

STEVENS, SUSAN WELCH, Ed.D. Clinical Experience's Role in Professional Socialization as Perceived by Entry-Level Athletic Trainers (2005)
Directed by Dr. David H Perrin 222pp.

Clinical experiences are integral to the education process in many professions. Professional socialization is one area of students' development enhanced by clinical experience. Professional socialization includes learning in the affective domain by experiencing moral, ethical and legal practice as well as developing confidence in students' clinical practice. This study examined the role of clinical experience for professional socialization in Commission on Accreditation of Allied Health Education Programs (CAAHEP) accredited athletic training education programs. This was done by examining entry-level athletic trainers' perceptions of the importance of four common clinical experiences in the development of selected affective domain educational competencies. These experiences were peer practice, approved clinical instructor (ACI) instruction, practice coverage and game coverage. The affective domain competencies were chosen because they included aspects of professional socialization such as role identity and moral ethical and legal practice of athletic training. A quantitative, researcher developed, web based survey was designed and used to collect perception data from newly certified athletic trainers who had graduated from a CAAHEP accredited athletic training education program. While all four common clinical experiences were reported as important to subject mastery of the competencies, ACI instruction and practice coverage were reported to be more important than both peer practice and game coverage. These results are important to athletic training educators as they try to develop

the best possible combination of classroom, laboratory and clinical experience to better prepare future generations of confident and successful practicing athletic trainers

CLINICAL EXPERIENCE'S ROLE IN PROFESSIONAL SOCIALIZATION
AS PERCEIVED BY ENTRY-LEVEL ATHLETIC TRAINERS

by

Susan Welch Stevens

A Dissertation Submitted to
the Faculty of The Graduate School at
The University of North Carolina at Greensboro
in Partial Fulfillment
of the Requirements for the Degree
Doctor of Education

Greensboro

2005

Approved by

Committee Chair

© 2005 Susan Welch Stevens

APPROVAL PAGE

This dissertation has been approved by the following committee of the
Faculty of The Graduate School at The University of North Carolina at Greensboro.

Committee Chair _____

Committee Members _____

Date of Acceptance by Committee

Date of Final Oral Examination

ACKNOWLEDGEMENTS

I would like to acknowledge and thank the following people for their assistance in making this project possible.

The athletic training faculty and staff at Elon University for being supportive of me during this process and giving me the time needed to focus on my coursework and research. Also you have been an important factor in keeping me not only motivated to finish but also sane in the process.

Past and present athletic training students at Elon, you have also been extremely important to the completion of this project and not just as my pilot subjects. You have served to keep me motivated and energized with your support, energy and quest for learning. Keep up the good work.

Rob Springer and his colleagues in the institutional research office at Elon University for assisting in the formatting of the web based survey, providing server space to host the survey and downloading data weekly for my analysis.

Denise Fandel and the Board of Certification for access to the database used to generate the sample of entry-level athletic trainers used for data collection.

The Mid-Atlantic Athletic Trainers' Association Research Grant Committee for helping to fund my project.

I would also like to thank my dissertation chair, Dr. David Perrin for his long hours and countless comments and revisions to the design of my research project as well as improving my writing style, my committee Dr. Randy Schmitz, Dr. Bill Karper and Dr. Jolene Henning, both for your technical support in assisting me in developing as a researcher, writer, and thinker but also for your continued motivation to get it done.

Finally, to Micah for knowing when to ask how it's going and when to leave me alone. Without you I'm not sure I'd have made it to this point. You have been supportive and encouraging when I needed it, and made sure I still took some time for me when I really needed it. You continue to keep me balanced and focusing on what is really important in life. You have given me the emotional strength to see this project and degree through and I am forever thankful.

TABLE OF CONTENTS

	Page
LIST OF TABLES.....	viii
CHAPTER	
I. INTRODUCTION.....	1
Statement of the Problem.....	3
Research Questions.....	3
Hypotheses.....	4
Delimitations	6
Assumptions/ Limitations.....	6
Operational Definitions.....	7
II. REVIEW OF THE LITERATURE.....	9
History of Athletic Training Education.....	9
NATA Approved Athletic Training Education Programs.....	11
External Accreditation.....	13
Dissolution of the Internship Route to Certification.....	15
Shift from Hours to an Outcome Based Curriculum.....	16
Outcome Based Learning.....	16
Joint Review Committee on Education Programs in Athletic Training Accreditation.....	17
Athletic Training Clinical Education Research.....	18
Supervisors.....	18
Experiences.....	21
Importance of Fieldwork in Other Allied Health Professions Education.....	25
Affective Domain.....	25
Professional Socialization.....	29

	Dialectical Perspective.....	30
	Developmental Model.....	31
	Stages of Socialization.....	31
	Formal Socialization.....	32
	Informal Socialization.....	33
	Personal Socialization.....	33
	Core Elements.....	34
	Clinical Experience.....	35
	Integration of Knowledge.....	36
	Thinking Skills.....	37
	Peer Learning in Clinical Experience.....	38
	Early field Experiences.....	39
	Summary.....	40
III.	METHODS.....	41
	Survey Development.....	41
	Validity and Reliability.....	42
	Survey Modification.....	44
	Second Pilot Test.....	46
	Results.....	46
	Ceiling Effect.....	46
	Reliability.....	47
	Sample.....	49
	Procedures.....	50
	Analysis.....	51
IV.	RESULTS.....	55
	Descriptive Statistics.....	55
	Importance of Clinical Experiences.....	58
	Demographic Effects.....	60
V.	DISCUSSION.....	64
	Approved Clinical Instructor Interaction.....	64
	Practice versus Game Coverage.....	66
	Peer Learning.....	69
	Demographic effects.....	71
	Response Rate and Generalizability of the Findings.....	71
	Implications for Athletic Training Education.....	74
	REFERENCES.....	77

APPENDIX A 2001 EC EDUCATIONAL COMPETENCIES AFFECTIVE DOMAIN.....	84
APPENDIX B LETTER AND SURVEY SENT TO ATHLETIC TRAINING EDUCATORS.....	90
APPENDIX C RESULTS FROM SURVEY SENT TO ATHLETIC TRAINING EDUCATORS.....	97
APPENDIX D SURVEY INSTRUMENT FOR PILOT ONE.....	103
APPENDIX E RESULTS OF PILOT ONE.....	120
APPENDIX F COVER LETTER FOR PILOT TWO.....	138
APPENDIX G RESULTS OF PILOT TWO.....	139
APPENDIX H INSTITUTIONAL REVIEW BOARD APPROVAL	194
APPENDIX I COVER LETTER FOR FINAL DATA COLLECTION.....	195
APPENDIX J SURVEY INSTRUMENT FOR PILOT TWO AND FINAL DATA COLLECTION	197

LIST OF TABLES

	Page
Table 1. Descriptive statistics for each activity's rated importance score calculated from pilot two, round one data.....	47
Table 2. Descriptive statistics for each activity's ranked importance score calculated from pilot two, round one data.....	47
Table 3. Internal consistency of each activity's rated importance scores for pilot two round one and round two as calculated from standardized alpha and intraclass correlation coefficient (ICC).....	48
Table 4. Internal consistency of each activity's ranked importance scores for pilot two calculated from standardized alpha and intraclass correlation coefficient (ICC) (*=not standardized alpha, **= 13 competencies without variance).....	48
Table 5. Stability of scores between the second pilot test round one and round two as calculated by intraclass correlation coefficients (ICC) for rating and ranking scores of each activity.....	49
Table 6 Table of specification using research questions and hypotheses from introduction.....	53
Table 7. Descriptive data calculated for each activity and composite rated importance score.....	56
Table 8. Descriptive data calculated for each activity and composite ranked importance score.....	56
Table 9. Data used in the calculation of response rate.....	57
Table 10. Internal consistency values as measured by standardized alpha and intraclass correlation coefficient (ICC) for the individual activities rated importance scores.....	57
Table 11. Internal consistency values as measured by standardized alpha and intraclass correlation coefficient (ICC) for the individual activities ranked importance scores.....	58
Table 12. Results of a pairwise comparison of the rated mean importance for the four activities in development of professional socialization.....	59

Table 13. Results of a pairwise comparison of the ranked mean importance for the four activities in development of professional socialization.....	60
Table 14. Results of one-way ANOVAs considering the effect of time spent in clinical education versus field experiences on the importance of clinical education (CE) and field experience (FE) for professional socialization.....	60
Table 15. Results of one-way ANOVAs considering the effect of supervision quality on the importance of clinical education (CE) and field experience (FE) for professional socialization.....	61
Table 16. Results of one-way ANOVAs considering the effect of number of semesters spent in clinical experience on the importance of clinical education (CE) and field experience (FE) for professional socialization utilizing both rated and ranked data.....	61
Table 17. Results of one-way ANOVAs utilizing the rated data considering the effect of time spent in clinical education versus field experience on the importance of each activity for professional socialization.....	62
Table 18. Results of one-way ANOVAs utilizing rated data considering the effect of quality of supervision on the importance of each activity for professional socialization.....	62
Table 19. Results of one-way ANOVAs utilizing rated data considering the effect of number of semesters spent in clinical experience on the importance of each activity for professional socialization.....	62
Table 20. Results of one-way ANOVAs utilizing ranked data considering the effect of time spent in clinical education versus field experience on the importance of each activity for professional socialization.....	63
Table 21. Results of one-way ANOVAs utilizing ranked data considering the effect of quality of supervision on the importance of each activity for professional socialization.....	63
Table 22. Results of one-way ANOVAs utilizing rated data considering the effect of number of semesters spent in clinical experience on the importance of each activity for professional socialization.....	63
Table 23. Average Likert Scale rating for each activity's importance for professional socialization on a six point scale with 1 being least important and six being most important.....	70

CHAPTER I

INTRODUCTION

Clinical experiences are vital to the education of professionals in the medical and allied health care professions.¹⁻³ In fact, many nursing and education students consider clinical experience to be the single most important aspect of their educational preparation.¹ Exposing students to clinical experiences that include an infinite variety of patients and conditions may improve professional skills,^{1,2,4,5} integrate theory and practice,^{1,2} increase critical thinking skills,⁵ enhance self-efficacy,^{1,6} socialize the student into the profession and develop a sense of altruism.¹ This exposure not only provides students with repeated opportunities to integrate theoretical and practical knowledge but it also helps students develop a sense of social responsibility and the importance of moral and ethical practice. Thus clinical experience allows students to continually integrate and reform knowledge to develop a personal professional competence.² This study examined the role of formal and informal clinical experience in the development of professional competence especially professional socialization. Professional socialization is the development of “knowledge, skills, values, roles and attitudes” pertaining to professional practice.⁷ Socialization was chosen as the focus because while students can develop competence in cognitive theories and even some psychomotor skills in a classroom, clinical experience is important for the development of role identity, critical thinking skills, and the affective domain.⁸

The NATA Education Council groups clinical experiences into two primary categories: clinical education and field experience. Clinical education is the formal learning, practicing and evaluation of clinical proficiencies in a classroom, lab or clinical setting under the supervision of an approved clinical instructor.⁹ This type of formal instruction is essential for the acquisition of knowledge that is central to the profession of athletic training. Athletic training laboratories and practicing or assessing clinical proficiencies are good opportunities to learn and master clinical skills. Field experience is the informal learning or practice of athletic training skills in a realistic situation under the supervision of a clinical instructor.⁹ These types of experiences such as providing athletic training services for an athletic team are important because the student is involved in the profession of athletic training. These clinical experiences are important to the education process because the students are not only learning and mastering clinical skills, but are also being socialized into the profession of athletic training. As the student is socialized into the profession of athletic training, they have the opportunity to develop competence in the affective domain of the NATA Education Council's educational competencies which comprise not only moral ethical and legal practice, but also role identity as an athletic trainer. This inclusion of professional socialization issues is why the affective domain competencies were chosen to represent professional socialization for the purposes of this study.

