic practice independently.
- Able to effectively and accurately analyze, examine, synthesize, evaluate and intervene all aspects of neurologic patient care with 0% cues.
- Readily identifies clinical presentations or responses that are inconsistent with a specific clinical pattern independently.
- Able to make sound clinical decisions based on complex, unfamiliar, or limited patient information independently.
- Capable of supervising others in simple and complex neurologic patient care such as entry-level physical therapy students, residents, and novice physical therapists.
- Willingly serves as a consultant or resource for others.
- Reflects often to identify areas of improvement and strength and implements strategies to enhance skills for optimizing clinical practice independently.

6. Slightly below master clinician
- Assumes a leadership role for managing patients with highly complex conditions and providing guidance in evidence-based practice.
- Adept at utilizing specific knowledge of pathology and/or patient population to modify examination and/or treatment.
- Discusses specific research to rationalize selection of tests and measures and/or treatments utilized (e.g. sensitivity/ specificity, clinical prediction rules, NNT, effect sizes).

7. Competent at master clinician
- Actively contributes to the enhancement of the clinical practice with an expansive view of physical therapy practice and the profession.
- Contributes to knowledge translation of neurologic physical therapy practice (e.g. advocating for the implementation of standardized outcome measures, evidence-based interventions, and documenting complex case management in case reports or conference presentations).
13. Develop and interpret data from the history and interviewing to develop an initial hypothesis / clinical impression

14. Plan Tests and Measures: able to select and prioritize tests and measures based on history, scientific merit, clinical utility, and fiscal cost to patient relative to criticality of data for systems screening and examination

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<tr>
<th>Skill or Activity (initial and date resident’s level of performance)</th>
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<th>Score</th>
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</thead>
<tbody>
<tr>
<td>1. Assess integumentary integrity</td>
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<tr>
<td>2. Assess vital signs / circulation / ventilation / respiration</td>
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<td>3. Assess arousal / attention / cognition</td>
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<td>4. Assess level of pain</td>
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<td>5. Assess posture</td>
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<td>6. Assess balance</td>
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<td>7. Assess gait</td>
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<td>8. Assess mobility / locomotion</td>
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<td>9. Assess sensory integrity and neuromotor development</td>
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<td>10. Assess motor function / coordination</td>
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<td>11. Assess muscle performance</td>
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<td>12. Assess ROM</td>
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<tr>
<td>13. Assess joint integrity / mobility</td>
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<tr>
<td>14. Assess reflex integrity / muscle tone</td>
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<td>15. Assess aerobic capacity</td>
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<td>16. Assess cranial and peripheral nerve testing</td>
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<td>17. Assess environmental, home and work barriers</td>
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<td>18. Assess prosthetic / assistive device requirements</td>
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Number of Items Assessed: 14

Total Score for This Section

Additional Comments:
19. Assess work / community / leisure integration and reintegration

Number of Items Assessed

Total Score for This Section

Additional Comments:

### Part 3: Evaluation, Diagnosis, and Prognosis

<table>
<thead>
<tr>
<th>Skill or Activity (initial and date resident’s level of performance)</th>
<th>Comments</th>
<th>Score</th>
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<tbody>
<tr>
<td>1. Accurately identify patient’s movement or functional problems according to the ICF framework (i.e. Body structure, body function, activity, participation, personal and environmental factors)</td>
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<td>2. Correlate history and patient / caregiver goals with exam findings</td>
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<td>3. Integrate instruments, tests, and evaluations used or performed by other healthcare professionals</td>
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<td>4. Differentiate patient’s limitations / movement problems that require compensatory vs. recovery-based interventions</td>
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<td>5. Accurately determine “Keep, Consult, Refer” decisions</td>
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<td>6. Diagnosis: interpret data from the history and exam findings to develop differential diagnosis</td>
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<tr>
<td><strong>Prognosis</strong>: predict optimal level of improvement in function</td>
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</table>

Number of Items Assessed

Total Score for This Section

Additional Comments:

### Part 4: Plan of Care, Procedural Interventions, and Outcomes

<table>
<thead>
<tr>
<th>Skill or Activity (initial and date resident’s level of performance)</th>
<th>Comments</th>
<th>Score</th>
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<tbody>
<tr>
<td>1. <strong>Determine optimal dosing</strong> (frequency and duration of plan of care)</td>
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<tr>
<td>2. <strong>Determine optimal evidence based intervention:</strong></td>
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<tr>
<td>Collaborate with patient / caregiver in setting goals, and develop an evidence based plan of care that prioritizes interventions related to recovery process, patient goals, resources, health and wellness</td>
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<tr>
<td>3. <strong>Provide patient / caregiver related instruction:</strong></td>
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<tr>
<td>Adapt communication strategies to meet educational and cognitive level of patient / caregiver, educate patient / caregiver on diagnosis, prognosis, treatment, responsibility, and self-management within the plan of care</td>
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<tr>
<td>4. <strong>Communication:</strong></td>
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</tr>
</tbody>
</table>
Ask questions which are helpful in determining patient problems; apply conflict resolution strategies in a timely manner; effectively adapt communication across the lifespan

5. **Provide therapeutic interventions:**
   Analyze relationship between biomechanics of therapeutic exercise and functional outcomes

6. **Adapt aerobic conditioning for patients with neurologic dysfunction.**

7. **Provide functional training in self-care, home management, work (job/school/play), community, leisure integration:**
   Optimize training despite communication, language, cultural, socioeconomic, educational variables; provide cues appropriately, select and implement training that enhances abilities for ADL’s including applying current research, determining problems amenable to training; skilfully interpret observed movement, and analyze relationship between postural control and upright function

8. **Perform manual therapy technique:**
   Appropriately prescribe manual therapy in a neurologic population

9. **Prescription, application, fabrication of devices and equipment including assistive, supportive, or prosthetic:**
   Choose appropriate devices based on predicted long-term health needs promote optimal function with least restrictive assistive devices; anticipate impact of devices across a wide range of functional activities and social/environmental contexts; prescribe/adapt devices for complex patients and adapt orthotics for neurologic populations

10. **Perform airway clearance techniques:**
    Adapt a variety of interventions that address ventilatory pump and gas exchange impairments including relationship between pulmonary status and swallow function, airway clearance techniques, and mechanical ventilation on intervention.

