



**HARDING
UNIVERSITY**

**DOCTOR OF PHYSICAL THERAPY
DEGREE PROGRAM**

STUDENT HANDBOOK

Revised May 2018

The DPT student handbook is updated annually and all DPT students are bound to the policies and procedures in the most current edition of the handbook.

The Harding University Physical Therapy Program Handbook is not intended to represent a contract, either specific or implied, with students enrolled in the College of Physical Therapy. Rather it is intended as a set of guidelines for students, faculty, and staff regarding the handling of student academic and non-academic affairs. The contents of the Handbook may be changed at any time at the discretion of the administration of Physical Therapy Program. Every effort will be made to inform students of changes in a timely and responsible manner utilizing the University e-mail system.

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INTRODUCTION

Welcome to the Doctor of Physical Therapy Program at Harding University. Many of the policies and procedures you need to know are included in this manual; others are included in the Harding *Student Handbook* (<http://www.harding.edu/PDF/StudentHandbook.pdf>) as may be amended from time-to-time.

The DPT student handbook is updated annually and all DPT students are bound to the policies and procedures in the most current edition of the handbook.

Regardless of whether the policies and procedures are listed here, the student is responsible for his/her education and behavior, which includes understanding all University policies and procedures that affect academic progress and use of University resources. The policies and procedures are subject to change, and each student is responsible for staying abreast of the latest policies and procedures.

We are glad you have selected Harding University's Doctor of Physical Therapy Program and we will assist you in whatever way we can to help you to be successful. We hope that you find your experience enriching, personally, spiritually, and academically.

History of Physical Therapy Program

In the fall of 2008, Dr. Burks, President of Harding University, appointed a group of individuals to determine the feasibility of establishing a new program at Harding University. The committee concluded that a Physical Therapy Program at Harding fit well with the mission of the university. Therefore, in 2010, a program director was hired and the Harding University Physical Therapy Program began. Over the course of 2010 and 2011, several faculty members were hired and the charter class of students was accepted and matriculated in the fall of 2011.

Mission and Vision

The mission of the Harding University Physical Therapy Program is to graduate physical therapists who are prepared to practice contemporary Physical Therapy Program from a service oriented Christian World View guided by scientific evidence, professional ethics, and responsibility.

Vision - The Physical Therapy Graduate Program will be recognized nationally for its leadership and innovation in Christian physical therapy education and scholarship as well as for its service to society and the profession. To accomplish this vision the Harding University Physical Therapy Program embraces the following University goals:

- 1. Generally, the integration of faith, learning and living** - developing the whole person through a commitment to Christ and to the Bible as the Word of God, an emphasis on lifelong intellectual growth, and the encouragement of Christian service and world missions through a servant-leadership lifestyle.

2. **Specifically, the development of Christian scholarship** - while acknowledging dependence on God, stressing Christian commitment to intellectual excellence through a strong liberal arts foundation and effective professional preparation.
3. **The promotion of Christian ethics** - creating an atmosphere that emphasizes integrity and purity of thought and action.
4. **The development of lasting relationships** - fostering personal and social relationships through interaction among faculty, staff and students; and stressing a lifelong commitment to marriage and the Christian family.
5. **The promotion of wellness** - emphasizing that the body is the temple of the Holy Spirit and that lifetime health habits contribute to a better quality of life.
6. **The promotion of citizenship within a global perspective** - developing a Christian understanding of and respect for other cultures through an emphasis on liberty and justice.

Core Values

HUPT desires to graduate physical therapists who accept the responsibility of improving the spiritual and physical wellness of the world by providing patient-centered care that ensures optimal physical therapy outcomes delivered through the highest standards of Christian service. Therefore, the educational philosophy employed in providing the Doctor of Physical Therapy curriculum to its students must be one that embraces the same mission. HUPT bases its educational program and position in the physical therapy community upon certain core values. The core values of the college are **advancement, Christianity, collaboration, trustworthiness, innovation, outreach, nurturing, and service**. These values are symbolized by the acronym **ACCTIONS**. The whole of these ACCTIONS is an educational philosophy that will develop lifelong learners who will care for their fellow man in their professional and personal lives while leading others to Christ.

- In **Advancement** of our students as individuals and physical therapists, the educational environment is one that supports each individual in reaching their fullest potential and of reaching the fullest potential of the curricular components.
- In demonstrating **Christianity**, the servant hood of Christ serves as the example for how to respond to and treat one another in the classroom as well as at experiential sites when modeling behavior for students to imitate.
- **Collaboration** is key to the educational philosophy in recognizing that no one member of the health care or educational environment is greater than another but that all must work together to provide optimal care for the individual being served.
- **Trustworthiness** in the education we provide is demonstrated in standing by one's word and always accepting the responsibility entrusted to us by other health care providers and the public.

- **Innovation** in education occurs as we seek to find the teaching and learning methodologies that are the best for student learning and then share these methodologies with others.
- **Outreach** is embraced as the faculty seek to touch the lives of the students, the community, and all other stakeholders in the Program's sphere of influence and make a difference in a positive way.
- **Nurturing** leads the faculty and students to care for one another and create an environment where learning is encouraged and inquiry is rewarded.
- **Service** in education drives us to do our best in whatever role we fill – that of teacher, mentor, learner, servant, or friend

Educational Philosophy

Philosophically, the HUPT curriculum reflects the perspective that student learning must be nurtured and allowed to mature over time, as basic content knowledge must be comprehended, applied, analyzed, and synthesized prior to evaluation. Thus the program embraces the Taxonomy of Physical Therapist Behaviors and encourages faculty to facilitate cognition using instructional methods that appeal to multiple learning styles while developing higher-order thinking skills. The curricular structure itself lends itself to this model, as facilitators are ever-scaffolding content, application, and problem solving skills, striving to integrate hands-on, multi-faceted methods into the same instructional unit. This intentional integration merges the required didactic and prescriptive curricular content in well-structured, sensory-enriched learning experiences that are more quickly embedded and retained.

These techniques are clearly demonstrated in the classroom where students initially see, hear, and communicate basic knowledge that is applied theoretically to controlled case studies and problem-solving situations. As students enter the laboratory and clinical settings, students develop sophisticated critical thinking skills, thus providing additional scaffolding for new content. This process of ever-refining cognitive and diagnostic skills is continuously supervised, monitored, and evaluated formally and informally until students matriculate through the degree plan. By layering pedagogical methods with orderly sequenced information presented in carefully crafted units, the classrooms and laboratories become not only opportunities for learning, but also treasure chests of knowledge that the facilitator and learner simultaneously unpack in an experiential community, creating an intricately orchestrated educative experience that grows all participants personally, professionally, and spiritually. This educational philosophy coupled with the connective threads of the HUPT Assessment Plan purposefully aligns student outcomes, faculty instruction, curricular content, Program Goals, and the University mission.

Program and Educational Goals and Outcomes

Students/Graduates will:

Goal 1: Graduates of the Harding University Physical Therapy Program will demonstrate the skills necessary to practice contemporary entry-level physical therapy in a safe, ethical and responsible manner.

Outcome 1: Students and graduates will demonstrate entry-level knowledge and skill in all didactic curricular components.

Outcome 2: Students and graduates will demonstrate entry-level clinical competence by the end of their clinical experiences.

Outcome 3: Students will demonstrate entry-level competence in critical thinking including but not limited to physical therapy evaluation, diagnosis, and treatment planning.

Outcome 4: Student/graduates will demonstrate entry-level competence in oral and written communication skills.

Goal 2: Students of the Harding University Physical Therapy Program will demonstrate the knowledge and skills necessary for evidence based physical therapy practice.

Outcome 1: Students will apply the skills of scientific inquiry in a scholarly project.

Goal 3: Students and Graduates of the Harding University Physical Therapy program will demonstrate cultural sensitivity in interactions with patients, employers and others with whom they interact.

Outcome 1: Students and graduates will demonstrate cultural sensitivity in their interactions with individuals they interact with in clinical settings.

Outcome 2: Students will demonstrate cultural sensitivity in a domestic or foreign physical therapy Christian service mission.

Goal 4: Students/graduates of the Harding University Physical Therapy program will demonstrate the knowledge and skills required for professionalism and life-long learning.

Outcome 1: Students will take responsibility for his or her own learning

Outcome 2: Students will hold professional ethics to the highest level;

Outcome 3: Student/graduates will respect fellow students, faculty, staff and other members of the Harding University community and other communities of which they are a part.

The Faculty of the Harding University Physical Therapy Program will:

Goal 1: Serve as role models in service: a) to the profession, b) to the community and local church c) to individuals in mission settings.

Outcome 1: Faculty members actively support the professional organization.

Outcome 2: Faculty will actively support the community and local church.

Outcome 3: Faculty will serve underserved populations in domestic or foreign physical therapy Christian service missions.

Goal 2: Promote the advancement of physical therapy education through sound educational principles and professional development.

Outcome 1: Faculty members will serve as role models of professional development for students and the professional community

Outcome 2: Faculty members will serve as role models of professional development as educators for students and the academic community.

Goal 3: Promote the advancement of scholarship through active participation in scholarly activity.

Outcome 1: Faculty members will serve as role models in scholarship to students and the academic community.

The Harding University Physical Therapy Program will:

Goal 1: Graduate service oriented physical therapists who are prepared to practice state of the art physical therapy serving the individual, employers, and the profession with from a Christian worldview.

Outcome 1: The physical therapy program will produce graduates who are assets to their patients and employers, practicing physical therapy from a service oriented Christian worldview.

Goal 2: Become the leader in Physical Therapy based Christian missions education.

Outcome 1: The Physical Therapy Program will prepare students and faculty for domestic and foreign Physical Therapy based missions.

Outcome 2: The Physical Therapy program will produce scholarship based on work done in therapy-based missions.

Accreditation Status

Effective January 29, 2014, Harding University was granted Accreditation status by the Commission on Accreditation in Physical Therapy Education (1111 North Fairfax Street, Alexandria, VA, 22314; phone: 703-706-3245; email: accreditation@apta.org).

THE FACULTY

Administration

Mike Williams, Ed.D.	President, Harding University
Jean-Noel Thompson, Ph.D.....	Executive Vice President
Marty Spears, PhD.	University Provost
Michael K. McGalliard, PT, Sc.D.....	Dean, College of Allied Health
Kevin Ramey, PT, Ph.D.....	Chair and Physical Therapy Program Director
Ruth Ann Mathis, PT, Ph.D.	Director of Clinical Education
.....	Director of Clinical Research

Faculty Information

Sipe, Cody, Ph.D.	Professor
Anita Killins, DPT, PhD., NCS, C/NDT.....	Associate Professor
Doug Steele	Associate Professor
Inna Swann, DPT, Ph.D.	Associate Professor
David Smith, PT, Sc.D.....	Assistant Professor
Don Wilcox, PhD, PT, GCS.....	Assistant Professor
Hunter Finney DPT.....	Assistant Professor

About the Faculty

Michael McGalliard, PT, ScD, COMT, is an Professor and is the Dean of the College of Allied Health, and Associate Provost for Health Sciences. He teaches content in the areas of Anatomy, musculoskeletal physical therapy, and Neuroscience, clinical reasoning. ,

Kevin Ramey PT, PhD is a Professor and Program Director of PT. Dr. Ramey teaches content in the areas of ethic, business, therapeutic exercise and clinical reasoning. Dr. Ramey completed a Doctor of Philosophy degree in Family and Consumer Science Education (Adult Education) at Texas Tech University in May 2008. He has held administrative/ management positions as a physical therapist since 1992.

Ruth Ann Mathis, PhD., PT is an Associate Professor and Director of Clinical Education. She is active within the department in Foundational Clinical Skills, Human Lifespan Development, General Medical and Post-Surgical Physical Therapy, Clinical Reasoning, and Clinical Education

Cody Sipe, PhD, CES, RCEP, is a Professor and teaches content in the areas of biomechanics, cardiopulmonary rehabilitation, physiology, exercise physiology, therapeutic exercise, human lifespan development, and evidence based physical therapy practice, and Health and Wellness Promotion

Anita Killins, PhD., DPT, is an Associate Professor. She teaches content in the areas of gross Anatomy, Neuroscience, Adult Clinical Neurology, and Motor Behavior. Dr. Killins has advanced clinical training and experience in the management and treatment of adults with hemiplegia, pediatrics, and women's health. She is certified as an LSVT clinician for the treatment of patients with Parkinson's disease. Her primary practice area has been in the outpatient setting with orthopedic and neurological diagnoses.

Hunter Finney, DPT is an Assistant Professor and teaches in the courses of Foundational Clinical Skills, General Medical and Post-Surgical, and Ethics. Dr. Finney has extensive experience in wound care and is a Certified Wound Specialist. She is a certified LSVT BIG clinician and a Certified Orthopedic Manual Therapist with additional advanced clinical training and experience in vestibular rehab.

David Smith, PT, Sc.D., OCS is an Assistant Professor and teaches content in the areas of biomechanics, musculoskeletal physical therapy practice, physical agents and modalities, and clinical reasoning. He has been a clinician for 17 years and has primarily practiced in the outpatient setting with orthopedic diagnoses. He is currently working on his ScD in physical therapy from Texas Tech University Health Sciences Center.

Inna Swann, DPT is an associate professor. She teaches content in the areas Anatomy, Human lifespan development, Pediatric physical therapy, and clinical reasoning. Dr. Swann is a Board-Certified Clinical Specialist in Pediatric Physical Therapy. Her clinical interests are in the areas of pediatrics and neurological conditions.

Don Wilcox, PhD, PT, GCS is an Assistant Professor and Dr. Wilcox teaches content in the areas of Cardiopulmonary, Orthotics and Prosthetics, Physical Agents and Modalities, Pathophysiology, and Geriatrics. He has been a Physical Therapist for 24 years with clinical experience in a variety of adult settings, including outpatient orthopedic and sports, inpatient rehabilitation, and home health.

Douglas Steele, DPT, MHS, PA-C, PT, CPT is an Associate Professor with teaching responsibility in the areas of Pathophysiology, Pharmacology, Diagnostic Imaging and Differential Diagnosis and Medical Missions. . Dr. Steele's research interests include global health, diagnostic imaging applications in physical therapy and health and human performance.

PHYSICAL THERAPY PROGRAM

Application and Admission

Applications are accepted through the Physical Therapist Centralized Application Service at www.ptcas.org . ***Submission of a completed application does not guarantee an interview, selection or admission into the Program.***

Admission to the Program

Admission to the Harding University Physical Therapy Program (HUPT) is contingent on maintaining a cumulative GPA of at least 3.0 on all previous pre-requisite course work, with a science prerequisite of 3.0 GPA. A student may not enter the HUPT while on academic warning status or academic suspension.

Once the student is admitted to the program, the student is considered to be a full-time student, including time spent in clinical rotation of the program, therefore, four credit hours constitute a full-time student.

Transfer Students

Transfer credits from other programs or institutions are not accepted toward the Doctor of Physical Therapy requirements. The scheduled curriculum does not lend itself to effectively transferring from another program. A student wishing to transfer to Harding University's program must apply through the standard application process and begin the program with the next matriculating cohort.

Mission

The mission component of the program is vital and central to the unique Christian world view focus of the program. Therefore, two mission courses culminate in a mission practicum in Africa. The cost for the practicum is included in the tuition for the program, the monies collected are not individually accountable, *and there will not be a breakdown of individual cost provided to the student.* No refunds will be given in the event the student withdraws or is dismissed from the program.

The mission courses and practicum are required in order to graduate with a Doctor of Physical Therapy degree from Harding University. In the event of extreme extenuating circumstances, such as unforeseen health risk, the student should discuss the circumstances with the Program Director. It may be required to provide documentation for extenuating circumstances. It will be the decision of the Program Director and the Dean of the College of Allied Health to determine if the circumstances warrant consideration for any alternative option in order to complete the mission practicum requirements. Any alternative option will be the decision of the Program Director, and it may be determined necessary for the student to withdraw from the program and attend the practicum in the next year with a different cohort of students (delaying graduation until the requirements are met). Under no circumstances will the student be allowed to opt out of completing the mission practicum and remain in the program.

Required Immunizations

Applicants selected for admission to the program must provide evidence of good health, no communicable diseases, and required immunizations and screenings prior to matriculation or in process prior to matriculation. Forms will be available to those accepted into the program. Immunizations and screening tests required are as follows:

- **M.M.R. (Measles, Mumps & Rubella)** – A series of two (2) vaccines is typically given in childhood. Documentation of immunization or a reactive titer indicating immunity is required.
- **Polio** – A completed series is typically given in childhood.
- **Primary Tetanus/Diphtheria series** – A completed series is typically given in childhood and required if you attended public schools.
- **Tdap** is now required of all students to meet the tetanus requirement. CDC has removed any spacing requirements between Td and Tdap. Healthcare workers should receive a one-time booster of Tdap. After a documented Tdap, then a Td immunization every ten (10) years is required. Documentation must be provided verifying a Tdap or Td booster within the past ten (10) years.
- **Hepatitis B series** – The series of three (3) shots to complete the immunization takes several months (up to 6 months), so it is important to start early. Documentation must be provided verifying ONE of the following:
 1. Initiation of the Hep B series (with intent to complete the series as indicated by a health care provider)

2. Completion of the Hep B series
 3. A reactive titer indicating immunity
- **Varicella/Chicken Pox** – Documentation must be provided verifying ONE of the following:
 1. Two doses of varicella vaccine given at least 28 days apart
 2. History of varicella or herpes zoster based on physician diagnosis (written notice)
 3. A reactive titer indicating immunity of disease
 - **Hepatitis A** – This is a two-shot series.

Required Screening Tests

Tuberculosis — PPDs are required annually and must be maintained throughout the PT program as long as patient contact is possible. Students will not be allowed any patient contact until this is completed. Most Health Departments offer the PPD as a **2-step PPD****; therefore, you should allow at least 21 days for completion of the series. **A chest x-ray will not substitute for a PPD unless there is a history of a past positive PPD** (greater than 10 mm induration). If there has been a known prior positive PPD response, please submit a copy of the Health Department card or a copy of the x-ray report.

Additionally, all Physical Therapy Program students are required to show proof of health insurance. A copy of the front and back of the health insurance card should be submitted to the Physical Therapy Administrative Office prior to admission and annually while in the program.

Technical Standards

Physical Therapy is an intellectually, physically, and psychologically demanding profession. In addition to the academic requirements for admission, candidates for the Physical Therapy Program degree must be able to exhibit mastery of technical standards for this field by performing the essential functions in each of the following categories: observation, communication, sensory/motor, intellectual, behavioral/social and ethical.

The abilities that a physical therapist must have to practice safely are those described in accreditation standards for the physical therapy program. Candidates for the degree must be able to meet these minimum standards for successful completion of degree requirements.

When a student is admitted to the Physical Therapy Program, a list of the technical standards is sent with each acceptance letter. Students must respond in writing whether they can meet the standards with or without accommodations. If accommodation is requested, the student must submit documentation of disability with proposed accommodation from a certified specialist to the Harding University Disabilities Director. The University will determine and provide reasonable accommodation to qualified students with a disability to enable them to meet these technical standards.

Standards

- **Observation:** Observation requires the functional use of vision, hearing and somatic sensations. A student must be able to participate in lecture and laboratory demonstrations, and must be able to observe a patient accurately, observe digital and waveform readings and other graphic images to determine a patient's condition.
- **Communication:** Communication includes speech, language, reading, writing and computer literacy. Students must be able to communicate effectively and sensitively with patients to elicit information regarding mood and activities, as well as perceive non-verbal communications. Students must also be able to communicate effectively and efficiently with other members of the health care community to convey information essential for safe and effective care. These skills include hearing, reading, computer literacy, and the appropriate use of oral and written English.
- **Sensory and motor function:** Students are required to possess motor skills sufficient to directly perform palpation, auscultation, muscle testing, range of motion and other examination procedures. Students must be able to execute motor movements required to provide general and therapeutic care, such as positioning heavy and/or immobile patients, gait training using therapeutic aids and orthotics, positioning and performing manual mobilization techniques, performing non-surgical wound debridement, and placing electromyography electrodes. These skills require coordination of both gross and fine muscular movement, equilibrium, the integrated use of touch and vision.
- **Intellectual abilities:** To effectively solve problems, students must be able to measure, calculate, reason, analyze, integrate and synthesize information in a timely fashion. The student must be able to synthesize knowledge and integrate the relevant aspects of a patient's history and examination findings to develop an effective treatment program.
- **Behavioral and Social Attributes:** A student must possess the psychological ability required for the full utilization of their intellectual abilities, for the exercise of good judgment, for the prompt completion of all responsibilities inherent to diagnosis and care of patients, and for the development of mature, sensitive, and effective relationships with patients. Students must be able to tolerate physically and mentally taxing workloads and function effectively under stress. They must be able to adapt to a changing environment, display flexibility and function in the face of uncertainties inherent in the clinical problems of patients. Students must demonstrate ethical behavior both in the classroom and during clinical experiences.

Because of the unusual demands of the physical therapy profession, a student who becomes ill, injured, or pregnant or who has another temporary medical condition during the program must report the illness, injury, pregnancy, or condition to the Program Director as soon as possible. The student must bring a completed "Health/Medical Condition Restrictions Form" from his or her healthcare provider outlining the student's current limitations in performing the essential functions outlined in the technical standards and the expected timeframe of limitations or stating that the student has no such limitations. The Physical Therapy Program will evaluate each individual situation to determine whether the student is able to continue in the curriculum and whether reasonable accommodations can be made.

Profile of the Graduate

The Harding University Physical Therapy Program graduate will be able to:

- Deliver physical therapy services in accordance with evidence-based practice guidelines
- Employ critical thinking to solve problems
- Educate patients, care givers, the public, and other health care providers in an effective manner
- Accept responsibility for patients' therapeutic outcomes
- Manage health care resources effectively through the application of healthcare management skills
- Conduct themselves in a professional and ethical manner, consistent with Christian ideals
- Serve actively in professional organizations
- Adapt to changes in the health care environment
- Engage in continuous professional development and lifelong learning

Curriculum Plan

Physical Therapy students do not choose courses as in traditional educational settings. The courses in each successive semester require competence in all courses taken before them and students in the curriculum progress from one semester to the next as a cohort group. When students' progress to the clinical experiences of the program, the student is considered full time during the four credit hours for the clinical experience.

FALL: SEMESTER 1

DPT8141	Human Pathophysiology	4 hrs
DPT8142	Functional Anatomy and Biomechanics	4 hrs
DPT8151	Human Gross Anatomy	5 hrs
DPT8152	Foundational Clinical Skills	5 hrs
		<u>5 hrs</u>
		18 hours

SPRING: SEMESTER 2

DPT8211	Clinical Reasoning 1	1hrs
DPT8222	Physical Agents and Modalities	2 hrs
DPT8223	Evidenced Based Physical Therapy Practice 1	2 hrs
DPT8241	Physiology of Therapeutic Exercise	4 hrs
DPT8225	Pharmacology	2 hrs
DPT8231	General Medical and Post-Surgical Physical Therapy	3 hrs
DPT8431	Neuroscience	3 hrs
		<u>3 hrs</u>
		17 hours

SUMMER: SEMESTER 3

DPT8311	Therapeutic Exercise	1 hr
DPT8312	Clinical Education and Communication	1 hr
DPT8321	Clinical Reasoning 2	2 hrs
DPT8324	Ethics and Professional Development	2 hrs
DPT8331	Motor Behavior	3 hrs
DPT8411	Medical Missions 1	1 hr
DPT8332	Musculoskeletal Physical Therapy Practice 1	3 hrs
		<u>3 hrs</u>
		13 hours

FALL: SEMESTER 4

DPT8434	Musculoskeletal Physical Therapy Practice 2	3 hrs
DPT8422	Human Lifespan Development	2 hrs
DPT8232	Cardiopulmonary Physical Therapy Practice	3 hrs
DPT8441	Clinical Internship 1	4 hrs
		<hr/>
		12 hours

SPRING: SEMESTER 5

DPT8612	Medical Mission 2	1 hr
DPT8511	Evidenced Based Physical Therapy Practice 2	1 hr
DPT8631	Diagnostic Imaging	3 hrs
DPT8532	Healthcare Business	3 hrs
DPT8551	Pediatric Physical Therapy Practice	5 hrs
DPT8552	Adult Neurological Physical Therapy Practice	5 hrs
		<hr/>
		18 hours

SUMMER: SEMESTER 6

DPT8611	Evidenced Based Physical Therapy Practice 3	1 hr
DPT8621	Health Wellness Promotion	2 hr
DPT8531	Orthotics & Prosthetics	3 hrs
DPT8521	Clinical Reasoning 3	2 hr
DPT8632	Screening and Differential Diagnosis	3 hrs
		<hr/>
		11 hours

FALL: SEMESTER 7

DPT8711	Licensure Preparation and Review I	1 hr
DPT8721	Medical Missions Practicum	2 hrs
DPT8741	Clinical Internship 1 (8 weeks)	4 hrs
DPT8742	Clinical Internship 2 (8 weeks)	4 hrs
		<hr/>
		11 hours

SPRING: SEMESTER 8

DPT8821	Licensure Preparation and Review II	2 hrs
DPT8841	Clinical Internship (8 weeks)	4 hrs
DPT8842	Clinical Internship (8 weeks)	4 hrs
		<hr/>
		10 hours

Curriculum Course Description

FIRST PROFESSIONAL YEAR FALL SEMESTER

8141. HUMAN PATHOPHYSIOLOGY. (4) This course is designed to define and explore elements of pathophysiology. This will include a survey of normal human physiology at the cellular, tissue, and organ levels. Further focus will include the disease processes that alter normal organ/systems physiology, the mechanisms that are responsible for these alterations, laboratory values used to describe the pathologies, and the implications of pathological processes in the rehabilitation setting. Pathophysiological principles are addressed with focus on the coordinated functions and activities of all major body systems.

8142. FUNCTIONAL ANATOMY AND BIOMECHANICS. (4) (Clinical Component Course.) This course focuses applied human anatomy, biomechanics, and kinesiology of the musculoskeletal system. This course will emphasize normal gross form and function as it relates to physical therapy practice. Topics such as joint structure and function will be hands-on surface anatomy and palpation labs will be utilized. Special emphasis will be placed on integrated human movement with clinically relevant applications.

8151. HUMAN GROSS ANATOMY. (5) Integrated study of gross human anatomy embodying gross morphology and coordinating with developmental and histological aspects of the body. Included is regional dissection with emphasis on the musculoskeletal, nervous, circulatory and respiratory systems. Prerequisites: Admission to the program.

8152. FOUNDATIONAL CLINICAL SKILLS. (5) (Clinical Practice Course) Focuses on foundational examination skills, tests, measures and interventions used in a variety of settings. This course incorporates 6 contact hours of laboratory experiences weekly. This course covers information including but not limited to documentation, goniometry, range of motion exercises, manual muscle testing, sensory testing, measuring vital signs, tests for balance, patient positioning and draping, gait assessment and gait training, bed mobility, transfers, wheelchair mobility, therapeutic massage, emergency procedures, first aid, infection control.

FIRST PROFESSIONAL YEAR SPRING SEMESTER

8221. CLINICAL REASONING I. (2) (Clinical Practice Course) Clinical Reasoning 1 is designed to explore the nature of clinical reasoning in the profession of physical therapy and examine strategies for assisting learners to develop their reasoning expertise. This course focuses on clinical problem solving used in minimally complex case studies. Knowledge and skills from the curriculum taught to this point will be incorporated. The laboratory course places less emphasis on didactic learning and more toward case competence, problem solving and patient care ability. In addition, computer-based tests reviewing the content outline of the licensure exam and a cumulative exam of the curriculum are included.