It is important to examine the role of clinical experience on student socialization because of the recent reforms in athletic training education. The reform process which included the move to accreditation by the Commission on Accreditation for Allied Health

Education Programs (CAAHEP) has elevated the quality of athletic training education and in turn increased the quality of entry-level athletic trainers graduating from these programs. Students achieve predetermined educational competencies and clinical proficiencies as a result of exposure to a structured education program consisting of classroom instruction, laboratory practice, one-on-one clinical education and supervised field experience. Additional research is needed to further clarify the role of clinical experiences in athletic training education. This knowledge will be useful for clinical coordinators to design the best possible combination of clinical experiences for athletic training students.

Statement of the Problem

The purpose of this study was to explore the importance of formal clinical education and informal field experience during entry-level education programs on the professional socialization of athletic trainers who graduated from CAAHEP-accredited education programs. Professional socialization was represented by selected NATA Athletic training affective domain education competencies which are required in all CAAHEP accredited athletic training education programs. The perceptions of entry-level certified athletic trainers who have recently completed a CAAHEP-accredited educational program were explored in this study.

Research Questions

1. Are formal clinical education experiences or informal field experiences perceived by entry-level athletic trainers to be more important for developing professional socialization?

Hypotheses

- A. Informal field experiences will be rated more important than formal clinical education experiences by entry-level athletic trainers for professional socialization.
 - B. Informal field experiences will be ranked more important than formal clinical education experiences by entry-level athletic trainers for professional socialization.
 - C. Practice coverage and game coverage will be rated more important than peer practice and ACI instruction by entry-level athletic trainers for professional socialization.
 - D. Practice coverage and game coverage will be ranked more important than peer practice and ACI instruction by entry-level athletic trainers for professional socialization.
2. How are perceptions of entry-level athletic trainers regarding the importance of formal clinical education experiences and informal field experiences for professional socialization affected by:
- a. the percentage of time spent in formal experiences during the education program?
 - b. the estimate of the overall quality of clinical supervision received?
 - c. when the field experiences began?

Hypotheses

- A. There are differences in the rated perception of importance for clinical education and field experience based on the time spent in formal clinical experiences.

B. There are differences in the ranked perception of importance for clinical education and field experience based on the time spent in formal clinical experiences.

C. There are differences in the rated perception of importance for peer practice, ACI instruction, practice coverage and game coverage by entry-level athletic trainers for professional socialization based on the time spent in formal clinical education.

D. There are differences in the ranked perception of importance for peer practice, ACI instruction, practice coverage and game coverage by entry-level athletic trainers for professional socialization based on the time spent in formal clinical education.

E. There are differences in the rated perception of importance for clinical education and field experience based on the time overall quality of supervision.

F. There are differences in the ranked perception of importance for clinical education and field experience based on the overall quality of supervision.

G. There are differences in the rated perception of importance for peer practice, ACI instruction, practice coverage and game coverage by entry-level athletic trainers for professional socialization based on the overall quality of supervision.

H. There are differences in the ranked perception of importance for peer practice, ACI instruction, practice coverage and game coverage by entry-level athletic trainers for professional socialization based on the overall quality of supervision.

- I. There are differences in the rated perception of importance for clinical education and field experience based on the length of clinical experiences.
- J. There are differences in the ranked perception of importance for clinical education and field experience based on the length of clinical experiences.
- K. There are differences in the rated perceptions of importance of peer practice, ACI instruction, practice coverage and game coverage for professional socialization according to percentage of the length of clinical experiences.
- L. There are differences in the ranked perceptions of importance of peer practice, ACI instruction, practice coverage and game coverage for professional socialization according to length of clinical experiences.

Delimitations

1. All subjects had graduated from a CAAHEP accredited athletic training education program within the past three years.
2. All subjects were employed as athletic trainers in a recognized practice setting.

Assumptions/ Limitations

1. Subjects who responded to the survey represented the larger population of entry-level certified athletic trainers.
2. Recent graduates of CAAHEP accredited entry-level athletic training education programs have developed competence in the NATA's Athletic Training Education Affective Competencies.
3. Entry-level athletic trainers remembered their clinical experiences and accurately recalled where specific competencies were learned and mastered.

4. Subjects were supervised by an approved clinical instructor during practice and game coverage experiences recalled during data collection.

Operational Definitions

1. Clinical education- learning, practicing, or being assessed on a clinical proficiency by an approved clinical instructor.⁹ Clinical education includes activities such as peer practice and one on one interaction with an ACI.
2. Field experience- unstructured learning or practice of athletic training skills in a real world setting under the supervision of a clinical instructor.⁹ This is an exposure to the daily activities of certified athletic trainers and other health care providers such as practice and game coverage.
3. Entry-level athletic trainer- a BOC certified athletic trainer who received certification between November 2002 and November 2003.
5. Professional socialization- development of “knowledge, skills, values, roles and attitudes” pertaining to professional practice.⁷
6. Affective domain- (as defined by NATA Athletic Training Educational Competencies) includes aspects of role actualization and moral, ethical and legal practice.
7. Quality of supervision- An overall estimate of the usefulness of the clinical supervisors to student learning during the educational program.
8. Role model- An individual who unintentionally acts to change student professional behaviors. (145)

9. Mentor- an individual who intentionally acts by explanation or demonstration to improve the professional behavior of a student. (145,210) This definition was adapted from two qualitative investigations conducted in athletic training education.

CHAPTER II

REVIEW OF THE LITERATURE

This literature review will address the following: the history of athletic training and specifically athletic training education, a brief explanation of outcome based theory, affective domain and professional socialization, and the importance of clinical experience in medical and allied health education especially as it pertains to the development of professional skills.

History of Athletic Training Education

Early athletic trainers learned by trial and error to develop their own concoctions, treatments, and dietary supplements to hasten recovery or enhance performance. SE Bilik, the father of modern athletic training, realized that the field would never gain respect if athletic trainers continued these practices.¹⁰ He believed that athletic trainers needed an education grounded in anatomical and scientific principles.¹⁰ So in 1916 he wrote “The Trainer’s Bible”^{10, 11} which was the first book devoted to the treatment of athletic injuries.¹²

Though the education movement began at the turn of the century, formal college education for athletic trainers did not really start until the 1930s. As colleges realized coaches needed knowledge about the body and training for enhanced performance not just how to play their sport; they also realized athletic trainers needed a formal education.¹³ Many physical education programs included classes in the sciences, which

also served as prerequisites for physical therapy school. The athletic training profession did not have its own body of knowledge or coursework so most people wanting to become athletic trainers were encouraged to attend physical therapy school.^{13, 14} These early students also began the tradition of working as an apprentice during their undergraduate career as a student athletic trainer.¹³

After World War II a number of athletic conferences decided that communication would serve them better than secret concoctions and remedies and formed local associations. These local associations came together and met in 1950 in Kansas City, MO, for the first annual meeting of the National Athletic Trainers' Association (NATA).^{11, 15} The mission statement for the new association was to "build and strengthen the profession of athletic training through the exchange of ideas, knowledge, and methods of athletic training."¹⁵ Two goals stated in that first year were the development of athletic training education programs at high schools and colleges, and to establish standards of performance.^{11, 16}

In 1955 William E. (Pinky) Newell was elected as Executive Secretary of the NATA.^{14, 15} Newell was a forward thinker with lots of ideas and served until 1968. Many of the accomplishments of the NATA during this time were a direct result of his hard work and dedication. Some of these accomplishments included starting a professional journal, writing a code of ethics^{11, 15} gaining recognition by many organizations as a professional association, beginning formal education programs, requiring a certification exam,¹⁵ facilitating a resolution by the American Medical Association's House of Delegates encouraging the incorporation of athletic trainers in all

sports programs,¹¹ and recognition by the American Medical Association as a professional association in 1967.^{14, 15, 17}

NATA Approved Athletic Training Education Programs

One of Newell's ideas was to create the Committee on Gaining Recognition.¹⁴ The committee decided to enhance athletic training's image by focusing on athletic training education and certification.¹⁴ The committee proposed the first curriculum model in 1959.^{14, 18, 19} Two primary features were the inclusion of physical therapy prerequisites and an opportunity to gain a teaching certification.¹⁴ Newell, also chair of the Committee on Gaining Recognition, appointed a subcommittee in December of 1968. Their charge was to study how many schools had athletic training education programs and whether these programs were adhering to the recommended curriculum.²⁰ This committee also developed a procedure for colleges and universities to submit their education programs for NATA approval.^{18, 20} Once the procedure was in place, the first athletic training education programs were approved in 1969.^{14, 18-20} The first 4 approved undergraduate programs were at Indiana State University, Mankato State University, Lamar University, and University of New Mexico. The first graduate programs were approved in 1972 at Indiana State University and the University of Arizona.¹⁴

The second focus of the Committee on Gaining Recognition was to ensure that all athletic trainers had a base level of competence. One of the ideas was a written and practical examination. It was hoped that the exam would help students design their own educational program and stimulate the development and growth of programs developed in colleges and universities.¹⁷ J. Lindsay McLean, first chair of the National Athletic

Trainers' Association Board of Certification (NATABOC)^{14, 21} wrote in 1969, "Such an examination would give our association a unity of purpose and direction at a time it is sorely needed."¹⁷ In June 1969 the procedures for certification of NATA members were presented to the NATA Board of Directors.²¹ The subjects of the first certification examination included "basic science, theory of athletic training, and practical application of athletic training."²¹ Initially there were five routes to become an Athletic Trainer, Certified (ATC). These routes included people who were already "actively engaged" in the profession, graduates of approved education programs, physical therapy graduates, apprentices, and special cases. Beginning in 2004 the only route to certification was graduation from a Commission on Accreditation of Allied Health Education Programs (CAAHEP) accredited education program.