11. **Perform integumentary repair and protective techniques**
    Skillfully prevent and manage integumentary impairment and educate neurologic patients/clients about importance of skin management

12. **Select appropriate outcome measures and collect collection to evaluate patient’s progress**

13. **Analyze and interpret data from outcome re-examination to modify patient’s plan of care and/or one’s own future practice**

<table>
<thead>
<tr>
<th>Number of Items Assessed</th>
<th>7/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Score for This Section</td>
<td></td>
</tr>
<tr>
<td>Additional Comments:</td>
<td></td>
</tr>
</tbody>
</table>

**References:**
- APTA Neuro Section Assessment of Resident Competency - Patient Assessment
- APTA Neuro Section Assessment of Resident Competency - Patient Treatment
- APTA appendix-a-clinical-performance-instrument2005
Form 4: Formative/Summative Assessment Form*

* Adapted from ABPTRFE Resource Manual, 2014

**Purpose:** Clinical mentor uses this form at **mid-term (6 month) and final (12 month)** during the 12-month residency as a formative/summative assessment of overall performance of the resident. This evaluation process allows the mentor to provide feedback to the resident over a period of time (rather than individual mentoring sessions), and to communicate between mentors on the resident’s learning outcomes and performance.

**Use:** The results of this assessment will be discussed between the resident and the
clinical mentor during mentoring hours. The assessment results are also available for
other mentors to review when assuming mentorship responsibilities for the resident. The
resident will submit the completed form electronically via secured login to the Advanced
Practicum course on Blackboard. The resident is to keep a signed paper copy in his or
her binder. Blank copy of this form is available at the Advanced Practicum course shell
on Blackboard.
• There are 11 areas to assess. Each area is worth up to 2 points.
• **The resident must achieve a total score ≥ 17 points (80% of 22 points) in
order pass the evaluation at the mid-term and final of the residency.**
• Failure to pass the Live Patient Examination/Intervention at the end of the clinical
rotation results in remediation (see Resident Handbook >> Policies & Procedures
>> Clinical Remediation).

<table>
<thead>
<tr>
<th>Resident Name</th>
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<tbody>
<tr>
<td>Mentor Name</td>
<td></td>
</tr>
<tr>
<td>Clinical Practice Setting</td>
<td></td>
</tr>
<tr>
<td>Dates of Rotation</td>
<td></td>
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<tr>
<td>Date Completed</td>
<td></td>
</tr>
<tr>
<td><strong>Total Score</strong></td>
<td>/22</td>
</tr>
<tr>
<td><em>(Passing score = 17 points)</em></td>
<td></td>
</tr>
</tbody>
</table>

**Evaluators must assess all areas in the Table.**
Each item is worth a maximum of 2 points using the scoring criteria below:

| Unsatisfactory (US) = 0 | Requires >5 cues from evaluator to continue task
|                        | Fails to include important tests and measures or evidence based intervention approaches
|                        | Does not use appropriate psychomotor skills
|                        | Demonstrates unsafe techniques
|                        | Gives no rationale for selection of tests and measures or intervention approach
|                        | Inefficient time management
|                        | Inappropriate clinical decision making process

| In Progress (IP) = 1 | Requires 2-5 cues from evaluator
|                     | Selects and completes appropriate test and measures in a safe manner; includes outcome measures
|                     | Selects and implements evidence based procedural interventions
|                     | Able to discuss evidence behind clinical decisions a majority of the time
|                     | Able to reflect and identify areas of improvement and strength

| Satisfactory (S) = 2 | Requires <2 cues from evaluator
|                     | Discusses specific evidence to rationalize test and measures and intervention approach utilized
|                     | Completes test and measures efficiently
- Describes patient-specific focus in intervention selection and adapts intervention approach to patient needs
- Relates outcomes to patient specific goals
- Utilizes specific knowledge of pathology and/or patient population to modify examination and/or intervention.
- Able to reflect and identify areas of improvement and strength as well as strategies to enhance skills

<table>
<thead>
<tr>
<th>Area Assessed</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Communication Skills</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>2. Hypothesis Development</td>
<td></td>
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</tr>
<tr>
<td>3. Examination Planning</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>4. Procedural Intervention Technique</td>
<td></td>
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</tr>
<tr>
<td>Performance</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>5. Treatment Progress</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>6. Patient/Family Education and Collaboration</td>
<td></td>
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<tr>
<td>7. Discharge Planning</td>
<td></td>
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<tr>
<td>8. Clinical Reasoning/Critical Thinking</td>
<td></td>
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<td></td>
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<tr>
<td>9. Problem Solving</td>
<td></td>
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<td></td>
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<tr>
<td>10. Documentation</td>
<td></td>
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</tr>
<tr>
<td>11. Effective Use of Time</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
The resident will utilize this form for self-assessment at 0 month, 6 month, and 12 months of enrollment in the Neurologic Residency program.

### Form 5: Resident Self-Assessment Survey*


The resident will utilize this form for self-assessment at 0 month, 6 month, and 12 months of enrollment in the Neurologic Residency program.

