

# Core Performance Standards Form

**Individuals with disabilities are encouraged to apply to the program. However, it is the responsibility of the student to notify the Chair of the Department of Physical Therapy if there is any reason why the abilities/expectations described in the Core Performance Standards cannot be met. Students who indicate they cannot meet one or more of these standards and who request a review in writing will, be reviewed by the Departmental Admissions Committee and the Equal Employment Opportunity / Affirmative Action Office (EEO/AA) to determine what, if any, reasonable accommodations might be possible to facilitate successful completion of the degree requirements.**

I, \_\_\_\_\_, have read the description of minimum core performance standards required for admission to, progression in and completion of the program in Physical Therapy and indicate by my signature that at this time, to the best of my knowledge, I possess these attributes and am able to perform the standards as listed without accommodation.

I, \_\_\_\_\_, have read the description of the minimum core performance standards required for admission to, progression in and completion of the program in Physical Therapy and indicate by my signature that at this time, to the best of my knowledge, I possess these attributes and am able to perform the standards as listed with accommodations. And, I understand that by acknowledging accommodations are necessary, I am required to submit to the Department Chair and the Office of Equal Employment Opportunity/Affirmative Action current, **written documentation** regarding the nature of the illness or disability.

\_\_\_\_\_  
Student Applicant

\_\_\_\_\_  
Date

Department of Physical Therapy - University of Texas Health Science Center at San Antonio

Applicant Name \_\_\_\_\_

**THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT SAN ANTONIO  
MASTER IN PHYSICAL THERAPY**

**REQUEST FOR WAIVER OF STATE REQUIRED PREREQUISITES**

Pursuant to my application for admission to the University of Texas Health Science Center at San Antonio, Master of Physical Therapy Program, I make the following statements:

Received Undergraduate degree: \_\_\_\_\_

Date awarded: \_\_\_\_\_

Institution: \_\_\_\_\_

I understand the following courses are required for admission to the PT Program

English	3 hours
English Composition	3 hours
United States History	6 hours
United States Government	3 hours
Texas Constitution	3 hours
Algebra or higher math	3 hours

I hereby request a waiver of the following course(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I understand that by requesting this waiver, I will be ineligible to receive the Bachelor of Science in Health Sciences (BSHS) from The University of Texas Health Science Center at San Antonio. Normally, the BSHS is awarded to students in the MPT program upon completion of the entire program. This waiver in no way jeopardizes my progress in the program and on satisfactory completion of the full curriculum and with faculty approval, I will be awarded the Master of Physical Therapy degree.

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness name (printed)

\_\_\_\_\_  
Witness signature

# APTA Information Permission Form

Date: \_\_\_\_\_

I, \_\_\_\_\_, will permit the Department of Physical Therapy to send my name and Social Security Number to the American Physical Therapy Association (APTA) and the Texas Physical Therapy Association (TPTA) for the purpose of identifying me as a student/graduate of the University of Texas Health Science Center at San Antonio, Physical Therapy Program.

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(Student's signature)

# HIPAA (Health Insurance Portability and Accountability Act)

## Confidentiality/Security Acknowledgment

The University of Texas Health Science Center at San Antonio (UTHSCSA) has a legal and ethical responsibility to safeguard the privacy of all patients and protect confidentiality and security of all health information. During your employment or affiliation with UTHSCSA you may hear information related to a patients' health or read or see computer or paper files containing confidential patient information, whether or not you are directly involved in providing patient services. You may also create documents containing confidential patient information, if part of your job description and as directed to do so by your supervisor.

As part of your employment or affiliation with UTHSCSA, you must strictly adhere to the following regarding confidentiality and security of patient information:

- ✓ *Confidential Patient Information.* I will regard patient confidentiality as a central obligation of patient care. I understand that all information, which in any way may identify a patient or which relates to a patient's health, must be maintained in the strictest confidence. Unless directed otherwise by my supervisor, I will not at any time during or after my employment or affiliation speak about or share any patient information with any person or permit any person to examine or make copies of any patient reports or other documents that I come into contact with or which I create, other than as permitted by this Agreement.
- ✓ *Permitted Use of Patient Information.* I understand that I may use and disclose confidential patient information only to other providers of health care services, as long as the purpose of the disclosure is the treatment, consultation, or referral of the patient. If my job description allows, I may also disclose information for payment and billing purposes. My supervisor or UTHSCSA must approve any other disclosure of health information.
- ✓ *Prohibited Use and Disclosure.* I understand that I must not use or disclose any patient information for any purpose other than stated in this Agreement. I may not release patient records to outside parties except with the written authorization of the patient, the patient's representative, or for other limited emergency circumstances. Special protections apply to mental health records, records of drug and alcohol treatment, and HIV related information. I must not physically remove records containing patient information from the provider's office, clinic, or facility, or alter or destroy such records. Personnel who have access to patient records must preserve their confidentiality and integrity, and no one is permitted access to patient information without a legitimate, work-related reason. I may not photocopy a patient record.

I also agree to immediately report to my supervisor or to the UTHSCSA Privacy Officer any non-permitted disclosure of confidential patient information that I make by accident or in error. I agree to report any use or disclosure of confidential patient information that I see or know of others making that may be a wrongful disclosure.

- ✓ *Safeguards.* In the course of my employment or affiliation, if I must discuss patient information with other healthcare practitioners in the course of my employment or affiliation, I will use discretion to ensure that others who are not involved in the patient's care cannot overhear such conversations. I understand that when confidential patient information is within my control, I must use all reasonable means to prevent it from being disclosed to others except as permitted by this Agreement.

Protecting the confidentiality of patient information means protecting it from unauthorized use or disclosure in any format, oral/verbal, fax, written, or electronic/computer.