In the 1970s athletic training began to truly develop its own identity. While it was still a viable option for athletic trainers to continue their education by attending physical therapy school it was no longer a necessity. Athletic training education programs grew and became more specific to athletic trainers. These changes led to new curriculum guidelines in the mid 1970s. These guidelines listed behavioral objectives for each of the 11 required classes.¹⁴

As the 1980s progressed the athletic training profession continued to grow and strengthen. People were starting to recognize athletic trainers as allied health care professionals and therefore expected more of them.¹⁴ Many state athletic training associations began lobbying for licensure.²¹ The 1970s guidelines were modified in 1983 by the Professional Education Committee following the 1982 role delineation study by

the NATABOC. This document became the first edition of *Competencies in Athletic Training*. Because of the scope and depth of information in the new competencies, a more formal education process was needed. A resolution was passed by the NATA calling for all approved programs to implement an athletic training major.^{14, 18} All NATA approved programs must have developed either a major or its equivalent before 1990. An equivalent was defined as a program of study which met the guidelines for an athletic training program and contained at least the minimum number of credit hours that constituted a major at the individual institution.¹⁴ In order to assist athletic training programs in this transition the Professional Education Committee (PEC) created the *Guidelines for Development and Implementation of NATA Approved Undergraduate Athletic Training Education Programs* in 1983. This document represented a major change in athletic training curriculums as instead of requiring specific courses, subject matter areas were required. The second major change was the beginning of an outcome-based model as the *Competencies in Athletic Training* document was integrated into the latest curriculum revision.

External Accreditation

Probably one of the largest milestones in athletic training history came on June 22, 1990 when the American Medical Association (AMA) designated athletic training as an allied health care profession.¹⁴ This recognition was important because it was a precursor to external accreditation. Accreditation by the AMA Committee on Allied Health Education (CAHEA) was sought because of the “perceived benefits of standardized education program requirements and external peer review by a highly

regarded, specialized accreditation agency.”¹⁴ As part of the new accreditation process the Professional Education Committee met with CAHEA to lay the groundwork for the Joint Review Committee on Education Programs in Athletic Training (JRC-AT). The JRC-AT was created as an interdisciplinary group responsible for reviewing athletic training education programs wishing to be accredited by CAHEA. One of their first tasks was to develop standards and guidelines for accreditation. Fortunately they were able to revise the Professional Education Committee’s 1983 *Guidelines* as the framework of the new document. The Competencies were also adopted to accompany the Standards and Guidelines. This document became *Essentials and Guidelines for an Accredited Education Program for the Athletic Trainer*. Once this document was in place in 1993, the PEC stopped “approval” of athletic training education programs. CAHEA took over accreditation. Barry University and High Point University became the initial athletic training programs to be accredited by an outside agency.

In 1992 CAHEA was disbanded and replaced by the Commission on Accreditation of Allied Health Education Programs (CAAHEP), an independent accreditation body for allied health care education programs.¹⁴ With this transition the *Essentials and Guidelines* became *Standards and Guidelines*, but the process remained essentially the same. In 1993 some additional government regulatory changes occurred, and CAAHEP became a recognized accreditation agency of the Council on Higher Education Accreditation (CHEA). CHEA recognizes many different accreditation agencies including nursing, physical therapy and the regional accrediting bodies for all colleges and schools i.e. Southern Association of Colleges and Schools (SACS).²²

Dissolution of the Internship Route to Certification

The most recent effort to elevate athletic training to the same level as other allied health care professions was the standardization of education programs. Since the initiation of the certification exam in 1970 there had been multiple routes to certification. Prior to January 2004 there were two, one was graduation from a CAAHEP accredited education program and the other was completion of the internship route which included basic courses and 1500 clinical hours. Because of a lack of standardization of the educational process the internship route was perceived by many athletic trainers as retarding the profession's development, especially in terms of gaining respect by other allied health care professionals and the public.

To investigate how to improve and standardize athletic training education the Education Task Force was created in 1994.^{14, 23} The Task Force forwarded 18 recommendations regarding education reform to the NATA Board of Directors in 1996, which were accepted. Two primary points were requiring that all certification exam candidates be graduates of a CAAHEP accredited program and reorganization of the clinical education experience.^{14, 23, 24} The NATA Board of Directors immediately created the Education Council to successfully implement these recommendations.

One aspect of the reorganization of clinical education was the development of the role for the clinical instructor. Since most athletic trainers did not have a background in education some standardization was needed. In 2001, the approved clinical instructor (ACI) and clinical instructor educator (CIE) concepts were developed. Each athletic training education program has a CIE who has been qualified by the Education Council to

train the program's own ACIs.^{9,25} This training is intended to provide the ACIs with some basic teaching and learning theory as well as provide a detailed background into the specific clinical education program designed by the institution whose students they will be teaching. This training session is important in the quest for a more structured and standardized clinical education experience. No longer are athletic training students just a cheap work force used to fill water bottles and tape ankles. They are students learning to integrate the theories and skills learned in the classroom in a clinical setting.

Shift from Hours to an Outcome Based Curriculum

Another component to the revised clinical education experience was the revision of the Educational Competencies, which went into effect in 2001. The new edition of these competencies included clinical proficiencies, which describe a set of measurable objectives of which the student must show entry-level mastery.²³ These proficiencies provide a structure to clinical education and give the student a framework for learning. The proficiencies have replaced the clinical hours requirement to sit for the BOC certification exam. There has also been an increase in the clinical education structure by CAAHEP as evidenced in the new standards and guidelines for accreditation.²³ This continued emphasis on outcome based clinical education programs is the way of the future in athletic training education.

Outcome Based Learning

Outcome based education shifts the focus from a teaching focus to a learning focus. The most important questions relate to what the final product should be and the skills students should be able to perform upon graduation. While these may be goals of

many programs, in outcome-based education they are the most important issues. First, the answer is carefully thought out and communicated to the faculty, students and other stakeholders in the program. Second, a commitment to the answer is needed because all curriculum decisions are made according to the question.²⁶ Outcome based education has some distinct advantages; it increases relevance of subject matter for the student and provides a very clear framework for a curriculum, yet still allows for flexibility and faculty autonomy. Another advantage is the accountability and student centered nature of the program. The student knows exactly what the outcomes are and is responsible for mastering them. They know exactly where they stand in the program and can devise a plan to succeed.^{26, 27} This type of model has also been described as a good way to structure clinical education without losing the inherent difference in each placement site. Again by focusing on the outcomes each setting can facilitate the students' learning with different experiences and strategies. Athletic training students achieve predetermined educational competencies and clinical proficiencies as a result of exposure to a structured education program consisting of classroom instruction, laboratory practice, one-on-one clinical education and supervised field experience.

Joint Review Committee on Education Programs in Athletic Training Accreditation

As athletic training continued to mature and reinforce itself as an allied health profession in the 1990s and 2000s there were more changes to come. Having recently finished another major education reform the JRC-AT and NATA examined the benefits and risks of continuing to fall under CAAHEP's accreditation umbrella. In early 2003 the JRC-AT decided to leave CAAHEP and become the accrediting body for athletic

training education programs.²⁸ The JRC-AT will pursue recognition as an accreditation agency of the Council on Higher Education Accreditation (CHEA). The JRC-AT is currently revising the standards and guidelines for accreditation.²⁸ JRC-AT will withdraw from CAAHEP in Spring of 2006. Beginning in the fall of 2006 athletic training education programs will be accredited by Commission on the Accreditation of Athletic Training Education (CAATE).²⁹

Athletic Training Clinical Education Research

As athletic training educators are developing education programs focusing on student needs and trying to determine how to best prepare future certified athletic trainers different areas of focus have developed. Athletic training educational researchers have examined clinical supervisors³⁰⁻³², the students³³ and the experience³⁴⁻³⁶ itself as they try to determine what the students need to learn and the best teaching methods to convey these objectives.

Supervisors

Clinical supervisors are the backbone of a quality experience for athletic training students. Supervisors' behaviors are extremely important in the development of athletic training students.³¹ Mentoring, professional acceptance, nurturing, modeling³¹ leadership style and years of experience³³ are a few of the areas in which a clinical instructor can influence athletic training students.

In a critical incident study, Curtis, Helion, and Dohmson³¹ identified categories of important behaviors by clinical instructors as reported by students in four accredited athletic training education programs. Students were asked to report behaviors that were

useful as well as detrimental to their learning. Mentoring, professional acceptance, nurturing and modeling were identified from the data, with mentoring being the most frequent.³¹ These data are also supported by Pitney and Ehlers³⁷ who interviewed 16 athletic training students to examine mentoring of athletic training students. Using a grounded theory approach they determined that there are prerequisites for a mentoring relationship which included the mentor being accessible and approachable as well as the student's own initiative. Interpersonal foundations were also important such as trust, similar values and a personal relationship. The final prerequisite for a mentoring relationship was the educational dimension. This included the mentor being a good facilitator of learning, designing individual experiences for students and encouraging the development of a professional perspective by the student.

Leadership style is also important. Clinical supervisors serve as mentors and models by passing along their leadership style to their students, and effective leadership is essential to motivating the students to reach their highest potential as students and future professionals. Meyer³² proposed situational leadership theory as a model for athletic training clinical supervisors to adopt. Situational leadership theory changes according to the situation and the students' characteristics. There are four different sub-styles (telling, coaching, participating, and delegating) that the supervisor can choose depending on both the situation and the student. The supervisor will tell a first year student very clearly what to do and how to do it. This style is suitable for that student, but a senior student with more knowledge and skills requires more responsibility to continue to develop into an entry-level professional. The senior would make and execute

a decision with supervision. This theory can also be modified according to situation. A senior may be told what to do if the situation requires it. By taking the level of the student and situation into account the supervisor can tailor the response to maximize student performance.

Since experience is essential for an athletic training student to develop into a competent, practicing professional, does the same hold true for a clinical instructor? Stemmons and Gangstead³³ say yes. They reported a decrease in athletic training student behaviors while being supervised by novice athletic trainers (defined as <1 year experience). They concluded that a lack of an educational background and teaching experience may have caused this decrease. Novice clinical instructors lack the background to provide a student-centered environment for the athletic training student. Their conclusions were to provide all clinical instructors with training, and to encourage students to take an active role in their own education. Also, program directors and clinical coordinators need to be sure all clinical instructors, especially novice clinical instructors are effective.³³

Since the behaviors of clinical instructors are so important to the growth and development of athletic training students, the level of supervision students are receiving is also very important. Put simply, clinical instructors cannot be mentors, leaders and teachers if they are absent from the clinical environment. Weidner and Pipkin³⁰ examined clinical supervision of athletic training students at 261 NCAA member institutions. They examined the amount of time students spent directly supervised and unsupervised, in what types of situations students were allowed to be unsupervised, and

what types of activities these unsupervised students were allowed to perform. The results were problematic yet not surprising. Seniors spend more time unsupervised than freshman, which was expected as seniors have more knowledge and skill proficiency. Students were also performing duties beyond the role of a first responder including using modalities and directing rehabilitation while not supervised. These activities are troublesome both from a state practice act view and from a clinical education view. Currently, 39 states regulate the practice of athletic training.³⁸ In these states it is illegal for anyone to perform the duties of an athletic trainer without being recognized by that state. From an educational standpoint, students require clinical instructors to exhibit a wide variety of behaviors to facilitate student development. The instructor cannot facilitate these behaviors if not present to supervise the student. A positive trend was that students in accredited or candidacy athletic training education programs were more likely to be first-responder trained and less likely to be unsupervised. NCAA division I institutions are more likely to have students practicing unsupervised.³⁰ It has been concluded that athletic training students are just that –students, and not a source of free labor to an understaffed athletic department³⁰. Clinical instructors need to be aware of how frequently students are left unsupervised and take steps to ensure athletic training students are receiving the amount and quality of clinical supervision needed.³⁰

Experiences

Most of the focus of research has been on the instructor and not the experience itself. Two studies have examined the clinical experience of athletic training students.³⁴

³⁶ The first was a comparison between total number of hours, sport assignments and

other demographic variables to the passing rate on the NATABOC entry-level certification exam.³⁶ While some variables affected certain sections of the exam, for example (e.g., older candidates scored higher on the practical portion of the exam), the total number of clinical hours was not related to a higher score or an increased passing rate for the exam in general. Particular sports were also examined to determine whether experience with a particular sport corresponded to a higher passing rate. Football anecdotally has been considered very important to an athletic training student's learning. However, students who worked with football did not have a higher exam passing rate than those students who did not have the opportunity to work with a football team. Sammarone-Turocy et al³⁶ agree with other athletic training educators that we should focus on providing quality experiences rather than a set quantity of experience. Students should be given structured experiences that require them to apply the knowledge and skills learned.