8222. PHYSICAL AGENTS AND MODALITIES. (2) (Clinical Component Course.) Theory, principles, literature review, and clinical applications associated with the choice and application of Physical Agent and Modalities in Physical Therapy practice. This course emphasizes: (1) Thermal modalities 2) Mechanical modalities; (3) electromagnetic modalities; (4) soft tissue mobilization techniques.

8223. EVIDENCE BASED PHYSICAL THERAPY PRACTICE I. (2) This course provides the student with an introduction to research design and statistics. Students will obtain the requisite knowledge about the research process and experimental designs commonly used in pre-clinical and clinical studies. The course will present the fundamental concepts of descriptive statistics and statistical inference. The course will teach the student the fundamentals of evidence appraisal to implement in evidence based physical therapy practice.

8241. PHYSIOLOGY OF THERAPEUTIC EXERCISE. (4) (Clinical Component Course.) This course will be lecture and lab based, exploring the principles guiding therapeutic exercise prescription by the physical therapist. The course is designed to provide students a solid scientific basis of normal physiological responses to acute and chronic exercise training. Topics will include metabolism, aerobic and anaerobic work, and muscle phenomena of strength, endurance and fatigue. It will also concentrate on developing skills of prescription in therapeutic exercise for specific body regions. The course will also have special emphasis on health and wellness of the general population.

8225. PHARMACOLOGY. (2) This introductory course covers key concepts related to the cellular actions, therapeutic uses, side effects and toxic actions of major drug classes used in humans. Students will learn key concepts that are important to understanding drug actions, including principles of pharmacokinetics (e.g., absorption, distribution, metabolism and excretion of drugs) as well as the physiological and cellular basis for a host of diverse drug actions. Major drug classes covered in this course include (among others), agents that act upon the nervous system (both central and peripheral), the musculoskeletal system, the heart, the cardiovascular system and the pulmonary system, as well as agents used to combat microbial disease, cancer and endocrine dysfunction. The overall goal of this course is to provide students with an in-depth understanding of how various drugs exert beneficial and untoward actions and to develop an appreciation for the actions of drugs in a rehabilitation context

8231. GENERAL MEDICAL AND POST SURGICAL PHYSICAL THERAPY PRACTICE. (3) (Clinical Practice Course) This course provides the physical therapy student with instruction in evaluation and management of patients under the general medical care of a health care practitioner and post-surgical interventions. Common medical conditions and surgical approaches will be presented and discussed; particularly concentrating on the involvement physical therapy may have in those patients' care. Students will be receiving instruction in review and interpretation of basic medical diagnostic imaging associated with musculoskeletal conditions. Students will also receive instruction in caring for patients following burn or wound. This course will further acquaint the physical therapy student with principles and fundamentals of physical therapy practice within the acute hospital setting, long-term acute care, sub-acute, and similar settings. This will include the interdisciplinary role of the physical

therapist in the health care team, recognition and proper usage of equipment associated with evaluation and physical therapy treatment of patients, reimbursement issues associated with provision of physical therapy services, and applications specific to physical therapy practice in the above settings.

8431. NEUROSCIENCE (3) This course provides students with a fundamental understanding of the functions and pathologies of the central nervous system (CNS) as a basic science course in the neuro-rehabilitation curriculum. The emphasis will be on “systems-level neuroanatomy,” i.e., functional neuroanatomy (e.g., motor and sensory pathways) and regional neuroanatomy (e.g., organization of spinal cord, brainstem, cerebral cortex, etc.). In addition, information processing by neurons will be addressed by coverage of axon physiology, synaptic neurotransmission and plasticity. The course will first survey the anatomical organization of the CNS, then sensory and motor functions of the CNS, and finish with a description of a number of neurological disorders that have clinical relevance to Physical Therapists.

FIRST PROFESSIONAL YEAR SUMMER SEMESTER

8311. THERAPEUTIC EXERCISE. (1) (Clinical Component Course.) This course will be a lab course exploring the principles guiding therapeutic exercise prescription and progression by the physical therapist treating patients with musculoskeletal conditions. The major emphasis will be on problem solving, exercise prescription and progression of therapeutic exercise for specific musculoskeletal conditions.

8312. CLINICAL EDUCATION AND COMMUNICATION. (1) This course includes lecture and class discussion regarding documentation practices and standards in physical therapy; professional behavior and communication in the clinical setting, including communication when dealing with the unusual or unexpected patient situations; generational and cultural differences; teaching and learning principles, including learning styles, as applied to student and patient education; and proper use of the *PT MACS* as an assessment tool. Activities include participation in the site-selection process for the first clinical education experience.

8321. CLINICAL REASONING II. (2) (Clinical Practice Course) Clinical Reasoning 2 is designed to explore the nature of clinical reasoning in the profession of physical therapy and examine strategies for assisting learners to develop their reasoning expertise. This course focuses on clinical problem solving used in moderately complex to advanced musculoskeletal physical therapy case studies; knowledge and skills from the curriculum taught to this point will be incorporated. The laboratory course places less emphasis on didactic learning and more toward case competence, problem solving and patient care ability. In addition, computer-based tests reviewing the content outline of the licensure exam and a cumulative exam of the curriculum are included. The lecture portion of the course will consist of review lectures from material covered in the first year of the curriculum

8324. ETHICS AND PROFESSIONAL DEVELOPMENT. (2) Study of principles that govern ethical decisions, professionalism, and ethical issues related to health care providers. An emphasis will be placed on ethics in the practice of physical therapy.

8331. MOTOR BEHAVIOR. (3)The course focuses on the principles of the current theories of motor control, motor learning, and recovery of function. Application to neurological physical therapist practice using a theoretical framework. The focus is on normal and pathological postural control, mobility, the function of the upper and lower extremities function.

8351. MUSCULOSKELETAL PHYSICAL THERAPY PRACTICE 1. (3) (Clinical Practice Course) Theory, principles, literature review, and clinical applications associated with Physical Therapy examination, evaluation, assessment, and intervention of musculoskeletal injuries and conditions of the upper extremity, lower extremity, and spine. This course emphasizes: (1) An introduction to physical therapy and manual therapy of the musculoskeletal system 2) History taking, systems review, examination and evaluation of patient's with musculoskeletal conditions; (2) the selection and implementation of manual therapy; (3) the management of patients with non-operative and post-surgical musculoskeletal disorders and or conditions affecting the extremities and spine

8411. MEDICAL MISSIONS I. (1) This course focuses on basic medical mission concepts as it applies to the Christian physical therapist. Additionally relevant ethical concepts such as pro bono service, Christian ethics, will be addressed. The goal of this course is to introduce the student to using Physical Therapy as missions tool to serve God and mankind. This course will include a basic history and theology of medical mission work, and current types of medical missions work that are being done in both foreign and domestic setting.

SECOND PROFESSIONAL YEAR FALL SEMESTER

8232 CARDIOPULMONARY PHYSICAL THERAPY PRACTICE. (3) (Clinical Practice Course) This course is designed to focus on the primary and secondary cardiopulmonary impairments that limit therapeutic and patient outcomes in various settings which include intensive care units, long term care, outpatients, school setting and home care. Emphasis is placed on the components of physical therapy practice – screening, examination, evaluation, diagnosis, and prognosis, development of a plan of care, intervention, and evaluations of outcomes. The inter-relationship of other health care professionals into the team care of patient will be discussed. Application of the following concepts is included: communication, individual and cultural differences, professional behavior, critical inquiry and clinical decision making, patient and caregiver education, pharmacological management, and management of health care delivery. The course incorporates lectures, small group case discussions, individual assignments, self-study assignments, and clinics labs/simulations.

8422. HUMAN LIFESPAN DEVELOPMENT. (2) The course focuses on normal development and growth with an in-depth approach to the physical development issues and theories for children and through the aging process throughout the human lifespan. Emphasis will be placed on healthy aging. Current issues, trends, and intervention programs will be discussed.

8434 MUSCULOSKELETAL PHYSICAL THERAPY PRACTICE II (3) (Clinical Practice Course) Theory, principles, literature review, and clinical applications associated with Physical Therapy examination, evaluation, assessment, and intervention of musculoskeletal injuries and conditions of the spine. This course emphasizes: (1) An introduction to physical therapy and manual therapy of the musculoskeletal system 2) History taking, systems review, examination and evaluation of patient's with musculoskeletal conditions; (2) the selection and implementation of manual therapy; (3) the management of patients with non-operative and post-surgical musculoskeletal disorders and or conditions affecting the spine.

8441. CLINICAL INTERNSHIP I. (4) Full-time clinical education internship in either the Outpatient Orthopedics or Acute Care or other equivalent foundational skill Rehab practice settings. The student integrates patient evaluation and management skills and develops entry-level competency in all skills necessary for entry into the profession of physical therapy. The student has the opportunity to develop advanced competencies beyond entry-level where applicable.

SECOND PROFESSIONAL YEAR SPRING SEMESTER

8511. EVIDENCED BASED PHYSICAL THERAPY PRACTICE II. (1) This seminar course will build on the information taught in the first Research Process Class and is designed to teach the student to critically appraise various types of research. Each week students will read research articles with a specific design and will individually critique the articles according to published guidelines. They will then meet weekly in small groups with a faculty mentor to discuss the research with regard to the strengths, weaknesses, and applicability of the assigned articles. Additionally, during this course the student will formulate a research question which will culminate in scholarly project.

8532. HEALTHCARE BUSINESS. (3) This course provides initial personnel management perspectives and skills needed by the entry- level physical therapist in a clinical setting. It focuses on organizing, directing, developing, and measuring the management and entrepreneurial components of physical therapist practice. Billing and coding procedures are included.

8551. PEDIATRIC PHYSICAL THERAPY PRACTICE. (5) (Clinical Practice Course). Introduction to the modification of physical therapy examination, evaluation, and management for the special developmental needs of children with orthopedic or neuromuscular conditions. Includes consideration of the requirements for physical therapy practice in specialized settings such as neonatal intensive care, Birth to Three programs, and public schools. Screening for referral and physical therapy consultation in pediatrics will be included. Treatment approaches are integrated from various sources including motor control theory, neurodevelopmental treatment, sensory integration and applied research.

8552. ADULT NEUROLOGICAL PHYSICAL THERAPY PRACTICE. (5) (Clinical Practice Course) This course examines the pathology, medical diagnosis process, and medical and surgical interventions of neuromuscular conditions in adults that are commonly seen by physical therapists. It focuses on physical therapy examination,

evaluation, and intervention for adult clients with neurological disorders based on current research, evidence, and practice guidelines.

8612. MEDICAL MISSIONS II. (1) This course will be taught in conjunction with the Harding University missions faculty and focuses on practical medical missions preparation. The student will be taught practical skills for mission work including but not limited to: 1) country specific missions strategies, 2) country specific cultural communication skills 3) strategies for establishing both domestic and foreign medical missions opportunities.

8631. DIAGNOSTIC IMAGING. (3) This course will cover the basic science behind multiple imaging modalities (x-rays, MRI, CT, Doppler, arthrograms, ABI, DUS, etc), positives and negatives of each intervention, and how to refer for imaging services or consultation. Anatomy of bone, joint, cartilage, and soft tissue for x-ray, MRI, and CT scanning will be discussed by joint region along with clinical reasoning algorithms for assistance with imaging selection and interpretation. Special features and views will be discussed as applicable for each imaging device. In addition, discussion of vascular modalities and special bone scans will be discussed.

SECOND PROFESSIONAL YEAR SUMMER SEMESTER

8521. CLINICAL REASONING III. (2) (Clinical Practice Course) Clinical Reasoning 3 is designed to explore the nature of clinical reasoning in the profession of physical therapy and examine strategies for assisting learners to develop their reasoning expertise. This course focuses on clinical problem solving. Case studies involving patient in the pediatric and adult neurological practice will be implemented to facilitate learning. Knowledge and skills from the curriculum taught to this point will be incorporated. The laboratory course places less emphasis on didactic learning and more toward case competence, problem solving and patient care ability.

8531. ORTHOTICS & PROSTHETICS. (3) This course is designed to give the physical therapy student knowledge of orthotic and prosthetic prescription, parts components, and physical therapy application. This course includes exercise prescription for amputees, evaluative procedures for orthotics and prosthetics, gait analysis, device checkouts and case studies. Course will also involve interactions with prosthetists and orthotists and prosthetic and orthotic device users

8611. EVIDENCED BASED PHYSICAL THERAPY PRACTICE III. (1) In this course the student will produce a scholarly work related to Physical Therapy using the skills developed in the first two research classes. This course will provide further instruction to perform this task.

8621. HEALTH/WELLNESS PROMOTION. (2) This course focuses on the principles of health promotion, wellness and adult fitness outlined in the Healthy People 2010. Emphasis is placed on risk stratification and methods to identify persons at risk for cardiovascular, pulmonary, metabolic disorders and musculoskeletal disorders. The role of the physical therapist in marketing and implementing health promotion and fitness programs for small business and industries will be discussed

8632. SCREENING & DIFFERENTIAL DIAGNOSIS. (3) This course will present the most essential responsibility of physical therapists, specifically, the recognition of co-morbid medical conditions. The making of a diagnosis depends on 3 major clinical indices: the subjective information obtained from the patient, the signs identified on physical examination, and the results obtained from diagnostic tests (imaging and laboratory tests). This course examines the relative value and importance of the subjective data obtained from the medical history as related to physical examination and imaging/laboratory investigations in the establishment of a diagnosis. Presented is the content knowledge and process skills necessary to enhance physical therapists' medical screening and clinical judgments regarding when to treat and when to refer their patients. Combined with students' existing knowledge and skills, this medical screening course will provide a more comprehensive evaluation scheme that will facilitate safe, effective, and efficient patient management within the context of a collaborative practice paradigm.

THIRD PROFESSIONAL YEAR FALL SEMESTER

8711. LICENSURE PREPARATION AND REVIEW I. (1) Integrative online seminar course format designed to prepare graduates for the licensure examination and entering the work force. Learning methods include establishment of comprehensive review plans, and provision of supplementary reviews lectures and materials. Additionally, the students will take a series of online examinations in licensure examination format to aid in preparations.

8721. MEDICAL MISSIONS PRACTICUM. (2) This course is a foreign medical missions training practicum. All prior coursework prepares the student for this experience.

The mission practicum is required in order to graduate with a Doctor of Physical Therapy degree from Harding University. The cost for the practicum, including travel, is included in the tuition. No refunds will be given in the event the student withdraws or is dismissed from the program.

8741. CLINICAL INTERNSHIP II. (4) Full-time clinical education internship in a variety of settings (Outpatient Orthopedics, Acute Care/Foundational Skills, Adult Neuro Rehab, or an Elective). The student integrates patient evaluation and management skills and develops entry-level competency in all skills necessary for entry into the profession of physical therapy. The student has the opportunity to develop advanced competencies beyond entry-level where applicable.

8742. CLINICAL INTERNSHIP III. (4) Full-time clinical education internship in a variety of settings (Outpatient Orthopedics, Acute Care/Foundational Skills, Adult Neuro Rehab, Pediatrics or an Elective). The student integrates patient evaluation and management skills and develops entry-level competency in all skills necessary for entry into the profession of physical therapy. The student has the opportunity to develop advanced competencies beyond entry-level where applicable.

THIRD PROFESSIONAL YEAR SPRING SEMESTER

8821. LICENSURE PREPARATION AND REVIEW II. (2) This course builds on the experience of the first senior seminar. Integrative online seminar course format designed to prepare graduates for the licensure examination and entering the work force. Learning methods include establishment of comprehensive review plans, and provision of supplementary reviews lectures and materials. In addition to taking a series of online examinations in licensure examination format, the students will be required to submit a case study according to APTA guidelines. This case study will be reviewed and discussed online by all course participants.

8841. CLINICAL INTERNSHIP IV. (4) Full-time clinical education internship in a variety of settings (Outpatient Orthopedics, Acute Care/Foundational Skills, Adult Neuro Rehab, Pediatrics or an Elective). The student integrates patient evaluation and management skills and develops entry-level competency in all skills necessary for entry into the profession of physical therapy. The student has the opportunity to develop advanced competencies beyond entry-level where applicable.

8842. CLINICAL INTERNSHIP V. (4) Full-time clinical education internship in a variety of settings (Outpatient Orthopedics, Acute Care/Foundational Skills, Adult Neuro Rehab, Pediatrics or an Elective). The student integrates patient evaluation and management skills and develops entry-level competency in all skills necessary for entry into the profession of physical therapy. The student has the opportunity to develop advanced competencies beyond entry-level where applicable.

Physical Therapy Program Cumulative hours = 110

Delineation of Course Tracks

Major Clinical Track Courses

DPT8152	Foundational Clinical Skills
DPT8231	General Medical and Post-Surgical Physical Therapy
DPT8332	Musculoskeletal Physical Therapy Practice 1
DPT8434	Musculoskeletal Physical Therapy Practice 2
DPT8232	Cardiopulmonary Physical Therapy Practice
DPT8552	Adult Neurological Physical Therapy Practice
DPT8551	Pediatric Physical Therapy Practice

Clinical Reasoning Courses

DPT8211	Clinical Reasoning 1
DPT8321	Clinical Reasoning 2
DPT8521	Clinical Reasoning 3

Clinical Component Courses

DPT8222	Physical Agents and Modalities
DPT8241	Physiology of Therapeutic Exercise
DPT8311	Therapeutic Exercise 2
DPT8531	Orthotics & Prosthetics
DPT8631	Diagnostic Imaging
DPT8632	Screening and Differential Diagnosis
DPT8621	Health Wellness Promotion

Research Track Courses

DPT8223	Evidenced Based Physical Therapy Practice 1
DPT8511	Evidenced Based Physical Therapy Practice 2
DPT8611	Evidenced Based Physical Therapy Practice 3

Clinical Education Courses

DPT8324	Ethics and Professional Development
DPT8312	Clinical Education and Communication
DPT8532	Healthcare Business Clinical Internships 1-5

Basic Science Courses

DPT8141	Human Pathophysiology
DPT8142	Functional Anatomy and Biomechanics
DPT8151	Human Gross Anatomy
DPT8225	Pharmacology
DPT8431	Neuroscience
DPT8331	Motor Behavior
DPT8422	Human Lifespan Development

Mission Track Courses

DPT8411	Medical Missions 1
DPT8612	Medical Mission 2
DPT8721	Medical Missions Practicum

ACADEMIC POLICIES

General Policy

Students at Harding are expected to be honorable and to observe standards of academic conduct appropriate to a community of Christian scholars. Harding expects from its students a higher standard of conduct than the minimum required to avoid discipline. A student whose deportment or scholarship is unsatisfactory may be dismissed from the Physical Therapy Program at any time. It is the policy of the Physical Therapy Program, reflected in the attitude of each member of the faculty, to spare no effort in helping each student to attain his/her objective, a successful Christian Physical Therapy career. The university will not graduate any student who doesn't satisfactorily complete all curricular activities.

Academic Honesty: Our Integrity Covenant

We, the members of the Harding community, recognize that our covenant of integrity is with three parties. First and foremost, students and faculty recognize their covenant with God. All morality is ultimately defined by the very nature of God, in whom all truth can be found. Desiring to reflect the heart and nature of Christ, we make a covenant with our God to be truthful and transparent. Second, we acknowledge that we have a covenant with each other. By doing our own work, working hard, and receiving credit and recognition that represent effort and sacrifice, we create and maintain an atmosphere of excellence and fairness. As members, therefore, of this Christian community we covenant with each other to guard and protect our commonly held trust. Third, integrity is a covenant that we make with ourselves. Our goal of being servants deserves our every effort to dedicate ourselves fully to those disciplines of study and research that will contribute to the formation of our character and our academic skills. Academic rewards obtained without personal and authentic effort rob us of both the spiritual

and professional preparation that God desires. Our academic integrity originates in the very nature of God, manifests itself in our commonly held and protected reputation, and reveals its value in the prepared Christ-like servant-hood that results from a disciplined life.

Our Integrity Principles and Policies

Honesty: Using only authorized collaboration, information, and study aids for assignments and testing and being completely truthful in all academic endeavors. Authenticity: Presenting only ideas and creative expressions that are unique, unless properly cited according to University guidelines. Submitting the work of another constitutes plagiarism.

Accountability: Holding ourselves to the highest ethical standards, and not allowing academic dishonesty in others to go unchallenged.

Our Integrity Pledge

I hereby pledge to God, to the Harding University academic community, and to myself that I will uphold godly standards of honesty, authenticity, and accountability in all my undertakings.

The HUPT integrity pledge mirrors that University's graduate policy found in the online catalogue. <http://www.harding.edu/catalog>

Integrity Policies

The University considers breaches of integrity to be serious offenses. All acts of dishonesty in any academic work constitute academic misconduct. This includes but is not necessarily limited to the following:

1. **Cheating**: Use or attempted use of unauthorized materials, information or study aids in any academic exercise. Such infractions include, but are not limited to, the following:
 - a. Using materials not authorized by the teacher, such as hidden notes, tape recorders, cell phones, cameras, text messages, wands, computers, or other electronic devices, for the completion of a quiz or test.
 - b. Copying from another student during a quiz or test
 - c. Copying another student's assignment or project.
 - d. Obtaining answers to online quizzes and tests.
2. **Plagiarism**: Representing the words, ideas or data of another as one's own in any academic exercise. Plagiarism is a type of stealing, whether done deliberately or by mistake. Such violations include, but are not limited to, the following:
 - a. Purchasing a paper from an electronic source or other entity.
 - b. Downloading a partial paper or an entire paper from the Internet and submitting it as one's own or allowing someone else (including tutors) to write, or significantly rewrite, a paper and then submitting it as one's own.
 - c. Using ideas, paraphrases, and/or direct quotes from a source without clear documentation of that source.

- d. Recycling a paper from a concurrent class or a class that was previously taken in high school or college without the permission of the instructor to do so.
 - e. Copying verbatim from a source without using quotation marks, even if the source has been cited.
 - f. Copying, in part or in whole, from a print source, media broadcast or recording, or the Internet or other electronic media without proper acknowledgement of the source.
 - g. Copying another person's sentence style and structure, key words, organizational plan, or unique words or ideas without proper documentation.
3. **Fabrication:** Falsification or unauthorized invention of any information or citation in an academic exercise. Such misconduct includes, but is not limited to, the following:
- a. Taking a course, test or quiz for another student.
 - b. Fabricating source information within an assigned paper and/or on the works cited page.
 - c. Fabricating lab or research information.
 - d. Submitting collaborative and/or group work as one's own, unless the instructor has given permission for students to do so.
 - e. Completing another student's class assignment for the student.
 - f. Collaborating on out-of-class assignments with students, professors, family members and/or friends when the instructor intended for students to work independently.
 - g. Claiming to have attended an assigned function, such as a service activity, a performance, a job interview, a home visit, a symposium, an observation, or a lecture without having attended the function or performed the actual service.
 - h. Lying to a University employee about assignments or attendance.
 - i. Making unauthorized use of University letterhead.
 - j. Forging a signature for academic purposes.
 - k. Attempting to change an assigned grade or other information on any official University document, data source or electronic item.
4. **Aiding and abetting academic dishonesty:** Intentionally helping or attempting to help another student commit an act of academic dishonesty. Such misconduct includes, but is not limited to, the following:
- a. Allowing another student to copy one's work and to submit the work as his or her own.
 - b. Stealing an exam or quiz from an instructor or copying a test or quiz and/or sharing it with other students.
 - c. Sharing test questions with another student who has not taken the test.
 - d. Giving answers to online quizzes and tests.
 - e. Sharing test results in a non-proctored test environment in which an honor code is imposed.
 - f. Failing to challenge dishonest conduct witnessed in other students.
5. **Conduct unbecoming a professional while participating in a practicum, internship, field experience, or any similar academic experience.** Such academic misconduct includes, but is not limited to, the following:

- a. Identifying oneself as a Harding student in off-campus locations for unauthorized academic, professional or personal gain (for example, using a student nursing ID badge to gain access to a hospital area for non-educational purposes).
 - b. Violating the legally protected privacy of employees or patients in learning environments.
 - c. Disregarding policies of work environments in which learning occurs.
 - d. Acting in a manner that violates course policies or policies of the academic division.
6. **Theft, abuse, hoarding or concealment of academic property.** Academic property includes, but is not limited to, the following:
- a. Library resources and materials
 - b. Laboratory equipment and supplies
 - c. Departmental or class resources
 - d. Tests and quizzes

Academic Support Resources

The Academic Advising Program functions to identify students in need of academic help. Because of the specificity and rigor of the Physical Therapy Curriculum. The Faculty advisor serves as the most appropriate academic support for study skill and content mentoring. If warranted or desired by the student, a different Faculty member can be enlisted to assist in the process in lieu of in addition to the assigned mentor.

Program Grading Scheme

Grading policies for Program courses (lecture and/or laboratory) will be determined by the faculty and noted on the course syllabi. The interpretation of the letter grades and their quality point values per credit hour is as follows:

A = 90-100%;
 B+ 85-89.99
 B = 80-84.99;
 C+=75=79.99
 C = 70-74.99%;
 D = 60-69.99%;
 F = <60%.

Practical Examinations and Remediation

1. In Major Clinical Track Practice Courses:

If a student does not achieve a passing score of at least 80% on any practical exam in a clinical practice course class, the student will be required to remediate (retake) the practical exam. The student will be permitted only one opportunity to remediate and pass a practical exam. If the student scores 80% or higher on the remediation, the remediated practical exam score and the original practical exam score will be averaged, with this average not to exceed a score of 80%. If the student does not score 80% or higher on the remediation of the practical exam or

refuses to remediate the exam, the student will be deemed to have failed the course and the Instructor will recommend to the Program Director that the student be academically suspended or dismissed. (Clinical Practice Course Include: DPT 8152, Foundational Clinical Skills; DPT 8231, GMPS; DPT 8332 and DPT 8434 Musculoskeletal PT 1 & 2; DPT8232 Cardiopulmonary PT; DPT 8551, Pediatrics PT; DPT8552, Adult Neurological PT; and DPT 8211, DPT8321, and DPT 8521, Clinical Reasoning Classes 1, 2 and 3.)

2. In Clinical Component Courses:

If a student does not achieve a passing score of at least 80% on any practical exam, the student will be required to remediate (retake) the practical exam. If the student scores 80% or higher on the first remediation, the remediated practical exam score and the original practical exam score will be averaged, with this average not to exceed a score of 80%. If the student does not score 80% or higher on the first remediation, the student will be required to remediate a second time. If the student scores 80% or higher on this second remediation, the score for all remediated practical exams and the original practical exam score will be averaged, with this average not to exceed a score of 70%. If the student fails to score 80% on the second remediation, the student will be required to remediate third time. Each successive attempt at retaking the practical will result in a 10 point reduction of the maximum possible score. If at any point the student refuses to remediate the exam, the student will be deemed to have failed the course and the Instructor will recommend to the Program Director that the student be academically dismissed.

Retake:	Maximum Score Possible
1	80%
2	70%
3	60%
4	50%

Standard of Performance

Each candidate for a Physical Therapy degree must secure credit in the approved courses of the Physical Therapy curriculum totaling 110 semester hours. In securing this credit, each candidate must have a grade point average of at least 3.0 and no grades less than —C in any given course. A student’s scholastic standing is normally determined by calculating a point average. This average, which is calculated for each semester and for the entire period of residence, is determined as follows: the total number of hours for which a grade is received is multiplied by the numerical equivalent for that grade. The results are added, and the sum is divided by the total number of hours for which grades have been assigned.

