BROOKLINE COLLEGE

PHYSICAL THERAPIST ASSISTANT PROGRAM

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APPLICATION REQUIREMENTS

2015-2016

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Weighted PTA Program Admission Process

TEAS V Score

TEAS V score 55-above	10 points
TEAS V score 50-54	8 points
TEAS V score 45-49	6 points
TEAS V score <45	0 points

GPA from previous Institution – Unweighted 4.0 scale

3.6 or higher	15 points
3.3 – 3.5	13 points
3.0 – 3.2	11 points
2.8 – 3.0	9 points
2.5 – 2.7	7 points
<2.4	0 points
GED of 450 or greater	0 points

College Experience

B.S. Degree or higher	10 points
A.S. Degree	5 points
2 completed college semesters	3 points
No college experience or < 2 semesters	0 points

Letter of Intent	/15 points
Recommendations (2)	/20 points / (10 points each recommendation)
Interview	/30 points

Highly recommended prior to application: 10 points

-10 observation hours completed, documented: 5 hours inpatient, 5 hours outpatient

Total Maximum Points: 110 Points

MEMORANDUM

DATE: 12/3/2015

TO: Prospective and Enrolled Students in the Physical Therapist/Physical Therapist Assistant Program at Brookline College, Phoenix Campus

FROM: Program Faculty and/or Administration

SUBJECT: Probationary Accreditation Status

On November 11, 2015 the Commission on Accreditation in Physical Therapy Education (CAPTE) continued the Probationary Accreditation status of the physical therapist/physical therapist assistant education program at Brookline College, Phoenix campus. Probationary Accreditation is an accredited status, but it does signal compliance issues in the program that are significant enough to jeopardize the quality of the program and that, if not addressed, may result in accreditation being withdrawn. CAPTE has reached this decision after a thorough review of materials provided by the program. The compliance issues have been clearly identified in CAPTE's Summary of Action and a time line for addressing the issues has been established. Normally, Probationary Accreditation does not extend beyond two years; CAPTE can, however, withdraw accreditation at any time a program is on probation if the situation warrants such an action.

Because Probationary Accreditation is an accredited status, students currently enrolled in the program who graduate in a timely manner will graduate from an accredited program. Similarly, prospective students who are admitted to the program are admitted to an accredited program. However, if in the future CAPTE withdraws accreditation, only students enrolled in the final twelve months of the program at the time of the final decision to withdraw accreditation will be considered by CAPTE to be graduates of an accredited program.

In the interest of the public trust that the accreditation process serves, all enrolled and prospective students are hereby notified that the accreditation status of the physical therapist/physical therapist assistant education program at Brookline College, Phoenix campus, is in jeopardy if the identified compliance issues are not adequately addressed in the time provided.

The administration and faculty of Brookline College would like to inform the students that we are undergoing a unified and determined endeavor, completing the compliance requests which address program deficiencies in the Summary of Action due March, 2016.

A copy of this letter and a list of all individuals to whom it has been distributed are being sent to CAPTE at its request. CAPTE expects that the program will provide students with accurate information about the program's status of Probationary Accreditation and reasonable information about the identified deficiencies.

Questions about the compliance issues resulting in probation should be directed to the program faculty. Questions regarding the accreditation process may be directed to the Department of Accreditation, Commission on Accreditation in Physical Therapy Education, American Physical Therapy Association, 1111 North Fairfax Street, Alexandria, VA 22314.

Lynn E. Bagnull, PT, MBA

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Confirmation of Receipt of CAPTE Memorandum regarding:

Continued Probationary Accreditation Status

I, (please print)_____acknowledge receipt of the CAPTE Memorandum dated 12/3/2015 informing me of the Continued Probationary Accreditation Status.

Signature_____Date:_____

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Physical Therapist Assistant Letter of Intent

The letter of intent (1-2 pages) must include the following:

1. What has been your motivation and/or inspiration to pursue the PTA profession?
2. Provide a summary of prior clinical, education, job, or other experiences that prepare you for entering this profession.
3. What are your personal goals/objectives for completing this PTA program?
4. How will the program requirements assist you to meet your goals and objectives in completing the program?
5. What clinical setting do you envision yourself to be working, upon successful completion of the Brookline PTA program?