The second study was an observational study of the quality of experience athletic training students are receiving.³⁴ This was accomplished by video taping athletic training students in the clinical setting and using a behavioral analysis system to analyze the tapes. The tapes were analyzed to determine what athletic training students are doing during their experiences. Time was categorized into four sections: Instructional time, clinical time, managerial time and unengaged time. The tapes were then coded according to these categories. The amount of time in each category was compared to class standing and sport assignment. The 20 athletic training students in this study spent 59% of their clinical education time unengaged which included waiting for athletes or ACIs, and

socializing. Only 30% of the time was spent in an active learning mode with the final 11% being managerial in nature. No indication was given where time spent observing practice watching for injuries was designated. Senior students spent significantly more time engaged in clinical behavior. This is not surprising since senior students have mastered a greater number of skills they should be given more responsibility during their placements. Senior students also spent much less time unengaged and presumably had also become more comfortable in their role, were more confident in their abilities and therefore participated more frequently. The surprise though was that beginning and intermediate students were not spending more time in an instructional mode. Clinical educators need to be working with these students to learn and practice the knowledge and skills needed to become a confident and role socialized senior and eventually entry-level athletic trainer. Also interesting was that students assigned to sports classified as upper extremity were more likely to be unengaged than students assigned to a mixed or lower extremity sport. These results may have been affected by the number of teams in season or the classification made by the authors, yet they do reflect a need for variation in the students' placements. If upper extremity sports inherently have more unengaged time in the placement then students need to be exposed to a variety of upper, lower and mixed assignments. Another limitation of this study was the mere presence of the video camera. Students may have been less likely to perform skills because of the presence of the camera. Though this study may have had limitations, it is important to have a benchmark for student time on task in order to maximize student engagement while in the clinical setting. These data can be used by athletic training educators to develop strategies to

keep students engaged and on task during clinical placements. Athletic training students are in the clinical setting for a limited time and educators need to make sure that the engaged time is maximized.³³

The final study examining student clinical experiences also examined the amount of active learning time students are engaged in during their clinical field experiences.³⁹ This study is very similar to the previous one as it was conducted by a similar group of authors. This examination used student self-reporting for one typical day to determine how much time was spent in instructional time, clinical time, managerial time, unengaged time and waiting time. Active learning time (ALT) was calculated as the sum of clinical time and instructional time. The percentage of ALT was determined by dividing ALT by the total opportunity time. These data were then compared using a number of variables including length of experience, Academic program standing, gender, season, NCAA level, clinical assignment, and clinical setting. They reported students were in ALT 51% of the time and unengaged 17%. Of the demographic factors clinical setting revealed significant differences with students in the clinical/ industrial/ corporate setting engaged in clinical time as both students in the college and high school setting. These students also spent less time waiting. This may be related to time spent observing practices counting as waiting time. Students in a mixed extremity assignment also spent more time in ALT. This may have been related to the inclusion students in the clinical/ industrial/ corporate setting. Gender, season and NCAA level did result in some differences but because of the number of variables included may have had more to do with the type of students in each program. Over all it was concluded that because clinical

experience is extremely important to athletic training education and educators should closely examine how students are engaged in learning while at clinical field-experience sites.³⁹

Importance of Fieldwork in Other Allied Health Professions Education

The importance of clinical experience has been well documented in medicine and other allied health professions. In fact, many nursing and education students consider clinical experience to be the single most important aspect of their educational preparation¹. Teacher education, nursing,¹ medicine,⁴ clinical laboratory technician³ and occupational therapy⁴⁰ are just a few examples of professional programs that require clinical experiences as part of the curriculum. However, no one can put his or her finger on exactly what role it plays. By exposing students to an infinite variety of patients and conditions, clinical experience may improve professional skills,^{1,2,4,5} facilitate integration of theory and practice,^{1,2} increase critical thinking skills,⁵ enhance self-efficacy,^{1,6} socialize the student into the profession and develop a sense of altruism.¹ This exposure not only provides students with repeated opportunities to integrate theoretical and practical knowledge but it also helps students develop a sense of social responsibility and the importance of moral and ethical practice. Thus clinical experience is useful in helping students by continually integrating and reforming knowledge to develop a personal professional competence.²

Affective Domain

The affective domain is commonly understood to include the emotional aspects of learning including confidence, motivation, attitudes, values, anxiety, satisfaction,

opinions, beliefs and personal interests.⁴¹ Student development in components of the affective domain is inherent in developing professional competence. Epstein and Hundert⁴² include emotions, values and reflections in their definition of professional competence. The framework for their new definition proposed a three component theory: Cognitive function, relational function, and affective/moral function. The affective/moral function includes “willingness, patience, and emotional awareness to use these skills judiciously.” Another example of the affective domain in professional education is the professional code of ethics. Reilly⁴³ explains the code of ethics as an “instrument of accountability.” These codes provide the consumer with documentation of the values of a profession. Therefore developing the affective domain is vital to the process of becoming a competent professional.^{42, 43}

Emotions, values, attitudes and motivations are complex and difficult to assess. The affective domain is found in almost every learning situation yet is rarely the focus of the lesson.^{41, 43} Perhaps this lack of emphasis is because of society’s views regarding values education.⁴⁴ Many people feel values education should be left to families and churches and not schools. There are other possible explanations for this lack of emphasis as well. Many educators find evaluating students’ affective development difficult.⁴⁴ In medical education Howe⁴⁵ discusses another possibility, the “hidden curriculum,” which is not designed or specified yet embedded in each learning environment. It is assumed by many educators that the ‘hidden curriculum’ had been learned just by exposure. Attitudes and values are one area she indicates falls within this ‘hidden curriculum.’

Howe⁴⁵ disagrees with learning by osmosis. When learning goals are not specified they are not always met. Different students and students in different clinical settings are exposed to varied attitudes and values. Students are intelligent enough to learn to act as appropriate for each setting. Because they are just acting, and not really learning the appropriate attitudes and values they fail to maintain them when moved to a different environment. Medical education should be teaching attitudes, yet they need to be removed from the 'hidden curriculum' and be formalized⁴⁵.

There are three needed elements for development in the affective domain. Experiences are needed to expose the student to a variety of people and situations so that different value systems are encountered. Furthermore, the student must be self engaged themselves during the experience and not just be an observer. This emersion into the experience leads to the next element necessary for affective domain development, critical thinking. The student must process the experience and think critically about the values and emotions that were observed by others and expressed by the student. Students make judgments and decisions based not just on facts presented but also according to aspects of the affective domain such as values, beliefs, attitudes and emotions.^{42,43}

There is reason to believe that the affective domain is not well developed by classroom work alone,⁸ but require clinical experiences in which students are provided an avenue to observe moral and ethical practices modeled by a mentor. Beyond this, clinical experience allows the student to actually engage in such behaviors.⁴⁶ Modeling is an excellent teaching technique for encouraging development in the affective domain,⁴³⁻⁴⁵ though it is important to ensure that students are not just imitating the instructor, but

processing why these behaviors are important or whether they fit into the student's value set. Clinical experience is an excellent opportunity for students to develop in the affective domain because it is an opportunity to be immersed in a learning culture that models the attitudes and values sought, encourages mentoring by clinical practitioners, provides an opportunity to learn from life experiences by interacting with patients, and can be an excellent situation to promote self-reflection.⁴⁵

The affective domain can be difficult to evaluate quantitatively and few quality instruments exist.^{42, 43, 45} Clinical experience is important for evaluation of the affective domain as well because "the values that we hold are reflected in the behaviors that we demonstrate."⁴³ Spence, Hicock and Wiggers⁴⁴ agree that direct observation during clinical rotations is the most accepted evaluation method for affective domain development. Epstein and Hundert⁴² have another take on evaluating the affective domain. They suggest that patients and peers may be the most appropriate people to assess a student's affective development.

Krathwohl, Bloom, and Masia⁴⁷ developed a taxonomy in an attempt to simplify the affective domain. They designed a continuum modeled after the cognitive domain previously created. Categories range from merely being aware of a stimulus all the way to incorporating new behavior into a revised philosophy. The basis for the new taxonomy was internalization. Internalization was defined in 1958 by English and English as "incorporating something within the mind or body; adopting as one's own the ideas, practices, standards, or values of another person or society." As cited in Krathwohl, Bloom and Masia. By using this definition of internalization there is a lot of similarity

between socialization and the affective domain.⁴⁷ The primary difference being socialization's emphasis on conformity versus the affective domain's acceptance of both conformity and individualism.

Professional Socialization

Professional socialization is yet another important role of clinical experience. Socialization has been defined as “the process by which persons acquire the knowledge, skill, and dispositions that make them more or less successful members of society.”⁴⁸ Therefore professional socialization is the process to achieve the development of competence in the cognitive, psychomotor, and affective competence required by one’s chosen profession. Notice the emphasis is the development of professional competence not just the mastery of either cognitive theories or psychomotor skills, but all the facets of becoming a successful professional which includes the affective domain as well. Although the final product is very important, socialization is really focusing on how the student reaches this destination. The story is really in the journey.

There are different theories of professional socialization. Some would argue for a dialectical struggle as the student is constantly reexamining the differences between their ideals and the real world practices.⁴⁹ Others argue for an internalization of professional mores.⁴⁸ The model that seems the most complete and will be discussed here is a developmental model. Within this developmental model first described by Thornton and Nardi⁵⁰ each of the others has a place as well. The dialectical struggle and internalization of the professions behaviors and expectations is seen through out each stage of Thornton and Nardi’s model. Their emphasis is on this developmental process in which students

are exposed to both a set of generalized experiences and individual experiences⁵⁰ As students move through this developmental process they are met with three core elements of socialization: knowledge acquisition, investment, and involvement. Students work within these elements in different ways as they progress through the stages of socialization, which are anticipatory, formal, informal, and personal.