Registration

Registration: Registration is the responsibility of the student. Time windows when registration should occur will be communicated to the students by the Administrative Coordinator on behalf of the Program Director.-Returning students typically preregister near the end of each semester for the following semester. Students who decide not to attend a term for which they have registered must withdraw from their classes. See the Withdrawal section of this handbook.

Class Attendance and Tardiness

Students are expected to attend class 100% of the time. Students must make up absences in accordance with the instructions provided by the instructor of the course in which the absences occurred. Excessive absences and tardiness from class are grounds for dismissal from the Physical Therapy Program.

Students should attend class in appropriate attire (see code of professional conduct and dress code), and academically prepared with assignments and textbooks.

If a student is 10 minutes late or later to class, or if the student is dressed inappropriately or unprepared academically, the following disciplinary policy will apply:

- 2 times: The student will be given a written warning;
- 3 times: The student will be placed on probation
- 5 times: The student will be dismissed from the Program.

If a student finds it necessary to be late for emergency or illness, the student is expected to call (not e-mail) the class instructor or the physical therapy office to advise of their late arrival. This will avoid the tardiness being counted under the disciplinary policy.

Laboratory Access and Use of Equipment

The general physical therapy facility and the labs and equipment contained therein will be accessible to students during regular administrative business hours Monday through Friday, 8:00 a.m. and 5:00 p.m. (closed on scheduled holidays). Entrance to the physical therapy facility before or after these hours may be gained through a designated door beginning at 6:00 am and ending at 12:00 a.m. The equipment utilized in the HUPT physical therapy program may not be taken from the premises for any reason at any time. **The equipment is NOT to be utilized at any time for personal use.**

The consumption of food and beverages is not allowed in laboratories. Food and beverages may be consumed in classrooms, public spaces, and the student lounge. Students are reminded that professional behavior includes having respect for building furnishings and maintaining a clean learning environment. Professional behavior also includes cleaning up after oneself and leaving no trash or spilled food or beverages behind. Demonstration of unprofessional behavior related to food or beverages may lead to the revocation of food privileges for the entire student body.

Examinations

The testing policy and procedures preserve the integrity and fairness of all examinations. Students must report for all examinations as scheduled. If a student is absent for an exam because of circumstances beyond their control, such as illness or death in the family, the student will be allowed to make up the exam if a valid excuse is provided. Official documentation (eg doctor's note or other official documentation) of the reason for the absence must be provided prior to making up an exam. If no valid excuse is provided, the grade recorded for the exam will be zero. The exam must be taken within seven days of the exam date and coordinated with the instructor's schedule. No key review will be allowed for any students until all students have taken the exam.

Visits to the restroom are not allowed during the exam unless a documented medical condition exists or a student becomes ill. No food or drink of any kind will be allowed while taking the exam. No cell phones, smart watches, or any other electronic devices are allowed in the exam room. No shorts may be worn during the exam time.

When a school delay or cancellation occurs, due to inclement weather or other emergency, on a day when a course examination is scheduled, the course coordinator will reschedule the examination and communicate the new examination date to the students.

National Board Examination

Students will not be given permission to sit for the national board examination prior to their completion of all degree requirements and their graduation date. The Licensure and Preparation course (DPT 8821) is an integral part of adequately equipping the student to pass the board examination.

Application for Graduation

Students who expect to qualify for graduation must register for graduation and pay the associated graduation fee in the fall semester of the third professional year.

Degree Requirements

1. Completion of the Harding University Physical Therapy curriculum (totaling 110 semester hours) with a passing grade in each course and with a 3.0 cumulative grade point average.
2. Recommendation by the faculty of the Harding University Physical Therapy Program of Physical Therapy.
3. Payment of all financial obligations to the University.
4. Compulsory attendance at graduation exercises.

Graduation Exercises

A commencement ceremony is held annually at the end of the spring semester. Only students who have met all degree requirements are eligible to participate. If a student is required to re-take a course or courses or has a delayed clinical rotation due to any circumstances the student may not participate in the commencement ceremony. Any exception to this policy due to circumstances beyond the student control must be appealed to the Office of the University Provost.

The traditional cap and gown, is considered formal academic attire for ceremonial events, and the addition of any ornamentation is quite limited by customary etiquette. Any addition to the formal academic regalia must be appropriate, must represent only recognized organizations within the University, and must be approved in advance of commencement by the Program Director.

Traditional hoods of academic regalia are bestowed upon the graduates at commencement. The hood is lined with the Harding University colors of gold and black and is trimmed in teal, denoting physical therapy.

Academic Progression, Warning, Probation, Suspension and Dismissal

The implementation of all guidelines will be in addition to that of existing policies and standards of the University as published in the current Harding University Graduate and Professional Catalog.

Glossary of Terms

Academic warning: Status of warning students of declining academic performance. Student is given written notification but status is not entered on student transcript.

Academic Probation: A student who fails to attain a 3.0 HUPT GPA in any academic semester will be placed on academic probation and notified in writing by the Program Director of this status.

Suspension: Temporary status of being removed from the program.

- a. **Academic suspension: Failure of 2 practical examinations in major clinical track courses**
- b. **Non-academic: Excessive absence or tardiness; violation of cell phone policy; repeated violations of the dress code**

Dismissal: permanent status of being removed from the program. The student is not allowed to rejoin the program unless he/she reapplies to the program and is selected to matriculate with another cohort of student. There is no guarantee that a dismissed student will be re-accepted if he/she re-applies for acceptance into the program.

Withdrawal: Student voluntarily removes him/herself from program

Academic Recycling: Student allowed to return to the program on year after suspension or withdrawal from program

1. **Academic Progression:**
 - a. Students must earn a grade of a C or greater in all courses in the professional curriculum in order to progress to the subsequent semester. Failure to earn a grade of C or greater in any course in the professional curriculum will result in dismissal from the HUPT professional program due to academic deficiency.
 - b. Students must maintain a cumulative GPA of 3.0 or higher and will have successfully completed all required first and second professional year courses and activities prior to beginning the third professional year. Students may not enter into a clinical rotation on academic probation.
 - c. A student is required to achieve a score of 80% or higher on all practical examination in major clinical track courses and clinical reasoning courses (as designated in the course syllabus). If the student fails to score 80%,

he/she will be required to remediate the exam and score an 80% on the remediation exam. If the student score less than 80% on the remediation or refuses to remediate the exam, the student will be deemed to have failed the course and the student will be academically suspended. (See pages 3-31.)

- d. A student with current and unresolved documented safety concerns will not be allowed to enter into a clinical rotation. Each student must be judged as safe and competent by the collective core faculty prior to advancing into a clinical experience. If a student is not allowed to progress into a clinical rotation due to documented reasons, he/she will be suspended from the program for one year to allow for resolution of the safety concern. Reasons being kept out of a clinical experience will include but are not limited to:
 - i. Lack of professionalism displayed in the classroom or lab environment
 - ii. Lack of initiative to correct academic or behavioral deficits.
 - iii. Serious lack of problem solving ability that would lead to an unsafe clinical environment for patients or the student if the student were allowed to proceed.
 - iv. Failure to achieve a passing score on a practical exam in any major clinical track practice course or refuses to remediate any practical exam in any course. (Clinical Practice Course Include: DPT 8152, Foundational Clinical Skills; DPT 8231, GMPS; DPT 8332 and DPT 8434 Musculoskeletal PT 1 & 2; DPT8232 Cardiopulmonary PT; DPT 8551, Pediatrics PT; DPT8552, Adult Neurological PT; and DPT 8211, DPT8321, and DPT 8521, Clinical Reasoning Classes 1, 2 and 3. **See page 29-30**)
 - v. Refusal, after being advised, to seek counseling, medical, or psychiatric help for a condition that is judged and documented by the faculty as being a safety risk in the clinical setting.
2. **Academic Warning:** Students' academic performance will be monitored by the HUPT faculty throughout the semester. Anyone identified as having a GPA < 3.0 will receive written communication indicating the need for improvement and the need to meet with the student's faculty advisor to obtain assistance. Commonly suggested sources of aid include: the course instructor(s), faculty advisors, and the Harding University Center for Student Success located on the second floor of the Student Center.
- a. If a student is not currently on academic probation but earns a semester GPA that is below 3.0, he or she will be placed on academic warning.
 - b. This status will go into the students file but will not go on the student's transcript. It will serve as an intermediate step prior to being placed on academic probation. It will be an official alert to the student that he/she is academically progressing in a negative manner with the potential to go on academic probation if matters to not change.

3. **Academic Probation:**

- a. Students must maintain a cumulative and per semester HUPT GPA of at least 3.0 in all professional course work. A student who fails to attain a 3.0 HUPT GPA in any academic semester will be placed on academic probation and notified in writing by the Program Director of this status.
 - b. A student who is on academic probation will not be allowed to participate in clinical rotations. Academic probation puts the level of understanding and performance of the student in question, thus posing a risk to the public, should a student enter into the clinical rotation.
 - c. To be removed from probation the student must raise his/her cumulative GPA to 3.0.
 - d. A student who is on academic probation and who fails to achieve a minimal cumulative grade point average of 3.0 at the conclusion of two consecutive semesters shall be considered for suspension or dismissal from the program.
 - e. Students who are on academic probation will have 2 semesters to raise their cumulative GPA to 3.0 in order to be removed from probationary status. The event may occur such that a student who is on academic probation earns a GPA that is sufficiently low enough that the student would be mathematically prohibited from attaining a 3.0 cumulative GPA after the 2 semesters. In this case the student will be dismissed from the program after 1 semester on academic probation
 - f. If a student is placed on academic probation on 4 separate occasions during the course of the Physical Therapy professional curriculum, the student will be dismissed from the program due to academic deficiency.
 - g. A student whose semester and/or cumulative GPA falls below 3.0 in the Doctor of Physical Therapy Program curriculum must successfully complete an academic recovery contract developed with the Program Director.
4. **Suspension:** The temporary status of being removed from the program. The student may be allowed to rejoin the program after one year. If the cohort size allows, the student may re-enter the program with the cohort of students of the new year. The student will be required to retake all classes (at the student's expense) in the semester in which the suspension occurred. If the student does not agree to these terms, the student will not be allowed to re-enter the program and will thus be dismissed from the program.

A. **Academic suspension: The student will be suspended for one year and may be allowed to return to the program one year later if:**

1. The student fails twice on a practical examination in a clinical track course or clinical reasoning course (see pages 25, 29-30) **and if:**

- a. The student is not on academic or non-academic probation at the time of the practical examination failures.
 - b. The student's semester GPA is above 2.5 for the said semester in which the practical examination failures occur.
 - c. The student has no documented violations of the student code of conduct, the APTA code ethics, or academic integrity policy.
 - i. If an event is occurs prior to, or after suspension, student will not be allowed to rejoin the program.
 - d. There are no safety concerns documented for the student by the faculty prior to the practical examination failure.
 - i. Examples of this include but are not limited to:
 1. Unheeded requests for the student to seek counseling, psychological, psychiatric, or medical help.
2. If the student is placed on academic suspension, the status will be noted on the student's transcript.
 3. In the instance that the student returns to the program one year later. The student will be required to retake all classes (at the student's expense) in the semester in which the failed practical occurred regardless of circumstance.
 - a. If the student has already completed the courses in the said semester, he/she will receive the higher grade earned for that course.
 4. If a student fails a practical examination twice he/she will not be allowed to continue in the program and receive a failing grade in the course in which the exam was failed. This failing grade will go on the student's transcript.

NOTE: A student is required to achieve a score of 80% or higher on all practical examination in major clinical track courses and clinical reasoning courses (as designated in the course syllabus). If the student fails to score 80%, he/she will be required to remediate the exam and score an 80% on the remediation exam. If the student score less than 80% on the remediation or refuses to remediate the exam, the student will be deemed to have failed the course and the student will be academically suspended. (See pages 36.)

B. Non-academic Suspension:

1. **Excessive absence or tardiness.**
2. **Violation of cell phone policy.**
3. **Repeated violations of the dress code.**
- 4.

5. Academic Dismissal:

A student in the Harding University Physical Therapy Program is subject to academic dismissal from the program for any of the following:

- a. Failure to earn a C or greater in any course in the curriculum.
- b. A student who is on academic probation and who fails to achieve a minimal cumulative grade point average of 3.0 at the conclusion of two consecutive semesters may be considered for dismissal from the program.
- c. A student who is on academic probation with a cumulative GPA sufficiently low as to mathematically preclude the student from attaining the required minimal 3.0 GPA at the conclusion of 2 consecutive semesters will be dismissed from the program after one semester on academic probation.
- d. Being placed on academic probation three separate occasions or is placed on academic probation for greater than 3 semesters total during the course of the Physical Therapy professional curriculum.
- e. In the event that a student is on probation at the end of the didactic portion of the fourth semester or at the end of the sixth semester, the student will be dismissed from the program. The dismissed student will have the option of re applying to the program to begin with the next matriculating cohort; however, there is no guarantee of re-admission to the program.
- f. If a student fails on two consecutive attempts on a practical examination in a major clinical track course or clinical reasoning course, the student will not be allowed to continue in the program.
 - i. The student will be dismissed from the program if he/she:
 1. The student is on academic or non-academic probation at the time of the practical examination failures.
 2. The student's semester GPA is less than or equal to 2.5 for the said semester in which the practical examination failures occur.
 3. The student has documented violations of the student code of conduct, the APTA code ethics, or academic integrity policy.
 4. There are safety concerns documented for the student by the faculty prior to the practical examination failure.
 - a. Examples of this include but are not limited to:
 - i. Unheeded requests for the student to seek counseling, psychological, psychiatric, or medical help.
- g. Violation of the academic integrity policy (see pages 26-27, 47)

- h. Violation of the University Code of Conduct.
 - i. Violation of any of the Codes of Professional Conduct (see page 45-46)
6. **Academic Recycling:** The following policies will be applied to repeating courses in the professional curriculum of the HUPT:

- a. If the student voluntarily withdraws (W) for any reason, or is suspended the student may be allow to re-enter the program. In this circumstance, the student must make a written request to the program and will be required to re-enter the curriculum one year later. This will be allowed if all of the applicable requirements are met for the circumstances of the withdrawal or suspension.

The student will re-enter with a different cohort of students, if a slot is available at the time of re-entry. **There is no guarantee of acceptance.** The student will be required to re-take the entire semester of courses at full cost to the student, including student tuition and fees.

- b. No course in the professional curriculum may be repeated more than once. Students dropped from the rolls of the HUPT may follow the University Academic Grievance Policy to file an appeal. Students may appeal decisions of an ad hoc Grievance Committee to the Assistant Provost of Health Sciences. Such appeals must be made in writing no later than 3 business days after notification of an ad hoc Grievance Committee decision.

Withdrawal

A student may find it necessary to voluntarily withdraw from the program for various academic or personal reasons.

The Physical Therapy Program is a block scheduled program, therefore *withdrawal from a course constitutes withdrawal from the program; no credit will be given for any of the courses in the semester – withdrawal from one course constitutes withdrawal from all courses for the semester. No refund of tuition or program fees will be given for the semester in which the withdrawal occurred.*

Transcript Notation: If the student chooses to withdraw, he or she will receive the transcript notation for the classes in which the student is currently enrolled.

- a. The student will receive a W (withdraw passing) if the student is passing all courses at the time of withdrawal.
- b. If the student is failing a class at the time of withdrawal, he/she will receive a WF (withdraw failing).

Students may withdraw from the HUPT program at any time, however, students must counsel with the Program Director prior to formal withdrawal. After this counseling session, the student must request to be withdrawn from the program by signing a standardized form (**Appendix 3**). The Program Director notifies the Dean of the College of Allied Health and submits the form to the University Registrar and Office of Public Safety, verifying that the student has withdrawn from the program. The student meets with the Registrar's office to complete the withdrawal process.

The student will submit the completed and signed withdrawal form to the Registrar's Office. Students will not be considered officially withdrawn until the registrar has received notification and completed the drop for all Physical Therapy program classes, and he/she will receive a W (withdrawn) for the course if the student has maintained a passing grade. Students who do not complete an official withdrawal will receive a failing grade for each class.

In the case of extenuating circumstances (such as prolonged documented illness or family emergency) a student may choose to withdraw from the course/ program. If the student is passing the course at the time of the withdrawal, he/she will receive a W. In this case, the student will have the option of withdrawing from the program and re-enter the curriculum one year later with a different cohort of students. The student will be required to re-take the entire semester of courses at full cost to the student, including student tuition and fees. If the student is failing the course at the time of withdrawal the student will be dismissed from the program on academic grounds.

Re-entry in the program: If the student withdraws while passing his/her classes, the student may be allowed to rejoin the program one year later if the subsequent cohort of students has number that would allow an additional student. Any student who withdraws or dismissed from the Physical Therapy Program must follow the stated procedures to be considered for re-admission.

Exceptions to re-entry: If the subsequent cohort will not allow the addition of another student, the student must re-apply to enter the program as a new student.

Applicants for re-admission are evaluated along with new applicants. **No withdrawn or dismissed student is ever guaranteed interview or re-admission to the Physical Therapy Program.** Students who have been dismissed for academic reasons or ethical misconduct and the dismissal has been upheld after all administrative recourse, are **not** eligible for readmission to the Physical Therapy Program.

Leave of Absence

In the event that a student in the Physical Therapy Program encounters a situation that requires a prolonged absence from the Program, that student may either request a leave of absence or withdraw from the Physical Therapy Program.

A request for a leave of absence must be submitted in writing to the Program Director with sufficient information to explain the situation. In the event that the student is ill or otherwise indisposed, the written requirement may be waived, and the Program Director may initiate the action independently. If the request for leave is deemed reasonable and appropriate for the circumstance, and if the student is in good academic standing at the time, the Program Director may grant the leave. Otherwise, the Program Director may, at his discretion, deny the leave, recommend that the student withdraw from the Physical Therapy Program, or may recommend that the student be dismissed from the Physical Therapy Program, following University policy. Conditions will be determined individually according to the merits of each case.

Temporary Health Condition

Because of the unusual demands of the physical therapy profession, a student who becomes ill, injured, or pregnant or who has another temporary medical condition during the program must report the illness, injury, pregnancy, or condition to the Program Director as soon as possible. The student must bring a completed "Health/Medical Condition Restrictions Form" (obtain from the Program Director's office) from his or her healthcare provider outlining the student's current limitations in performing the essential functions outlined in the technical standards and the expected timeframe of limitations or stating that the student has no such limitations. The Physical Therapy Program will evaluate each individual situation to determine whether the student is able to continue in the curriculum and whether reasonable accommodations can be made.

A student who is ill, injured, or pregnant or who has another temporary medical condition has the responsibility of meeting with the Program Director, Director of Clinical Education, and other faculty designated by the Program Director to be informed of the risks and requirements involved in remaining in the Program. The student must inform his or her physician of the risks, essential functions, and technical standards of the Physical Therapy Program. If the student remains in the Program, the student accepts responsibility for any increased risks to himself or herself or to others associated with the illness, injury, pregnancy, or condition.

Incomplete Grade

If an emergency interrupts a student progress in the courses of the program and a leave of absence is granted during a semester, a temporary incomplete grade may be given at the end of the semester. It requires approval from the Program Director, the Dean of the College of Allied Health and the Provost. An extension period is granted according to the individual need for the leave, the Physical Therapy Program and University guidelines.

Academic Grievance Policy

A student has the right to file an appeal if there is disagreement with the final grade that has been awarded in a course. Concerns may relate, but are not limited to: failure to abide by stated requirements described in the course syllabus, a disputed test question, and discrimination based on age, sex, religion, race, marital status, national origin or disability. The procedure for resolving a grievance is outlined in the University Academic Grievance Policy found in the Graduate and Professional Catalog. If the appeal is not resolved by the ad hoc Grievance Committee, further appeal rights are limited. The student may present the appeal in writing to the Assistant Provost of Health Sciences. This must be done within 3 business days of notification of the committee's decision.

Academic Grievance Procedure

If a student believes that he or she has reason to question the decision of a faculty member with regard to the final grade received in a course or the unreasonable denial of academic progression, a procedure has been established to resolve the grievance. **Please note that the following academic grievance policies and procedures do not include matters of academic misconduct.** These matters are covered in the section titled "Academic Integrity Policy."

This **student-initiated** procedure is as follows:

1. The student must register his or her complaint in writing to the faculty member within seven business days following the alleged incident, except that if the grievance involves a final grade, it must be filed within ten business days after final grades are posted by the Registrar. Within the written complaint, the student must set forth reasons and grounds for the grievance.
2. Upon receipt of the complaint, within three business days the faculty member must meet with the student (in person, by telephone, or by email) and strive to resolve the problem.
3. If a resolution cannot be reached within five business days, then it is the student's responsibility to register the complaint in writing with the department chair or dean of the program.
4. Upon receipt of the complaint, the department chair or dean of the program must meet with the faculty member and the student (in person or by telephone) within three business days and strive to resolve the problem.
5. If resolution cannot be reached during this meeting, then the faculty member must document in writing the efforts made to seek resolution and that a resolution has not been achieved. This document must be shared with the student and the department chair or dean of the program within two business days of the failure to reach a resolution.
6. If the student remains dissatisfied, then within three business days of being notified that a resolution has not been met, it is the student's responsibility to initiate the grievance appeal procedure (below). NOTE: A file of all written documents must be maintained by the dean or department chair. The faculty member must forward copies of all written documents to the dean or department chair.

Grievance Appeal Process

If a student has followed the above process, and still feels that the grievance has not been equitably resolved, the procedure for filing further appeal is outlined in the University Academic Grievance Policy found in the Graduate and Professional Catalog. <http://www.harding.edu/catalog/>

Official Records of Academic Grievance Proceedings

The Office of the Provost shall ensure maintenance of the official records related to academic grievance proceedings.

NOTE: As in the case of any policy and policy guidelines, Harding University reserves the right to change them or to make appropriate revisions, additions, amendments or corrections. Faculty and students will be notified of any substantial changes.

Filing a Complaint with CAPTE

(CAPTE) Commission on Accreditation of Physical Therapy Education

The Physical Therapy Program is a candidate for accreditation by Commission on Accreditation of Physical Therapy Education (CAPTE) and leads to eligibility to take the National Physical Therapy Examination (NPTE).

The only mechanism through which the Commission on Accreditation in Physical Therapy Education (CAPTE) can act on a student's concerns is through the formal complaint process. Students should be aware that the complaint **MUST** be related specifically to one or more of the Evaluative Criteria, to the Statement on Integrity in Program Closure, or to the Statement of Integrity in Accreditation. In other words, the student will need to link the complaint to violation of the Criteria or the Statements.

The Criteria can be found in the CAPTE Accreditation Handbook. Also, in order for CAPTE to consider the complaint to be bona fide, the student **MUST** have exhausted all avenues for redress at the institution. The student will need to understand that CAPTE cannot function as an arbiter between them and the school.

Should CAPTE find that the complaint has merit and that the program is out of compliance with the Evaluative Criteria or the Statements, CAPTE can only require the program to come into compliance with the Evaluative Criteria. If the student wishes to pursue filing a complaint against a program, please contact the Department of Accreditation and they will provide the appropriate forms and information for doing so.

(CAPTE) Commission on Accreditation of Physical Therapy Education
The Department of Accreditation
American Physical Therapy Association
1111 North Fairfax Street
Alexandria, VA 22314
(703) 706-3245
www.apta.org

Students with Disabilities

It is the policy for Harding University to accommodate students with disabilities, pursuant to federal and state law. Therefore, any student with a *documented disability* (e.g. physical, learning, or psychological) who needs to arrange reasonable accommodations must contact the Program Director and the Disabilities Office at the *beginning* of the academic year and provide appropriate documentation approved by ADA Guidelines. (If the diagnosis of the disability occurs during the academic year, the student must self-identify with the Disabilities Director and the Program Director *as soon as possible* in order to get academic accommodations in place for the remainder of the academic year.) The Disabilities Office is located in the Student Center, telephone (501) 279-4019.

A student with a *documented* disability must make a written request for accommodations which will be taken into consideration by the Program Director. It is the responsibility of the student to self-identify with the Disabilities Office. The necessary forms are available from the Harding University Disabilities Director.

Upon receiving the appropriate documentation approved by ADA Guidelines, academic accommodations may be set up with the Program Director and the course instructor as recommended by the Disabilities Director.

Reasonable accommodations will be provided depending on the *documentation of the disability from a certified psychological examiner, psychologist, or medical doctor who*

made the diagnosis of the disability. This statement represents responsiveness to federal expectations. It also reveals the desire on the part of the institution to meet its own commitments to students in the academic arena who have *documented* disabilities as well as to those patients who will be served by the students. Decisions regarding granting of accommodations will take into consideration the student's ultimate ability to function in the clinical setting and in their future ability to practice Physical Therapy.

Early Assurance Program

The Early Assurance Program (EAP) is intended to guarantee highly qualified students an admission interview, *but not a guarantee of admission to the Program*, for a position in the Physical Therapy Program after the successful completion of prerequisite courses and maintenance of certain academic criteria at Harding University. To be eligible for the Physical Therapy Program of Physical Therapy's Early Assurance Program current high school seniors must meet the following requirements:

Enroll at Harding University beginning the fall semester after graduation from high school. Attain an ACT composite score of at least 27 or SAT total of 1200. Complete the application for the Early Assurance Program by November 1 of the freshman year.

Once admitted to the EAP a student must meet the following academic requirements in order to receive an admission interview for the DPT. Program as an EAP student:

1. Be continuously enrolled at Harding University while in the EAP.
2. Satisfy all of the prerequisite classes for entry into the DPT program with a grade of B or better.
3. Participate in the academic advising and career seminar programs provided by the pre-Physical Therapy Program advisor at Harding University.
4. Attain a minimum cumulative grade point average of 3.75 in all course work and a science grade point average of at least 3.75.
5. Begin the DPT program no later than three years after beginning pre-Physical Therapy Program course work
6. Adhere to the Code of Conduct at Harding University.

Completion of these requirements guarantees the EAP student an admission interview with the Physical Therapy Program. This interview is the final step in the admissions process and is weighed heavily in decisions for admission. **NOTE: The admission interview does not guarantee admission into the Physical Therapy Program.**

International Students

An applicant who is not a citizen of the United States must follow the normal admissions procedure. The applicant must have a TOEFL score of 550 (if the applicant is an international student whose first language is not English). The applicant must also have completed all pre-Physical Therapy Program course requirements in an American college or university. The Physical Therapy Program Admissions Committee does not evaluate transcripts from outside the United States. If course work has been earned in a foreign country, several steps to proceed are required. In order for the Physical Therapy Program Admissions Committee to determine whether the courses taken in a foreign country can be transferred for credit, foreign transcripts must be reviewed or evaluated

by an undergraduate American institution. All of the credit accepted for transfer must appear on the transcript of an American university. Transfer credit must be identified as courses equivalent to those in the American university. In order to receive a transcript including the evaluation of transfer credit, the international student must be enrolled at the undergraduate American institution. Until this procedure has been accomplished, an application for admission cannot be accepted.

Federally funded financial aid is restricted for students who are not citizens or permanent residents of the United States. It is required that the student provide documentation of financial ability to pay all expenses for the first year of study and demonstrate adequate health insurance coverage in the United States.

Student Advising Program

All students in the Physical Therapy Program will be assigned to a faculty advisor each year. The Student Advising Program is under the direction of the Program Director. This program provides information for successful matriculation and professional development of our students and key faculty members are utilized as resource personnel. The faculty will assess the student's generic abilities based on observation of the student's performance. Generic abilities are attributes, characteristics or behaviors that are not explicitly part of the profession's core of knowledge and technical skills but are, nevertheless, required for success in the profession. (See Appendix 1.)