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Physical Therapist Assistant Program

MINIMUM PTA ADMISSION REQUIREMENTS DECLARATION STUDENT FORM

- I understand that all submitted documents and completed forms become the property of the College and are non-returnable.
- I understand that deceit in the application procedure is cause for dismissal from the program.
- I understand that I must provide official high school transcript, GED transcript, or AZ DOE CPE.
- I understand no student will be admitted in the program with a disqualifying criminal history or child abuse clearance.
- I understand no student will be admitted with a disqualifying result or failure to meet a specified deadline in the drug screening.
- I understand students accepted into the program must submit a health examination form completed by a physician/nurse practitioner/physician's assistant with immunization history including verification through blood work. No student will be admitted with a disqualifying result or failure to meet the specified deadline.
- I understand the statements below regarding clinical experiences:
  - You may have to travel to your clinical experience.
  - You may choose to seek housing nearer your clinical experience.
  - You are responsible for arranging your own transportation to and from the clinical facility. In addition, any cost for parking is solely the responsibility of the student.
  - Students who drive must present proof of car registration, insurance and driver's license.
  - You must have a valid, current driver's license in order to drive a motor vehicle on the premise of a clinical site.
  - The motor vehicle that you drive on the premise of a clinical site must have a valid vehicular registrations and tags.
  - The insurance of a motor vehicle that you drive on the premise of a clinical site must be valid and current.
- I, the undersigned:
  - Have read and understand the Physical Therapist Assistant Program **Minimum Admission Requirements**.
  - I understand that I am responsible for doing and paying the cost of requirements designated to the candidate.
  - I understand that meeting the requirements is not a guarantee of admission into the program.

_____ _____

Signature of Candidate Date

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BROOKLINE COLLEGE - PHYSICAL THERAPIST ASSISTANT

MINIMUM ADMISSION REQUIREMENTS AND PRECLINICAL REQUIREMENTS DECLARATION

Eligibility Requirements:	**Responsible Person**	**Responsible for Cost**
Official high school transcript or GED with scores (minimum 450 GED score)	Candidate	Candidate
*A GED from a state or jurisdiction other than AZ or a high school diploma from a jurisdiction other than the U.S. requires a Certificate of Preliminary Education (CPE) from AZ DOE.	Candidate	Candidate
At least 17 years of age – provide documentation	Candidate	Candidate
U.S. citizen, permanent resident, or eligible non-citizen – provide documentation	Candidate	Candidate
Admission requirements:	Candidate	Candidate
Official high school transcript, GED transcript, or AZ DOE CPE	Candidate	Candidate
Official college transcripts, if applicable	Candidate	Candidate
Satisfactory performance on the TEAS (Entrance Exam) *(Note: testing fee is subject to change)*	Candidate	Candidate
The following required items are to be completed after conditional acceptance to the PTA program has been received by the candidate.	Candidate	Candidate
Completion of an AZ Criminal & AZ Child Abuse background check *Non-resident of Arizona must also submit a Criminal Record check from the state in which he/she resides.*	College	College
Completion of satisfactory drug screening	College	College
Personal Health History	Candidate	Candidate
Physical Exam by health care provider	Candidate	Candidate
Mumps, rubella, rubella, and varicella titers	Candidate	Candidate
Booster vaccination(s) of mumps, rubella, rubella, and/or varicella if titer non-reactive/non-immune with a repeat titer to verify immunity	Candidate	Candidate
Tetanus-diphtheria booster vaccination within the last 10 years	Candidate	Candidate
Tuberculosis screening (must be completed in the same year as admission to the PTA program)	Candidate	Candidate
Hepatitis B vaccination series of three (3) doses completed or in progress	Candidate	Candidate
Seasonal influenza vaccine is required annually	Candidate	Candidate
Liability insurance and injury insurance	College	College
Student personal health insurance	Candidate	Candidate
CPR certification	Candidate	College

REV: 11-2-15

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Physical Therapist Assistant Observation Declaration

Name of Applicant: _____

The Brookline College highly recommends that applicants complete a minimum of 10 hours of observation in at least two Physical Therapy Departments. Five (5) hours should be spent in an inpatient facility (hospital or nursing home) and five (5) hours in an outpatient clinic. Observation credit should only be given for actual time spent observing patient care. Individuals working as paid employees in a physical therapy department may use their regular working hours to complete this requirement. Observation may be completed with a licensed Physical Therapist or licensed/registered Physical Therapist Assistant, and hours will only be accepted if signed by the supervising PTA or PT. Properly documented observation hours will be accepted on forms from other educational institutions as long as it is approved by the Physical Therapist Assistant Program Director.