Finally the role of clinical experience in the development of professional socialization will be discussed. Clinical experiences must be designed to ensure that students are exposed to both individual and group experiences needed to develop a professional identity which is the hallmark of professional socialization.⁴⁸

Dialectical Perspective

A major aspect of professional socialization is a personal resolution of the discrepancy between ideal practice as experienced in the classroom or laboratory and the reality of the imperfect real world. Resolution of this discrepancy is essential to the student's development.⁴⁹ This appears to be a molding process in which students' conceptions of a professional are pulled and stretched in different directions by many different groups, including their own preconceptions, peers, family, institutions, professional organizations and experiences. Over time this internal twisting and pulling molds students' professional identities into that of a novice professional. The molding process can be considered a dialectic process. A dialectic is the struggle within a person to examine and think about differing views, conceptions and attitudes in order to synthesize a new personal view. When students struggle with the discrepancy between their ideal perceptions of clinical practice and the real world of clinical practice, not only

are their perceptions changed but the varied factors, which influence them, are changed in some way as well.⁵¹ In other words, as the student changes to fit the expected role, they also change the expected role to fit themselves.⁵⁰ This struggle is evident within each facet of professional socialization and is very much a part of the developmental process.

Developmental Model

Thornton and Nardi⁵⁰ are among the first to recognize professional socialization as a developmental process. Their model includes both sociological and psychological parameters as an individual learns and accepts a new role. They emphasize the importance of the interaction between the individual and the role as the individual is changed to fit the role and in the later stages how the role is modified to fit the individual. They break professional socialization into four stages: anticipatory, formal, informal, and personal.

Stages of Socialization

When conceptualizing professional socialization as a developmental process there are certain stages the student progresses through as they develop the three core elements. The first stage is anticipatory socialization. Each student has preconceived thoughts about the profession of interest gained from the news media, personal observation and interaction with a professional and interaction with third parties who have interacted with a professional. With these ideas the student pursues or is recruited into a professional education program. Early on the student becomes aware of the expectations of being a professional in the chosen field. These include cognitive theories, psychomotor skills, ethical practice and expected behaviors.⁴⁸ This awareness provides an early opportunity

for growth as the student enters a dialectical struggle to change and mold the preconceived ideas with the new information.⁴⁹

From a practical sense these students focus on learning rules and procedures. They enjoy using professional jargon and are anxious to comply with faculty and upperclassman instructions. They do not yet have the knowledge or skill to take initiative, but are anxious to learn and fit in. They are like a sponge ready to soak up new information and behaviors.⁴⁸

As a student becomes comfortable with the expectations of the chosen profession they apply and are accepted into the education program and move into the formal socialization stage.

Formal Socialization.

As the student becomes comfortable with these initial expectations of the chosen profession they make a decision to apply to the education program. Once accepted into the program they move into the formal stage of professional socialization. The primary source of information about professional expectations changes as they are now insiders. Expectations are learned primarily from role incumbents.⁵⁰ Classroom learning is the main source of learning cognitive theories and practical skills necessary to be a successful practicing professional. These expectations are generally clear, explicit and stated directly. These expectations tend to be idealistic because they are important to the function of the profession. They are the “must” do behaviors.⁵⁰ Another source of expectations is observation. Seeing and then reproducing expectations is an important component of professional preparation.⁴⁸

As the student is successful in the classroom and clinical setting they are given increased responsibility. As these responsibilities increase the student feels confirmed in their decisions and as a future professional.⁴⁸ Because of this desire to fit in and be successful and because the student is still getting used to the new role the emphasis is on knowledge and skills. Attitudes will be observed and imitated, but it is more to fit in as a member of the group rather than a true reaction to the situation.⁵⁰

Informal Socialization

Once comfortable with the theories and skills needed to fulfill the chosen role the student moves into the informal stage of professional socialization. In this stage the student is immersed into the professional culture.⁴⁸ The primary source of expectations is now peers and practicing professionals.^{48, 50} Because the student has already mastered the theories and skills needed to be successful the focus here is on attitudes and other grey areas of professional practice. The student is exposed to the adaptability inherent in the professional role while still being able to meet expectations.⁴⁸ They begin to mold and change their personal role to fit both the expectations and their own personality.⁵⁰

Personal Socialization

The final stage of professional socialization is personal. This stage is characterized by the formation of an individual professional identity.⁴⁸ Students continue to adapt the professional role to fit their own personalities. This is done by modifying the role by adding individual expectations. By adding these expectations students are “imposing their own style” upon the role.⁵⁰ Because of the modification of expectations the dissention between individual and role is reduced. By the personal stage

there is a connection between the individual and the role to produce a “mutual transformation.” Often the personal stage is encountered after students have graduated and have become practicing professionals.⁴⁸

Core Elements

The socialization process incorporates three core elements: knowledge acquisition, investment and involvement.⁴⁸ Knowledge acquisition is important because all professions have a core body of knowledge that must be acquired for successful practice. Part of this knowledge acquisition involves learning affective components of practice and the art of self-reflection. With this information, students can focus on changing behaviors and increasing confidence. As students learn the theories and constructs of the profession and the ability to self-reflect, they can begin to assume the role of a professional. As students continue to grow into this role, they develop a professional identity, which is vital to the socialization process.⁴⁸

Students must also make a personal investment to the profession. They need to commit time and energy to learning more about their professional role. Faculty mentoring becomes important in this element because students learn how to act like a successful professional from these mentors. The mentor passes along not just theories and skills, but also the values and mores of the profession. The greater the personal investment by students the more they will learn and feel compelled to follow these values. The level of professional socialization achieved by students is related to the level of commitment they feel toward the profession.⁴⁸

Involvement in the profession is also important. By interacting with practicing professionals and students at other levels of preparation, students experience first hand the philosophy and attitudes of the profession. It also provides students the opportunity to actually assume the role of a professional. This participation allows students to internalize the attitudes and philosophy of the profession and make them their own. This internalization and personal modification of the tenets of the profession lead to role identification. Students actually begin to view themselves as professionals. Although the core elements of professional socialization are discussed individually here, they are truly interrelated.⁴⁸

Clinical Experience

An important aspect of professional competence is the growth of a professional identity. This identity is formed as the student is socialized into a profession. Developing professional skills are as important as developing theoretical knowledge and psychomotor skills.⁵² Clinical experience aids socialization by including the student in the realm of professional practice. For example, many new nursing graduates are concerned with their lack of ability to actually fulfill the role of a nurse on a ward. They are not as concerned with a lack of theoretical or practical knowledge, but more the details of working a shift. Dunn et al¹ describes role integration as a major theme while examining benefits of field experience in nursing, adult education and teacher education programs. By assuming the role of an important and contributing member of the professional team the student integrates the theories, skills and attitudes learned in the classroom in a real practice setting.¹ Clinical experience is one opportunity to see this

professional socialization in action by providing students with opportunities to acquire and practice new knowledge, increase their sense of commitment to the profession and get involved in a professional role.

Integration of Knowledge

A competent professional is said to have not just theoretical knowledge, but also professional knowledge. Professional knowledge is the what, where, how and why to perform one's role as a professional. Professional knowledge is broken down into a number of components: Tacit, process, propositional, personal, and moral knowledge.⁵ Tacit knowledge is knowing how to respond to a situation but unable to explain the thought process behind the response. It is using patterns and perceptions to draw a conclusion.⁴² With experience a practitioner develops shortcuts instead of processing information step by step as a novice does. The expert can't explain how or why the shortcut is followed, they just know it. Personal knowledge is somewhat similar in that it is also primarily gained through experience. It may be thought of as following a hunch based on an impression. It is important to allow personal knowledge to act only as an insight to stimulate further thought and information gathering, not the end result.^{5, 42}

Many times tacit or personal knowledge provides the impetus for gathering information and then using their propositional knowledge. Propositional knowledge is simply knowing something no matter whether it came from a memory, or a public or private source.⁵

Professionals process all these types of knowledge using thinking and decision making skills to determine the best course of action. This use of previous knowledge is

process knowledge.⁵ The last component of professional knowledge is moral principles. These principles serve as an overarching guide for professional practice.

Clinical experience is vital for the development of professional knowledge and professional competence. Clinical experience allows the students to develop each of the four components of professional knowledge and provide a detailed context in which to learn and build this framework for a successful clinical practice.

Another aspect of clinical experience is integration of knowledge. It is not only important for students to have a good foundation of knowledge but to be able to adapt and use the knowledge in clinical practice as a practicing professional. Professional education should not remove knowledge from its context and teach theories and skills in isolation.^{42, 53} The student should instead be encouraged to remain flexible in their application of knowledge within a number of different and complex contexts.⁵ This integration is key to a professional's competence. When a practitioner can not just espouse factual knowledge, but actually process information, choose the appropriate skills, perform them, and interpret the results then they are a competent professional.^{1, 5, 42}

Thinking Skills

Another way to describe this integration of knowledge is the development of thinking skills. Thinking skills such as critical thinking, problem solving and clinical reasoning are all essential components of a competent professional.^{5, 54} These thinking skills are best developed in context.⁵ The context provides not only real world application of knowledge but it is also a powerful student motivator because of the perceived relevance to future practice.⁵

There is empirical evidence to support these theories of using clinical experience as a teaching method for thinking skills in occupational therapy. Sladyk and Scheckly⁵⁴ reported a significant increase in clinical reasoning scores following a 12 week fieldwork experience. Upon closer analysis of the data 70% of the subjects greatly improved their clinical reasoning scores. The authors also examined other variables including types of learning activities during the experience and number of learning activities. Examples of these activities included seeing similar patients, journaling, case studies, supervisor behaviors, etc. There were no differences reported for either variable.

Peer Learning in Clinical Experience

Peer practice is commonly accepted to involve individuals working collaboratively to enhance performance. Peer learning is thought to improve student reflection, promote a deeper understanding of cognitive theories,⁵⁵⁻⁵⁷ assist students in applying theory to clinical practice,⁵⁶⁻⁵⁸ problem solving⁵⁶⁻⁵⁸ and self-direction.⁵⁷ These concepts are important to the development of an independent practitioner. Peer learning is primarily used to allow students to work together to share experiences and learn and grow from each other. Most research in peer learning and clinical education discusses developing a reflective practitioner who can transfer knowledge from one situation to another by virtue of the deeper understanding of theoretical knowledge gained by peer learning practices.⁵⁵⁻⁵⁸ From a professional development standpoint, peer learning can be important as it provides opportunity for the student to practice being a colleague.^{57, 58} There is limited literature which indicates this practice helps the student develop a sense of professional identity.⁵⁷⁻⁵⁹

Early Field Experiences

There is also debate in other professional fields whether early field experiences are beneficial or not. Secret, Norwood and Keatley⁵² concluded that early field experience can enhance students development of professional skills and socialization into nursing. The key is to structure the experience to ensure the students feel like they belong to the profession, know how to care for the person and feel affirmed in their decisions and career choices. If the student is put into situations that isolate the student from the profession or are made to feel inadequate to accept the required role for the experience, then the field experience will decrease professional skills.⁵²

Duquette reported conflicting perceptions of students in highly field based education programs for teachers.⁶⁰ Elementary education students actually perceived a need for more classes especially in education theory and professional knowledge base to become better teachers. Secondary education students enrolled in the same program disagreed. They indicated the need for field experiences. However, it must be remembered that the secondary education students had taken more theory based courses in their area of concentration. Duquette concluded that while fieldwork is important to the education of teachers, educational theory is also essential to the development of a good novice teacher and should not be forgotten⁶⁰. A balance between classroom work and field experience needs to be reached. More and earlier field experience may not be the answer.