General Formal Advising:

The responsibilities of the faculty are:

1. Meet with advisees at least once per semester to advise utilizing the Generic Abilities Advising Form.
2. Advise. Mentor, and/or refer students as appropriate.
3. Monitor student academic progress and assist the student in seeking appropriate help.
4. Provide status reports on each advisee to the Program Director at the end of each semester

The responsibilities of Student Advisees are:

1. To be aware of all Physical Therapy Program and University requirements as published in the graduate and professional catalog.
2. Students are required to meet with his/her faculty advisor at least once per semester for Generic Abilities advising.
3. Seek help from the faculty advisor in the event that academic or personal problems arise that are negatively affecting the student's performance in the program.

Special Circumstances:

Students identified as having special needs (such as low current or cumulative grade point average, or failing grades) are required to participate in an intensified academic recovery plan. Students may also participate in this plan voluntarily. This plan requires a coordinated effort between the involved student and the core faculty.

School-Wide Assessment

As part of the ongoing assessment, evaluation, and review of the Physical Therapy Program curriculum, student information is used for evaluation and feedback to improve the educational program and to document student progress. Course evaluations, faculty evaluations, student progress assessment and feedback, surveys, videotaped encounters and group work are included in this process. Data are primarily reported in the aggregate, and individual identification will be protected.

There will be some instances when videotape review will be used to teach and assess interviewing skills and group dynamics. All persons being videotaped will give their consent prior to any other use of the videotaped material.

When data are used for documenting and publishing about the curriculum and student outcomes, appropriate institutional review will occur and aggregate data will be used. If the use of identifying information is needed, appropriate student consent will be obtained.

NON-ACADEMIC POLICIES

Attitude and Conduct

Harding expects its students to conduct themselves as responsible citizens in a Christian community. Enrollment at the University is viewed as a privilege that brings the attendant responsibilities and accountability. In order to encourage Christian living and growth, the University administers the student Code of Conduct.

Upon registration to the University, students acknowledge and agree to abide by this code. Harding University reserves the right to refuse admission or dismiss students whose lifestyle is not consistent with the Christian principles for which Harding stands; and when the general welfare of the institution requires such action. Students suspended for disciplinary reasons during a semester may receive a grade of F in all courses for that semester.

Drug Free School

Harding's policy states that drug and alcohol possession or use is not tolerated. The Drug-free Schools and Communities Act requires our school to outlaw the possession, use or distribution of illegal drugs and alcohol by students and school employees on school property or during school activities

Code of Professional Conduct

Within the Harding University Physical Therapy Program, the Code of Professional Conduct, as outlined below, has been established

(i) Preamble

The students, faculty and administration of the Harding University Physical Therapy Program (HUPT) cultivate professional and ethical standards by upholding the core values which are: advancement, Christianity, collaboration, trustworthiness, innovation, outreach, nurturing, and service. The vision and goals of the Physical Therapy Program are intended to create an atmosphere conducive to the professionalism of all members of the community. That atmosphere is supported and promoted by mutual respect and trust between students, faculty and administration. This code, set by administration,

faculty and students, is a set of professional and ethical behaviors befitting a member of our community. Everyone in this community is responsible for upholding the standards in this Code of Professional Conduct. Therefore, any conduct determined as having an adverse effect on the Harding community may be subject to disciplinary action.

(ii) Professional Conduct

As members of the Physical Therapy Program and the professional Physical Therapy students are expected to create and sustain a professional identity founded on our core values. Adherence to these principles is vital to the assurance of the development of a professional relationship between the physical therapist and society. These principles must become a part of a student's everyday life. To accomplish the goals of professional development, students must:

- a) DEVELOP a sense of loyalty and duty to the profession of Physical Therapy contributing to the well-being of others and by enthusiastically accepting the responsibility and accountability for membership in the profession.
- b) FOSTER professional competency through life-long learning, teamwork, and unity within the profession in order to provide optimal patient care.
- c) SUPPORT professional colleagues by actively encouraging personal commitment to the *Code of Ethics for Physical therapists* as set forth by the profession.
- d) DEDICATE their lives and practice to excellence. This will require an ongoing assessment of personal and professional values.
- e) MAINTAIN the highest ideals and professional attributes to insure and facilitate the professional commitment required of the Physical Therapist.

Faculty and administration are also responsible for upholding similar professional standards as applicable to their roles within the community.

(iii) Conduct in Physical Therapy Program-related Activities in the Classroom and On Campus

The classroom and campus environment are primary settings for teaching and learning. As such, it is the responsibility of students and faculty to maintain an atmosphere that is conducive to teaching and learning. Behavior is expected to adhere to professional standards and to contribute in a positive way to the learning process. Behaviors that are rude, disruptive, or that infringe on the rights of faculty or other students to effectively engage in the teaching/learning process as well as absences from required activities such as academic advising meetings and specified chapel or devotional times will not be tolerated.

(iv) Conduct in Physical Therapy Program-related Activities Off Campus

This Code of Professional Conduct extends beyond the classroom and campus to hospitals, and various other practice settings where our students and faculty may engage in professional activities. Patient confidentiality and sensitivity to the needs of all patients, including those with different cultural backgrounds, are critical in order to contribute maximally to patient care.

(v) Professional Appearance / Attire

Additional professional standards include appropriate dress and proper attention to personal hygiene. Students preparing for careers in a health profession must take particular care regarding their appearance, specifically avoiding concerns of their appearance being unkempt. Specific activities and settings require particular attire and appearance. Students must be aware of and adhere to these expectations and

requirements.

(vi) Academic Integrity

Mutual trust is a basic component of any community. Harding University expects students, as members of the academic community, to take seriously their position in that community. Students are expected to insure the continuance of trust among themselves and between them and the faculty by accepting responsibility for their own work. The University considers breaches of this trust and responsibility to be serious offenses. A student who engages in academic dishonesty is subject to disciplinary action under the Academic Integrity Policy, which is published in the University Graduate and Professional Catalog.

(vii) Chemical Dependence / Impairment

Health care professionals – including future physical therapists – are faced with the challenges of chemical impairment. Physical Therapy Program students need to be aware of these challenges and acknowledge that the HUPT administration will take steps to assist chemically impaired students within the boundaries of the law. This statement does not preclude the academic dismissal of the student from HUPT. The University's policies regarding personal wellness are published annually in the Harding University Student Handbook.

(viii) Non-Academic Disciplinary Procedures

Any student who violates the Code of Professional Conduct is subject to disciplinary action under the Non-Academic Judicial Policies, which are published in the HUPT Student Handbook. Any student who violates the University Code of Conduct is subject to disciplinary action under the Code of Conduct Disciplinary Procedures. Both of these documents are published on the Harding University web site:

<http://www.harding.edu/catalog/>

Non-Academic Judicial Procedures

1. Any member of the University community may file charges against any student for misconduct. Charges shall be prepared in writing and directed to the Program Director. Any charge should be submitted as soon as possible after the event takes place.
2. The Program Director may conduct an investigation to determine if the charges have merit and/or if they can be disposed of administratively by mutual consent of the parties involved on a basis acceptable to the Program Director. Any such administrative disposition shall be final, and there shall be no subsequent proceedings. If the charges cannot be disposed of by mutual consent, the Program Director will convene a Non-Academic Disciplinary Committee to hear the matter and render a decision.
3. All charges shall be presented to the accused student in written form. A time shall be set for a hearing, no less than five days after the student has been notified.
4. Hearings shall be conducted by the Non-Academic Disciplinary Committee according to the following guidelines:
 - a. Hearings normally shall be conducted in private.
 - b. Admission of any person to the hearing shall be at the discretion of the Non-Academic Disciplinary Committee.
 - c. The complainant and the accused may present written evidence and witnesses, subject to cross-examination by the Non-Academic Disciplinary Committee.

- d. Hearings shall be conducted under informal procedures. All procedural questions are subject to the final determination of the chair of the Non-Academic Disciplinary Committee.
 - e. After the hearing, the Non-Academic Disciplinary Committee shall determine by majority vote whether the student has violated the Code of Conduct, and if so what sanction(s) should be imposed. The Non-Academic Disciplinary Committee's determination shall be made on the basis of whether it is more likely than not that the accused student violated the Code.
5. A single verbatim record, such as a tape recording, shall be made of all hearings before the Non-Academic Disciplinary Committee. The record shall be the property of the University.
 6. The following sanctions may be imposed for violations of the Code of Conduct:
 - a. Warning — a written notice that the student has violated institutional regulations.
 - b. Probation — a written reprimand for violation of specified regulations, with notice that further violations during the probationary period include the probability of more severe sanctions.
 - c. Loss of Privileges — denial of specific privileges.
 - d. Fines — not to exceed one hundred dollars.
 - e. Restitution — Compensation for loss, damage or injury. This may take the form of appropriate service or monetary or material replacement.
 - f. Discretionary Sanctions — Work assignment, service to the University, other community service, or other creative sanctions.
 - g. Suspension — Temporary separation of the student from the University for a specified period of time. Conditions for readmission may be specified.
 - h. Expulsion — Permanent separation of the student from the University.
 7. Non-Academic disciplinary sanctions shall not be made part of the student's permanent academic record, but shall become part of the student's confidential record. Upon graduation, the student's confidential record shall be expunged of disciplinary actions other than suspension or expulsion. Suspension or expulsion shall be expunged from the student's confidential record five years after final disposition of the case.

Appeals

1. A decision reached or a sanction imposed by the Non-Academic Disciplinary Committee may be appealed by the accused student or the complainant to the Assistant Provost for Health Science. Such appeals shall be in writing, stating the reason(s) for the appeal, and shall be delivered to the Assistant Provost within two days of the student's receipt of notice of the decision.
2. Except as required to explain the basis of new evidence, an appeal shall be limited to review of the record of the hearing and supporting documents for one or more of the following purposes:
 - a. To determine whether the original hearing was conducted fairly in light of the charges and evidence presented in accordance with prescribed procedures.
 - b. To determine whether the evidence presented at the hearing was sufficient to support the decision.
 - c. To determine whether the sanction(s) imposed was appropriate for the violation.

- d. To consider new evidence or facts not brought out in the original hearing because they were not known to the appealing party at the time of the hearing.
3. In cases involving appeals by a student accused of violating the Code of Conduct, review of the sanction(s) upon appeal may not result in more severe sanctions for the accused student than those imposed by the Non-Academic Disciplinary Committee.
4. In cases involving appeals by complainants, the Assistant Provost, upon review of the case, reduce or increase the sanctions imposed by the Non-Academic Disciplinary Committee or remand the case to the Non-Academic Disciplinary Committee for consideration.

Appearance and Dress Policy

Dress Policy and Appearance

All members of the Harding community are expected to maintain standards of modesty and decency in dress appropriate to the Christian lifestyle and consistent with professional employment expectations. Physical therapy students must dress in professional attire appropriate for a professional clinical setting.

The following are required for professional physical therapy student dress:

NOTE: Some class days may require more than one type of attire. The student will be expected to come prepared to meet the specific dress codes for all events and activities of the day.

1. Lecture Classes:
Black, gray or navy scrubs for all regular scheduled classes. It is acceptable to wear clean long or short sleeve tee shirts with scrub pants, but the shirts should be without holes and should be plain or with Harding emblems.
2. PT Lab Classes: In order to participate and practice physical therapy skills, some labs may require appropriate athletic wear. This will be communicated by the course instructor. Students should wear shorts and tee shirts and female students should wear a sports bra underneath.
3. Gross Anatomy Lab: Each 1st year student should designate a set of scrubs to be worn only in the gross anatomy lab. This will inhibit the introduction of mold spores into the lab and cadavers.
4. Other:
 - a. Students are expected to show good grooming habits and personal hygiene in their appearance.
 - b. Hair must be neat, clean and free of extreme styles and colors.
 - c. No open toed shoes or sandals.
 - d. Piercing is limited to the wearing of earrings and a small nose or eyebrow stud or ring.

e. Men's facial hair must be neat and trimmed.,
For experiences outside the PT building (activities on the main campus, or observations at clinics) students are expected to dress in business casual or in scrubs.

The Program Director, in consultation with the faculty, staff and students, may designate special —dress-up or dress- down days.

For clinical education experiences, students are expected to abide by the dress code of the assigned facility. Students should contact the center coordinator of clinical education at the assigned site ***prior*** to their scheduled *clinical experiences* to inquire about their policies.

THIS WILL BE UP TO THE CLINICAL SITE

1. Students will always wear their name picture ID tags indicating "PT Intern" if required by the clinical site. Nametags should be obtained from the clinical site facility. Additionally, the student should wear the official University Physical Therapy program-issued badge.
2. A white lab jacket worn over street clothes ***may*** be required by the facility.

Sexual Harassment

Harding University reaffirms the principle that students, faculty, and staff have the right to be free from sex discrimination in the form of sexual harassment by any member of the academic community.

Sexual harassment is **defined** as an attempt to coerce an unwilling person into a sexual relationship, or to subject a person to unwanted sexual attention, or to punish a refusal to comply, or to create a sexually intimidating, hostile, or offensive environment. Sexual harassment is generally understood to include a wide range of behaviors, from the actual coercing of sexual relations to the unwelcome or inappropriate emphasizing of sexual identity. This definition will be interpreted and applied consistent with Christian standards of behavior and conduct.

A student who believes that he or she has been sexually harassed may obtain redress through informal and formal procedures of the University. Complaints about sexual harassment will receive prompt and equitable response. The right to confidentiality of all members of the academic community will be respected in both informal and formal procedures, insofar as is possible. Retaliation against individuals for bringing bona fide complaints of sexual harassment is expressly prohibited. Knowingly or willfully making a false claim is subject to discipline up to but not limited to suspension from school. Formal procedures will not be initiated without a signed and verified written complaint. An individual found to have engaged in sexual harassment is subject to disciplinary action for violation of the policy, consistent with existing procedures.

Sexual harassment claims made by a student against another student are filed with the Office of Student Life. Claims made by a student against a faculty or staff member are filed with the Office of Human Resources located in the Ezell Building, Room 131.

Student Complaints

Harding University Physical Therapy Program is committed to a policy of fair treatment of its students in their relationships with the administration, faculty, staff, and fellow students. The purpose of this policy is to establish, implement, and inform a student complaint procedure.

Early Resolution

Verbal Complaints:

a. Prior to contacting the Program Director, the student shall attempt to resolve the issue with the individual(s) involved. If the student is not satisfied with the outcome after meeting with the individual or does not feel comfortable talking to the individual involved, the student may contact the Program Director.

b. The Program Director may counsel the student to discuss the issue with the individual. If the student does not feel comfortable talking to the person involved, the Program Director will investigate the complaint, attempt to reconcile differences, and propose a solution.

c. The program Director will document all verbal complaints.

Written Complaints:

a. In the event a student proceeds beyond a verbal complaint he/she may file a written complaint. The complaint must be signed and dated by the student filing the complaint and submitted using the attached Student Complaint Form ([Appendix 2](#)). All complaints will be handled in accordance with written policies of Harding University and the Physical Therapy Program. The Director shall, based upon the complaint and information from any further investigation deemed necessary, promptly determine the facts surrounding the issue, determine the validity of the complaint, and resolve the issue. If the Director deems it necessary or appropriate, the Dean of the College of Allied Health shall consider the matter. The student shall address the issue and initiate action under this policy within 30 days of the event giving rise to the complaint.

c. If a reconciliation or resolution of the difference cannot be achieved, the Program Director will provide a written statement of his or her recommendation to all parties within ten working days following the initial receipt of the student's report of the complaint. All involved parties will then have ten working days to respond. Every effort should be made to resolve the issue without going beyond this level. The Program Director will attempt to facilitate a resolution before proceeding with a hearing.

Complaints regarding the general or academic misconduct of another student

Policies and procedures governing complaints regarding the general or academic misconduct of students are defined in the Code of Professional and Academic Conduct (Student Code), which is Academic Policies Section of this handbook. Students, faculty,

and staff are all encouraged to report violations of the Student Code in accordance with the Disciplinary Procedures outlined in the Student Code.

Inclement Weather Policy

If the President of the University cancels University classes for all or a portion of a day due to inclement weather, an announcement will be made on Pipeline and through the campus emergency notification system. To opt in to the campus emergency notification system follow the instructions at <http://www.harding.edu/emergency/info.html>. You may call 501-279-4000 or 5000 for current information. When school opening is delayed, classes for the day will begin at the announced time, following the regular schedule of class sequence and length. When school opening is canceled for the day, didactic classes will be rescheduled at the discretion of the course coordinator and may be outside of normal class hours, if necessary.

Closure of the University does not affect Physical Therapy Program clinical experience responsibilities if the clinical site is open. When on Physical Therapy Program clinical experiences, the student is expected to follow the clinical site policy first and then proceed using sound judgment regarding safely reaching the clinical site. The student will need to contact their clinical instructor to make arrangements to make up for time missed due to the weather.

Hazard Communication Program, General University Policy

The purpose of this notice is to inform you Harding University is complying with the OSHA Hazard Communication Standard, Title 29 Code of Federal Regulations 1910.1200, by compiling a hazardous chemicals list, by using MSDS's, by ensuring that containers are labeled, and by providing training. (See Appendix 3)

Hazing Policy

The University adheres to the Arkansas Hazing Law as outlined below.

§ 6-5-201. Definition (a) As used in this subchapter, unless the context otherwise requires, "hazing" means: (1) Any willful act on or off the property of any school, Physical Therapy Program, university, or other educational institution in Arkansas by one (1) student alone or acting with others which is directed against any other student and done for the purpose of intimidating the student attacked by threatening him with social or other ostracism or of submitting such student to ignominy, shame, or disgrace among his fellow students, and acts calculated to produce such results; or (2) The playing of abusive or truculent tricks on or off the property of any school, Physical Therapy Program, university, or other educational institution in Arkansas by one (1) student alone or acting with others, upon another student to frighten or scare him; or (3) Any willful act on or off the property of any school, Physical Therapy Program, university, or other educational institution in Arkansas by one (1) student alone or acting with others which is directed against any other student done for the purpose of humbling the pride, stifling the ambition, or impairing the courage of the student attacked or to discourage him from remaining in that school, Physical Therapy Program, university, or other educational institution, or reasonably to cause him to leave the institution rather than submit to such acts; or (4) Any willful act on or off the property of any school, Physical Therapy Program, university, or other educational institution in Arkansas by one (1) student alone or acting with others in striking, beating, bruising, or maiming; or seriously offering, threatening, or attempting to strike, beat, bruise, or maim; or to do or seriously offer, threaten, or attempt to do physical violence to any student of any such educational institution; or any assault upon any such student made for the purpose of committing any of the acts, or producing any of the results, to such student as defined in this section.

§ 6-5-202. Restrictions (a) No student of any school, Physical Therapy Program, university, or other educational institution in Arkansas shall engage in what is commonly known and recognized as hazing or encourage, aid, or assist any other student in the commission of this offense. (b) (1) No person shall knowingly permit, encourage, aid, or assist any person in committing the offense of hazing, or willfully acquiesce in the commission of such offense, or fail to report promptly his knowledge or any reasonable information within his knowledge of the presence and practice of hazing in this state to an appropriate administrative official of the school, Physical Therapy Program, university, or other educational institution in Arkansas. (2) Any act of omission or commission shall be deemed hazing under the provisions of this subsection.

§ 6-5-203. Hazing (a) The offense of hazing is a Class B misdemeanor. (b) Upon conviction of any student of the offense of hazing, he shall, in addition to any punishment imposed by the court, be expelled from the school, Physical Therapy Program, university, or other educational institution he is attending.

Harding's Policy Against Hazing

1. Mark 12:31 —The second is this Love your neighbor as yourself.' There is no

commandment greater than these.

2. Philippians 2:3—Do nothing out of selfish ambition or vain conceit, but in humility consider others better than yourselves.

Harding's policy regarding hazing is as follows:

• No student shall:

- 1) engage in what is commonly known and recognized as hazing, or permit, encourage, aid or assist any person, whether a student or not, in the commission of hazing.
- 2) knowingly permit, encourage, aid or assist any person, whether a student or not, in committing hazing, or
- 3) willfully acquiesce in the commission of hazing, or
- 4) fail to report promptly his or her knowledge or any reasonable information within his or her knowledge of the presence and practice of hazing to any club sponsor or any officer of the university.
- 5)

Cell Phones

Out of courtesy for all those participating in the learning process, all cell phones must be turned off before entering any classroom, lab or formal academic, performance, or experiential event. At the instructors' discretion, cell phones may be utilized as recording devices for lecture.

If a student is caught texting on the cell phone, the following applies:

- 2x: Student is given a written warning.
- 3x: Student is placed on disciplinary probation.
- 5x: Student is dismissed from the program.

Computer Accessibility

Every student is required to have his/her own laptop computer upon entry into the program. The minimum requirements will be listed after acceptance into the program.

Food in Classrooms

The consumption of food and beverages is not allowed in laboratories. Food and beverages may be consumed in classrooms, public spaces, and the student lounge. Students are reminded that professional behavior includes having respect for building furnishings and maintaining a clean learning environment. Professional behavior also includes cleaning up after oneself and leaving no trash or spilled food or beverages behind. Demonstration of unprofessional behavior related to food or beverages may lead to the revocation of food privileges for the entire student body.

Fundraising

Harding University is blessed with talented, caring, and generous students, faculty, and staff. All fund-raising projects must be sponsored by a campus organization. The sponsoring organization must contact the Program Director to place the project on the Physical Therapy Program calendar and to assess whether the project poses any duplication of effort within the Harding University Health Sciences community. Once approved by the Program Director, the project must be approved by the Harding University Office of Student Life before any collections can be made.

A —Request for Fund Raising form must be given to the University Office of Student Life before the collection. This report includes:

1. The nature of the fund-raising effort.
2. How the money will be collected.
3. Who will collect and count the funds.
4. Other pertinent information.

After the collection, a Fund-Raising Report form must be submitted that summarizes the event.

Rules, Regulations and Procedures

In addition to the rules and regulations contained here, students are expected to adhere to the rules and policies of Harding University and to the rules, regulations and policies of other institutions or facilities where they may be assigned. Harding University's rules and guidelines can be found in the University Student Handbook. Any conflicting policies should be discussed with the Physical Therapy Program Director. All information herein is subject to change with timely notification to students in writing.

Non-Discriminatory Statement

Harding is committed to the policy of providing equal opportunity for all persons and does not discriminate in admissions, programs, or any other educational functions and services on the basis of race, color, creed, national origin, sex, age, veteran status, religion or disability to those who meet its admission criteria and are willing to uphold its values as stated in the Code of Conduct.

Based upon this commitment, Harding follows the principle of nondiscrimination and operates with applicable federal and state laws prohibiting discrimination. As a recipient of federal financial assistance, Harding is required by Title IX of the Educational Amendments of 1972, as amended, not to discriminate on the basis of gender in its admission policies, treatment of students, employment practices or educational programs except as required by religious tenets of the churches of Christ. Harding has a nondiscrimination policy available upon request in the offices of Student Services and Human Resources. Inquiries concerning the application of federal and state laws or regulations maybe referred to the Office of Human Resources, Box 12257, 900 E. Center Ave., Searcy, AR 72149-0001; telephone (501) 279-4380. The person to ensure compliance with the nondiscrimination policy and discrimination laws and regulations is the chief financial officer of the University.

CLINICAL EDUCATION

Clinical Risks and Standard Precautions

HUPT adopts the CDC guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings ([Appendix 4](#)). Standard Precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection in clinical settings. Standard precautions apply to non-intact skin, mucous membranes, blood, all body fluids, secretions, and excretions except sweat, regardless of whether or not they contain visible blood.

Physical Therapy Clinical Experience Placement

A student who is on academic probation will not be allowed to participate in clinical

rotations. The first consideration in engaging in the clinical environment is the safety of the public and patient. Academic probation puts the level of understanding and performance of the student in question. In the event that a student is on probation at the end of the didactic portion of the fourth semester or at the end of the sixth semester, the student will be dismissed from the program. The dismissed student will have the option of re-applying to the program to begin with the next matriculating cohort.

Clinical Experiences Requirements

Five Physical Therapy Clinical practice experiences are required. These must include:

- 1) inpatient/acute care,
- 2) outpatient orthopedic care
- 3) adult neurological care.

The other 2 experiences may include an approved elective setting Each Physical Therapy clinical practice experience is 8 weeks in length, 40 hours weekly.

Clinical Performance

Student performance in the clinical experience courses is assessed by the clinical instructor at mid-term through the CPI or when issues are communicated by the clinical instructor and discussed with a faculty member either onsite or by telephone conference. Any performance related concerns are discussed at this time and plans, including timelines, are developed to address any deficiencies in the student's performance. The Clinical Instructor will perform a final rating on the student at the completion of the experience. The Director of Clinical Education evaluates the students' performance on the clinical experience and assigns a grade of "Credit" or "No-Credit" based on the assessments by the clinical instructor and metrics within the CPI, consistent with the syllabus for the clinical experience course.

Background Checks and Drug Screening

A criminal background check and drug screen will be necessary for each student. Students will be responsible for completing the Criminal Background Check process only one time during their period of enrollment in the Physical Therapy program in order to receive an initial verification of clearance unless a particular site has requirements that are more stringent. However, should an incident occur during the time that a student is enrolled in the program that may result in a change in his/her Criminal Background Clearance status, it is the responsibility of the student to immediately inform the PT Program Director and Director of Clinical Education that such an event has occurred.

*Note: Conviction of certain felonies may prohibit licensure as a physical therapist in some states. **Completion of a professional course of study in Physical Therapy by convicted felons does not insure eligibility to sit for the professional licensure examination in all states.** Direct communication with the PT licensure board of the state in which one wishes to practice as a physical therapist will be required to determine eligibility and/or restrictions for licensure.*

Students failing to comply with the requirements of a clinical experience will be placed on non-academic probation and will be required to repeat the experience. In this case, the student will withdraw from the program and re-enter the curriculum one year later with a different cohort of students.

Location of Clinical Experience

Students are assigned to Physical Therapy Program clinical practice experiences in a variety of geographic areas. Each clinical experience will be chosen by lottery and according to the individual student's academic needs. Students with extenuating circumstances (as determined by the DCE) will be given special consideration in this process when possible. Due to limited availability of Physical Therapy Program practice experience sites, however, students may be assigned to locations further away than the Central Arkansas area. The student will be responsible for securing lodging at distant sites, and all expenses incurred are the student's responsibility.

HIPAA training

All students complete mandatory HIPAA training. Records of successful completion of HIPAA training are maintained on file by the physical therapy program. HIPAA training includes HIPAA Privacy for Patient Care and HIPAA Security overview for Patient Care. *HIPAA requirements must be met before participation in any clinical education experience.*

Patients

Throughout the clinical education process, CIs will select and assign students to work with specific patients who may assist the student in applying knowledge and gaining skills. Patients may refuse involvement with students at any time during the clinical education process with no risk to their rights and access to care.

Information Security/Patient Rights

- a) Use of Patient Non Protected Health Information and Clinical Facility Information -- Students wishing to obtain information such as patient care protocols, administrative information, audit processes or any other information deemed to be under the auspices of the facility, need to request this first from the CI and, if approved, from the departmental manager or supervisor. An explanation regarding the reason for the request as well as the intended use of the information should be provided. If the facility has a policy, procedure or practice in place, this must be followed. If the request is not approved, the information should not be copied or physically removed from the clinical facility.
- b) Use of Patient Images and Materials --Students wishing to use images or other materials that could identify patients and family members need to follow the facility's policy for doing so. This generally entails speaking with the CI and department manager first. If initial approval is received, the next step may be having another person (perhaps a CI) speak with the patient about this request. If the request is approved, a formal, written facility release, signed by necessary parties, will need to be completed. Students should not initiate conversations about such a request with a patient before speaking with a CI and/or manager/supervisor.