_____Total Hours _____Total Days

I certify that the hours listed above were fulfilled by me. I understand that the PTA Admission Committee may verify this document for authenticity and I realize that falsification of information will result in my application to the PTA Program being withdrawn for consideration.

Applicant Signature _____

Date _____

NOTE: *Additional forms may be obtained from the PTA Program Director if needed.*

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Physical Therapist Assistant Observation Documentation Form

Date	Start Time	End Time	# of Hours	Name of the Facility	Location (City, State)	Phone	Setting (In/Outpatient)	Signature of supervising PT/PTA AND Certificate/License #

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Physical Therapy Assistant Dress Code

The following guidelines have been established to meet the dress requirements for Brookline College Physical Therapy Assistant Program:

- Three Brookline College polo shirts are issued to each student. Students are required to wear the college uniform in all class room and clinical settings unless the clinical setting requires other clinical attire. If any part of the uniform needs to be replaced it will be done so at the cost to the student. Additional uniforms may be purchased through the college. If a student is not wearing the entire college, issued/approved uniform they will be asked to leave campus or clinical setting. This will result in an absence. If the uniform cannot be worn during pregnancy, the Program Director should be consulted regarding acceptable dress. Students who wish adaptations to the uniform for cultural and/or religious reasons need to consult with Program Director and or the Director of Education prior to the first day of class.
- The student uniform must be clean, neat.
- No long sleeve shirts or visible T-shirts may be worn under tunic top when in uniform.
- Do not wear colored undergarments that are visible through the uniform.
- Hair must be clean, worn off the collar and pulled back from face while in uniform, (especially while working in the lab). Hair color that is distracting or not in good taste is not permitted.
- No jewelry is to be worn with the uniform except wedding rings, engagement rings, and a wristwatch with a second hand. No neck chains, ornamental pins, or bracelets are to be worn with the uniform.
- No hats, caps, headbands, or bandannas of any kind may be worn in the classroom or the clinical areas.
- No visible tattoos are permitted in class or clinical setting; they must be covered.
- One pair of small plain post earrings may be worn in pierced ears. NO dangling earrings should be worn. No body piercing jewelry is to be visible. Clear spacers may replace body piercing while in class or at clinicals. If the removal is not an option, the reason should be discussed with the Program Director prior to the first clinical day. If the reason is justified, the jewelry will need to be covered. This policy is in effect for the safety of both students and patients to eliminate potential sources of infection and/or injury as well as to avoid distractions to patients who are in the care of students. Clinical facility may have additional regulations or guidelines that will be required.
- Makeup should be minimal and subtle. Neatly trimmed beards and mustaches are permitted.

- Students will maintain personal hygiene. Students will bathe daily and use deodorant. No offensive body odor or cigarette smell.
- Cologne, after-shave, or perfumes are not permitted in the classroom or clinical facility.
- Picture ID badge is worn in a visible area at all times both in school and clinical facilities.
- Socks or neutral nylons must be worn with uniforms.
- Shoes must have closed toes, low heels, and a strap over the heel.
- Fingernails must be clean and short. Light pastel or neutral color polish is acceptable, no artificial nails, wraps, or extenders of any length.
- No chewing gum while in uniform.

Occupational Safety and Health Administration (OSHA) regulations require protective eye wear be worn while conducting or observing any procedures in lab sessions. Personal corrective glasses or goggles may be substituted with the permission of the instructor. Students improperly dressed for lab will not be allowed to initiate any procedures and may be expelled from the lab during procedures at the discretion of the instructor until they are dressed in accordance with regulations.

I understand the above dress code and agree to comply with all components. I understand that violations may result in disciplinary action.

_____ _____

Signature Date

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INSTRUCTIONS FOR COMPLETION OF HEALTH FORM

This health form must be completed by **ALL** students. Students may not start clinical experiences until the form is complete and on file. Students are encouraged to retain a photocopy of their forms for their personal records.