Stress levels are another aspect of field experience to keep in mind. In nursing education, initial clinical experiences can be very stressful. While Admi is not suggesting eliminating them from nursing education programs she does illustrate that

beginning nursing students experience very different stresses than more experienced nurses. These stresses need to be managed by the student before learning and caring for patients can be accomplished. Some of these stresses were related to a lack of background knowledge and experience⁶¹. These conflicts between the benefits and detriments to early field experiences are also likely to affect athletic training students' perceptions of clinical experience.

Summary

Athletic training is still a relatively young profession as evidenced by its short history. The leaders of the profession have brought athletic training from such a lowly beginning to its current level of respect largely through education. It is important to continue this growth and development by ensuring that future generations of athletic training students receive the best possible education. Athletic training educators are conducting research into a number of areas of clinical experience but there is not enough information as of yet to completely define the role of clinical experience as part of a well balanced education program. One area that has not been explored is the role of clinical experience in the development of the affective domain and another closely related topic professional socialization. Other allied health professions educators have examined clinical experience as a method to develop not only the affective domain and socialize students into the chosen profession but also as a good way to develop problem solving and thinking skills. This research is important for athletic training educators to examine and build upon to develop a better understanding of the role clinical experience can play in the development of these traits in athletic training students.

CHAPTER III

METHODS

This study was designed using a descriptive methodology. Reported data described entry-level athletic trainers' perceptions of certain aspects of their education program. These methods were chosen as a first step in defining the role of clinical experience as part of an entry-level athletic training education program. Subjects were asked to rate the importance of clinical experience in their mastery of selected educational competencies. These data were then used to describe the perceived importance of different clinical experiences to students' development of competence. Survey methods were chosen because surveys provide an idea of what subjects think rather than trying to measure a behavior.^{62, 63} Because the focus of this study was perceptions, a survey was an appropriate tool.

Survey Development

The researcher developed the survey using a representative sample of the affective domain educational competencies written by the NATA Education Council. Appendix A includes a list of all affective domain competencies as defined by the Education Council. This sample was chosen in consultation with a group of athletic training educators (n=4) with at least five years of teaching experience. The educators were chosen by convenience, and included program directors, clinical coordinators and ATEP faculty members. The group was given a copy of the affective educational competencies for each

of the following practice areas: risk management and injury prevention, pathology of injuries and illnesses, assessment and evaluation, acute care of injuries and illnesses, pharmacology, therapeutic modalities, therapeutic exercise, general medical conditions, nutritional aspects, psychosocial intervention and referral, health care administration, and professional development and responsibilities. They were asked to rank the competencies in order of importance (1=most important) to the practice of athletic training. Appendix B contains a copy of the letter and the survey that was sent to the educators. The three competencies in each practice domain ranked as the most important (lowest score) as determined by this group formed the content of the survey. The ranked scores for each competency are included in Appendix C.

The framework of the survey included definitions and examples of clinical education and field experience. Pilot subjects were asked to rate the importance of clinical education and field experience in their development of competence in the selected competencies using a Likert scale from 1=not important to 5=extremely important. A short demographic section followed to allow the investigator to examine whether the amount of time spent in each type of experience, quality of supervision, or early or late initiation of experiences affected the ratings.

Validity and Reliability

Face and content validity of the survey instrument were determined by the same group of athletic training educators described above to insure an accurate representation of each practice domain.^{62, 63} Face validity was assessed by a group of athletic training students (N=5) during their last semester of undergraduate coursework. These students

were asked to carefully read and complete the survey while commenting on the directions, format and ease of completing the survey. A focus group interview was used for data collection. The format of the survey was modified using these data. Reliability of the instrument was assessed using a pilot sample of entry-level athletic trainers who graduated from Elon University. These alumni met all of the inclusion criteria to be used in the study, and Institutional Review Board approval was granted (File # 023316) before pilot testing began. Appendix D contains the instrument used during this round of pilot testing. Subjects followed the same procedure that was used for final data collection. One month after completing the survey subjects were asked to complete the survey a second time so the results could be compared. Pearson Product Moment correlations were calculated for both clinical education $r(2) = .570$, $p = .430$ and field experience $r(2) = .794$, $p = .206$ to determine the stability of the instrument. An item analysis⁶² of pilot data from the first round of testing was also calculated to measure internal consistency (Standardized $\alpha_{CE} = .954$, standardized $\alpha_{FE} = .946$). Appendix E contains a complete correlation table.

Upon closer examination of these pilot data, a possible ceiling effect was identified. The ceiling effect was suspected because of high mean composite scores for both clinical education ($M_{CE} = 155.2$, $SD_{CE} = 20.3$) and field experience ($M_{FE} = 162.4$, $SD_{FE} = 16.2$). The highest possible composite score of 185 for each clinical education and field experience would indicate a rating of extremely important for all of the education competencies. The possible reasons for these results may have been that 1) the data were accurate and thus there was no ceiling effect, 2) the survey was not sensitive enough to

distinguish the differences in perceived importance of clinical experience and field experience, or 3) subjects had difficulty in distinguishing between clinical education and field experience. Because of the possibility of a ceiling effect the survey was reformatted in an effort to increase the sensitivity of the instrument as well as to make it easier for subjects to differentiate between clinical education and field experience.

Survey Modification

The format of the survey was modified because sensitivity of the instrument and confusion of subjects may have played a role in inflating the first pilot data. Instead of a definition of clinical education and field experience being followed by a table of education competencies, each competency was separated into its own table with a list of four activities commonly occurring during clinical experience. The four activities were practicing clinical proficiencies with peers in an AT lab/ clinical course, individual instruction/ assessment of clinical proficiencies with an approved clinical instructor, practice coverage under the supervision of a clinical instructor and game coverage under the supervision of a clinical instructor. These activities were categorized into either clinical education or field experience using the Education Council's definitions⁹. Peer practice and ACI instruction were categorized as clinical education. Practice and game coverage were categorized as field experience. Subjects were asked to rate each activity according to its importance in their mastery of each specific education competency. These 36 tables were followed by the same demographic questions as used in previous testing.

Since the format of the survey had changed, content validity testing was repeated. The survey was distributed to the same sample of athletic training educators who were used for prior validity testing. The subjects were asked to provide written comment via email on the new format and directions. They were also asked to analyze the activities chosen to represent both clinical education and field experience. Their third task was to carefully read the competencies and determine if any were not essential to provide a good representation of the affective domain. The reason for the emphasis on the educational competencies is that given the new format the instrument was long and time consuming to complete. If 66% or more of the panel suggested a competency be removed from the survey it was deleted. Five competencies were removed at this time. After comments from the panel of experts the instrument was also changed to a six point Likert scale rating the activities from least important to most important. In addition subjects were asked to rank each activity according to its importance in development of the specified competency. This addition was included to encourage subjects to decide which activities were the most important to their learning. It was hoped that these changes would eliminate the ceiling effect. After making the changes the survey was returned to the panel of experts for one last examination for both face and content validity. Two thirds of the panel responded in a positive manner that the format and directions for the instrument were clear and concise and that the instrument was a good representation of the affective domain. One panel member did not respond.

Second Pilot Test

Following all of the revisions and validity assessments the survey was pilot tested for internal consistency and stability. Appendix F includes the cover letter sent to all subjects for pilot two. Appendix J contains the modified survey instrument. Subjects followed the same procedure that was used in the final data collection. Two weeks after completing the survey, subjects completed the survey a second time for comparison. The sample for this round of testing was upper-class students in accredited athletic training programs. Second-year students enrolled in the University of North Carolina at Greensboro's entry-level master's program and Elon University's undergraduate program were chosen to participate in this aspect of pilot testing for convenience even though they did not exactly represent the population that was used for the final data collection. Since all students had at least one year of clinical experience and had been exposed to the education competencies, these subjects were deemed sufficient for purposes of reliability testing of the survey instrument. Subjects outside of the test population were chosen so as to not limit or duplicate subjects for final data collection.

Results

Ceiling Effect

One concern of the previous instrument was a possible ceiling effect. An examination of the descriptive statistics, found in Table 1 and 2, indicated that while a small ceiling effect may have still existed it did appear to be decreased following the instrument revisions. The maximum possible score for rated data was 186 (6 X 31) and

the ranked data maximum score was 124 (4 X 31). The means were high but not all compressed near the upper limit of the instrument.

Table 1. Descriptive statistics for each activity's rated importance score calculated from pilot two, round one data.

Activity	Round 1 \bar{x} (SD)	Round 2 \bar{x} (SD)
Peer practice	121.1 (34.8)	119.7 (29.5)
Game coverage	137.0 (13.9)	133.6(13.2)
Practice coverage	140.1 (16.8)	134.3(18.3)
ACI practice	149.0 (19.1)	144.7 (19.4)

Table 2. Descriptive statistics for each activity's ranked importance score calculated from pilot two, round one data.

Activity	Round 1 \bar{x} (SD)	Round 2 \bar{x} (SD)
ACI instruction	53.4 (15.0)	65.7(25.0)
Practice coverage	81.0 (20.8)	86.1(19.9)
Game coverage	87.1 (19.8)	90.5(15.3)
Peer practice	93.3 (25.7)	96.9(22.8)

Reliability

Reliability testing consisted of both internal consistency and stability testing. The results of pilot two are included in Appendix G. For internal consistency an item analysis was calculated from round one data for each of the four activities Likert scores with a range of standardized alpha =.8541-.9802. Table 3 includes the internal consistency data for each specific activity. The round one ranked data for each activity were also tested for internal consistency by item analysis. The range of the four activities was standardized alpha=.8874-.9707. Table four includes specific internal consistency data

for the four activities ranked data. Round one data were used for analysis because of a low return rate for round two (n=3). Stability was assessed using a test-retest method. This analysis indicated poor stability but it is impossible to draw any conclusions from these data because of the small sample size. Table five includes the stability data for each activity for reference. The composite scores for each activity were compared from the first round of testing to the second round of testing with an intraclass correlation ICC (3,1) formula. The (3,1) formula was chosen because the intent was to examine the reliability of the instrument rather than generalize these data to any other population.

Table 3. Internal consistency of each activity's rated importance scores for pilot two round one and round two as calculated from standardized alpha and intraclass correlation coefficient (ICC).