<table>
<thead>
<tr>
<th>Directions: Place an “X” in the box that BEST describes behavior observed for aspect of the competency.</th>
<th>Unsatisfactory Performance 1</th>
<th>Satisfactory Performance 2</th>
<th>Superior Performance 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. FOUNDATION SCIENCES (including changes across the lifespan)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Anatomy/Neuroanatomy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) I am able to describe musculoskeletal structures.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) I am able to describe vascular structures-normal and pathological.</td>
<td></td>
<td></td>
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<tr>
<td>(c) I am able to describe respiratory structures.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(d) I am able to explain neuroplasticity-CNS responses to learning and inquiry; cortical remodeling.</td>
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<td></td>
</tr>
<tr>
<td>(e) I am able to explain the nervous system-including but not limited to: neurotransmitters; neuroanatomical changes across the lifespan; cross section detail of structures.</td>
<td></td>
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</tr>
<tr>
<td>Rate your overall performance for this competency and record rating:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) Unsatisfactory, (2) Satisfactory, (3) Superior</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Overall Rating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Physiology/Neurophysiology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) I am able to describe pain-neurogenic pain; pain related to non-neurologic structures.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) I am able to explain perception.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(c) I am able to explain sensory and motor physiology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(d) I am able to explain the impact of neurological conditions on other body</td>
<td></td>
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</tr>
</tbody>
</table>
I am able to explain system responses to trauma and stress and exertion.

**Rate your overall performance for this competency and record rating:**
(1) Unsatisfactory, (2) Satisfactory, (3) Superior

**Overall Rating**

### Self-Assessment Tools
**Description of Specialty Practice: Neurologic**

**KNOWLEDGE AREA: FOUNDATION SCIENCES**

**Directions:** Place an “X” in the box that BEST describes behavior observed for aspect of the competency.

<table>
<thead>
<tr>
<th>Movement Science</th>
<th>Un satisfactory Performance 1</th>
<th>Satisfactory Performance 2</th>
<th>Superior Performance 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) I am able to explain positive and negative symptoms related to neurological conditions.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) I am able to explain motor learning in persons with and without motor, sensory/perceptual, and/or cognitive pathology.</td>
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<td></td>
<td></td>
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<tr>
<td>(c) I am able to explain theories of motor control.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(d) I am able to explain the potential impact of movement impairments on the musculoskeletal system over time.</td>
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</tr>
</tbody>
</table>

**Rate your overall performance for this competency and record rating:**
(1) Unsatisfactory, (2) Satisfactory, (3) Superior

**Overall Rating**

### Self-Assessment Tools
**Description of Specialty Practice: Neurologic**

**KNOWLEDGE AREA: BEHAVIORAL**

**Directions:** Place an “X” in the box that BEST describes behavior observed for aspect of the competency.

<table>
<thead>
<tr>
<th>Behavioral Sciences</th>
<th>Un satisfactory Performance 1</th>
<th>Satisfactory Performance 2</th>
<th>Superior Performance 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Psychology/Neuropsychology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) I am able to explain expected emotional/behavioral responses to illness and recovery.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>(b) I am able to explain affective disorders.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(c) I am able to explain the impact of personality on illness and recovery.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
(d) I am able to explain the impact of substance abuse disorders on the movement system.
(e) I am able to explain learning disorders.
(f) I am able to explain cultural social systems.
(g) I am able to explain memory.
(h) I am able to explain attention.
(i) I am able to explain cognitive processes and executive functions.
(j) I am able to explain normal and dysfunctional sexual behavior.
(k) I am able to explain perceptual disorders.
(l) I am able to explain hemispheric specialization.

Rate your overall performance for this competency and record rating:
(1) Unsatisfactory, (2) Satisfactory, (3) Superior
Overall Rating __________________

2. Teaching and Learning Theory
(a) I am able to explain learning theories.
(b) I am able to apply behavior modification strategies.
(c) I am able to apply teaching strategies/methods.
(d) I am able to apply knowledge of domains of
(e) I am able to apply knowledge of measurement of
(f) I am able to apply educational theory and methods related to patients/clients with neurological conditions.

Rate your overall performance for this competency and record rating:
(1) Unsatisfactory, (2) Satisfactory, (3) Superior
Overall Rating __________________

3. Communication
(a) I am able to apply principles of empathy.
(b) I am able to apply behavior modification strategies.
(c) I am able to effectively communicate with persons who are sensory or cognitively impaired.
(d) I have effective listening and observation
(e) I have effective conflict management techniques.

Rate your overall performance for this competency and record rating:
(1) Unsatisfactory, (2) Satisfactory, (3) Superior
Overall Rating __________________

Self-Assessment Tools
Description of Specialty Practice: Neurologic

KNOWLEDGE AREA: BEHAVIORAL SCIENCES

Directions: Place an “X” in the box that BEST describes behavior observed for aspect of the competency.

Unsatisfactory Performance 1  Satisfactory Performance 2  Superior Performance 3

4. Decision Making
(a) I am able to execute decision theory.

(b) I am able to utilize group decision-making techniques.

(c) I am able to utilize legal and federal regulations (e.g., Americans with Disabilities Act).

(d) I am able to utilize ethics and related decision-making processes.

Rate your overall performance for this competency and record rating:
(1) Unsatisfactory,  (2) Satisfactory,  (3) Superior

Overall Rating __________________

Self-Assessment Tools
Description of Specialty Practice:
Neurologic KNOWLEDGE AREA:

Directions: Place an “X” in the box that BEST describes behavior observed for aspect of the competency.

<table>
<thead>
<tr>
<th>Unsatisfactory Performance 1</th>
<th>Satisfactory Performance 2</th>
<th>Superior Performance 3</th>
</tr>
</thead>
</table>

C. CLINICAL SCIENCES

1. Kinesiology

(a) I am able to explain electromyographic patterns during functional tasks and postural control

(b) I am able to explain biomechanics.

(c) I am able to describe joint morphology

Rate your overall performance for this competency and record rating:
(1) Unsatisfactory,  (2) Satisfactory,  (3) Superior

Overall Rating __________________

2. Pathokinesiology

(a) I am able to explain automatic control of posture and movement.

(b) I am able to describe voluntary control of movement, including timing, speed, and sequencing.

(c) I am able to describe the relationship between spasticity and movement.

Rate your overall performance for this competency and record rating:
(1) Unsatisfactory,  (2) Satisfactory,  (3) Superior

Overall Rating __________________

3. Pathology

(a) I am able to explain circulatory pathology.