- ✓ *Computer Security.* If I keep any identifiable patient information on a PDA, laptop, or other electronic device, I will ensure that my supervisor knows I am using it and has approved such use. I agree not to send patient information in an email unless my supervisor directs me to do so. I will not attempt to access information by using a user identification code or password other than my own, nor will I release my user identification code or password code to anyone, or allow anyone to access or alter information under my identity.
- ✓ *Return or Destruction of Information.* If my employment or affiliation with UTHSCSA requires that I take patient information off the UTHSCSA campus or off the property of UTHSCSA's affiliates, I will ensure that I have UTHSCSA's or the other facility's permission to do so, I will protect the patient information from disclosure to others, and I will ensure that all patient information is returned to the appropriate facility.

Unless specifically stated in my job description, I am not authorized to destroy any type of original patient information maintained in any medium, i.e., paper, electronic, etc.

- ✓ *Termination.* When I leave my employment or affiliation at UTHSCSA or complete my training or residency at UTHSCSA, I will ensure that I take no identifiable patient information with me, and I will return all patient information in any format to the UTHSCSA or other appropriate facility. If it is not original documents, but rather my own personal notes, I must ensure that such information is destroyed in a manner that renders it unreadable and unusable by anyone. Discharge or termination, whether voluntary or not, shall not affect my ongoing obligation to safeguard the confidentiality and security of patient information and to return or destroy any such information in my possession.
- ✓ *Violations.* I understand that violation of this Agreement may result in corrective action, up to and including termination of my employment or affiliation. In addition, violation of privacy regulations could also result in fines or jail time.
- ✓ *Disclosures Required by Law.* I understand that I am required by law to report suspected child or elder abuse to the appropriate authority. I agree to cooperate with any investigation by the Department of Health and Human Services or any oversight agency, such as to help them determine if UTHSCSA is complying with federal or state privacy laws.

I understand that nothing in this Agreement prevents me from making a disclosure of confidential patient information if I am required by law to make such a disclosure.

I understand that if I believe in good faith that UTHSCSA has engaged in conduct that is unlawful or otherwise violates clinical or professional standards, or that the care, services, or conditions provided by the UTHSCSA potentially endangers one or more patients, workers, or the public, a disclosure of confidential information may be made, but only to the appropriate public authority and/or to the attorney retained by me for the purpose of determining legal options with regard to the suspected misconduct.

My supervisor is \_\_\_\_\_

*By my signature below, I acknowledge that I have read the terms and conditions of this acknowledgment.*

Signature \_\_\_\_\_

**Please circle:      UTHSCSA Employee      Medical Resident      Student**

Printed name \_\_\_\_\_

Date \_\_\_\_\_

Address/Phone \_\_\_\_\_

\_\_\_\_\_  
 This Agreement must be signed by all UTHSCSA employees and students who are exposed in any way to patient information, medical residents, interns, or students in any program that exposes them to patient information in any capacity.

## Student Data Master of Physical Therapy Program

<b>Name:</b>														
<b>First Name</b>	<b>Last Name:</b>													
<b>Local Address</b>														
<b>City</b>	<b>State:</b>	<b>Zip Code</b>												
<b>Local Phone:</b>	<b>e-mail:</b>													
<b>Current Degree(s) (B.S., B.A., etc.)</b>	<b>Major</b>													
<b>Hometown/Origin-city</b>	<b>State/Province</b>	<b>Country</b>												
<p><b>Race or Ethnicity (Not Required – Information is used only for program reporting purposes. CHECK ONE)</b></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30px; border: 1px solid black;"><input type="checkbox"/></td> <td>African American</td> </tr> <tr> <td style="border: 1px solid black;"><input type="checkbox"/></td> <td>Hispanic/Latino, Latina</td> </tr> <tr> <td style="border: 1px solid black;"><input type="checkbox"/></td> <td>American Indian</td> </tr> <tr> <td style="border: 1px solid black;"><input type="checkbox"/></td> <td>Asian</td> </tr> <tr> <td style="border: 1px solid black;"><input type="checkbox"/></td> <td>White/Anglo</td> </tr> <tr> <td style="border: 1px solid black;"><input type="checkbox"/></td> <td>Other</td> </tr> </table>			<input type="checkbox"/>	African American	<input type="checkbox"/>	Hispanic/Latino, Latina	<input type="checkbox"/>	American Indian	<input type="checkbox"/>	Asian	<input type="checkbox"/>	White/Anglo	<input type="checkbox"/>	Other
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<input type="checkbox"/>	Asian													
<input type="checkbox"/>	White/Anglo													
<input type="checkbox"/>	Other													
<h3>Acknowledgement Form</h3>														
<p>I, _____, have received the information as presented in <i>Master of Physical Therapy Program Handbook of Student Policies and Procedures— 2007-2008</i> and agree to read/download and request clarification of any information not clearly understood.</p>														
<b>Student's Signature:</b>		<b>Date:</b>												

## UTHSCSA Department of Physical Therapy Honor Code

- I understand that I am responsible for knowing and obeying the Rules and Regulations of The University of Texas Board of Regents and the UTHSCSA School of Allied Health Sciences as they pertain to scholastic dishonesty.
- I understand that if I am found guilty of an act of scholastic dishonesty, the penalties can be severe, including expulsion from the School.
- Accordingly, I pledge that I will neither give nor receive unauthorized help on any examination, paper, or assignment that requires individual responsibility and that I will be scrupulously honest in the conduct of my research and the presentation of my research results.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

**Documented cases of scholastic dishonesty will be handled according to the regulations and guidelines found in the UTHSCSA Student Guide.**