	Round 1			Round 2		
	Alpha	ICC	95% CI	Alpha	ICC	95% CI
Game	.8541	.86	.62-.98	.1440	.00	-.30-.97
Practice	.9485	.95	.87-.99	.8514	.85	.42-1.00
ACI	.9611	.95	.88-.99	.8210	.84	.36-1.00
Peer	.9802	.98	.95-1.00	.7712	.60	-.67-.99

Table 4. Internal consistency of each activity's ranked importance scores for pilot two calculated from standardized alpha and intraclass correlation coefficient (ICC) (*=not standardized alpha, **= 13 competencies without variance)

Activity	Round 1			Round 2		
	Alpha	ICC	95% CI	Alpha	ICC	95% CI
Game	.8874	.89	.72-.98	.3640*	.36	-2.8-1.00**
ACI	.9065	.91	.77-.98	.9936	.99	.94-1.00
Practice	.9694	.97	.92-.99	.9931	.99	.96-1.00
Peer	.9707	.97	.91-1.00	.9811	.98	.92-1.00

Table 5. Stability of scores between the second pilot test round one and round two as calculated by intraclass correlation coefficients (ICC) for rating and ranking scores of each activity

Activity	Ratings ICC (3,1)	Rankings ICC (3,1)
ACI instruction	0.06	0.73
Game coverage	0.12	0.05
Peer practice	0.13	-0.03
Practice coverage	0.26	0.13

The range of the ICCs across the four activities was ICC=0.06-0.26. The composite score for each activity was calculated as a simple sum of all Likert scores for the activity. Stability of the ranked data was examined in the same way using a composite score of the ranked data for each of the four activities with a range of ICC=-0.03-0.73. The composite score was calculated by a simple sum of all the ranked data for each of the activities. Table five also includes the stability scores for the ranked data.

These data (ICC=-0.03-.73) were concerning, but it was decided that the internal consistency values from round one were sufficient to proceed. The final data collection did not include multiple rounds of testing therefore poor stability which may have been sample size related was not sufficient to change the instrument.

Sample

Entry level BOC certified athletic trainers who graduated from a CAAHEP accredited entry-level education programs served as the study population. These individuals were selected because by graduating from such a program and passing the certification exam, it is assumed they have developed competence in the NATA Educational Competencies and Clinical Proficiencies. Entry-level athletic trainers were

chosen because recent graduates have more perspective into the profession of athletic training and were able to provide more complete data. To be included in the study, each subject must have been employed as a certified athletic trainer in a recognized practice setting.

Sample size needs were determined by calculating the effect size from round one data using $f = \sqrt{SS_{bet}/k\sigma^2(1-\rho)}$ as suggested by Green⁶⁴ for a repeated measures design.

The effect size ($f_{rate}=.0951$, $f_{rank}=.1978$) was then used to determine the appropriate sample size at power =.80 and $p=.05$ from the power table in Barcikowski and Robey⁶⁵. Sample size needs according to the rated data was 142 and ranked data was 192. Nine hundred twenty-nine subjects from the above population were chosen by the Board of Certification. This number was chosen to adjust for incorrect email addresses, subjects that were not currently employed as athletic trainers and return rate. A list of the exam candidates' email addresses who became certified between November 2002 and November 2003 was requested from The BOC.

Procedures

The survey was created using INQUISITE survey development software and published to a secure web site hosted by Elon University. Subjects received an email invitation to participate in the study including a brief description of the survey and a description of how informed consent was obtained. Passive informed consent was given by submission of the survey. Also included was a hyperlink to the web site hosting the survey so subjects needed only to click on the link to be taken directly to the survey instrument. There were no changes to the survey between the final pilot study and data

collection. Appendix H includes a copy of the cover letter sent to all subjects. Appendix I contains the survey instrument used. An IRB application including the final survey instrument was submitted and approved as exempted from review (File # 045108) before final data collection began. Appendix H includes the IRB exemption. All responses were kept confidential. Subjects were asked for their email address only to insure their removal from the reminder email list. Due to server issues these data were lost and not able to be retrieved. All subjects received four email reminders; the first after two weeks of being invited to participate, another after four weeks, the third and fourth reminders were sent at one week intervals. The reminder schedule was extended because of the server issues discussed above and winter break.

Web based procedures were chosen because of evidence of an increased response rate.⁶² Also, by using the internet, the data could be directly coded into an Excel file making data reduction and analysis faster. Internet access should have been available to most of the sample either at work or on a personal computer. All subjects should have been familiar with using the internet and accessing web pages as part of their education. Since this study was not concerned with ethnicity or socioeconomic status using computer based methods should not have affected the data.

Analysis

Each subject received two separate composite scores: one being the sum of all rated responses on the importance of the two activities categorized as clinical education and the second being the sum of all rated responses on the importance of the two activities categorized as field experience. These composite scores were used to assess

differences in the perceived role of formal and informal clinical experiences in the development of professional socialization using a repeated measures ANOVA. All analyses were calculated using SPSS (Statistical Package for Social Scientists) version 11.5. The composite scores were then also used to determine whether any of the demographics affected the perceived importance of clinical education or field experience using separate one way ANOVAs. Each activity was also examined individually with a repeated measures ANOVA to determine the perceived role of peer practice, one on one instruction with an ACI, practice coverage or game coverage on professional socialization of athletic trainers. Subjects were also asked to rank each of the four activities according to its importance in their development of competence. These rankings were examined using a repeated measures ANOVA to determine differences in the rankings for each activity. Table six describes the analysis in further detail. The assumption of sphericity was not violated; therefore, the degrees of freedom were not adjusted using either the Greenhouse and Geisser or Huynh and Feldt correction.

Table 6. Table of specification using research questions and hypotheses from Introduction

Research Question #1	Hypothesis	Peer practice	1-1 ACI	Practice coverage	Game Coverage	Percent CE & FE	Quality Super.	First exp.	Analysis
A		Rated CE Composite Score	Rated FE Composite Score	Rated FE Composite Score					$H_0: \mu_{CE} = \mu_{FE}$ Repeated measures ANOVA DV= imp score IV= Experience (2 levels)
B		Ranked Composite Score	Ranked Composite Score	Ranked Composite Score					$H_0: \mu_1 = \mu_2 = \mu_3 = \mu_4$ Repeated measures ANOVA DV=imp score IV=Experience (2 levels)
C		Rated Scores	Rated Scores	Rated Scores	Rated Scores				$H_0: \mu_1 = \mu_2 = \mu_3 = \mu_4$ Repeated measures ANOVA DV=imp score IV=activity (4 levels)
D		Ranked Scores	Ranked Scores	Ranked Scores	Ranked Scores				$H_0: \mu_1 = \mu_2 = \mu_3 = \mu_4$ Repeated measures ANOVA DV=imp score IV=activity (4 levels)

Table 6. Table of specification using research questions and hypotheses from Introduction Continued

Research Question #2	Hypothesis	Peer practice	1-1 ACI	Practice coverage	Game Coverage	Percent CE & FE	Quality Super.	First exp.	Analysis
A		Rated CE composite score		Rated FE Composite Score		X			$H_0: \mu_1 = \mu_2 = \mu_3 = \mu_4 = \mu_5$ 1 X 5 ANOVA DV=imp score IV=% time in CE (5 levels)
B		Ranked CE Composite Score		Ranked FE Composite Score		X			$H_0: \mu_1 = \mu_2 = \mu_3 = \mu_4 = \mu_5$ 1 X 5 ANOVA DV=imp score IV=% time in CE (5 levels)
C		Rated Score	Rated Score	Rated Score	Rated Score	X			$H_0: \mu_1 = \mu_2 = \mu_3 = \mu_4 = \mu_5$ 1 X 5 ANOVA DV=imp score IV=% time in CE (5 levels)
D		Ranked Score	Ranked Score	Ranked Score	Ranked Score	X			$H_0: \mu_1 = \mu_2 = \mu_3 = \mu_4 = \mu_5$ 1 X 5 ANOVA DV=imp score IV=% time in CE (5 levels)
E		Rated CE Composite Score		Rated FE Composite Score			X		$H_0: \mu_1 = \mu_2 = \mu_3 = \mu_4 = \mu_5$ 1 X 5 ANOVA DV=imp score IV=Qual. Supervision (5 levels)
F		Ranked CE Composite Score		Ranked FE Composite Score			X		$H_0: \mu_1 = \mu_2 = \mu_3 = \mu_4 = \mu_5$ 1 X 5 ANOVA DV=imp score IV=Qual. Supervision (5 levels)
G		Rated Scores	Rated Scores	Rated Scores	Rated Scores		X		$H_0: \mu_1 = \mu_2 = \mu_3 = \mu_4 = \mu_5$ 1 X 5 ANOVA DV=imp score IV=Qual. Supervision (5 levels)
H		Ranked Score	Ranked Score	Ranked Score	Ranked Score		X		$H_0: \mu_1 = \mu_2 = \mu_3 = \mu_4 = \mu_5$ 1 X 5 ANOVA DV=imp score IV=Qual. Supervision (5 levels)
I		Rated CE Composite Score		Rated FE Composite Score				X	$H_0: \mu_1 = \mu_2 = \mu_3 = \mu_4 = \mu_5$ 1 X 4 ANOVA DV=imp score IV= first exp (4 levels)
J		Ranked CE Composite Score		Ranked FE Composite Score				X	$H_0: \mu_1 = \mu_2 = \mu_3 = \mu_4 = \mu_5$ 1 X 4 ANOVA DV=imp score IV= first exp (4 levels)
K		Rated Scores	Rated Scores	Rated Scores	Rated Scores			X	$H_0: \mu_1 = \mu_2 = \mu_3 = \mu_4 = \mu_5$ 1 X 4 ANOVA DV=imp score IV= first exp (4 levels)
L		Ranked Score	Ranked Score	Ranked Score	Ranked Score			X	$H_0: \mu_1 = \mu_2 = \mu_3 = \mu_4 = \mu_5$ 1 X 4 ANOVA DV=imp score IV= first exp (4 levels)

Percent CE & FE= percent of time spent in formal and informal experiences, Quality, Super= overall quality of supervision, first exp.= when clinical experiences began

CHAPTER IV

RESULTS

This study examined the importance of various clinical experiences in professional socialization of athletic trainers. This chapter is organized into sections according to the hypotheses discussed in chapter one. Briefly stated, informal clinical education experiences are more important than formal field experiences to the development of professional socialization skills. The amount of time spent in formal and informal clinical experiences, quality of supervision or length of clinical experiences will increase the perceived importance of formal and informal clinical experiences in development of professional socialization for both rated and ranked data.

Descriptive Statistics

A score was calculated to represent each of the four activities investigated by summing the Likert score for each competency. Likewise the rankings for each competency were summed to provide a ranked score. These scores were used to represent each activity in all further analyses. Composite scores for clinical education and field experience were also calculated by summing the activity scores. Clinical education was represented by the peer practice and ACI instruction while field experience was represented by practice and game coverage. Descriptive statistics for each activity's rated score and rated composite scores are located in table 7. Table 8 contains the descriptive statistics for each activity's ranked score and ranked composite score.