(b) I am able to explain neuropathology.

(c) I am able to describe musculoskeletal pathology.

(d) I am able to describe respiratory pathology.

(e) I am able to describe developmental abnormalities of the nervous system.
Rate your overall performance for this competency and record rating:
(1) Unsatisfactory,   (2) Satisfactory, (3) Superior
Overall Rating ________________

4. Pharmacology

(a) I am able to explain drug reactions and dosage

(b) I am able to explain the effects on the musculoskeletal and nervous systems.

(c) I am able to explain interaction of pharmacological agents.

(d) I am able to explain long term use of drugs.

(e) I am able to explain toxicology.

Rate your overall performance for this competency and record rating:
(1) Unsatisfactory,   (2) Satisfactory, (3) Superior
Overall Rating ________________

Self-Assessment Tools
Description of Specialty Practice: Neurologic
KNOWLEDGE AREA: CLINICAL SCIENCES

Directions: Place an “X” in the box that BEST describes behavior observed for aspect of the competency.

Unsatisfactory Performance 1  Satisfactory Performance 2  Superior Performance 3

5. Motor Development

(a) I am able to identify milestones.

(b) I am able to explain changes across the life span.

(c) I am able to explain theories of motor development.

Rate your overall performance for this competency and record rating:
(1) Unsatisfactory,   (2) Satisfactory, (3) Superior
Overall Rating ________________

6. Psychiatry

(a) I am able to identify common psychiatric symptoms/syndromes/classifications.

(b) I am able to identify the effect of psychiatric disease and/or treatment on the movement system.

Rate your overall performance for this competency and record rating:
(1) Unsatisfactory,   (2) Satisfactory, (3) Superior
Overall Rating ________________

7. Epidemiology

(a) I am able to describe the prevalence of neurologic disease/conditions/signs/symptoms.

(b) I am able to identify the incidence of neurologic disease/conditions/signs/symptoms.
(c) I am able to describe the prognostic indicators in neurologic disease conditions signs/symptoms.

(d) I am able to identify the risk factors relevant to health status across the life span.

(e) I am able to identify morbidity, mortality, and natural history of neurologic conditions.

Rate your overall performance for this competency and record rating:
(1) Unsatisfactory, (2) Satisfactory, (3) Superior
Overall Rating __________________

---

**Self-Assessment Tools**

**Description of Specialty Practice: Neurologic**

**KNOWLEDGE AREA: SCIENCES RELATED TO CRITICAL**

Directions: Place an “X” in the box that BEST describes behavior observed for aspect of the competency.

<table>
<thead>
<tr>
<th>Direction</th>
<th>Un satisfactory Performance 1</th>
<th>Satisfactory Performance 2</th>
<th>Superior Performance 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>D. SCIENCES RELATED TO CRITICAL INQUIRY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Research Design</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>(a)</td>
<td>I am able to explain qualitative and quantitative research design.</td>
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<tr>
<td>(b)</td>
<td>I am able to explain theory development.</td>
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<td></td>
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<tr>
<td>(c)</td>
<td>I am able to explain principles of measurement.</td>
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<td></td>
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<tr>
<td>(d)</td>
<td>I am able to explain sensitivity and specificity.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(e)</td>
<td>I am able to explain reliability.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(f)</td>
<td>I am able to explain validity.</td>
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</tbody>
</table>

Rate your overall performance for this competency and record rating:
(1) Unsatisfactory, (2) Satisfactory, (3) Superior
Overall Rating __________________

2. Statistics

(a) I am able to explain parametric and nonparametric data.

(b) I am able to explain descriptive statistics.

(c) I am able to explain statistical inference.

(d) I am able to explain statistical testing (eg, analysis of variance, analysis of frequencies, correlation, regression) concepts and applications to research interpretation.

(e) I am able to explain the concepts and application of statistical power to research interpretation.

Rate your overall performance for this competency and record rating:
(1) Unsatisfactory, (2) Satisfactory, (3) Superior
Overall Rating __________________
<table>
<thead>
<tr>
<th><strong>Self-Assessment Tools</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description of Specialty Practice: Neurologic</strong></td>
</tr>
<tr>
<td><strong>PRACTICE EXPECTATIONS: PROFESSIONAL ROLES, RESPONSIBILITIES, AND VALUES</strong></td>
</tr>
</tbody>
</table>

Directions: Place an “X” in the box that BEST describes behavior observed for aspect of the competency.

<table>
<thead>
<tr>
<th>Unsatisfactory Performance 1</th>
<th>Satisfactory Performance 2</th>
<th>Superior Performance 3</th>
</tr>
</thead>
</table>

### A. PROFESSIONAL ROLES, RESPONSIBILITIES, AND VALUES

#### 1. Leadership

(a) I am able to seek mentoring relationships.

(b) I am able to model professionalism and maturity in decision-making and interpersonal interactions.

(c) I am able to identify multiple strategies to resolve a problem.

(d) I am able to use evidence-based practice to shape system policies and procedures.

(e) I am able to collaborate with others to solve problems.

Rate your overall performance for this competency and record rating: (1) Unsatisfactory, (2) Satisfactory, (3) Superior

<table>
<thead>
<tr>
<th>Overall Rating</th>
</tr>
</thead>
</table>

#### 2. Virtuous Behavior

(a) I am able to model respect and compassion for all people.

(b) I am able to establish trustworthy relationships with colleagues, patients/clients, employers and the public.

(c) I am able to effectively recognize and resolve problems in difficult situations.

(d) I am able to demonstrate a continued pursuit of additional and more advanced knowledge, skills, and abilities.

Rate your overall performance for this competency and record rating: (1) Unsatisfactory, (2) Satisfactory, (3) Superior

<table>
<thead>
<tr>
<th>Overall Rating</th>
</tr>
</thead>
</table>

#### 3. Education

(a) I am able to implement, evaluate, and modify an educational plan/learning experience.

(b) I am able to select appropriate teaching strategies and necessary resources based on educational needs and characteristics of the learner.