RESEARCH

Protection of Human Subjects

The HUPT takes protection of human subjects very seriously. Research of any type, including surveys is subject to the rules and regulations of the University's Institutional Review Board (IRB). Refer to <https://www.harding.edu/irb>

All faculty and/or student research involving humans must be reviewed and approved. In general, the IRB must review research involving special protected groups such as minors, pregnant women, the mentally incompetent and prisoners.

Use of Human Subjects For Classroom or Laboratory Demonstration

Whenever an individual is asked to serve as a demonstration subject for any learning experience their safety and privacy are paramount. HIPAA rules and regulations are applicable in these situations. If a student intends to invite an individual to be part of a demonstration or presentation, they should notify the faculty or staff member responsible for the class in advance.

Student's Responsibility To Know And Understand Contraindications Before Volunteering To Be A Demonstration/Practice Subjects

To become an effective and safe Physical Therapist, DPT students should experience the treatments that they will be administering. This provides them with the experience necessary to interpret patient's responses to various treatments. However, students with contraindications to specific treatments should not expose themselves to unnecessary risk and includes conditions that may be aggravated by various physical agents or exercise protocols. If a student has a condition or suspects that they may have a condition that could make it unsafe for them to experience a particular treatment, it is the students responsibility to notify the instructor.

STUDENT SERVICES AND INFORMATION

Campus Security and Safety

Harding University promotes a safe and healthful environment for all employees, students, and visitors. The University is committed to complying with state and federal legislative acts dealing with safety. The campus safety philosophy provides a guiding vision and general policy by which we conduct business and safety together every day.

The Office of Public Safety is located on the north side of the Heritage building across from Admissions Services. Campus phone number is ext. 5000 or, if calling from off campus, dial 279-5000.

Student Information and Technology Communications

Student Support and Communications provides all University students with an e-mail/Internet account while they are enrolled at Harding. The account serves as the official electronic communication channel for the University and must be checked regularly. **Use of this account will constitute acceptance of the rules and regulations as stated in the following policies:**

1. Code of Practice for the Acceptable Use of Information Technology Resources at Harding University
2. Policy for the Use of Information Technology Resources
3. Policy for the Use of Electronic Mail at Harding University

All of these policies can be found on the web, <http://www.harding.edu/its>

Campus Health Care/Immunizations

The Health Services Center provides free health services and resources for enrolled students. Student Health Services is a walk-in clinic with no appointments necessary. Symptomatic treatment is provided for minor illnesses such as colds, headache, sinus congestion, upset stomach, aches, sprains, first aid for accidental injury, blood pressure screening, and allergy injections with physician permission. Students are assisted with referrals and appointments with local health professionals and agencies. Transportation may be provided if necessary. Office hours are 7:30 a.m. to 4:15 p.m. weekdays through fall and spring. Hours for summer sessions are 7:30 a.m. to 12:30 p.m. In addition, it is strongly recommended that students identify with a local physician for local medical assistance or in case of an emergency.

Health Insurance

Students are required to have their own health insurance. With changes brought by the Affordable Care Act, the university is no longer able to offer a voluntary student health insurance plan for our domestic students. The University does not assume financial responsibility for any professional services that require a physician or any medical, surgical, or emergency services or hospitalization. Students are financially responsible for the costs of his/her services. Contact information: Student Health Services, HU Box 12271, Searcy, AR 72149-5615. Phone: (501) 279-4346 Fax: (501) 279-4577.

If you need coverage, we encourage you to consider the following options:

1. **CHECK WITH YOUR PARENTS PLAN** – Under the Affordable Care Act children can remain on their parent’s plan up to the age of 26. The ability to remain covered does not consider income or marital status.
2. **APPLY FOR COVERAGE IN THE HEALTH INSURANCE MARKETPLACE** - Health insurance is available for purchase at <https://www.healthcare.gov/young-adults/>. Students are responsible for having health coverage that qualifies as minimum essential coverage.
3. **APPLY FOR INDIVIDUAL COVERAGE** – If you do not qualify for a special enrollment into the Health Insurance Marketplace, you can still obtain coverage through various insurance carriers across the country. In most cases, these plans will not meet the federal government’s new “minimum essential coverage” requirements. These plans may cost less because in most cases they will not cover pre-existing conditions.

Emergency Call Boxes: Yellow emergency call boxes have been placed in strategic locations on campus. If there is criminal activity or a physical emergency, a person should press the red button on the box and report the problem to the Public Safety dispatcher. There is a direct line from each call box to the Public Safety Office. Officers are immediately dispatched to the locations of all emergency call box calls regardless of the call.

Public Safety officers are on duty 24 hours a day, every day of the year. The Office of Public Safety may be contacted for on-campus emergencies as well as other student and visitor needs, such as locked keys in a vehicle, jump starting a battery, emergency transportation to the hospital, and courtesy escorts after dark.

Public Safety officers are medical First Responders and certified in CPR. They have additional training in crime prevention, emergency response and other public safety concerns. Any suspicious behavior, on-campus traffic accidents, on-campus emergencies, and all crimes occurring on campus should be reported immediately to the Office of Public Safety. In addition to regular uniformed patrol officers, the Office of

Public Safety also has a number of armed officers commissioned by the state of Arkansas. Security cameras are used in various locations on campus.

Emergency Procedures

The following steps should be followed when an accident, injury, or other related emergency occurs.

1. Notify the Harding University Department of Public Safety immediately by dialing 279-5000 from ANY telephone nearest you. Give the location of the injured person and briefly describe the apparent injury. The Harding Department of Public Safety will then 1) place the 911 call and then 2) dispatch an officer to the scene and direct a bystander to guide any emergency vehicles to the scene on campus. No employee should assume the responsibility of transporting an injured or ill person. If there is difficulty in reaching Harding Department of Public Safety by telephone, send another person to the Harding Department of Public Safety.
2. Any attempt to render first aid or other treatment by an untrained party should be limited to only those steps necessary to sustain life and make the injured person as comfortable as possible.
3. Remain with the injured party at all times until professional medical aid arrives. A security officer trained as a First Responder will be on hand as soon as possible to maintain order and render whatever assistance possible.
4. After the injured person has been removed or treated by trained medical personnel, give the public safety officer on the scene as accurate a description as possible of the apparent cause of the accident and the nature of the injury.

By receiving professional medical treatment through standard emergency procedures, the victim of a serious injury or illness stands a much greater chance of survival and avoidance of serious after-effects.

EMERGENCY TELEPHONE NUMBERS:

Harding University Public Safety: 279-5000

Searcy Police Department/Fire Department: 911

Campus Health Services Center: 279-4346

Poison Control Center: 1-800-222-1222

Students who perceive their personal safety or security to be at risk will be allowed to leave a Physical Therapy Program clinical experience site with proper notice to the Program Director and to the clinical preceptor. If adequate remediation of the problem cannot be quickly obtained, an alternate clinical assignment will be made for that student.

Evacuation Plan

In the event of an emergency requiring that the building be evacuated, follow these procedures:

- Stay calm, do not rush, and do not panic.
- Gather your personal belongings, if it is safe to do so.
- Proceed to the nearest exit.
- Proceed to the parking lot on the south side of the building, going into the field if necessary.

- Wait for further instructions.
- Do not re-enter the building until you have been instructed to do so.

Identification

University ID Name badges will be provided for students at the beginning of the professional year. These name badges must be worn at all Physical Therapy Program clinical experience sites. Additional or replacement name badges will be provided at the student's expense for an approximate cost of \$10.00. These may be obtained through the Office of Public Safety.

Physical Therapy Program students must be readily identifiable at all times. In all Physical Therapy Program clinical experience areas or places where other health professionals or patients are likely to be met, a program approved nametag identifying the wearer as a Physical Therapy Program student must be properly worn and visible. When meeting another health professional or a patient, a Physical Therapy Program student must introduce him/herself as a Physical Therapy Program student and do so with sufficient clarity to insure that the other person understands. Some Physical Therapy Program clinical experience sites may require additional identification.

Students employed in health care fields or settings are not permitted to identify themselves as Physical Therapy Program students while employed in another capacity.

Mental and Physical Health and Welfare of Students

The mental and physical health of students can strongly affect their academic and social success at the University, as well as influencing the other members of the University community.

Harding University provides counseling services through the following two avenues: the Professional Counseling Program and the Counseling Center. Both are staffed by professionally trained counselors. The Professional Counseling Program is located in the Thornton Education Center and the Counseling Center is located on the third floor of the McInteer building. Through the services offered by Christian counselors, students receive confidential assistance with personal, relational, and social problems. Strong emphasis is given to education and prevention of drug and alcohol-related problems. Any student can obtain help in assessing and overcoming difficulties in personal living. Students may also participate in small groups with specialized needs. A student may voluntarily request help or s/he may be referred by a proper representative of the University, a parent, or other interested persons. All services provided are non-fee services. Individuals requiring long-term professional help may be referred to an appropriate source. **Students may access the Counseling Center at counseling@harding.edu or the Professional Counseling Program at 501-279-4347.**

The Health Services Center provides services as previously described in the **Campus Health Care.**

Parking and Transportation

Professional students must pay applicable fees to have a University-issued parking sticker and vehicles **MUST** be registered or a parking ticket will be issued. Entering

students will have time to complete this after their arrival on campus. To obtain a parking sticker go to: www.thepermitstore.com. Enter Harding as your destination. Information needed is your University ID and vehicle information. You will select option as a Student B. If there are questions, call the Office of Parking Services at 279-4005.

It is the policy of Harding University to permit all students to have and drive automobiles on campus and in the community under certain conditions and exceptions as cited below:

Vehicle Registration

1. All students enrolled at Harding University, living on or off campus, and their spouses must register their vehicles.
2. All vehicles driven on the University's campus must be properly licensed and registered with the Office of Parking Services.
3. All students who own one or more vehicles are required to register the vehicle(s) and correctly display a valid parking permit.
4. Permits must be affixed to the vehicle in the manner in which they were designed by the manufacturer. This will constitute the final phase of vehicle registration. The permit must be correctly/permanently affixed to avoid penalty.
5. Specific registration instructions can be found online at <https://www.harding.edu/public-safety>.
6. The Office of Parking Services may utilize online resources to locate unregistered vehicles. The Office of Parking Services may also tow unregistered vehicles after the vehicle has accumulated five citations. (Separate citations may be written for a vehicle parked improperly and for not being registered.) Unregistered student-owned or driven vehicles may be registered by the Office of Parking Services with a \$35 surcharge added to the student's account in addition to any citations the vehicle may have received.
7. Students who falsify registration information are subject to disciplinary action.

Special Circumstances

1. Physically disabled persons who are connected with the University and who suffer a permanent or temporary physical disability may apply at the Office of Parking Services for special parking consideration.
2. Faculty, staff, and students who have a motor vehicle registered and, for some extraordinary circumstance, find it necessary to operate and park an unregistered vehicle on campus, may obtain a temporary permit without cost for a period of no longer than two weeks from the Office of Parking Services.
3. Students may not store or drive golf carts or all terrain vehicles (ATVs) on campus without prior approval from the Office of Student Life.

Rules and Regulations

1. Every person operating a vehicle on campus is held responsible for acquainting himself/herself with and obeying the traffic and parking regulations of the University.
2. Vehicles must be parked in designated slots (red spaces are for faculty/staff only).
3. Vehicles are considered parked when left unattended.
4. Tickets are written 24 hours a day, seven days a week. Example: If a vehicle is parked in a handicap slot, loading zone or staff area, it is subject to a ticket every

- hour (also see towing policy).
5. Reserved slots are restricted 24 hours a day.
 6. Students may park in faculty/staff areas (i.e. red spaces) from 5 p.m. to 7:30 a.m., unless otherwise restricted.
 7. Loading zones are for emergency and maintenance vehicles. Students loading and unloading will be allowed for 15 minutes.
 8. Overnight parking (curfew to 7 a.m.) is NOT allowed on the north and east sides of campus and where otherwise posted.
 9. No vehicle shall be parked in such a fashion as to obstruct pedestrian or vehicle traffic.
 10. Double parking is not permitted on the campus at any time.
 11. Parking is prohibited for vehicles in the following areas: all areas not distinctly designated as parking areas; red curbs; service lane zones and roads; traffic lanes within parking lots; on the grass or sidewalks; on a pedestrian crossing.
 12. Students driving vehicles with faculty/staff stickers are required to park in student parking. A record will be kept of all fees and penalties assessed. Students may not register for the next semester until all fees have been paid.

Exceptional Circumstances

If you park illegally because of car failure, notify the Office of Parking Services. You will be required to move the vehicle within 24 hours unless other arrangements are made with the manager of Parking Services.

Appeals Process

To contest a parking citation, one must submit an appeal within 10 days of when the citation was written to the Traffic Appeals Committee via the Web site, www.scapay.com. The Appeals Committee is made up of Harding staff and faculty members. Committee members review each appeal and make their decision based on the information contained in the appeal as well as information from the ticket itself. When there is a question about an appeal, members of the committee may consult with the manager of Parking Services to find a resolution. The decision of the Traffic Appeals Committee is final.

Towing Policy

The University reserves the right to remove or have removed by impounding any vehicle parked in such a way as to constitute a serious hazard or any vehicle that impedes vehicular or pedestrian traffic movement, the operation of emergency equipment, the making of essential repairs and services, or for other cogent reasons, such as failure to properly register the vehicle, continuous parking violations (five tickets), or abandoned vehicles. Owners of such vehicles will be required to pay all costs involved in removing, impounding, or storing such vehicles.

General Information

1. The campus and buildings of Harding University are private property. The Office of Parking Services is responsible for regulating and enforcing traffic and parking regulations.
2. All parking violations should be handled through the Office of Parking Services located on the second floor of the Ezell building.
3. All traffic accidents or mishaps should be handled through the Office of Public

- Safety by calling 279- 5000.
4. All Harding students are required to carry a valid Harding ID card at all times while on campus. This ID card must be surrendered to any Harding University faculty member, staff member, public safety officer, or parking enforcement officer upon request.
 5. Harding University assumes no financial responsibility for any vehicle or its contents while parked on campus.

Penalties for Each Violation

Penalties for parking violations vary depending on the type of violation and the number of tickets received. Penalties may be amended by the Vice President for Finance. Penalties may be paid at the business office. Specific penalties for each fine can be found online at www.harding.edu/publicsafety.

Transportation/Housing

Physical Therapy Program clinical experiences are offered at sites are located various distances from Searcy. The majority will be outside of the local area and some may be out of state. Students must provide their own transportation to experiential sites and classroom activities. It is therefore required that all Physical Therapy Program students have a means of transportation. This includes a valid driver's license and current auto liability insurance if transportation is to be provided through a personal vehicle.

Students are responsible for their own housing during all phases of the professional curriculum. Available University-owned housing can be viewed at www.harding.edu/housing. The Office of Student Affairs and Admissions will assist with locating suitable housing for the first two years of the professional curriculum, but the student is ultimately responsible for making adequate housing arrangements. Students will be responsible for arranging housing at all clinical experience locations.

Physical Therapy Program Student Organizations

APTA is the professional organization for physical therapists. As a student in a physical therapy program, you are eligible to become a student member

Professional Meeting Attendance

The Physical Therapy Program acknowledges that viable professional organizations are essential to the well being of the Physical Therapy profession and contribute to the maintenance of high professional standards, thereby assisting in assuring that Physical Therapists offer their patients state-of-the-art health care. As a result, the Physical Therapy Program encourages its students to become actively involved in professional organizations and provides them with the opportunity to do so.

The Physical Therapy Program also recognizes that the primary responsibility of students is to achieve academic excellence and that any activity which hinders their pursuit of academic excellence is not in the best interest of the students or profession.

Each student involvement will be dealt with on a case-by-case basis according to the student's individual ability and need. For the student's sake, no student who is on academic probation will be allowed to miss class or exams to attend activities or meetings of any professional organization.

Outside Employment

While enrolled in the Physical Therapy degree program at Harding University, students are expected to devote their maximum efforts to successful completion of the professional curriculum. The Physical Therapy Program does not prohibit part-time employment provided it does not conflict with the student's ability to maintain satisfactory academic performance. Student employment schedules are not a consideration in the Physical Therapy Program's scheduling of classes, laboratories, reviews, recitations, examinations, practice experiences, experiential meetings, or other curricular activities.

APTA Guidelines for Student And Employer Contracts

Because many physical therapy students undergo financial hardship during their years of study and because some physical therapy practices are in need of physical therapists, some practices offer financial assistance to physical therapy students for a promise of future employment. Most often these arrangements are mutually beneficial but on occasion the student later discovers that the agreement is less than satisfactory. Students, at the time of entering into these agreements, are typically unaware of all the legal ramifications involved and all of the consideration that should go into seeking a first job. These guidelines represent the interests of both the employer and the student.

Guidelines for Fairness in Offering Student Financial Assistance in Exchange for a Promise of Future Employment:

- 1) Notification by the employer if the place of employment may be in an isolated area or as a solo practitioner such that the new graduate will not have ready access to mentoring and regular collegial relationships or any resource for professional growth and development.
- 2) Disclosure by the employer of ownership of the practice.
- 3) Notification by the employer to the student if the practice is involved in any situation in which a referring practitioner can profit as a result of referring patients for physical therapy and notification that the APTA is opposed to such situations.
- 4) Student awareness of any potential future tax obligations that may be incurred upon graduation as the result of deferred income.
- 5) The agreement must not, in any way, interfere with the process and planning of the student's professional education.
- 6) It should be understood that the school is not a party to the agreement and is not bound to any conditions of the agreement.
- 7) There should be a clearly delineated, fair and reasonable buy out provision in which the student understands the legal commitment to pay back the stipend with reasonable interest in the event that there is dissatisfaction or reason for release from the contract on the student's part at any time during the term of the agreement.
- 8) A no penalty bailout provision should be provided in the event of change of ownership, but the student may be required to adhere to a reasonable payback schedule.
- 9) Avoidance of non-compete clauses is recommended but if there is one, a reasonable limitation of time and distance should be incorporated.

A student's interests may best be served by obtaining appropriate counsel prior to signing the contract

Other Student Services

More information on services offered to Harding University students in regards to Harding ID card, Student Center and Cafeteria, Bookstore, Health Services, Parking, Career Services, the Professional Counseling Program, the Counseling Center, the Media Center, Technology, and Library Services can be found in the University Student Handbook, it can be viewed at www.harding.edu/student-life.

FINANCIAL INFORMATION

Types of Financial Assistance

Financing a Physical Therapy Program education is a concern shared by virtually all prospective students and their families. The financial information contained in the following pages presents educational expenses in a realistic manner and suggests ways that you can meet them.

Harding University, a private institution without benefit of tax support, must meet its operating costs by income from student tuition and fees, government grants, auxiliary enterprises, gifts, and endowment earnings. As tuition and fees are discussed in the following pages, you will discover that the cost of attending Harding is moderate compared to many Physical Therapy Programs and universities of the same size and quality. The following financial aid programs are available to students who enroll at Harding University Physical Therapy Program.

Financial Aid

Financial aid may be available in the form of scholarships, grants, loans, veterans' programs, and vocational rehabilitation programs. These funds are administered wholly or in part by the Office of Financial Aid Services. Requests for information and assistance should be directed to Harding University, Box 12282, Searcy, AR 72149-2282; telephone 501-279-4081 or 1-800-477-3243 (toll free); or e-mail finaidgrad@harding.edu.

Requirements: Application for aid should be made as follows:

1. Apply or be admitted to Harding University Physical Therapy Program through the Physical Therapy Centralized Application System (PTCAS). Application information can be found online at [Harding Physical Therapy](#) web page.
2. Complete the Free Application for Federal Student Aid (FAFSA) at www.fafsa.gov.
3. Financial aid awards are based on current federal and state regulations. To help meet students' needs (as determined by the FAFSA), awards are made in the following order: grants, scholarships, loans and work-study (by request). Students have the right to accept or decline any aid offered.

Financial Aid Funding Limitations

Full-Tuition Limitation: The combined maximum award for all Harding-funded grants, scholarships, discounts, or other assistance is limited to a student's full-tuition charges. Should a student receive multiple Harding-funded awards in excess of full tuition, the awards will be reduced to actual tuition costs.

Direct-Costs Limitation: Harding-funded scholarship assistance may be combined with other financial assistance (including private, state and federal grants and

scholarships), not to exceed a student's actual direct costs. Direct costs include full tuition, technology fees, and standard fees.. The cost of books, activity fees, and the costs associated with maintaining or purchasing a computer are not considered direct costs. Should a student receive multiple awards in excess of direct costs, Harding-funded scholarships will be reduced until total scholarships/discounts do not exceed direct costs.

Financial Aid Budget Limitation: Aid in the form of student loans and work-study may be received in excess of direct costs, not to exceed a student's financial aid budget. A financial aid budget includes all direct costs, as well as reasonable allowance for books, transportation to and from school, and personal expenses. Please refer to the financial aid Web site for a listing of all financial aid budget components.

Return of Title IV Funds (Federal Aid): Professional students receiving Title IV financial aid (federal loans, federal grants, etc.) and who withdraw, drop out or are dismissed before completing more than 60 percent of the payment period are subject to a calculation to determine if the funds must be returned to the federal or state financial aid programs. In some cases, all Title IV aid must be returned. **The calculation of the return of these funds may result in the student owing a balance to the University and/or the federal government.** Once the student has completed more than 60 percent of the payment period, all federal financial aid assistance is considered to be earned, and the funds may be retained. If funds must be returned, the order of return is as follows: Unsubsidized Federal Direct Loan; Subsidized Federal Direct Loan; Federal PLUS Loan; other Title IV aid programs. A detailed explanation of the required Return of Title IV Funds calculation is available in the Office of Financial Aid Services and on the University Web site at www.harding.edu/finaid.

Financial Aid Probation and Suspension: Students who receive Title IV financial aid must make satisfactory progress toward a degree. Satisfactory progress includes maintaining a cumulative grade point average of at least 3.0 (or as determined by the PT program) by the completion of the first professional year in attendance. Enrollment, academic progress and grade point average monitoring occurs at the end of each semester. Failure to maintain the required grade point average or successfully completing degree work as specified will result in financial aid probation status. Probation is removed at the end of a semester where the student has satisfied the grade point average and enrollment criteria. Failure to remove financial aid probation status the following semester results in financial aid suspension. Students in financial aid suspension are not eligible to receive Title IV financial aid. Students with mitigating circumstances regarding financial aid may appeal in writing to the Harding University Physical Therapy Program Director. Appeals must be received by August 1 for the fall term.

Loan Programs

Federal Direct Student Loans: The federal Direct student loan program makes loans available to both undergraduate and graduate students. Loans are made through the U.S. Department of Education and are electronically processed by the Financial Aid Services Office. Through this program students borrow at an interest rate of 6.8 percent. Repayment does not begin until six months after students graduate or cease taking a half-time load of study. The government pays the interest while students are in school if they qualify for a subsidized loan based on need. Students who do not qualify on the basis of need are given unsubsidized loans and are responsible for the interest that

accrues while in school. The government limits the amounts of subsidized and unsubsidized that may be awarded each semester.

Federal Graduate/Professional PLUS Loans: Students may borrow up to the cost of attendance minus their Direct loans and any other aid. Repayment begins within 60 days of graduating, dropping below part-time or leaving a program of study. Students may postpone repayment after graduation by requesting forbearance. Interest is fixed at 7.9%. Students without a credit history are eligible; those with adverse credit may require an endorser.

Employment Programs

Graduate students are eligible to apply for Graduate Assistantships if they are enrolled full time. More information is available from the office of the Program Director.

Veterans Programs

Veterans must be certified for eligibility by their local VA offices and must contact the appropriate representative in the Office of Financial Aid Services. Veterans of the post-Vietnam period must have made contributions into the educational program (Montgomery and New GI Bill) in order to receive benefits. An educational program is also available to certain members of the Reserves and National Guard. Widows and children of eligible veterans should contact the Office of Veterans Affairs to apply for assistance through educational benefits.

Disabled veterans entering under Public Law 16 should apply to their state Veterans Administration headquarters for counseling and approval, and then contact the Office of Financial Aid Services. In compliance with the Veterans Administration's minimum standards of progress, if a student receives VA assistance, is placed on academic probation, and does not remove this probation within one semester, he or she will be suspended from receiving VA education benefits for the following semester.

EXPENSES

Typical Expenses

Please note that tuition rates and miscellaneous fees are subject to change without prior notice. For a student enrolled in the professional block curriculum tuition is \$15,530 per semester, subject to increase.

The tuition includes the cost of the medical mission program for the required Medical Missions Practicum. The foreign medical mission occurs between fall and spring semester of the third professional year.

Other expenses include books/equipment (estimated to be \$700.00-\$1000.00 per semester in the first and second professional years but less or nonexistent in the third and professional year); University technology fee of \$250 per semester; required laptop/software, travel to practice sites; criminal background check and drug screening as needed for specific practice sites (estimated to be \$75.00); and a graduation fee.

Upon acceptance to the Physical Therapy Program of Physical Therapy, students must submit a \$500.00 non-refundable tuition deposit, to hold their place in the class. The deposit is due 14 days from acceptance. This fee is applied toward the first semester's tuition.

Financial Responsibility

Harding's financial well-being is dependent upon prompt payment of accounts. For this reason, Harding transcripts and diplomas will not be released if a student has failed to take care of any indebtedness to the University. Exception is made for government loans if they are not past due. Failure to meet financial obligations to the University may result in the delinquent account being placed with a collection agency. Students are responsible for all attorney fees and other collection costs incurred by the University in collecting accounts. Term charges are not reduced for late enrollment. There will be a \$25 service charge on all dishonored checks.

Payment of Accounts

Payments may be mailed in or made in person at the Business Office, located in the Administration Building. Payments may be in the form of cash, check, money order or credit card. Visa, MasterCard, and Discover credit cards are accepted.

Payment Options

1. Pay the total balance by the due date on the first billing statement.
2. Enroll in Harding University Payment Plan. Enrollment fee is \$25 per term (fall and spring only). Deadline to enroll is the first day of classes. Pay the balance due in four monthly payments. A late fee of \$35 will be assessed if a due date is not met. No interest will accrue on the Harding Payment Plan.
3. Accounts not paid in full or not enrolled in the payment plan will be subject to a 9 percent per annum interest charge compounded monthly. Interest charges are not reduced for delays in receiving financial aid.
4. Any additional charges incurred during a term will be posted to the student's account and should be paid by the due date on the statement. Examples include adding classes, traffic fines, library fines, adding declining balances, etc. Any credits posted to an account will appear on the monthly statement. Zero balance statements are only mailed at the beginning of the term.

Students wishing to apply for financial aid must complete a Free Application for Federal Student Aid. Deadlines must be observed, and supporting documents may be required. Applications must be completed each year the student requests financial aid. Students must be sure to observe filing dates beginning with April 15 for the following school year. Students are notified periodically of documentation (if any) that is missing from their financial aid file.

If prior term charges have not been paid in full, enrollment for a future term will be delayed until payment is received or satisfactory payment arrangements have been approved.