Physical Examination

Students must see a health care provider who may be a physician (MD or DO), Nurse Practitioner (ARNP) or Physician Assistant (PA) for the physical examination who must complete and sign the attached form. **Students are responsible for the cost of the physical examination and immunizations.**

Immunizations

All immunization records must include (1) your name, (2) the name and signature of the healthcare provider giving the immunization, and (3) the date of immunization. ALL immunizations must be documented. Take documentation of past immunizations to the health care provider. Without documentation, the provider will not be able to complete the form. If your immunization record is incomplete, consult your health care provider or the Health Department before scheduling your physical. Many of the tests or immunizations may need to be completed before you get your physical.

1. MMR (measles/rubeola, mumps, rubella)

If you have had all three illnesses or do not have documented proof of having received the vaccinations, you must have a titer drawn for **each** illness.

Positive results - attach a copy of the results to the health declaration form.
Negative results - you **must** get your first MMR vaccination and attach documentation to the health declaration form. The second MMR must be completed within one month and proof submitted to the nursing school.

2. Varicella (chickenpox)

There are 2 options to meet this requirement :

a. attach a copy of proof of a positive IgG titer for varicella; or

b. if a **negative titer**, attach a copy of proof to the health form that you received the first vaccination. The second vaccination must be completed in 4-8 weeks, and submit proof to the nursing school.

3. Tetanus/diphtheria (Td or Tdap) immunization

Attach a copy of proof of Td vaccination you received within the past 10 years to the health forms.

4. Tuberculosis (TB)

Options to meet this requirement are:

a. attach a copy of proof of TB skin test (PPD/Mantoux) completed within the last six (6) months; or

b. a **positive** TB skin test requires proof of a recent chest x-ray and a note from the physician stating you are free of active TB disease symptoms.

5. Hepatitis B

Options to meet this requirement include:

a. proof of completion of three (3) Hepatitis B injections attached to health form, or

b. proof of a positive HBSAB antibody titer attached to health form, or

c. proof of the first in a series of 3 Hepatitis B injections attached to health form. The 2nd injection **must** be received in one month, and the 3rd 5 months after the second. Submit subsequent documents to the nursing school.

d. submit a signed waiver form releasing Brookline College and clinical sites from liability.

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HEALTH FORM

Applicant: _____
(Print) Last First MI Date of Birth

Address: _____
Number and Street Apt Number

_____
City State Zip

(____) _____ (____) _____
Home Phone Number Cell Number Date

TO BE FILLED OUT BY STUDENT

Check all items that apply, past or present, to your health history.

____ Rheumatic Fever	____ Asthma	____ Depression
____ Heart Disease	____ Latex Allergy	____ Mental Illness
____ Kidney Disease	____ Allergies/Hay Fever	____ Hernia
____ Chronic rashes	____ Fainting	____ Hepatitis
____ High Blood Pressure	____ Chest Pain	____ Speech Disorder
____ Cancer	____ Convulsive Disorder/Seizures	____ Back/Spine Injury and/or Disorder
____ Diabetes	____ Tuberculosis	____ Eating Disorder
____ Other, please explain	____	____

If you checked any of the above, please explain and give dates: _____

_____

_____

Students are expected to fully participate in all activities required by the Physical Therapy Assistant Program. This includes, but is not limited to the following:

- Ability to lift 40 or more pounds
- Ability to exercise critical thinking, reasoning and judgment in client care situations
- Ability to perform psychomotor skills necessary for carrying out physical therapist assistant procedures
- Hearing and visual acuity and depth perception necessary to perform clinical physical therapist assistant experience
- Lift, move and operate equipment used in the care of patients
- Walking and standing for prolonged periods for eight hours or more
- Psychological stability to perform physical therapist assistant functions effectively in stressful situations

I understand that a physical therapist assistant student must be able to meet the physical and psychological requirements listed above. I have read and understand the requirements and I am able to perform all of the listed functions.

Print student Name _____ Date _____

Student Signature _____ Date _____

***Falsification or altering the Health Forms or supporting documents in any manner will result in immediate dismissal from the program.**

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TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN'S ASSISTANT

Required of all students.