(c) I am able to educate physical therapy students to become knowledgeable and skillful in neurologic physical therapy.
(d) I am able to educate physical therapists to enhance knowledge and master skill in neurologic physical therapy.

(e) I am able to educate other health care professionals and outside agencies about neurologic physical therapy.

Rate your overall performance for this competency and record rating:
(1) Unsatisfactory, (2) Satisfactory, (3) Superior

Overall Rating __________________

Self-Assessment Tools
Description of Specialty Practice: Neurologic

PRACTICE EXPECTATIONS: PROFESSIONAL ROLES, RESPONSIBILITIES, AND VALUES (continued)

Directions: Place an “X” in the box that BEST describes behavior observed for aspect of the competency.

Unsatisfactory Performance 1 Satisfactory Performance 2 Superior Performance 3

4. Consultation

(a) I am able to understand the scope of physical therapist practice.

(b) I am able to synthesize information from a wide variety of sources when providing consultative services.

(c) I am able to develop and implement new programs to promote health and fitness of patients/clients with neurological impairment.

(d) I am able to advocate for neurologically impaired patients/clients with policy- and law-making bodies.

(e) I am able to render an opinion about patients/clients with neurological dysfunction to external organizations.

(f) I am able to establish screening procedures for neurologic problems.

(g) I am able to provide peer review and utilization review.

(h) I am able to effectively contribute to patient management in multidisciplinary setting.

Rate your overall performance for this competency and record rating:
(1) Unsatisfactory, (2) Satisfactory, (3) Superior

Overall Rating __________________

5. Evidence-Based Practice

(a) I am able to evaluate the efficacy and effectiveness of new and established examination tools, interventions, and technologies.

(b) I am able to appropriately apply new research information, methods, or instruments to clinical practice.

(c) I am able to participate in planning and conducting clinical research.
(d) I am able to participate in collecting and interpreting patient/client outcome data.

(e) I am able to synthesize research information from a variety of sources to develop evidence-based clinical practice.

Rate your overall performance for this competency and record rating:
(1) Unsatisfactory,  (2) Satisfactory,  (3) Superior
Overall Rating __________

Self-Assessment Tools
Description of Specialty Practice: Neurologic
PRACTICE EXPECTATIONS: PATIENT/CLIENT MANAGEMENT

Directions: Place an “X” in the box that BEST describes behavior observed for aspect of the competency.

<table>
<thead>
<tr>
<th></th>
<th>Unsatisfactory Performance</th>
<th>Satisfactory Performance</th>
<th>Superior Performance</th>
</tr>
</thead>
</table>

B. PATIENT/CLIENT MANAGEMENT

1. Examination
   (a) History
      i. I am able to perform an interview that is patient/client-guided.
      ii. I am able to integrate knowledge of disease with medical history taking.

   Rate your overall performance for this competency and record rating:
   (1) Unsatisfactory,  (2) Satisfactory,  (3) Superior
   Overall Rating __________

   (b) Systems Review
      i. I am able to anticipate screening procedures based on identified pathology, previous interventions, patient history, and observation.

   Rate your overall performance for this competency and record rating:
   (1) Unsatisfactory,  (2) Satisfactory,  (3) Superior
   Overall Rating __________

   (c) Tests and Measures
i. I am able to appropriately examine communication, cognition, affect, and learning styles.

ii. I am able to select and prioritize tests and measures based on history, systems review, scientific merit, clinical utility, and physiologic of fiscal cost to patient relative to criticality of data.

iii. I am able to perform kinematic observations of tasks.

iv. I am able to perform measures such that data is accurate and precise.
   - Aerobic capacity/endurance (eg, timed walk test- 6, 9,12-minute walk test, Physical Performance Test, Physiologic Cost Index)
   - Arousal, attention, and cognition (eg, assessment of factors that influence motivation level consciousness, orientation, recall)
   - Assistive and adaptive devices (eg, assessment of appropriateness, use, effect on impairment, alignment and fit, safety)
   - Circulation (screens for circulatory abnormalities)
   - Cranial and peripheral nerve integrity (eg, Hallpike- Dix Maneuver, gaze stability, nural provocation)
   - Environmental, home and work (job/school/play) barriers (eg, architectural barriers)

### Self-Assessment Tools

**Description of Specialty Practice: Neurologic**

**PRACTICE EXPECTATIONS: PATIENT/CLIENT MANAGEMENT**

Directions: Place an “X” in the box that BEST describes behavior observed for aspect of the competency.

<table>
<thead>
<tr>
<th></th>
<th>Unsatisfactory Performance</th>
<th>Satisfactory Performance</th>
<th>Superior Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>(c) Tests and Measures (continued)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Gait, locomotion, and balance (eg, analysis with and without assistive or other devices, on various terrains, in different environments, safety assessment)
  - Dizziness Rating Scale
  - Dynamic Gait Index
  - Timed Up & Go
  - Tinetti's Performance Oriented Mobility Assessment
  - Berg Balance Test
  - Clinical Test of Sensory Integration in Balance
  - Functional reach Test
  - Tandem (Sharpened) Rhomberg
  - Dynamic posturography
  - Temporal gait measures
  - Kinematic/kinetic gait analysis
  - Rancho Los Amigos Observational Gait Analysis

- Integumentary integrity

- Joint integrity and mobility (eg, mobility assessment of joint hyper-and hypo-mobility to include passive accessory motions, response to manual provocation)

- Motor function
  - Motor learning and motor control
  - Amyotrophic Lateral Sclerosis Rating Scale
  - Ataxia Rating Scale
  - Chedoke-McMaster Stroke Assessment
  - Modified Ashworth Scale
  - Motor Assessment Scale
  - Nonequilibrium coordination testing
  - Upright motor control
  - American Spinal Cord Injury Classification
  - Fugl-Meyer Assessment
  - National institutes of Health Stroke Scale

- Muscle performance (including strength, power, and endurance)

- Neuromotor development and sensory integration (eg, assessment of appropriate development, dexterity, coordination, and integration of somatosensory, visual, and vestibular systems)

- Orthotic, protective, and supportive devices (eg, assessment of appropriateness, use, effect on impairment, alignment and fit, safety)
### Self-Assessment Tools

**Description of Specialty Practice: Neurologic**

**PRACTICE EXPECTATIONS: PATIENT/CLIENT MANAGEMENT**

Directions: Place an “X” in the box that BEST describes behavior observed for aspect of the competency.