Refunds

Students are granted admission with the understanding that they are to remain for the duration of the curriculum. A student who enrolls in the professional curriculum but does not attend or stops attending and does not officially withdraw may not receive a refund. If a student officially withdraws from HUPT, (see Withdrawal section of the HUPT handbook) a refund of tuition will be made according to University policy. A refund of tuition will be made based on the following schedule. (Days indicated are days of the term, excluding Saturday and Sunday.)

Day 1-3	100 percent refund of tuition
Day 4-5	90 percent refund of tuition
Day 6-10	80 percent refund of tuition
Day 11-15	60 percent refund of tuition
Day 16-20	40 percent refund of tuition
Day 21-25	20 percent refund of tuition
Day 26-end of term	No refund

Credit Balance Refunds: Students may request a refund through Pipeline. No refunds are issued during the first week following registration.

Tuition Refund Plan: A protective insurance program provided by DEWAR Insurance Company is available and enrollment is voluntary. The policy will minimize the financial loss for students who suffer a serious illness or accident and have to leave the University. Enrollment is processed by the Business Office.

STUDENT RECORDS AND RIGHT OF PRIVACY

(Family Education Rights and Privacy Act of 1974)

The Family Educational Rights and Privacy Act of 1974 (called FERPA and also known as the Buckley Amendment) regulates a student's right of access to and privacy regarding his or her education records. A student has the right of access to his or her records, and only persons authorized by the act may access a student's records without his or her permission. Occasionally, the media, employers, and scholarship donors request lists of students who rank in the top ten, one-fourth, and one-third of freshman, sophomore, junior, senior, graduate, and professional classes. Academic ranking, as well as directory information such as name, campus address, permanent address, e-mail address, telephone number, date and place of birth, major field of study, class rosters, class schedules, participation in officially recognized activities and sports, weight and height of members of athletic teams, dates of attendance, degrees, achievements, academic awards, honors, most recent previous educational agency or institutions attended, social clubs, academic clubs and societies, and photographs are available to any person inquiring. However, if you do not wish this information to be released, refer to the Harding University Student Education Records Policy on file with the Registrar's Office.

(Appendix 1)

-Generic Abilities

Instructions: Assess each ability based on your observation of the student's performance. Mark the scale to reflect your final rating. Comments and examples provide valuable information. Please sign and date the assessment.

B – Beginning Level D – Developing Level E – Entry Level

1. Commitment to Learning Comments & Examples:
2. Interpersonal Skills Comments & Examples:
3. Communication Skills Comments & Examples:
4. Effective Use of Time and Resources Comments & Examples:
5. Use of Constructive Feedback Comments & Examples:
6. Problem-Solving Comments & Examples:
7. Professionalism Comments & Examples:
8. Responsibility Comments & Examples:
9. Critical Thinking Comments & Examples:
10. Stress Management Comments & Examples:

Student Name:

CI Name:

Facility Name:

Date:

Generic Abilities**

Generic abilities are attributes, characteristics or behaviors that are not explicitly part of the profession's core of knowledge and technical skills but are, nevertheless, required for success in the profession. Ten generic abilities were identified through a study conducted at UW-Madison In 1991-92. The ten abilities and definitions developed are:

	Generic Ability	Definitions
1.	Commitment to Learning	The ability to self-assess, self-correct, and self-direct; to identify needs and sources of learning, and to continually seek new knowledge and understanding
2.	Interpersonal Skills	The ability to interact effectively with patients, families, colleagues, other health care professionals, and the community and to deal effectively with cultural and ethnic diversity issues.
3.	Communication Skills	The ability to communicate effectively (i.e., speaking, body language, reading, writing, listening) for varied audiences and purposes.
4.	Effective Use of Time and Resource	The ability to obtain the maximum benefit from a minimum investment of time and resources
5.	Use of Constructive Feedback	The ability to identify sources of and seek out feedback and to effectively use and provide feedback for improving personal interaction
6.	Problem Solving	The ability to recognize and define problems, analyze data, develop and implement solutions, and evaluate outcomes.
7.	Professionalism	The ability to exhibit appropriate professional conduct and to represent the profession effectively.
8.	Responsibility	The ability to fulfill commitments and to be accountable for actions and outcomes.
9.	Critical Thinking	The ability to question logically; to identify, generate and evaluate elements of logical argument; to recognize and differentiate facts, illusions, assumptions, and hidden assumptions; and to distinguish the relevant from the irrelevant.
10	Stress Management	The ability to identify sources of stress and to develop effective coping behaviors

***Developed by the Physical Therapy Program, University of Wisconsin-Madison May et al. Journal of Physical Therapy Education 9:1, Spring 1995*

(Appendix 2)
Student Complaint Form

Individuals may file a complaint without fear of threats or retaliation.

Student Complaint Form Harding University Physical Therapy Program

Student Name:

Local Contact Information Street Address:

City/State/Zip:

Telephone: Home:

Work:

Cell:

E-mail Address:

Permanent Contact Information

Street Address:

City/State/Zip:

Telephone: Home: Work: Cell:

E-mail Address:

NOTICE: Information on filing student complaints is provided in the Harding University Physical Therapy Program Student Handbook and on the Web site.

In the space below, please state in detail your complaint. You may use additional pages if necessary.

In the space below, please state in detail what resolution or relief you are seeking. You may use additional pages if necessary.

Signature

Date

Upon completion, please place the Student Complaint Form in an envelope, seal and mark the envelope "Confidential" and deliver to the Director of the Harding University Physical Therapy Program.

(Appendix 3)
Withdrawal Form:

**HARDING UNIVERSITY
Physical Therapy
WITHDRAWAL FORM**

Harding ID # Date	Last Name	First Name
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NOTE: If a student withdraws from the program for any reason, that student may be provided an opportunity to re-enter the program in a subsequent year. This requires that the student reapply for admission into the program. If accepted for readmission the student would return to the program, joining a new cohort of students.

Semester hours enrolled: _____

Course(s)

Course(s)

I understand that no refund is available to me for this term, I further understand that if I wish to continue a DPT degree, I must re-apply to the program but that there no guarantee of re-admission to the program at a later date.

Student signature

Michael McGalliard, PT, ScD
Chair, Department of Physical Therapy

Student Affairs Coordinator

Copies of form to:

Office of Security, Box 10841
Registrar's Office, Box 10766
Office of Dean, College of Allied Health
Student Loan Office, Box 12242

Business Office, Box 10770
Office of the Provost, Box 10773

****Withdrawal date is determined by the date the Registrar's Office received this form.****

(Appendix 4)

Hazardous Material:

A product, waste or combination of substances which because of its quantity, concentration, physical, chemical, toxic, radioactive, or infectious characteristics may reasonably pose a significant, actual, or potential hazard to human health, safety, welfare, or the environment when improperly treated, stored, transported, used, disposed of, or otherwise managed. Hazardous materials include - without limitation - synthetic organic chemicals, petroleum products, heavy metals, radioactive or infectious materials, and all substances defines as "toxic" or "hazardous" under MGL Chapters 21C and 21 E using the Massachusetts Oil and Hazardous Material List in 310 CMR 40.

Procurement of Hazardous Materials

A. General requirements

1. Only authorized faculty and staff may order hazardous materials or acutely hazardous materials.
2. Procure hazardous materials in the smallest quantities available which meet the maximum usage requirements for a reasonable time period.

When the hazardous material is received, the material shall be stored, if not used immediately, in accordance with the manufacturer's MSDS or label warnings, or the appropriate sections of the Chemical Hygiene Plan.

Handling and Use of Hazardous Material

A. Storage

All hazardous material must be stored in appropriate cabinets, flammable material storage cabinets etc. until use and returned for safekeeping after use. Containers of hazardous materials should not be left on bench tops when not in use.

B. MSDS Information

1. It is important that anyone using hazardous material read the Material Safety Data Sheet (MSDS) associated with the hazardous material before its use.
2. Anyone handling or using hazardous material shall use personal protective equipment as noted in the MSDS or as indicated in the Amherst College Chemical Hygiene Plan.

C. Disposal of Empty Hazardous Material Containers

1. Empty containers may be discarded into a "Glass Only" box or a wastebasket as appropriate. A container is considered empty if the contents have been removed by the normal procedure for that hazardous material, pouring, scooping, etc.

D. Hazardous Material on hand without Future Use

Any hazardous material which is deemed unacceptable for future use or is identified as excess material without future need, will be declared hazardous waste by attachment of the appropriate hazardous waste label and managed in accordance with the Harding University Hazardous Waste Management Policy.

(Appendix 5)

CDC Guidelines - Standard Precautions

(Excerpts Only)

To view the entire document, please visit:

<http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf>

2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings

Part I: Review of Scientific Data Regarding Transmission of Infectious

I.B. Rationale for Standard and Transmission-Based Precautions in healthcare settings

Transmission of infectious agents within a healthcare setting requires three elements: a source (or reservoir) of infectious agents, a susceptible host with a portal of entry receptive to the agent, and a mode of transmission for the agent. This section describes the interrelationship of these elements in the epidemiology of HAIs.

I.B.1. Sources of infectious agents Infectious agents transmitted during healthcare derive primarily from human sources but inanimate environmental sources also are implicated in transmission. Human reservoirs include patients 20-28, healthcare personnel 29-35 17, 36-39, and household members and other visitors 40-45. Such source individuals may have active infections, may be in the asymptomatic and/or incubation period of an infectious disease, or may be transiently or chronically colonized with pathogenic microorganisms, particularly in the respiratory and gastrointestinal tracts. The endogenous flora of patients (e.g., bacteria residing in the respiratory or gastrointestinal tract) also are the source of HAIs 46-54.

I.B.2. Susceptible hosts Infection is the result of a complex interrelationship between a potential host and an infectious agent. Most of the factors that influence infection and the occurrence and severity of disease are related to the host. However, characteristics of the host-agent interaction as it relates to pathogenicity, virulence and antigenicity are also important, as are the infectious dose, mechanisms of disease production and route of exposure 55. There is a spectrum of possible outcomes following exposure to an infectious agent. Some persons exposed to pathogenic microorganisms never develop symptomatic disease while others become severely ill and even die. Some individuals are prone to becoming transiently or permanently colonized but remain asymptomatic. Still others progress from colonization to symptomatic disease either immediately following exposure, or after a period of asymptomatic colonization. The immune state at the time of exposure to an infectious agent, interaction between pathogens, and virulence factors intrinsic to the agent are important predictors of an individuals' outcome. Host factors such as extremes of age and underlying disease (e.g. diabetes 56, 57), human immunodeficiency virus/acquired immune deficiency syndrome [HIV/AIDS] 58, 59, malignancy, and transplants 18, 60, 61 can increase susceptibility to infection as do a variety of medications that alter the normal flora (e.g., antimicrobial agents, gastric acid suppressants, corticosteroids, antirejection drugs, antineoplastic agents, and immunosuppressive drugs). Surgical procedures and radiation therapy impair defenses of the skin and other involved organ systems. Indwelling devices such as urinary catheters, endotracheal tubes, central venous and arterial catheters 62- 64 and synthetic implants facilitate development of HAIs by allowing potential pathogens to bypass local defenses that would ordinarily impede their invasion and by providing surfaces for development of biofilms that may facilitate adherence of microorganisms and protect from antimicrobial activity 65. Some

infections associated with invasive procedures result from transmission within the healthcare facility; others arise from the patient's endogenous flora 46-50. High-risk patient populations with noteworthy risk factors for infection are discussed further in Sections I.D, I.E., and I.F.

I.B.3. Modes of transmission Several classes of pathogens can cause infection, including bacteria, viruses, fungi, parasites, and prions. The modes of transmission vary by type of organism and some infectious agents may be transmitted by more than one route: some are transmitted primarily by direct or indirect contact, (e.g., *Herpes simplex* virus [HSV], respiratory syncytial virus, *Staphylococcus aureus*), others by the droplet, (e.g., influenza virus, *B. pertussis*) or airborne routes (e.g., *M. tuberculosis*). Other infectious agents, such as bloodborne viruses (e.g., hepatitis B and C viruses [HBV, HCV] and HIV are transmitted rarely in healthcare settings, via percutaneous or mucous membrane exposure. Importantly, not all infectious agents are transmitted from person to person. These are distinguished in Appendix A. The three principal routes of transmission are summarized below.

I.B.3.a. Contact transmission The most common mode of transmission, contact transmission is divided into two subgroups: direct contact and indirect contact.

I.B.3.a.i. Direct contact transmission Direct transmission occurs when microorganisms are transferred from one infected person to another person without a contaminated intermediate object or person. Opportunities for direct contact transmission between patients and healthcare personnel have been summarized in the Guideline for Infection Control in Healthcare Personnel, 1998 and include:

blood or other blood-containing body fluids from a patient directly enters a caregiver's body through contact with a mucous membrane or breaks (i.e., cuts, abrasions) in the skin mites from a scabies-infested patient are transferred to the skin of a caregiver while he/she is having direct ungloned contact with the patient's skin 68, 69. a healthcare provider develops herpetic whitlow on a finger after contact with HSV when providing oral care to a patient without using gloves or HSV is transmitted to a patient from a herpetic whitlow on an ungloned hand of a healthcare worker (HCW) 70,

I.B.3.a.ii. Indirect contact transmission Indirect transmission involves the transfer of an infectious agent through a contaminated intermediate object or person. In the absence of a point-source outbreak, it is difficult to determine how indirect transmission occurs. However, extensive evidence cited in the Guideline for Hand Hygiene in Health-Care Settings suggests that the contaminated hands of healthcare personnel are important contributors to indirect contact transmission. Examples of opportunities for indirect contact transmission include:

- Hands of healthcare personnel may transmit pathogens after touching an infected or colonized body site on one patient or a contaminated inanimate object, if hand hygiene is not performed before touching another patient.
- Patient-care devices (e.g., electronic thermometers, glucose monitoring devices) may transmit pathogens if devices contaminated with blood or body fluids are shared between patients without cleaning and disinfecting between patients
- Shared toys may become a vehicle for transmitting respiratory viruses (e.g., respiratory syncytial virus or pathogenic bacteria (e.g., *Pseudomonas aeruginosa* 80) among pediatric patients.
- Instruments that are inadequately cleaned between patients before disinfection or sterilization (e.g., endoscopes or surgical instruments) 81-85 or that have manufacturing defects that interfere with the effectiveness of reprocessing may transmit bacterial and viral pathogens.

Clothing, uniforms, laboratory coats, or isolation gowns used as personal protective equipment

(PPE), may become contaminated with potential pathogens after care of a patient colonized or infected with an infectious agent, (e.g., MRSA 88, VRE 89, and *C. difficile* 90. Although contaminated clothing has not been implicated directly in transmission, the potential exists for soiled garments to transfer infectious agents to successive patients.

I.B.3.b. Droplet transmission Droplet transmission is, technically, a form of contact transmission, and some infectious agents transmitted by the droplet route also may be transmitted by the direct and indirect contact routes. However, in contrast to contact transmission, respiratory droplets carrying infectious pathogens transmit infection when they travel directly from the respiratory tract of the infectious individual to susceptible mucosal surfaces of the recipient, generally over short distances, necessitating facial protection. Respiratory droplets are generated when an infected person coughs, sneezes, or talks or during procedures such as suctioning, endotracheal intubation, cough induction by chest physiotherapy 97 and cardiopulmonary resuscitation 98, 99. Evidence for droplet transmission comes from epidemiological studies of disease outbreaks 100-103, experimental studies 104 and from information on aerosol dynamics 91, 105. Studies have shown that the nasal mucosa, conjunctivae and less frequently the mouth, are susceptible portals of entry for respiratory viruses 106. The maximum distance for droplet transmission is currently unresolved, although pathogens transmitted by the droplet route have not been transmitted through the air over long distances, in contrast to the airborne pathogens discussed below. Historically, the area of defined risk has been a distance of <3 feet around the patient and is based on epidemiologic and simulated studies of selected infections 103, 104. Using this distance for donning masks has been effective in preventing transmission of infectious agents via the droplet route. However, experimental studies with smallpox 107, 108 and investigations during the global SARS outbreaks of 2003 101 suggest that droplets from patients with these two infections could reach persons located 6 feet or more from their source. It is likely that the distance droplets travel depends on the velocity and mechanism by which respiratory droplets are propelled from the source, the density of respiratory secretions, environmental factors such as temperature and humidity, and the ability of the pathogen to maintain infectivity over that distance 105. Thus, a distance of <3 feet around the patient is best viewed as an *example* of what is meant by “a short distance from a patient” and should not be used as the sole *criterion* for deciding when a mask should be donned to protect from droplet exposure. Based on these considerations, it may be prudent to don a mask when within 6 to 10 feet of the patient or upon entry into the patient’s room, especially when exposure to emerging or highly virulent pathogens is likely. More studies are needed to improve understanding of droplet transmission under various circumstances.

Droplet size is another variable under discussion. Droplets traditionally have been defined as being >5 μm in size. Droplet nuclei, particles arising from desiccation of suspended droplets, have been associated with airborne transmission and defined as <5 μm in size 105, a reflection of the pathogenesis of pulmonary tuberculosis which is not generalizable to other organisms. Observations of particle dynamics have demonstrated that a range of droplet sizes, including those with diameters of 30 μm or greater, can remain suspended in the air 109. The behavior of droplets and droplet nuclei affect recommendations for preventing transmission. Whereas fine airborne particles containing pathogens that are able to remain infective may transmit infections over long distances, requiring AIIR to prevent its dissemination within a facility; organisms transmitted by the droplet route do not remain infective over long distances, and therefore do not require special air handling and ventilation. Examples of infectious agents that are transmitted via the droplet route include *Bordetella pertussis* 110, influenza virus 23, adenovirus 111, rhinovirus 104, *Mycoplasma pneumoniae* 112, SARS-associated coronavirus (SARS-CoV) 21, 96, 113, group A streptococcus 114, and *Neisseria meningitidis* 95, 103, 115. Although respiratory syncytial virus may be transmitted by the droplet route, direct contact with infected respiratory secretions is the most important determinant of transmission and consistent adherence to Standard plus Contact Precautions prevents transmission in healthcare settings

Rarely, pathogens that are not transmitted routinely by the droplet route are dispersed into the air over short distances. For example, although *S. aureus* is transmitted most frequently by the contact route, viral upper respiratory tract infection has been associated with increased dispersal of *S. aureus* from the nose into the air for a distance of 4 feet under both outbreak and experimental conditions and is known as the “cloud baby” and “cloud adult” phenomenon¹¹⁸⁻¹²⁰.

I.B.3.c. Airborne transmission Airborne transmission occurs by dissemination of either airborne droplet nuclei or small particles in the respirable size range containing infectious agents that remain infective over time and distance (e.g., spores of *Aspergillus* spp, and *Mycobacterium tuberculosis*). Microorganisms carried in this manner may be dispersed over long distances by air currents and may be inhaled by susceptible individuals who have not had face-to-face contact with (or been in the same room with) the infectious individual¹²¹⁻¹²⁴. Preventing the spread of pathogens that are transmitted by the airborne route requires the use of special air handling and ventilation systems (e.g., AIIRs) to contain and then safely remove the infectious agent^{11, 12}. Infectious agents to which this applies include *Mycobacterium tuberculosis*¹²⁴⁻¹²⁷, rubeola virus (measles)¹²², and varicella-zoster virus (chickenpox)¹²³. In addition, published data suggest the possibility that variola virus (smallpox) may be transmitted over long distances through the air under unusual circumstances and AIIRs are recommended for this agent as well; however, droplet and contact routes are the more frequent routes of transmission for smallpox^{108, 128, 129}. In addition to AIIRs, respiratory protection with NIOSH certified N95 or higher level respirator is recommended for healthcare personnel entering the AIIR to prevent acquisition of airborne infectious agents such as *M. tuberculosis*¹².

For certain other respiratory infectious agents, such as influenza^{130, 131} and rhinovirus¹⁰⁴, and even some gastrointestinal viruses (e.g., norovirus¹³² and rotavirus¹³³) there is some evidence that the pathogen may be transmitted via small-particle aerosols, under natural and experimental conditions. Such transmission has occurred over distances longer than 3 feet but within a defined airspace (e.g., patient room), suggesting that it is unlikely that these agents remain viable on air currents that travel long distances. AIIRs are not required routinely to prevent transmission of these agents. Additional issues concerning examples of small particle aerosol transmission of agents that are most frequently transmitted by the droplet route are discussed below.

I.B.3.d. Emerging issues concerning airborne transmission of infectious agents.

I.B.3.d.i. Transmission from patients The emergence of SARS in 2002, the importation of monkeypox into the United States in 2003, and the emergence of avian influenza present challenges to the assignment of isolation categories because of conflicting information and uncertainty about possible routes of transmission. Although SARS-CoV is transmitted primarily by contact and/or droplet routes, airborne transmission over a limited distance (e.g. within a room), has been suggested, though not proven¹³⁴⁻¹⁴¹. This is true of other infectious agents such as influenza virus¹³⁰ and noroviruses^{132, 142, 143}. Influenza viruses are transmitted primarily by close contact with respiratory droplets^{23, 102} and acquisition by healthcare personnel has been prevented by Droplet Precautions, even when positive pressure rooms were used in one center¹⁴⁴ However, inhalational transmission could not be excluded in an outbreak of influenza in the passengers and crew of a single aircraft¹³⁰. Observations of a protective effect of UV lights in preventing influenza among patients with tuberculosis during the influenza pandemic of 1957-'58 have been used to suggest airborne transmission^{145, 146}.

In contrast to the strict interpretation of an airborne route for transmission (i.e., long distances beyond the patient room environment), short distance transmission by small particle aerosols generated under specific circumstances (e.g., during endotracheal intubation) to persons in the immediate area near the patient has been demonstrated. Also, aerosolized particles <100 µm can remain suspended in air when room air current velocities exceed the terminal settling

velocities of the particles 109. SARS-CoV transmission has been associated with endotracheal intubation, noninvasive positive pressure ventilation, and cardio-pulmonary resuscitation 93, 94, 96, 98, 141. Although the most frequent routes of transmission of noroviruses are contact and food and waterborne routes, several reports suggest that noroviruses may be transmitted through aerosolization of infectious particles from vomitus or fecal material 142, 143, 147, 148. It is hypothesized that the aerosolized particles are inhaled and subsequently swallowed.

Roy and Milton proposed a new classification for aerosol transmission when evaluating routes of SARS transmission: 1) *obligate*: under natural conditions, disease occurs following transmission of the agent only through inhalation of small particle aerosols (e.g., tuberculosis); 2) *preferential*: natural infection results from transmission through multiple routes, but small particle aerosols are the predominant route (e.g. measles, varicella); and 3) *opportunistic*: agents that naturally cause disease through other routes, but under special circumstances

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may be transmitted via fine particle aerosols 149. This conceptual framework can explain rare occurrences of airborne transmission of agents that are transmitted most frequently by other routes (e.g., smallpox, SARS, influenza, noroviruses). Concerns about unknown or possible routes of transmission of agents associated with severe disease and no known treatment often result in more extreme prevention strategies than may be necessary; therefore, recommended precautions could change as the epidemiology of an emerging infection is defined and controversial issues are resolved.

I.D. Transmission risks associated with specific types of healthcare settings

Numerous factors influence differences in transmission risks among the various healthcare settings. These include the population characteristics (e.g., increased susceptibility to infections, type and prevalence of indwelling devices), intensity of care, exposure to environmental sources, length of stay, and frequency of interaction between patients/residents with each other and with HCWs. These factors, as well as organizational priorities, goals, and resources, influence how different healthcare settings adapt transmission prevention guidelines to meet their specific needs 315, 316. Infection control management decisions are informed by data regarding institutional experience/epidemiology, trends in community and institutional HAIs, local, regional, and national epidemiology, and emerging infectious disease threats.

I.D.1. Hospitals Infection transmission risks are present in all hospital settings. However, certain hospital settings and patient populations have unique conditions that predispose patients to infection and merit special mention. These are often sentinel sites for the emergence of new transmission risks that may be unique to that setting or

I.D.1.c. Pediatrics Studies of the epidemiology of HAIs in children have identified unique infection control issues in this population 63, 64, 366-370. Pediatric intensive care unit (PICU) patients and the lowest birthweight babies in the high-risk nursery (HRN) monitored in the NNIS system have had high rates of central venous catheter-associated bloodstream infections 64, 320, 369-372. Additionally, there is a high prevalence of community-acquired infections among hospitalized infants and young children who have not yet become immune either by vaccination or by natural infection. The result is more patients and their sibling visitors with transmissible infections present in pediatric healthcare settings, especially during seasonal epidemics (e.g., pertussis 36, 40, 41, respiratory viral infections including those caused by RSV 24, influenza viruses 373, parainfluenza virus 374, human metapneumovirus 375, and adenoviruses 376; rubeola [measles] 34, varicella [chickenpox] 377, and rotavirus 38, 378).

Close physical contact between healthcare personnel and infants and young children (eg. cuddling, feeding, playing, changing soiled diapers, and cleaning copious uncontrolled

respiratory secretions) provides abundant opportunities for transmission of infectious material. Practices and behaviors such as congregation of children in play areas where toys and bodily secretions are easily shared and family members rooming-in with pediatric patients can further increase the risk of transmission. Pathogenic bacteria have been recovered from toys used by hospitalized patients 379; contaminated bath toys were implicated in an outbreak of multidrug-resistant *P. aeruginosa* on a pediatric oncology unit 80. In addition, several patient factors increase the likelihood that infection will result from exposure to pathogens in healthcare settings (e.g., immaturity of the neonatal immune system, lack of previous natural infection and resulting immunity, prevalence of patients with congenital or acquired immune deficiencies, congenital anatomic anomalies, and use of life-saving invasive devices in neonatal and pediatric intensive care units) 63. There are theoretical concerns that infection risk will increase in association with innovative practices used in the NICU for the purpose of improving developmental outcomes. Such factors include co-bedding 380 and kangaroo care 381 that may increase opportunity for skin-to-skin exposure of multiple gestation infants to each other and to their mothers, respectively; although infection risks may actually be reduced among infants receiving kangaroo care 382. Children who attend child care centers 383, 384 and pediatric rehabilitation units 385 may increase the overall burden of antimicrobial resistance (eg. by contributing to the reservoir of community-associated MRSA [CA-MRSA]) 386-391. Patients in chronic care facilities may have increased rates of colonization with resistant GNBs and may be sources of introduction of resistant organisms to acute care settings 50.

I.D.2. Nonacute healthcare settings Healthcare is provided in various settings outside of hospitals including facilities, such as long-term care facilities (LTCF) (e.g. nursing homes), homes for the developmentally disabled, settings where behavioral health services are provided, rehabilitation centers and hospices 392. In addition, healthcare may be provided in nonhealthcare settings such as workplaces with occupational health clinics, adult day care centers, assisted living facilities, homeless shelters, jails and prisons, school clinics and infirmaries. Each of these settings has unique circumstances and population risks to consider when designing and implementing an infection control program. Several of the most common settings and their particular challenges are discussed below. While this Guideline does not address each setting, the principles and strategies provided may be adapted and applied as appropriate.

I.D.2.a. Long-term care The designation LTCF applies to a diverse group of residential settings, ranging from institutions for the developmentally disabled to nursing homes for the elderly and pediatric chronic-care facilities 393-395. Nursing homes for the elderly predominate numerically and frequently represent long-term care as a group of facilities. Approximately 1.8 million Americans reside in the nation's 16,500 nursing homes 396. Estimates of HAI rates of 1.8 to 13.5 per 1000 resident-care days have been reported with a range of 3 to 7 per 1000 resident-care days in the more rigorous studies 397-401. The infrastructure described in the Department of Veterans Affairs nursing home care units is a promising example for the development of a nationwide HAI surveillance system for LTCFs 402.

