University of Missouri – Columbia
School of Health Professions
Department of Physical Therapy

Please fill out the information below and fax or mail back to the DCE in the envelope provided.

Fax (573) 884-8369

MID-TERM REPORT FORM

Facility Name:______________________________

Student Name: ______________________________

Clinical Instructor Name: ______________________

Clinical Instructor Phone Number: _____________________

Clinical Instructor Email: ____________________________

Student: Please fill in the appropriate information:

Graduation Year: ________

Affiliation (please circle):

1 2 3 4 5

Is the student having any difficulty in the following areas:

1. Safety Yes ___ No___
2. Professional behavior Yes ___ No___
3. Ethical and legal practice Yes ___ No___
4. Attendance Yes ___ No___

Do you feel that significant changes need to be made before you would feel comfortable giving this student a "passing" grade on this affiliation?

Yes ___ No ___

Comments if checked "yes":
____
____

CAPTE: Pg. B-7, Item P-11; Pg. B-13, Item F-13; Pg. B-14, Item F-16; Pg. B-25, Item CP-2.9