

The University of Kansas Medical Center
Department of Physical Therapy & Rehabilitation Sciences
3056 Robinson Hall 3901 Rainbow Blvd., Kansas City, KS 66160-7601 (913) 588-6799

CLINICAL GOALS

CLINICAL PRACTICA I, II, III, IV

Student's Name _____

Date of Clinical _____

Facility/Site Name _____

Address _____

To be completed prior to start of practicum

1. Clinical experience to date: (include prior practica and jobs)

2. Goals/objectives for this practicum:

	Goals Met	Not Met
a.		
b.		
c.		
d.		
e.		

3. Procedures/patient profile I feel comfortable doing: (refer to self-assessment to complete)

4. Procedures/patient profile I would like further experience with (refer to self –assessment to complete).