LTCFs are different from other healthcare settings in that elderly patients at increased risk for infection are brought together in one setting and remain in the facility for extended periods of time; for most residents, it is their home. An atmosphere of community is fostered and residents share common eating and living areas, and participate in various facility-sponsored activities 403, 404. Since able residents interact freely with each other, controlling transmission of infection in this setting is challenging 405. Residents who are colonized or infected with certain microorganisms are, in some cases, restricted to their room. However, because of the psychosocial risks associated with such restriction, it has been recommended that psychosocial needs be balanced with infection control needs in the LTCF setting 406-409. Documented LTCF outbreaks have been caused by various viruses (e.g., influenza virus 35, 410-412, rhinovirus 413, adenovirus (conjunctivitis) 414, norovirus 278, 279 275, 281) and bacteria, including group

A streptococcus 162, *B. pertussis* 415, non-susceptible *S. pneumoniae* 197, 198, other MDROs, and *Clostridium difficile* 416)

I.D.2.b. Ambulatory Care In the past decade, healthcare delivery in the United States has shifted from the acute, inpatient hospital to a variety of ambulatory and community-based settings, including the home. Ambulatory care is provided in hospital-based outpatient clinics, nonhospital-based clinics and physician offices, public health clinics, free-standing dialysis centers, ambulatory surgical centers, urgent care centers, and many others. In 2000, there were 83 million visits to hospital outpatient clinics and more than 823 million visits to physician offices 442; ambulatory care now accounts for most patient encounters with the health care system 443. In these settings, adapting transmission prevention guidelines is challenging because patients remain in common areas for prolonged periods waiting to be seen by a healthcare provider or awaiting admission to the hospital, examination or treatment rooms are turned around quickly with limited cleaning, and infectious patients may not be recognized immediately. Furthermore, immunocompromised patients often receive chemotherapy in infusion rooms where they stay for extended periods of time along with other types of patients.

There are few data on the risk of HAIs in ambulatory care settings, with the exception of hemodialysis centers 18 , 444, 445. Transmission of infections in outpatient settings has been reviewed in three publications 446-448. Goodman and Solomon summarized 53 clusters of infections associated with the outpatient setting from 1961-1990 446. Overall, 29 clusters were associated with common source transmission from contaminated solutions or equipment, 14 with person- to-person transmission from or involving healthcare personnel and ten associated with airborne or droplet transmission among patients and healthcare workers. Transmission of bloodborne pathogens (i.e., hepatitis B and C viruses and, rarely, HIV) in outbreaks, sometimes involving hundreds of patients, continues to occur in ambulatory settings. These outbreaks often are related to common source exposures, usually a contaminated medical device, multi-dose vial, or intravenous solution 82, 449-453. In all cases, transmission has been attributed to failure to adhere to fundamental infection control principles, including safe injection practices and aseptic technique. This subject has been reviewed and recommended infection control and safe injection practices summarized 454.

Airborne transmission of *M.tuberculosis* and measles in ambulatory settings, most frequently emergency departments, has been reported 34, 127, 446, 448, 455-457. Measles virus was transmitted in physician offices and other outpatient settings during an era when immunization rates were low and measles outbreaks in the community were occurring regularly 34, 122, 458. Rubella has been transmitted in the outpatient obstetric setting 33; there are no published reports of varicella transmission in the outpatient setting. In the ophthalmology setting, adenovirus type 8 epidemic keratoconjunctivitis has been transmitted via incompletely disinfected ophthalmology equipment and/or from healthcare workers to patients, presumably by contaminated hands 17, 446, 448, 459-462.

If transmission in outpatient settings is to be prevented, screening for potentially infectious symptomatic and asymptomatic individuals, especially those who may be at risk for transmitting airborne infectious agents (e.g., *M. tuberculosis*, varicella-zoster virus, rubeola [measles]), is necessary at the start of the initial patient encounter. Upon identification of a potentially infectious patient, implementation of prevention measures, including prompt separation of potentially infectious patients and implementation of appropriate control measures (e.g., Respiratory Hygiene/Cough Etiquette and Transmission-Based Precautions) can decrease transmission risks 9, 12. Transmission of MRSA and VRE in outpatient settings has not been reported, but the association of CA- MRSA in healthcare personnel working in an outpatient HIV clinic with environmental CA-MRSA contamination in that clinic, suggests the possibility of transmission in that setting 463. Patient-to-patient transmission of *Burkholderia species* and *Pseudomonas aeruginosa* in outpatient clinics for adults and children with cystic fibrosis has

been confirmed 464, 465.

I.D.2.d. Other sites of healthcare delivery Facilities that are not primarily healthcare settings but in which healthcare is delivered include clinics in correctional facilities and shelters. Both settings can have suboptimal features, such as crowded conditions and poor ventilation. Economically disadvantaged individuals who may have chronic illnesses and healthcare problems related to alcoholism, injection drug use, poor nutrition, and/or inadequate shelter often receive their primary healthcare at sites such as these 484. Infectious diseases of special concern for transmission include tuberculosis, scabies, respiratory infections (e.g., *N. meningitides*, *S. pneumoniae*), sexually transmitted and bloodborne diseases (e.g., HIV, HBV, HCV, syphilis, gonorrhea), hepatitis A virus (HAV), diarrheal agents such as norovirus, and foodborne diseases 286, 485-488. A high index of suspicion for tuberculosis and CA-MRSA in these populations is needed as outbreaks in these settings or among the populations they serve have been reported 489-497.

Patient encounters in these types of facilities provide an opportunity to deliver recommended immunizations and screen for *M. tuberculosis* infection in addition to diagnosing and treating acute illnesses 498. Recommended infection control measures in these non-traditional areas designated for healthcare delivery are the same as for other ambulatory care settings. Therefore, these settings must be equipped to observe Standard Precautions and, when indicated, Transmission-based Precautions.

I.F.2. Infections transmitted through blood, organs and other tissues The potential hazard of transmitting infectious pathogens through biologic products is a small but ever present risk, despite donor screening. Reported infections 530 transmitted by transfusion or transplantation include West Nile Virus infection cytomegalovirus infection 531, Creutzfeldt-Jacob disease 230, hepatitis C 532, infections with *Clostridium* spp. 533 and group A streptococcus 534, malaria 535, babesiosis 536, Chagas disease 537, lymphocytic choriomeningitis 538, and rabies 539, 540. Therefore, it is important to consider receipt of biologic products when evaluating patients for potential sources of infection.

Part II:

Fundamental elements needed to prevent transmission of infectious agents in healthcare settings

II.A. Healthcare system components that influence the effectiveness of precautions to prevent transmission

II.A.1. Administrative measures Healthcare organizations can demonstrate a commitment to preventing transmission of infectious agents by incorporating infection control into the objectives of the organization's patient and occupational safety programs 543-547. An infrastructure to guide, support, and monitor adherence to Standard and Transmission-Based Precautions 434, 548, 549 will facilitate fulfillment of the organization's mission and achievement of the Joint Commission on Accreditation of Healthcare Organization's patient safety goal to decrease HAIs 550. Policies and procedures that explain how Standard and Transmission-Based Precautions are applied, including systems used to identify and communicate information about patients with potentially transmissible infectious agents, are essential to ensure the success of these measures and may vary according to the characteristics of the organization.

II.A.3. Adherence of healthcare personnel to recommended guidelines

Adherence to recommended infection control practices decreases transmission of infectious agents in healthcare settings 116, 562, 636-640. However, several observational studies have shown limited adherence to recommended practices by healthcare personnel 559, 640-657.

Observed adherence to universal precautions ranged from 43% to 89% 641, 642, 649, 651, 652. However, the degree of adherence depended frequently on the practice that was assessed and, for glove use, the circumstance in which they were used. Appropriate glove use has ranged from a low of 15% 645 to a high of 82% 650. However, 92% and 98% adherence with glove use have been reported during arterial blood gas collection and resuscitation, respectively, procedures where there may be considerable blood contact

II.D. Hand hygiene

Hand hygiene has been cited frequently as the single most important practice to reduce the transmission of infectious agents in healthcare settings 559, 712, 713 and is an essential element of Standard Precautions. The term “hand hygiene” includes both handwashing with either plain or antiseptic-containing soap and water, and use of alcohol-based products (gels, rinses, foams) that do not require the use of water. In the absence of visible soiling of hands, approved alcohol-based products for hand disinfection are preferred over antimicrobial or plain soap and water because of their superior microbicidal activity, reduced drying of the skin, and convenience 559. Improved hand hygiene practices have been associated with a sustained decrease in the incidence of MRSA and VRE infections primarily in the ICU 561, 562, 714-717. The scientific rationale, indications, methods, and products for hand hygiene are summarized in other publications 559, 717. The effectiveness of hand hygiene can be reduced by the type and length of fingernails 559, 718, 719. Individuals wearing artificial nails have been shown to harbor more pathogenic organisms, especially gram negative bacilli and yeasts, on the nails and in the subungual area than those with native nails 720, 721. In 2002, CDC/HICPAC recommended (Category IA) that artificial fingernails and extenders not be worn by healthcare personnel who have contact with high-risk patients (e.g., those in ICUs, ORs) due to the association with outbreaks of gram-negative bacillus and candidal infections as confirmed by molecular typing of isolates 30, 31, 559, 722-725. The need to restrict the wearing of artificial fingernails by all healthcare personnel who provide direct patient care or by healthcare personnel who have contact with other high risk groups (e.g., oncology, cystic fibrosis patients), has not been studied, but has been recommended by some experts 20. At this time such decisions are at the discretion of an individual facility’s infection control program. There is less evidence that jewelry affects the quality of hand hygiene. Although hand contamination with potential pathogens is increased with ring-wearing 559, 726, no studies have related this practice to HCW-to-patient transmission of pathogens.

II.E. Personal protective equipment (PPE) for healthcare personnel

PPE refers to a variety of barriers and respirators used alone or in combination to protect mucous membranes, airways, skin, and clothing from contact with infectious agents. The selection of PPE is based on the nature of the patient interaction and/or the likely mode(s) of transmission. Guidance on the use of PPE is discussed in Part III. A suggested procedure for donning and removing PPE that will prevent skin or clothing contamination is presented in the Figure. Designated containers for used disposable or reusable PPE should be placed in a location that is convenient to the site of removal to facilitate disposal and containment of contaminated materials. Hand hygiene is always the final step after removing and disposing of PPE. The following sections highlight the primary uses and methods for selecting this equipment.

II.E.1. Gloves Gloves are used to prevent contamination of healthcare personnel hands when 1) anticipating direct contact with blood or body fluids, mucous membranes, nonintact skin and other potentially infectious material; 2) having direct contact with patients who are colonized or infected with pathogens transmitted by the contact route e.g., VRE, MRSA, RSV 559, 727, 728; or 3) handling or touching visibly or potentially contaminated patient care equipment and environmental surfaces 72, 73, 559. Gloves can protect both patients and healthcare

personnel from exposure to infectious material that may be carried on hands 73. The extent to which gloves will protect healthcare personnel from transmission of bloodborne pathogens (e.g., HIV, HBV, HCV) following a needlestick or other puncture that penetrates the glove barrier has not been determined. Although gloves may reduce the volume of blood on the external surface of a sharp by 46-86% 729, the residual blood in the lumen of a hollowbore needle would not be affected; therefore, the effect on transmission risk is unknown.

Gloves manufactured for healthcare purposes are subject to FDA evaluation and clearance 730. Nonsterile disposable medical gloves made of a variety of materials (e.g., latex, vinyl, nitrile) are available for routine patient care 731. The selection of glove type for non-surgical use is based on a number of factors, including the task that is to be performed, anticipated contact with chemicals and chemotherapeutic agents, latex sensitivity, sizing, and facility policies for creating a latex-free environment 17, 732-734. For contact with blood and body fluids during non-surgical patient care, a single pair of gloves generally provides adequate barrier protection 734. However, there is considerable variability among gloves; both the quality of the manufacturing process and type of material influence their barrier effectiveness 735. While there is little difference in the barrier properties of unused intact gloves 736, studies have shown repeatedly that vinyl gloves have higher failure rates than latex or nitrile gloves when tested under simulated and actual clinical conditions 731, 735-738. For this reason either latex or nitrile gloves are preferable for clinical procedures that require manual dexterity and/or will involve more than brief patient contact. It may be necessary to stock gloves in several sizes. Heavier, reusable utility gloves are indicated for non-patient care activities, such as handling or cleaning contaminated equipment or surfaces 11, 14, 739. During patient care, transmission of infectious organisms can be reduced by adhering to the principles of working from “clean” to “dirty”, and confining or limiting contamination to surfaces that are directly needed for patient care. It may be necessary to change gloves during the care of a single patient to prevent

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cross-contamination of body sites 559, 740. It also may be necessary to change gloves if the patient interaction also involves touching portable computer keyboards or other mobile equipment that is transported from room to room. Discarding gloves between patients is necessary to prevent transmission of infectious material. Gloves must not be washed for subsequent reuse because microorganisms cannot be removed reliably from glove surfaces and continued glove integrity cannot be ensured. Furthermore, glove reuse has been associated with transmission of MRSA and gram-negative bacilli 741-743.

When gloves are worn in combination with other PPE, they are put on last. Gloves that fit snugly around the wrist are preferred for use with an isolation gown because they will cover the gown cuff and provide a more reliable continuous barrier for the arms, wrists, and hands. Gloves that are removed properly will prevent hand contamination (Figure). Hand hygiene following glove removal further ensures that the hands will not carry potentially infectious material that might have penetrated through unrecognized tears or that could contaminate the hands during glove removal 559, 728, 741.

II.E.2. Isolation gowns Isolation gowns are used as specified by Standard and Transmission-Based Precautions, to protect the HCW's arms and exposed body areas and prevent contamination of clothing with blood, body fluids, and other potentially infectious material 24, 88, 262, 744-746. The need for and type of isolation gown selected is based on the nature of the patient interaction, including the anticipated degree of contact with infectious material and potential for blood and body fluid penetration of the barrier. The wearing of isolation gowns and other protective apparel is mandated by the OSHA Bloodborne Pathogens Standard 739. Clinical and laboratory coats or jackets worn over personal clothing for comfort and/or purposes of identity are not considered PPE.

When applying Standard Precautions, an isolation gown is worn only if contact with blood or body fluid is anticipated. However, when Contact Precautions are used (i.e., to prevent transmission of an infectious agent that is not interrupted by Standard Precautions alone and that is associated with environmental contamination), donning of both gown and gloves upon room entry is indicated to address unintentional contact with contaminated environmental surfaces 54, 72, 73, 88. The routine donning of isolation gowns upon entry into an intensive care unit or other high-risk area does not prevent or influence potential colonization or infection of patients in those areas^{365, 747-750}.

Isolation gowns are always worn in combination with gloves, and with other PPE when indicated. Gowns are usually the first piece of PPE to be donned. Full coverage of the arms and body front, from neck to the mid-thigh or below will ensure that clothing and exposed upper body areas are protected. Several gown sizes should be available in a healthcare facility to ensure appropriate coverage for staff members. Isolation gowns should be removed before leaving the patient care area to prevent possible contamination of the environment outside the patient's room. Isolation gowns should be removed in a manner that prevents contamination of clothing or skin (Figure). The outer, "contaminated", side of the gown is turned inward and rolled into a bundle, and then discarded into a designated container for waste or linen to contain contamination.

II.E.3. Face protection: masks, goggles, face shields

II.E.3.a. Masks Masks are used for three primary purposes in healthcare settings: 1) placed on healthcare personnel to protect them from contact with infectious material from patients e.g., respiratory secretions and sprays of blood or body fluids, consistent with Standard Precautions and Droplet Precautions; 2) placed on healthcare personnel when engaged in procedures requiring sterile technique to protect patients from exposure to infectious agents carried in a healthcare worker's mouth or nose, and 3) placed on coughing patients to limit potential dissemination of infectious respiratory secretions from the patient to others (i.e., Respiratory Hygiene/Cough Etiquette). Masks may be used in combination with goggles to protect the mouth, nose and eyes, or a face shield may be used instead of a mask and goggles, to provide more complete protection for the face, as discussed below. **Masks should not be confused with particulate respirators that are used to prevent inhalation of small particles that may contain infectious agents transmitted via the airborne route as described below.** The mucous membranes of the mouth, nose, and eyes are susceptible portals of entry for infectious agents, as can be other skin surfaces if skin integrity is compromised (e.g., by acne, dermatitis) 66, 751-754. Therefore, use of PPE to protect these body sites is an important component of Standard Precautions. The protective effect of masks for exposed healthcare personnel has been demonstrated 93, 113, 755, 756. Procedures that generate splashes or sprays of blood, body fluids, secretions, or excretions (e.g., endotracheal suctioning, bronchoscopy, invasive vascular procedures) require either a face shield (disposable or reusable) or mask and goggles 93-95, 96, 113, 115, 262, 739, 757. The wearing of masks, eye protection, and face shields in specified circumstances when blood or body fluid exposures are likely to occur is mandated by the OSHA Bloodborne Pathogens Standard 739. Appropriate PPE should be selected based on the anticipated level of exposure.

Two mask types are available for use in healthcare settings: surgical masks that are cleared by the FDA and required to have fluid-resistant properties, and procedure or isolation masks 758 #2688. No studies have been published that compare mask types to determine whether one mask type provides better protection than another. Since procedure/isolation masks are not regulated by the FDA, there may be more variability in quality and performance than with surgical masks. Masks come in various shapes (e.g., molded and non-molded), sizes, filtration efficiency, and method of attachment (e.g., ties, elastic, ear loops). Healthcare facilities may find that different types of masks are needed to meet individual healthcare personnel needs.

II.E.3.b. Goggles, face shields Guidance on eye protection for infection control has been published 759. The eye protection chosen for specific work situations (e.g., goggles or face shield) depends upon the circumstances of exposure, other PPE used, and personal vision needs. Personal eyeglasses and contact lenses are NOT considered adequate eye protection (www.cdc.gov/niosh/topics/eye/eye-infectious.html). NIOSH states that, eye protection must be comfortable, allow for sufficient peripheral vision, and must be adjustable to ensure a secure fit. It may be necessary to provide several different types, styles, and sizes of protective equipment. Indirectly-vented goggles with a manufacturer's anti-fog coating may provide the most reliable practical eye protection from splashes, sprays, and respiratory droplets from multiple angles. Newer styles of goggles may provide better indirect airflow properties to reduce fogging, as well as better peripheral vision and more size options for fitting goggles to different workers. Many styles of goggles fit adequately over prescription glasses with minimal gaps. While effective as eye protection, goggles do not provide splash or spray protection to other parts of the face.

II.E.4. Respiratory protection The subject of respiratory protection as it applies to preventing transmission of airborne infectious agents, including the need for and frequency of fit-testing is under scientific review and was the subject of a CDC workshop in 2004 763. Respiratory protection currently requires the use of a respirator with N95 or higher filtration to prevent inhalation of infectious particles. Information about respirators and respiratory protection programs is summarized in the *Guideline for Preventing Transmission of Mycobacterium tuberculosis in Health-care Settings, 2005* (CDC.MMWR 2005; 54: RR-17 12

II.F. Safe work practices to prevent HCW exposure to bloodborne pathogens

II.F.1. Prevention of needlesticks and other sharps-related injuries Injuries due to needles and other sharps have been associated with transmission of HBV, HCV and HIV to healthcare personnel 778, 779. The prevention of sharps injuries has always been an essential element of Universal and now Standard Precautions 1, 780. These include measures to handle needles and other sharp devices in a manner that will prevent injury to the user and to others who may encounter the device during or after a procedure. These measures apply to routine patient care and do not address the prevention of sharps injuries and other blood exposures during surgical and other invasive procedures that are addressed elsewhere 781-785.

Since 1991, when OSHA first issued its Bloodborne Pathogens Standard to protect healthcare personnel from blood exposure, the focus of regulatory and legislative activity has been on implementing a hierarchy of control measures. This has included focusing attention on removing sharps hazards through the development and use of engineering controls. The federal Needlestick Safety and Prevention Act signed into law in November, 2000 authorized OSHA's revision of its Bloodborne Pathogens Standard to more explicitly require the use of safety-engineered sharp devices 786. CDC has provided guidance on sharps injury prevention 787, 788, including for the design, implementation and evaluation of a comprehensive sharps injury prevention program

II.F.2. Prevention of mucous membrane contact Exposure of mucous membranes of the eyes, nose and mouth to blood and body fluids has been associated with the transmission of bloodborne viruses and other infectious agents to healthcare personnel 66, 752, 754, 779. The prevention of mucous membrane exposures has always been an element of Universal and now Standard Precautions for routine patient care 1, 753 and is subject to OSHA bloodborne pathogen regulations. Safe work practices, in addition to wearing PPE, are used to protect mucous membranes and non-intact skin from contact with potentially infectious material. These include keeping gloved and ungloved hands that are contaminated from touching the mouth, nose, eyes, or face; and positioning patients to direct sprays and splatter away from the face of the caregiver. Careful placement of PPE before patient contact will help avoid the need to make PPE adjustments and possible face or mucous membrane contamination during use.

In areas where the need for resuscitation is unpredictable, mouthpieces, pocket resuscitation masks with one-way valves, and other ventilation devices provide an alternative to mouth-to-mouth resuscitation, preventing exposure of the caregiver's nose and mouth to oral and respiratory fluids during the procedure.

II.G. Patient placement

II.G.1. Hospitals and long-term care settings Options for patient placement include single patient rooms, two patient rooms, and multi-bed wards. Of these, single patient rooms are preferred when there is a concern about transmission of an infectious agent. Although some studies have failed to demonstrate the efficacy of single patient rooms to prevent HAIs 791, other published studies, including one commissioned by the American Institute of Architects and the Facility Guidelines Institute, have documented a beneficial relationship between private rooms and reduction in infectious and noninfectious adverse patient outcomes 792, 793. The AIA notes that private rooms are the trend in hospital planning and design. However, most hospitals and long-term care facilities have multi-bed rooms and must consider many competing priorities when determining the appropriate room placement for patients (e.g., reason for admission; patient characteristics, such as age, gender, mental status; staffing needs; family requests; psychosocial factors; reimbursement concerns). In the absence of obvious infectious diseases that require specified airborne infection isolation rooms (e.g., tuberculosis, SARS, chickenpox), the risk of transmission of infectious agents is not always considered when making placement decisions. When there are only a limited number of single-patient rooms, it is prudent to prioritize them for those patients who have conditions that facilitate transmission of infectious material to other patients (e.g., draining wounds, stool incontinence, uncontained secretions) and for those who are at increased risk of acquisition and adverse outcomes resulting from HAI (e.g., immunosuppression, open wounds, indwelling catheters, anticipated prolonged length of stay, total dependence on HCWs for activities of daily living) 15, 24, 43, 430, 794, 795. Single-patient rooms are always indicated for patients placed on Airborne Precautions and in a Protective Environment and are preferred for patients who require Contact or Droplet Precautions 23, 24, 410, 435, 796, 797. During a suspected or proven outbreak caused by a pathogen whose reservoir is the gastrointestinal tract, use of single patient rooms with private bathrooms limits opportunities for transmission, especially when the colonized or infected patient has poor personal hygiene habits, fecal incontinence, or cannot be expected to assist in maintaining procedures that prevent transmission of microorganisms (e.g., infants, children, and patients with altered mental status or developmental delay). In the absence of continued transmission, it is not necessary to provide a private bathroom for patients colonized or infected with enteric pathogens as long as personal hygiene practices and Standard Precautions, especially hand hygiene and appropriate environmental cleaning, are maintained. Assignment of a dedicated commode to a patient, and cleaning and disinfecting fixtures and equipment that may have fecal contamination (e.g., bathrooms, commodes 798, scales used for weighing diapers) and the adjacent surfaces with appropriate agents may be especially important when a single-patient room can not be used since environmental contamination with intestinal tract pathogens is likely from both continent and incontinent patients 54, 799. Results of several studies to determine the benefit of a single-patient room to prevent transmission of *Clostridium difficile* are inconclusive 167, 800-802. Some studies have shown that being in the same room with a colonized or infected patient is not necessarily a risk factor for transmission 791, 803-805. However, for children, the risk of healthcare-associated diarrhea is increased with the increased number of patients per room 806. Thus, patient factors are important determinants of infection transmission risks, and the need for a single-patient room and/or private bathroom for any patient is best determined on a case-by-case basis.

II.G.2. Ambulatory settings Patients actively infected with or incubating transmissible infectious diseases are seen frequently in ambulatory settings (e.g., outpatient clinics, physicians' offices, emergency departments) and potentially²¹, expose healthcare personnel and other patients,

family members and visitors 34, 127, 135, 142, 827. In response to the global outbreak of SARS in 2003 and in preparation for pandemic influenza, healthcare providers working in outpatient settings are urged to implement source containment measures (e.g., asking coughing patients to wear a surgical mask or cover their coughs with tissues) to prevent transmission of respiratory infections, beginning at the point of initial patient encounter 9, 262, 828 as described below in section III.A.1.a. Signs can be posted at the entrance to facilities or at the reception or registration desk requesting that the patient or individuals accompanying the patient promptly inform the receptionist if there are symptoms of a respiratory infection (e.g., cough, flu-like illness, increased production of respiratory secretions). The presence of diarrhea, skin rash, or known or suspected exposure to a transmissible disease (e.g., measles, pertussis, chickenpox, tuberculosis) also could be added. Placement of potentially infectious patients without delay in an examination room limits the number of exposed individuals, e.g., in the common waiting area.

II.J. Patient care equipment and instruments/devices

Medical equipment and instruments/devices must be cleaned and maintained according to the manufacturers' instructions to prevent patient-to-patient transmission of infectious agents 86, 87, 325, 849. Cleaning to remove organic material must always precede high level disinfection and sterilization of critical and semi-critical instruments and devices because residual proteinaceous material reduces the effectiveness of the disinfection and sterilization processes 836, 848. Noncritical equipment, such as commodes, intravenous pumps, and ventilators, must be thoroughly cleaned and disinfected before use on another patient. All such equipment and devices should be handled in a manner that will prevent HCW and environmental contact with potentially infectious material. It is important to include computers and personal digital assistants (PDAs) used in patient care in policies for cleaning and disinfection of non-critical items. The literature on contamination of computers with pathogens has been summarized 850 and two reports have linked computer contamination to colonization and infections in patients 851, 852. Although keyboard covers and washable keyboards that can be easily disinfected are in use, the infection control benefit of those items and optimal management have not been determined.

In all healthcare settings, providing patients who are on Transmission-Based Precautions with dedicated noncritical medical equipment (e.g., stethoscope, blood pressure cuff, electronic thermometer) has been beneficial for preventing transmission 74, 89, 740, 853, 854. When this is not possible, disinfection after use is recommended. Consult other guidelines for detailed guidance in developing specific protocols for cleaning and reprocessing medical equipment and patient care items in both routine and special circumstances 11, 14, 18, 20, 740, 836, 848.

In home care, it is preferable to remove visible blood or body fluids from durable medical equipment before it leaves the home. Equipment can be cleaned on-site using a detergent/disinfectant and, when possible, should be placed in a single plastic bag for transport to the reprocessing location 20, 739.