Height_____ Weight_____ B/P_____/_____ Pulse Rate_____

Head _____ Skin _____

Eyes _____ Nose _____

Ears_____ Neck/Thyroid _____

Throat _____ Mouth_____

Chest/Lungs _____ Heart _____

Breast _____ Abdomen _____

Hernia _____ Cardiovascular _____

Neurological _____ Musculo-skeletal _____

Upper Extremities _____ Lower Extremities _____

Vision Problems _____ Hearing Problems _____

Remarks (please attach additional sheet as needed): _____

_____

_____

Does the student have any active disease or is any treatment being followed which should be periodically checked? If so, please explain:

_____

_____

_____

Is he/she taking any routine medications? Y__ N __

If so, please list type and amount: _____

_____

_____

_____

_____

_____

_____

_____

Other conditions (please list):_____

_____

_____

_____

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Any physical or psychological limitations? If so, please explain:

Date _____ **Printed Name:**_____

Signature_____**Title**_____

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HEALTH CARE PROVIDER SIGNATURE FORM

Instructions for Completion of Health Care Provider Signature Form:

The health care provider **must** sign the Health Care Provider Signature Form and indicate whether the applicant will be able to function as a nursing student. Health care providers who qualify to sign this declaration include a licensed physician (M.D., D.O.), a nurse practitioner, or physician's assistant.

Applicant Name (Please Print)_____

It is essential that physical therapy assistant students be able to perform a number of physical activities in the clinical portion of the program. At a minimum, students will be required to lift patients, stand for several hours at a time, and perform bending activities. Students who have a chronic illness or condition must be maintained on current treatment and be able to implement direct patient care. The clinical physical therapist assistant experience also places students under considerable mental and emotional stress as they undertake responsibilities and duties impacting patients' lives. Students must be able to demonstrate rational and appropriate behavior under stressful conditions.

I believe the applicant_____**WILL** or _____ **WILL NOT** be able to function as a physical therapy assistant student as described above.

If not, please explain: _____

_____

_____

_____

Licensed Healthcare Examiner (M.D., D.O., N.P., P.A.)

Date : _____Printed Name:_____

Signature:_____Title:_____

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IMMUNIZATION DOCUMENTATION

1. MMR

Requires documented proof of two MMRs in lifetime or a positive titer for each of the diseases.

1st MMR date:_____ 2nd MMR date:_____

OR

Results and date of titer: Measles/Rubeola_____ Mumps_____ Rubella_____

I have attached documented proof as specified above. Circle: Yes or No

2. Varicella (Chickenpox)

Requires documented proof of two (2) vaccinations or positive IgG titer.

1st Varicella date:_____ 2nd Varicella date:_____ OR Date and results of IgG titer_____

I have attached documented proof as specified above. Circle: Yes or No

3. Tetanus/Diphtheria (Td or Tdap) immunization within the past 10 years

Td date:_____

I have attached documented proof as specified above. Circle: Yes or No

4. Tuberculin Test (PPD intradermal only)

PPD Date: _____ Read: _____ Result in mm: _____

If Positive, then a chest x-ray (every two (2) years) and a note from a provider stating you are free of active TB disease symptoms. Date: _____ Result: _____ (Attach copy of x-ray report)

5. Hepatitis B

Documented evidence of completed series or positive antibody titer. If beginning series, first injection must be prior to admission and series completed within 6 months.

Date of 1st injection:_____ Date of 2nd injection:_____ Date of 3rd injection: _____

Date and results of IgG titer_____

I have attached documented proof as specified above. Circle: Yes or No

Students opting to decline HEPATITIS B immunization MUST SIGN declination statement below.

I understand that during my participation in the physical therapist assistant program at Brookline College, I may be exposed to blood or other potentially infectious materials and I may be at risk of acquiring the Hepatitis B Virus (HBV) infection. I have been informed of the need to be vaccinated with hepatitis B vaccine; however, I decline the Hepatitis B vaccination at this time. I understand that by declining this vaccination, I continue to be at risk of acquiring Hepatitis B, a serious disease. I understand that the physical therapist assistant Program cannot mandate that I take this vaccination in order to continue my education in my chosen health science program. My failure to be immunized could jeopardize the successful fulfillment of the requirements of my program at Brookline College, which may prevent me from graduating. I further understand and agree that I cannot hold Brookline College responsible for any injury or illness arising from my activity and or exposure to blood or other blood-borne pathogens in my program and clinical areas.

Name: (Print)_____ Date:_____

Student Signature:_____