<table>
<thead>
<tr>
<th>(c) Tests and Measures (continued)</th>
<th>Un satisfactory Performance</th>
<th>Satisfactory Performance</th>
<th>Superior Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain assessment using questionnaires, behavioral scales, and analog scales.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posture (eg, body or body segment (s) structure, alignment, changes in different positions, and body contours)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prosthetic requirements (eg, assessment of appropriateness, use, effect on impairment, alignment and fit, and safety)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range of motion (eg, single-joint and multisegmental muscle and length)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reflex integrity (eg, assessment of normal and pathological reflexes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-care and home management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Basic and instrumental activities of daily living</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Fatigue Impact Scale</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Task analysis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Functional Independence Measure (FIM)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sensory integrity (eg, proprioception, kinesthesia, vibration, and perception of vertical orientation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ventilation and respiration (eg, breathing patterns, chest wall mobility, and perceived exertion)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work (job, school, play), community, and leisure integration or reintegration (including instrumental activities of daily living)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Activity of Balance Confidence Scale (ABC)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Dizziness Handicap Inventory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Falls Efficacy Scale (FES)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Hoehn and Yahr (Parkinson Disease Level of Involvement Scale)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Quality of life measures (SF-36 or SF-12)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Stroke Impact Scale</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- United Parkinson Disease Rating Scale (UPDRS)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Rate your overall performance for this competency and record rating:

(1) Unsatisfactory, (2) Satisfactory, (3) Superior

Overall Rating __________________
2. Evaluation

(a) I am able to predict present or potential disability based on impairments, functional limitations, (including results from task or motion analysis) and potential for recovery.

(b) I am able to develop clinical judgments based on data collected from the examination.

<table>
<thead>
<tr>
<th>Self-Assessment Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description of Specialty Practice: Neurologic</td>
</tr>
<tr>
<td>PRACTICE EXPECTATIONS: PATIENT/CLIENT MANAGEMENT</td>
</tr>
<tr>
<td>Directions: Place an “X” in the box that BEST describes behavior observed for aspect of the competency.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Evaluation (continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(c) I am able to differentiate impairments/functional limitations that require compensatory movement strategies vs strategies that focus on recovery of normal movement.</td>
</tr>
<tr>
<td>(d) I am able to link impairments, functional limitations, and psychosocial factors to the patient/client’s and caregiver’s expressed goals.</td>
</tr>
<tr>
<td>(e) I am able to interpret observed movement and function.</td>
</tr>
<tr>
<td>(f) I am able to integrate instruments, tests, screens, and evaluations used or performed by other health care professionals.</td>
</tr>
</tbody>
</table>

| Rate your overall performance for this competency and record rating: |
| (1) Unsatisfactory, (2) Satisfactory, (3) Superior |
| Overall Rating __________________ |

3. Diagnosis

(a) I am able to interpret data from the examination to develop a differential diagnosis.

(b) I am able to differentiate impairments/functional limitations disabilities which are amenable to intervention.

(c) I am able to refer patient/client to other professionals for findings that are outside the scope of the physical therapist’s knowledge, experience, or expertise.

| Rate your overall performance for this competency and record rating: |
| (1) Unsatisfactory, (2) Satisfactory, (3) Superior |
| Overall Rating __________________ |

4. Prognosis
(a) I am able to predict optimal level of improvement in function.

(b) I am able to predict amount of time to achieve optimal level of improvement in function.

(c) I am able to collaborate with patient/client and family in setting goals.

(d) I am able to develop a plan of care that prioritizes interventions related to the recovery process, patient/client goals, resources, health and wellness.

Rate your overall performance for this competency and record rating:
(1) Unsatisfactory,    (2) Satisfactory,    (3) Superior
Overall Rating

**Self-Assessment Tools**

**Description of Specialty Practice: Neurologic**

**PRACTICE EXPECTATIONS: PATIENT/CLIENT MANAGEMENT**

Directions: Place an "X" in the box that BEST describes behavior observed for aspect of the competency.

<table>
<thead>
<tr>
<th>Unsatisfactory Performance 1</th>
<th>Satisfactory Performance 2</th>
<th>Superior Performance 3</th>
</tr>
</thead>
</table>

5. **Intervention** (selects/modify interventions based on on-going evaluation and prognosis and changes across the lifespan, type and severity of involvement, and potential benefit relative to physiological or fiscal cost to the patient)

(a) Coordination, Communication, and Documentation

i. I am able to integrate communication strategies with therapeutic intervention.

ii. I am able to adapt communication to meet the educational and cognitive level of the patient/client and caregiver.

iii. I am able to ask questions which are helpful in determining patient/client status.

iv. I am able to apply conflict resolution strategies in a timely manner.

v. I am able to effectively adapt communication strategies across the lifespan.

Rate your overall performance for this competency and record rating:
(1) Unsatisfactory, (2) Satisfactory, (3) Superior
Overall Rating

(b) Patient/Client-Related Instruction

i. I am able to educate patient/clients on diagnosis, prognosis, treatment, responsibility, and self-management within plan of care.