Part III: Precautions to Prevent Transmission of Infectious Agents There are two tiers of HICPAC/CDC precautions to prevent transmission of infectious agents, Standard Precautions and Transmission-Based Precautions. Standard Precautions are intended to be applied to the care of all patients in all healthcare settings, regardless of the suspected or confirmed presence of an infectious agent. **Implementation of Standard Precautions constitutes the primary strategy for the prevention of healthcare-associated transmission of infectious agents among patients and healthcare personnel.** Transmission-Based Precautions are for patients who are known or suspected to be infected or colonized with infectious agents, including certain epidemiologically important pathogens, which require additional control measures to effectively prevent transmission. Since the infecting agent often is not known at the time of admission to a healthcare facility, Transmission-Based Precautions are used empirically, according to the

clinical syndrome and the likely etiologic agents at the time, and then modified when the pathogen is identified or a transmissible infectious etiology is ruled out. Examples of this syndromic approach are presented in Table 2. The HICPAC/CDC Guidelines also include recommendations for creating a Protective Environment for allogeneic HSCT patients. The specific elements of Standard and Transmission-Based Precautions are discussed in Part II of this guideline. In Part III, the circumstances in which Standard Precautions, Transmission-Based Precautions, and a Protective Environment are applied are discussed. See Tables 4 and 5 for summaries of the key elements of these sets of precautions

III. Standard Precautions Standard Precautions combine the major features of Universal Precautions (UP) 780, 896 and Body Substance Isolation (BSI) 640 and are based on the principle that all blood, body fluids, secretions, excretions except sweat, nonintact skin, and mucous membranes may contain transmissible infectious agents. Standard Precautions include a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered (Table 4). These include: hand hygiene; use of gloves, gown, mask, eye protection, or face shield, depending on the anticipated exposure; and safe injection practices. Also, equipment or items in the patient environment likely to have been contaminated with infectious body fluids must be handled in a manner to prevent transmission of infectious agents (e.g. wear gloves for direct contact, contain heavily soiled equipment, properly clean and disinfect or sterilize reusable equipment before use on another patient).

The application of Standard Precautions during patient care is determined by the nature of the HCW-patient interaction and the extent of anticipated blood, body fluid, or pathogen exposure. For some interactions (e.g., performing venipuncture), only gloves may be needed; during other interactions (e.g., intubation), use of gloves, gown, and face shield or mask and goggles is necessary. Education and training on the principles and rationale for recommended practices are critical elements of Standard Precautions because they facilitate appropriate decision-making and promote adherence when HCWs are faced with new circumstances 655, 681-686. An example of the importance of the use of Standard Precautions is intubation, especially under emergency circumstances when infectious agents may not be suspected, but later are identified (e.g., SARS-CoV, *N. meningitides*). The application of Standard Precautions is described below and summarized in Table 4. Guidance on donning and removing gloves, gowns and other PPE is presented in the Figure. Standard Precautions are also intended to protect patients by ensuring that healthcare personnel do not carry infectious agents to patients on their hands or via equipment used during patient care.

III.III.1. New Elements of Standard Precautions Infection control problems that are identified in the course of outbreak investigations often indicate the need for new recommendations or reinforcement of existing infection control recommendations to protect patients. Because such recommendations are considered a standard of care and may not be included in other guidelines, they are added here to Standard Precautions. Three such areas of practice that have been added are: Respiratory Hygiene/Cough Etiquette, safe injection practices, and use of masks for insertion of catheters or injection of material into spinal or epidural spaces via lumbar puncture procedures (e.g., myelogram, spinal or epidural anesthesia). While most elements of Standard Precautions evolved from Universal Precautions that were developed for protection of healthcare personnel, these new elements of Standard Precautions focus on protection of patients.

III.III.1.a. Respiratory Hygiene/Cough Etiquette The transmission of SARS-CoV in emergency departments by patients and their family members during the widespread SARS outbreaks in 2003 highlighted the need for vigilance and prompt implementation of infection control measures at the first point of encounter within a healthcare setting (e.g., reception and triage areas in emergency departments, outpatient clinics, and physician offices) 21, 254, 897.

The strategy proposed has been termed Respiratory Hygiene/Cough Etiquette 9, 828 and is intended to be incorporated into infection control practices as a new component of Standard Precautions. The strategy is targeted at patients and accompanying family members and friends with undiagnosed transmissible respiratory infections, and applies to any person with signs of illness including cough, congestion, rhinorrhea, or increased production of respiratory secretions when entering a healthcare facility 40, 41, 43. The term *cough etiquette* is derived from recommended source control measures for *M. tuberculosis* 12, 126.

The elements of Respiratory Hygiene/Cough Etiquette include 1) education of healthcare facility staff, patients, and visitors; 2) posted signs, in language(s) appropriate to the population served, with instructions to patients and accompanying family members or friends; 3) source control measures (e.g., covering the mouth/nose with a tissue when coughing and prompt disposal of used tissues, using surgical masks on the coughing person when tolerated and appropriate); 4) hand hygiene after contact with respiratory secretions; and 5) spatial separation, ideally >3 feet, of persons with respiratory infections in common waiting areas when possible. Covering sneezes and coughs and placing masks on coughing patients are proven means of source containment that prevent infected persons from dispersing respiratory secretions into the air 107, 145, 898, 899. Masking may be difficult in some settings, (e.g., pediatrics, in which case, the emphasis by necessity may be on cough etiquette 900. Physical proximity of <3 feet has been associated with an increased risk for transmission of infections via the droplet route (e.g., *N. meningitidis* 103 and group A streptococcus 114 and therefore supports the practice of distancing infected persons from others who are not infected. The effectiveness of good hygiene practices, especially hand hygiene, in preventing transmission of viruses and reducing the incidence of respiratory infections both within and outside 901-903 healthcare settings is summarized in several reviews 559, 717, 904.

These measures should be effective in decreasing the risk of transmission of pathogens contained in large respiratory droplets (e.g., influenza virus 23, adenovirus 111, *B. pertussis* 827 and *Mycoplasma pneumoniae* 112. Although fever will be present in many respiratory infections, patients with pertussis and mild upper respiratory tract infections are often afebrile. Therefore, the absence of fever does not always exclude a respiratory infection. Patients who have asthma, allergic rhinitis, or chronic obstructive lung disease also may be coughing and sneezing. While these patients often are not infectious, cough etiquette measures are prudent.

Healthcare personnel are advised to observe Droplet Precautions (i.e., wear a mask) and hand hygiene when examining and caring for patients with signs and symptoms of a respiratory infection. Healthcare personnel who have a respiratory infection are advised to avoid direct patient contact, especially with high risk patients. If this is not possible, then a mask should be worn while providing patient care.

III.III.1.b. Safe Injection Practices The investigation of four large outbreaks of HBV and HCV among patients in ambulatory care facilities in the United States identified a need to define and reinforce safe injection practices 453. The four outbreaks occurred in a private medical practice, a pain clinic, an endoscopy clinic, and a hematology/oncology clinic. The primary breaches in infection control practice that contributed to these outbreaks were 1) reinsertion of used needles into a multiple-dose vial or solution container (e.g., saline bag) and 2) use of a single needle/syringe to administer intravenous medication to multiple patients. In one of these outbreaks, preparation of medications in the same workspace where used needle/syringes were dismantled also may have been a contributing factor. These and other outbreaks of viral hepatitis could have been prevented by adherence to basic principles of aseptic technique for the preparation and administration of parenteral medications 453, 454. These include the use of a sterile, single-use, disposable needle and syringe for each injection given and prevention of contamination of injection equipment and medication.

Whenever possible, use of single-dose vials is preferred over multiple-dose vials, especially when medications will be administered to multiple patients. Outbreaks related to unsafe injection practices indicate that some healthcare personnel are unaware of, do not understand, or do not adhere to basic principles of infection control and aseptic technique. A survey of US healthcare workers who provide medication through injection found that 1% to 3% reused the same needle and/or syringe on multiple patients 905. Among the deficiencies identified in recent outbreaks were a lack of oversight of personnel and failure to follow-up on reported breaches in infection control practices in ambulatory settings. Therefore, to ensure that all healthcare workers understand and adhere to recommended practices, principles of infection control and aseptic technique need to be reinforced in training programs and incorporated into institutional policies that are monitored for adherence 454.

M. Transmission-Based Precautions There are three categories of Transmission-Based Precautions: Contact Precautions, Droplet Precautions, and Airborne Precautions. Transmission-Based Precautions are used when the route(s) of transmission is (are) not completely interrupted using Standard Precautions alone. For some diseases that have multiple routes of transmission (e.g., SARS), more than one Transmission-Based Precautions category may be used. When used either singly or in combination, they are always used in addition to Standard Precautions. See Appendix A for recommended precautions for specific infections. When Transmission-Based Precautions are indicated, efforts must be made to counteract possible adverse effects on patients (i.e., anxiety, depression and other mood disturbances 920-922, perceptions of stigma 923, reduced contact with clinical staff 924-926, and increases in preventable adverse events 565 in order to improve acceptance by the patients and adherence by HCWs.

III.IV.1. Contact Precautions Contact Precautions are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the patient or the patient's environment as described in I.B.3.a. The specific agents and circumstance for which Contact Precautions are indicated are found in Appendix A. The application of Contact Precautions for patients infected or colonized with MDROs is described in the 2006 HICPAC/CDC MDRO guideline 927. Contact Precautions also apply where the presence of excessive wound drainage, fecal incontinence, or other discharges from the body suggest an increased potential for extensive environmental contamination and risk of transmission. A single-patient room is preferred for patients who require Contact Precautions. When a single-patient room is not available, consultation with infection control personnel is recommended to assess the various risks associated with other patient placement options (e.g., cohorting, keeping the patient with an existing roommate). In multi-patient rooms, >3 feet spatial separation between beds is advised to reduce the opportunities for inadvertent sharing of items between the infected/colonized patient and other patients. Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Donning PPE upon room entry and discarding before exiting the patient room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination (e.g., VRE, *C. difficile*, noroviruses and other intestinal tract pathogens; RSV) 54, 72, 73, 78, 274, 275, 740.

III.IV.2. Droplet Precautions Droplet Precautions are intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions as described in I.B.3.b. Because these pathogens do not remain infectious over long distances in a healthcare facility, special air handling and ventilation are not required to prevent droplet transmission. Infectious agents for which Droplet Precautions are indicated are found in Appendix A and include *B. pertussis*, influenza virus, adenovirus, rhinovirus, *N. meningitidis*,

and group A streptococcus (for the first 24 hours of antimicrobial therapy). A single patient room is preferred for patients who require Droplet Precautions. When a single-patient room is not available, consultation with infection control personnel is recommended to assess the various risks associated with other patient placement options (e.g., cohorting, keeping the patient with an existing roommate). Spatial separation of > 3 feet and drawing

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the curtain between patient beds is especially important for patients in multi-bed rooms with infections transmitted by the droplet route. Healthcare personnel wear a mask (a respirator is not necessary) for close contact with infectious patient; the mask is generally donned upon room entry. Patients on Droplet Precautions who must be transported outside of the room should wear a mask if tolerated and follow Respiratory Hygiene/Cough Etiquette.

III.IV.3. Airborne Precautions Airborne Precautions prevent transmission of infectious agents that remain infectious over long distances when suspended in the air (e.g., rubeola virus [measles], varicella virus [chickenpox], *M. tuberculosis*, and possibly SARS-CoV) as described in I.B.3.c and Appendix A. The preferred placement for patients who require Airborne Precautions is in an airborne infection isolation room (AIIR). An AIIR is a single-patient room that is equipped with special air handling and ventilation capacity that meet the American Institute of Architects/Facility Guidelines Institute (AIA/FGI) standards for AIIRs (i.e., monitored negative pressure relative to the surrounding area, 12 air exchanges per hour for new construction and renovation and 6 air exchanges per hour for existing facilities, air exhausted directly to the outside or recirculated through HEPA filtration before return) 12, 13. Some states require the availability of such rooms in hospitals, emergency departments, and nursing homes that care for patients with *M. tuberculosis*. A respiratory protection program that includes education about use of respirators, fit-testing, and user seal checks is required in any facility with AIIRs. In settings where Airborne Precautions cannot be implemented due to limited engineering resources (e.g., physician offices), masking the patient, placing the patient in a private room (e.g., office examination room) with the door closed, and providing N95 or higher level respirators or masks if respirators are not available for healthcare personnel will reduce the likelihood of airborne transmission until the patient is either transferred to a facility with an AIIR or returned to the home environment, as deemed medically appropriate. Healthcare personnel caring for patients on Airborne Precautions wear a mask or respirator, depending on the disease-specific recommendations (Respiratory Protection II.E.4, Table 2, and Appendix A), that is donned prior to room entry. Whenever possible, non-immune HCWs should not care for patients with vaccine-preventable airborne diseases (e.g., measles, chickenpox, and smallpox).

V. Syndromic and empiric applications of Transmission-Based Precautions

Diagnosis of many infections requires laboratory confirmation. Since laboratory tests, especially those that depend on culture techniques, often require two or more days for completion, Transmission-Based Precautions must be implemented while test results are pending based on the clinical presentation and likely pathogens. Use of appropriate Transmission-Based Precautions at the time a patient develops symptoms or signs of transmissible infection, or arrives at a healthcare facility for care, reduces transmission opportunities. While it is not possible to identify prospectively all patients needing Transmission-Based Precautions, certain clinical syndromes and conditions carry a sufficiently high risk to warrant their use empirically while confirmatory tests are pending (Table 2). Infection control professionals are encouraged to modify or adapt this table according to local conditions.

VI. D. Discontinuation of Transmission-Based Precautions Transmission-Based Precautions remain in effect for limited periods of time (i.e., while the risk for transmission of the infectious agent persists or for the duration of the illness (Appendix A). For most infectious diseases, this duration reflects known patterns of persistence and shedding of infectious agents associated with the natural history of the infectious process and its treatment. For some diseases (e.g., pharyngeal or cutaneous diphtheria, RSV), Transmission-Based Precautions remain in effect until culture or antigen-detection test results document eradication of the pathogen and, for RSV, symptomatic disease is resolved. For other diseases, (e.g., *M. tuberculosis*) state laws and regulations, and healthcare facility policies, may dictate the

duration of precautions¹²). In immunocompromised patients, viral shedding can persist for prolonged periods of time (many weeks to months) and transmission to others may occur during that time; therefore, the duration of contact and/or droplet precautions may be prolonged for many weeks 500, 928-933.

The duration of Contact Precautions for patients who are colonized or infected with MDROs remains undefined. MRSA is the only MDRO for which effective decolonization regimens are available 867. However, carriers of MRSA who have negative nasal cultures after a course of systemic or topical therapy may resume shedding MRSA in the weeks that follow therapy 934, 935. Although early guidelines for VRE suggested discontinuation of Contact Precautions after three stool cultures obtained at weekly intervals proved negative 740, subsequent experiences have indicated that such screening may fail to detect colonization that can persist for >1 year 27, 936-938. Likewise, available data indicate that colonization with VRE, MRSA 939, and possibly MDR-GNB, can persist for many months, especially in the presence of severe underlying disease, invasive devices, and recurrent courses of antimicrobial agents.

It may be prudent to assume that MDRO carriers are colonized permanently and manage them accordingly. Alternatively, an interval free of hospitalizations, antimicrobial therapy, and invasive devices (e.g., 6 or 12 months) before reculturing patients to document clearance of carriage may be used. Determination of the best strategy awaits the results of additional studies. See the 2006 HICPAC/CDC MDRO guideline 927 for discussion of possible criteria to discontinue Contact Precautions for patients colonized or infected with MDROs.

Part IV: Recommendations

These recommendations are designed to prevent transmission of infectious agents among patients and healthcare personnel in all settings where healthcare is delivered. As in other CDC/HICPAC guidelines, each recommendation is categorized on the basis of existing scientific data, theoretical rationale, applicability, and when possible, economic impact. The CDC/HICPAC system for categorizing recommendations is as follows: **Category IA** Strongly recommended for implementation and strongly supported by well-designed experimental, clinical, or epidemiologic studies. **Category IB** Strongly recommended for implementation and supported by some experimental, clinical, or epidemiologic studies and a strong theoretical rationale. **Category IC** Required for implementation, as mandated by federal and/or state regulation or standard. **Category II** Suggested for implementation and supported by suggestive clinical or epidemiologic studies or a theoretical rationale. **No recommendation**; unresolved issue. Practices for which insufficient evidence or no consensus regarding efficacy exists.

IV. Standard Precautions Assume that every person is potentially infected or colonized with an organism that could be transmitted in the healthcare setting and apply the following infection control practices during the delivery of health care.

IV.A. Hand Hygiene

IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces⁷²

Category IB/IC

IV.A.2. When hands are visibly dirty, contaminated with proteinaceous material, or visibly soiled with blood or body fluids, wash hands with either a nonantimicrobial soap and water or an antimicrobial soap and water

Category IA

IV.A.3. If hands are not visibly soiled, or after removing visible material with nonantimicrobial soap and water, decontaminate hands in the clinical situations described in

IV.A.2.a-f. The preferred method of hand decontamination is with an alcohol-based hand rub

Alternatively, hands may be washed with an antimicrobial soap and water. Frequent use of alcohol-based hand rub immediately following handwashing with non-antimicrobial soap may increase the frequency of dermatitis⁵⁵⁹.

Category IB

Perform hand hygiene:

IV.A.3.a. Before having direct contact with patients. *Category IB*

IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings

Category IA

IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient)

Category IB

IV.A.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. *Category II*

IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient

Category II

IV.A.3.f. After removing gloves

IV.A.4. Wash hands with non-antimicrobial soap and water or with antimicrobial soap and water if contact with spores (e.g., *C. difficile* or *Bacillus anthracis*) is likely to have occurred. The physical action of washing and rinsing hands under such circumstances is recommended because alcohols, chlorhexidine, iodophors, and other antiseptic agents have poor activity against spores^{559, 956, 983}.

Category II

IV.A.5. Do not wear artificial fingernails or extenders if duties include direct contact with patients at high risk for infection and associated adverse outcomes (e.g., those in ICUs or operating rooms)

IV.A.5.a. Develop an organizational policy on the wearing of non-natural nails by healthcare personnel who have direct contact with patients outside of the groups specified above

Category II

IV.B. Personal protective equipment (PPE) (see Figure)

IV.B.1. Observe the following principles of use:

IV.B.1.a. Wear PPE, as described in IV.B.2-4, when the nature of the anticipated patient interaction indicates that contact with blood or body fluids may occur

Category IB/IC

IV.B.1.b. Prevent contamination of clothing and skin during the process of removing PPE

IV.B.1.c. Before leaving the patient's room or cubicle, remove and discard PPE

IV.B.2. Gloves

IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin (e.g., of a patient incontinent of stool or urine) could occur

. *Category IB/IC*

IV.B.2.b. Wear gloves with fit and durability appropriate to the task

Category IB

IV.B.2.b.i. Wear disposable medical examination gloves for providing direct patient care.

IV.B.2.b.ii. Wear disposable medical examination gloves or reusable utility gloves for cleaning the environment or medical equipment.

IV.B.2.c. Remove gloves after contact with a patient and/or the surrounding environment (including medical equipment) using proper technique to prevent hand contamination (see Figure). Do not wear the same pair of gloves for the care of more than one patient. Do not wash gloves for the purpose of reuse since this practice has been associated with transmission of pathogens.

. *Category IB*

IV.B.2.d. Change gloves during patient care if the hands will move from a contaminated body-site (e.g., perineal area) to a clean body-site (e.g., face). *Category II*

IV.B.3. Gowns

IV.B.3.a. Wear a gown, that is appropriate to the task, to protect skin and prevent soiling or contamination of clothing during procedures and patient-care activities when contact with blood, body fluids, secretions, or excretions is anticipated.

Category IB/IC

IV.B.3.a.i. Wear a gown for direct patient contact if the patient has uncontained secretions or excretions

Category IB/IC

IV.B.3.a.ii. Remove gown and perform hand hygiene before leaving the patient's environment

Category IB/IC

IV.B.3.b. Do not reuse gowns, even for repeated contacts with the same patient.

IV.B.3.c. Routine donning of gowns upon entrance into a high risk unit (e.g., ICU, NICU, HSCT unit) is not indicated

Category IB

IV.B.4. Mouth, nose, eye protection

IV.B.4.a. Use PPE to protect the mucous membranes of the eyes, nose and mouth during procedures and patient-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions and excretions. Select masks, goggles, face shields, and combinations of each according to the need anticipated by the task performed

IV.B.5. During aerosol-generating procedures (e.g., bronchoscopy, suctioning of the respiratory tract [if not using in-line suction catheters], endotracheal intubation) in patients who are not suspected of being infected with an agent for which respiratory protection is otherwise recommended (e.g., *M. tuberculosis*, SARS or hemorrhagic fever viruses), wear one of the following: a face shield that fully covers the front and sides of the face, a mask with attached shield, or a mask and goggles (in addition to gloves and gown)

Category IB

IV.C. Respiratory Hygiene/Cough Etiquette

IV.C.1. Educate healthcare personnel on the importance of source control measures to contain respiratory secretions to prevent droplet and fomite transmission of respiratory pathogens, especially during seasonal outbreaks of viral respiratory tract infections (e.g., influenza, RSV, adenovirus, parainfluenza virus) in communities¹⁴

Category IB

IV.C.2. Implement the following measures to contain respiratory secretions in patients and accompanying individuals who have signs and symptoms of a respiratory infection, beginning at the point of initial encounter in a healthcare setting (e.g., triage, reception and waiting areas in emergency departments, outpatient clinics and physician offices).

IV.C.2.a. Post signs at entrances and in strategic places (e.g., elevators, cafeterias) within ambulatory and inpatient settings with instructions to patients and other persons with symptoms of a respiratory infection to cover their mouths/noses when coughing or sneezing, use and dispose of tissues, and perform hand hygiene after hands have been in contact with respiratory secretions.

Category II

IV.C.2.b. Provide tissues and no-touch receptacles (e.g., foot-pedaloperated lid or open, plastic-lined waste basket) for disposal of tissues.

Category II

IV.C.2.c. Provide resources and instructions for performing hand hygiene in or near waiting areas in ambulatory and inpatient settings; provide conveniently-located dispensers of alcohol-based hand rubs and, where sinks are available, supplies for hand washing.

Category IB

IV.C.2.d. During periods of increased prevalence of respiratory infections in the community (e.g., as indicated by increased school absenteeism, increased number of patients seeking care for a respiratory infection), offer masks to coughing patients and other symptomatic persons (e.g., persons who accompany ill patients) upon entry into the facility or medical office and encourage them to maintain special separation, ideally a distance of at least 3 feet, from others in common waiting areas

Category IB

IV.C.2.d.i. Some facilities may find it logistically easier to institute this recommendation year-round as a standard of practice.

Category II

IV.D. Patient placement

IV.D.1. Include the potential for transmission of infectious agents in patient-placement decisions. Place patients who pose a risk for transmission to others (e.g., uncontained secretions, excretions or wound drainage; infants with suspected viral respiratory or gastrointestinal infections) in a single-patient room when available

Category IB

IV.D.2. Determine patient placement based on the following principles □

Route(s) of transmission of the known or suspected infectious agent □

Risk factors for transmission in the infected patient

Risk factors for adverse outcomes resulting from an HAI in other patients in the area or room being considered for patient-placement

Availability of single-patient rooms

Patient options for room-sharing (e.g., cohorting patients with the same infection)

Category II

IV.E. Patient-care equipment and instruments/devices

956

IV.E.1. Establish policies and procedures for containing, transporting, and handling patient-care equipment and instruments/devices that may be contaminated with blood or body fluids

Category IB/IC

IV.E.2. Remove organic material from critical and semi-critical instrument/devices, using recommended cleaning agents before high level disinfection and sterilization to enable effective disinfection and sterilization processes

Category IA

IV.E.3. Wear PPE (e.g., gloves, gown), according to the level of anticipated contamination, when handling patient-care equipment and instruments/devices that is visibly soiled or may have been in contact with blood or body fluids

Category IB/IC

IV.F. Care of the environment¹¹

IV.F.1. Establish policies and procedures for routine and targeted cleaning of environmental surfaces as indicated by the level of patient contact and degree of soiling¹¹.

Category II

IV.F.2. Clean and disinfect surfaces that are likely to be contaminated with pathogens, including those that are in close proximity to the patient (e.g., bed rails, over bed tables) and frequently-touched surfaces in the patient care environment (e.g., door knobs, surfaces in and surrounding toilets in patients' rooms) on a more frequent schedule compared to that for other surfaces (e.g., horizontal surfaces in waiting room).

Category IB

IV.F.3. Use EPA-registered disinfectants that have microbiocidal (i.e., killing) activity against the pathogens most likely to contaminate the patient-care environment. Use in accordance with manufacturer's instructions.

Category IB/IC

IV.F.3.a. Review the efficacy of in-use disinfectants when evidence of continuing transmission of an infectious agent (e.g., rotavirus, *C. difficile*, norovirus) may indicate resistance to the in-use product and change to a more effective disinfectant as indicated.

Category II

IV.F.4. In facilities that provide health care to pediatric patients or have waiting areas with child play toys (e.g., obstetric/gynecology offices and clinics), establish policies and procedures for cleaning and disinfecting toys at regular intervals.

Category IB

- Use the following principles in developing this policy and procedures: *Category II*

- Select play toys that can be easily cleaned and disinfected
- Do not permit use of stuffed furry toys if they will be shared
- Clean and disinfect large stationary toys (e.g., climbing equipment) at least weekly and whenever visibly soiled
- If toys are likely to be mouthed, rinse with water after disinfection; alternatively wash in a dishwasher

- When a toy requires cleaning and disinfection, do so immediately or store in a designated labeled container separate from toys that are clean and ready for use

IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently (e.g., daily)^{850 851, 852, 997}.

Category IB

IV.F.5.a. No recommendation for use of removable protective covers or washable keyboards. *Unresolved issue*

IV.G. Textiles and laundry

IV.G.1. Handle used textiles and fabrics with minimum agitation to avoid contamination of air, surfaces and persons

Category IB/IC

IV.G.2. If laundry chutes are used, ensure that they are properly designed, maintained, and used in a manner to minimize dispersion of aerosols from contaminated laundry

Category IB/IC

IV.H. Safe injection practices The following recommendations apply to the use of needles, cannulas that replace needles, and, where applicable intravenous delivery systems

IV.H.1. Use aseptic technique to avoid contamination of sterile injection equipment

Category IA

IV.H.2. Do not administer medications from a syringe to multiple patients, even if the needle or cannula on the syringe is changed. Needles, cannulae and syringes are sterile, single-use items; they should not be reused for another patient nor to access a medication or solution that might be used for a subsequent patient^{453, 919, 1004, 1005}

Category IA

IV.H.3. Use fluid infusion and administration sets (i.e., intravenous bags, tubing and connectors) for one patient only and dispose appropriately after use. Consider a syringe or needle/cannula contaminated once it has been used to enter or connect to a patient's intravenous infusion bag or administration set⁴⁵³.

Category IB

IV.H.4. Use single-dose vials for parenteral medications whenever possible

Category IA

IV.H.5. Do not administer medications from single-dose vials or ampules to multiple patients or combine leftover contents for later use

Category IA

IV.H.6. If multidose vials must be used, both the needle or cannula and syringe used to access the multidose vial must be sterile.

Category IA

IV.H.7. Do not keep multidose vials in the immediate patient treatment area and store in accordance with the manufacturer's recommendations; discard if sterility is compromised or questionable

Category IA

IV.H.8. Do not use bags or bottles of intravenous solution as a common source of supply for multiple patients

Category IB

IV.I. Infection control practices for special lumbar puncture procedures Wear a surgical mask when placing a catheter or injecting material into the spinal canal or subdural space (i.e., during myelograms, lumbar puncture

Category IB

Worker safety Adhere to federal and state requirements for protection of healthcare personnel from exposure to bloodborne pathogens