Rate your overall performance for this competency and record rating:
(1) Unsatisfactory, (2) Satisfactory, (3) Superior
Overall Rating
(c) Procedural Interventions
i. Therapeutic exercise
   - I am able to perform task-specific training.
   - I am able to analyze the relationship between biomechanics of therapeutic exercise and functional outcome.
   - I am able to anticipate the impact of multisystem impairments on the ability to perform therapeutic exercise.
   - I am able to prescribe a precise exercise program related to functional limitations.
   - I am able to interpret, integrate, and correctly apply research findings to therapeutic exercise prescriptions.
   - I am able to adapt aerobic conditioning for patients/clients with neurologic dysfunction.
   - I am able to integrate physiological findings in the adaptation of therapeutic exercise programs.

ii. Functional training in self-care and home management and in work (job/school/play), community, and leisure integration and reintegration
   - I am able to analyze the interaction between multiple system impairments and environment.
   - I am able to optimize training despite communication/language, cultural, socioeconomic, and educational variables.
   - I am able to provide assistance and cues which will challenge the patient/client appropriately.
   - I am able to skillfully prescribe/adapt devices for complex patients.
   - I am able to predict the impact of a device on the biomechanics and efficiency of movement.
   - Orthotics
     - I am able to adapt orthotics for use in a neurologic population
v. Airway clearance techniques
- I am able to adapt a variety of interventions that address ventilatory pump and gas exchange impairments, including but not limited to:
  - Knowledge of the impact of mechanical ventilation on intervention: relationship between pulmonary status and swallowing function; airway clearance techniques.
- I am able to analyze the impact of movement dysfunction on ventilation and respiration.

vi. Integumentary Repair and Protective Techniques
- I am able to skillfully prevent and manage integumentary impairment.
- I am able to educate neurologic patient/clients about the importance of skin management.

Rate your overall performance for this competency and record rating:
(1) Unsatisfactory, (2) Satisfactory, (3) Superior
Overall Rating ____________

Self-Assessment Tools
Description of Specialty Practice: Neurologic
PRACTICE EXPECTATIONS: PATIENT/CLIENT MANAGEMENT (continued)

Directions: Place an “X” in the box that BEST describes behavior observed for aspect of the competency.

<table>
<thead>
<tr>
<th>6. Outcomes</th>
<th>Unsatisfactory Performance 1</th>
<th>Satisfactory Performance 2</th>
<th>Superior Performance 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) I am able to select appropriate outcome measures and participates in data collection.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) I am able to analyze and interpret data to modify own future practice.</td>
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<td></td>
</tr>
</tbody>
</table>

Rate your overall performance for this competency and record rating:
(1) Unsatisfactory, (2) Satisfactory, (3) Superior
Overall Rating ____________
Appendix D: UMHS Physical Therapist Job Description

<table>
<thead>
<tr>
<th>For Human Resources Use Only</th>
<th>Job Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved Title/SG</td>
<td></td>
</tr>
<tr>
<td>Full Time Rate</td>
<td>Std Hours</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Approved By</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Part One</td>
<td></td>
</tr>
<tr>
<td>Incumbent Name</td>
<td>UMID</td>
</tr>
<tr>
<td>Current Job Title/SG</td>
<td></td>
</tr>
<tr>
<td>Physical Therapist</td>
<td>Current Job Code</td>
</tr>
<tr>
<td></td>
<td>Current Std Hrs</td>
</tr>
<tr>
<td>Current Salary</td>
<td></td>
</tr>
<tr>
<td>Part Two</td>
<td></td>
</tr>
<tr>
<td>Dept Name</td>
<td></td>
</tr>
<tr>
<td>PM&amp;R Occupational Therapy &amp;</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy Divisions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dept ID</td>
</tr>
<tr>
<td></td>
<td>PCN</td>
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<tr>
<td>Part Three</td>
<td></td>
</tr>
<tr>
<td>Proposed Job Title/SG</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Proposed Job Code</td>
</tr>
<tr>
<td></td>
<td>Proposed Full Time Rate</td>
</tr>
<tr>
<td>Part Four</td>
<td></td>
</tr>
<tr>
<td>SUPERVISION OF STAFF: If Applicable, list staff to be supervised by this position and check the type of supervision.</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Title</td>
</tr>
<tr>
<td>~0-3 FTEs</td>
<td>Physical Therapist Assistants</td>
</tr>
<tr>
<td></td>
<td>Functional</td>
</tr>
<tr>
<td>~0-3 FTEs</td>
<td>Rehabilitation Technicians</td>
</tr>
<tr>
<td></td>
<td>Functional</td>
</tr>
<tr>
<td>~0-3 FTEs</td>
<td>Physical Therapy Interns</td>
</tr>
<tr>
<td></td>
<td>Functional</td>
</tr>
<tr>
<td>Part Five</td>
<td></td>
</tr>
<tr>
<td>BENCHMARK INCUMBENTS: (optional) List other University employees doing substantially the same work.</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Title</td>
</tr>
<tr>
<td></td>
<td>Department</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Part Six DUTIES: List the major job duties and % of time spent on each. Be specific and list essential functions first.

<table>
<thead>
<tr>
<th>% of Time</th>
<th>Duties</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>35%</strong></td>
<td><strong>Evaluating and Planning Patient Care</strong></td>
</tr>
<tr>
<td></td>
<td>1. Insure prompt initiation of patient treatment when referrals are received.</td>
</tr>
<tr>
<td></td>
<td>2. Assist in the coordination and prioritization of patient care when referrals exceed staffing levels or there is an unscheduled absence on the team.</td>
</tr>
<tr>
<td></td>
<td>3. Interpret referrals to ensure appropriate patient care.</td>
</tr>
<tr>
<td></td>
<td>4. Ensure the appropriate precautions are identified and followed during treatment.</td>
</tr>
<tr>
<td></td>
<td>5. Evaluate and re-evaluate patients appropriately and accurately.</td>
</tr>
<tr>
<td></td>
<td>6. Establish goals based on the evaluation findings, functional limitations, patient/family input and the age of the patient.</td>
</tr>
<tr>
<td></td>
<td>7. Develop focused individually designed treatment plans based on the goals and modify as appropriate for the patient population and age of the patients.</td>
</tr>
<tr>
<td></td>
<td>8. Monitor patients throughout the provision of treatment and respond quickly and appropriately to changes in the patients’ status.</td>
</tr>
<tr>
<td></td>
<td>9. Determine appropriate assistive and mobility equipment and facilitate obtaining equipment.</td>
</tr>
<tr>
<td></td>
<td>10. Discharge patients from physical therapy when goals or projected outcomes have been attained or patient discharge is appropriate for other reasons.</td>
</tr>
<tr>
<td></td>
<td>11. Provide for appropriate follow-up care or referrals.</td>
</tr>
</tbody>
</table>

<p>| <strong>40%</strong>   | <strong>Providing Patient Care</strong> |
|           | 1. Manage daily schedule to meet or exceed productivity standards. |
|           | 2. Provide appropriate treatment modalities, exercise and functional activities to meet established goals directly or through assistive personnel. |
|           | 3. Select activities that will help individuals learn work/life management skills and pain control within the limits of their physical or mental capabilities. |
|           | 4. Utilize independent clinical decision making on a daily basis to progress patients and modify treatment depending upon the patients’ needs and medical status. |
|           | 5. Instruct patients and caregivers in exercises and functional mobility activities to assist the patient in reaching established goals. |
|           | 6. Ensure staff and patient safety throughout the continuum of care through demonstration and education. |</p>
<table>
<thead>
<tr>
<th>15%</th>
<th>Communication and Documentation of Patient Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Maintain ongoing communication with all assistive personnel providing any part of the patients’ treatment.</td>
</tr>
<tr>
<td>2.</td>
<td>Consult with, and serve as a resource to, other health care professionals regarding therapy administered and projected treatment goals.</td>
</tr>
<tr>
<td>3.</td>
<td>Communicate and work cooperatively with other health care professionals to ensure the coordinated care of patients, participate in discharge planning, and provide appropriate recommendations.</td>
</tr>
<tr>
<td>4.</td>
<td>Utilize medical information systems to obtain current patient information.</td>
</tr>
<tr>
<td>5.</td>
<td>Complete timely and legible patient care and billing documentation according to established division standards.</td>
</tr>
<tr>
<td>6.</td>
<td>Report malfunctioning equipment or missing equipment to supervisor or directly to maintenance/biomedical engineering, as appropriate.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10%</th>
<th>Education of Self and Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Keep current in clinical practice by working with and sharing information with team members and through continuing education opportunities.</td>
</tr>
<tr>
<td>2.</td>
<td>Complete orientation checklists, core competencies, and clinical competencies.</td>
</tr>
<tr>
<td>3.</td>
<td>Assist in orienting staff.</td>
</tr>
<tr>
<td>4.</td>
<td>Provide feedback and act on feedback received in a professional manner.</td>
</tr>
<tr>
<td>5.</td>
<td>Assist in the development of orientation materials and competencies as requested.</td>
</tr>
<tr>
<td>6.</td>
<td>Educate health care professionals, community groups, career classes and others as approved by supervisor.</td>
</tr>
<tr>
<td>7.</td>
<td>Serve on department, division, or team projects/committees as requested.</td>
</tr>
<tr>
<td>8.</td>
<td>Assist supervisor in determining and providing for the clinical inservice needs of the team.</td>
</tr>
<tr>
<td>9.</td>
<td>Participate in the clinical education program for physical therapy interns.</td>
</tr>
<tr>
<td>10.</td>
<td>May publish in professional journals and/or book chapters.</td>
</tr>
<tr>
<td>11.</td>
<td>Participate in research in an area of interest with approval from management team.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TOTAL 100%</th>
<th>AGE RANGE OF PATIENTS TREATED:</th>
<th>YEARS THROUGH YEARS</th>
</tr>
</thead>
</table>
Part Seven POSITION QUALIFICATIONS: Include education, experience, licenses, registrations and certifications.

<table>
<thead>
<tr>
<th>University Minimum Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Bachelor of Science Degree or Master of Science Degree or Doctor of Physical Therapy Degree.</td>
</tr>
<tr>
<td>3. Ability to understand and communicate information both orally and in writing so others will understand.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Department Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Specific physical therapy positions may require specialized experience.</td>
</tr>
<tr>
<td>2. Ability to perform physical activities that require considerable use of your arms and legs and moving your whole body, such as lifting, balancing, standing, walking, stooping, kneeling, crawling, and supporting patients throughout the entire work day.</td>
</tr>
</tbody>
</table>

Part Eight Provide any additional comments or information not covered above.

**ALL EMPLOYEES ARE EXPECTED TO:**

1. Demonstrate ethical behavior, honesty, integrity, and respect for others during interactions with supervisor, programmatic area colleagues, peers, staff, and patients.
2. Comply with Health System and Division regulations, policies and procedures.
3. Assume responsibility for the order of office and work areas.
Appendix E: Physical Therapy Department Academic Standards Appeal Form

Physical Therapy Department
Academic Standards Appeal Form

Name: _____________________________  Date: ________________

Basis of Appeal (please check one or more):

_____ The academic standards decision made by the Physical Therapy Department faculty is in violation of established departmental, school or university policies or procedures.

_____ A significant omission occurred in the operational processes of the Academic Standards Policy and Procedure for the Physical Therapy Department.

_____ New evidence is available to present which bears upon the validity of the faculty’s decision.

_____ The decision of the faculty is clearly prejudicial, grossly inequitable, or academically indefensible.

Evidence must be supplied to support the above appeal claim. Actual evidentiary documents should be provided prior to or at the departmental appeal hearing. Only evidence pertinent to the basis of the appeal will be considered in the appeal process. All evidence pertinent to the case should be provided during the departmental appeal process.

Submit this form to the Director of Physical Therapy within five days after receipt of written documentation of the faculty’s decision if quick action on the appeal is required to enable you to continue on your established educational track. If a timely appeal is not an issue, you have thirty (30) days in which to submit this form.

____________________________________________________________________________________________

Resident Signature       Date

____________________________________________________________________________________________

Signature of PT Dept. Director       Date of Appeal Hearing Decision