Table 7. Descriptive data calculated for each activity and composite rated importance score

Activity	Mean	Standard deviation
Peer practice	115.45	27.58
Game coverage	118.62	19.20
Practice coverage	127.15	19.00
ACI instruction	135.35	19.76
Field experience composite (Game + Practice)	245.77	36.10
Clinical experience composite (Peer + ACI)	250.80	40.62

Table 8. Descriptive data calculated for each activity and composite ranked importance score

Activity	Mean	Standard deviation
ACI instruction	60.52	18.39
Practice coverage	74.58	19.762
Game coverage	88.62	19.34
Peer practice	89.82	24.45
Field experience composite (Game + Practice)	150.33	31.03
Clinical experience composite (Peer + ACI)	163.20	32.81

The response rate was 13% which was calculated by determining the number of individuals that both received the email and met all inclusion criteria to participate in the study. Table 9 provides details about the calculation of response rate. The figures indicating the average percentage of graduates gaining employment in athletic training or pursuing a graduate degree was adapted from the JRC-AT tracking data published in the NATA News.^{66, 67}

Table 9. Data used in the calculation of response rate.

Initial sample	929
Undeliverable emails	99
Sample who received emails	830
Entry-level graduates employed ATC (mean 98-02) ^(JRC-AT Entry)	42%
Entry –level graduate enrollment in advanced athletic training or other non health science graduate program (2002)	16%
Graduate level students employed in athletic training ^(JRC-AT Grad)	86%
Graduate students employed from this sample (16*.86)	13.8%
This sample employed as an athletic trainer	55.8%
Adjusted sample size	462.8
Total returned surveys (62-2 less than ½ complete)	60
Adjusted response rate.	0.130

Internal consistency was also calculated for both rated and ranked data for each activity using an item analysis. The range for the rated data was standardized alpha=.9349 - .9697. Reliability of the ranked data was determined in the same manner with a range of standardized alpha=.8751 - .9446. Tables 10 and 11 include further details about the specific internal consistency data for each activity.

Table 10. Internal consistency values as measured by standardized alpha and intraclass correlation coefficient (ICC) for the individual activities rated importance scores

Activity	Alpha	ICC	95% CI
Game coverage	.9349	.93	.91-.96
Practice coverage	.9422	.94	.92-.96
ACI Instruction	.9600	.96	.94-.97
Peer practice	.9697	.97	.96-.98

Table 11. Internal consistency values as measured by standardized alpha and intraclass correlation coefficient (ICC) for the individual activities ranked importance scores

Activity	Alpha	ICC	95% CI
Game coverage	.8751	.88	.83-.92
ACI Instruction	.9284	.93	.90-.95
Peer practice	.9439	.94	.92-.96
Practice coverage	.9448	.94	.92-.96

Importance of Clinical Experiences

The first research question related to whether entry-level athletic trainers perceived clinical experiences to be important in the development of professional socialization. Using the composite scores, there were no differences in the importance of clinical education and field experiences in development of the selected affective domain competencies, $f(1,59)=1.017$, $p=.317$, $\eta^2=.017$, $(1-\beta)=.168$. However, when considering each activity separately there were statistically significant differences, $f(3,56)=18.568$, $p=.000$, $\eta^2=.239$. Table 12 details where these differences occurred. ACI instruction was more important than the other three activities. Practice coverage was more important than both game coverage and peer practice

Table 12. Results of a pairwise comparison of the rated mean importance for the four activities in development of professional socialization.

	Activity	Mean Difference	Std. Error	Significance
Peer	ACI	-19.90	3.30	.000
	Practice	-11.70	3.76	.003
	Game	-3.17	3.72	.398
ACI	Peer	19.90	3.30	.000
	Practice	8.20	2.15	.000
	Game	16.73	2.40	.000
Practice	Peer	11.70	3.77	.003
	ACI	-8.20	2.15	.000
	Game	8.53	1.61	.000
Game	Peer	3.17	3.72	.398
	ACI	-16.73	2.40	.000
	Practice	-8.53	1.61	.000

Using composite scores to represent the ranked data, clinical education was more important than field experience, $f(1,59)=4.216, p=.044, \eta^2=.067$. Among ranked data there were also differences in level of importance of specific activities in the development of competence in the affective domain, $f(3,56)26.892, p=.000, \eta^2=.313$. ACI instruction was again considered the most important activity. Practice coverage was also more important than both game coverage and peer practice. Table 13 details the differences among each activity.

Table 13. Results of a pairwise comparison of the ranked mean importance for the four activities in development of professional socialization.

	Activity	Mean Difference	Std. Error	Significance
Peer	ACI	29.30	3.89	.000
	Practice	15.23	4.59	.002
	Game	1.20	3.97	.764
ACI	Peer	-29.30	3.89	.000
	Practice	-14.07	3.45	.000
	Game	-28.10	3.63	.000
Practice	Peer	-15.23	4.59	.002
	ACI	14.07	3.45	.000
	Game	-14.03	2.75	.000
Game	Peer	-1.20	3.97	.764
	ACI	28.10	3.63	.000
	Practice	14.03	2.75	.000

Demographic Effects

There were no differences between the clinical education and field experience composite scores with any of the demographic factors. The amount of time spent in clinical education versus field experience, quality of supervision, or early versus late clinical experience had no effect on the importance of either clinical education or field experience in either rated or ranked data. Tables 14 through 16 outline the specific analyses.

Table 14. Results of one-way ANOVAs considering the effect of time spent in clinical education versus field experiences on the importance of clinical education (CE) and field experience (FE) for professional socialization.

Experience type	F(df)	Significance
Rated CE Composite	.439(3,56)	.726
Rated FE Composite	2.322(3,56)	.085
Ranked CE composite	.444(3,56)	.723
Ranked FE composite	.923(3,56)	.436

Table 15. Results of one-way ANOVAs considering the effect of supervision quality on the importance of clinical education (CE) and field experience (FE) for professional socialization.

Experience type	F(df)	Significance
Rated CE Composite	2.218(3,56)	.096
Rated FE Composite	1.624(3,56)	.194
Ranked CE composite	.631(3,56)	.598
Ranked FE composite	2.169(3,56)	.102

Table 16. Results of one-way ANOVAs considering the effect of number of semesters spent in clinical experience on the importance of clinical education (CE) and field experience (FE) for professional socialization utilizing both rated and ranked data.

Experience type	F(df)	Significance
Rated CE Composite	.569(3,56)	.569
Rated FE Composite	.694(3,56)	.504
Ranked CE composite	.745(3,56)	.479
Ranked FE composite	.110(3,56)	.896

When comparing rated data for specific activities there were also no differences in the perception of importance between any of the four activities while considering the percentage of time spent in clinical education as compared to field experience, quality of supervision or when the education program's clinical experiences began (Tables 17-19). Upon examination of the ranked data for specific activities (Tables 20-22) there were two notable differences. Athletic trainers who began their field experience in the third year of the program ranked ACI instruction as less important than those who had earlier field experience. These findings may not be meaningful as eight subjects were in the late experience group. Subjects who rated their supervision as above average ranked game coverage as less important than subject's with excellent supervision. Again this may be a

subject number artifact. The group (n=35) that rated supervision above average was larger than any of the other groups.

Table 17. Results of one-way ANOVAs utilizing the rated data considering the effect of time spent in clinical education versus field experience on the importance of each activity for professional socialization.

Activity	F(df)	Significance
Peer Practice	.125(3,56)	.945
ACI interaction	1.062(3,56)	.373
Practice Coverage	2.396(3,56)	.078
Game Coverage	1.943(3,56)	.133

Table 18. Results of one-way ANOVAs utilizing rated data considering the effect of quality of supervision on the importance of each activity for professional socialization.

Activity	F(df)	Significance
Peer Practice	2.562(3,56)	.064
ACI interaction	.985(3,56)	.406
Practice Coverage	2.023(3,56)	.121
Game Coverage	1.182(3,56)	.325

Table 19. Results of one-way ANOVAs utilizing rated data considering the effect of number of semesters spent in clinical experience on the importance of each activity for professional socialization.

Activity	F(df)	Significance
Peer Practice	1.992(2,57)	.146
ACI interaction	.318(2,57)	.729
Practice Coverage	.787(2,57)	.460
Game Coverage	.482(2,57)	.620

Table 20. Results of one-way ANOVAs utilizing ranked data considering the effect of time spent in clinical education versus field experience on the importance of each activity for professional socialization.

Activity	F(df)	Significance
Peer Practice	.460(3,56)	.711
ACI interaction	.968(3,56)	.414
Practice Coverage	1.609(3,56)	.197
Game Coverage	.433(3,56)	.730

Table 21. Results of one-way ANOVAs utilizing ranked data considering the effect of quality of supervision on the importance of each activity for professional socialization.

Activity	F(df)	Significance
Peer Practice	.360(3,56)	.782
ACI interaction	1.409(3,56)	.250
Practice Coverage	.723(3,56)	.543
Game Coverage	3.369(3,56)	.025

Table 22. Results of one-way ANOVAs utilizing rated data considering the effect of number of semesters spent in clinical experience on the importance of each activity for professional socialization.

Activity	F(df)	Significance
Peer Practice	2.784(2,57)	.070
ACI interaction	3.876(2,57)	.026
Practice Coverage	.775(2,57)	.465
Game Coverage	.271(2,57)	.764

CHAPTER V

DISCUSSION

The primary findings were that both clinical education and field experience were equally important to entry-level athletic trainers' perceptions of professional socialization. Clinical education was measured by combining the scores for peer practice and ACI instruction, while field experience was measured by combining practice and game coverage. A closer examination of the data reveals that the four activities may have balanced each other resulting in one composite score being relatively equal to the other. When the activities are examined separately, differences in importance did arise between ACI interaction, practice coverage, game coverage and peer practice.

Approved Clinical Instructor Interaction

ACI interaction was considered the most important activity by both rated and ranked data. These data support the thought that clinical supervisors are the backbone of a quality experience for athletic training students. In the allied health care and athletic training literature the terms role model and mentor are used without consistent definitions.^{31, 37, 49, 68} These variations across studies result in both terms being used to represent a similar ACI- student relationship. Because of the inconsistent use of terminology this study considered the term "role model" to be when the ACI was exhibiting behaviors observed by students which changed the students' practice but were not intended solely to change behavior. An ACI practicing as a moral and ethical athletic

trainer would be a good role model even though they are not consciously trying to change the students' behaviors. The term "mentor" was defined as a close relationship between two individuals where the mentor acts intentionally to change the behavior of the student. An ACI demonstrating and explaining moral and ethical practice to a student in order to change student behavior is acting as a mentor. These definitions are adapted from two qualitative athletic training studies conducted where data were collected from students about the role of ACIs³¹ and mentors.³⁷

Pitney and Ehlers³⁷ reported that undergraduate athletic training students who consider themselves in a mentor/student relationship identify either the ACI or clinical instructor as the mentor. Perhaps it is this role of mentor performed by the ACI that subjects perceived as so important to their professional socialization. Mentoring was continually reported in the athletic training literature^{31, 32, 37, 69} as well as other allied health literature^{49, 70} as vital to professional socialization. Mentors and role models are thought to aid in students' role identity, by either intentionally or unintentionally allowing development of skills, values and behaviors necessary for successful practice.⁴⁹

Closing the theory practice gap is one area of professional socialization that is assisted by a relationship with a professional role model or mentor. Closing the theory practice gap allows the student to adjust their professional identity from that of an idealistic student to that of a novice professional.⁴⁹ Mentors were considered very important in assisting students to feel like they belonged to the health care team and had the knowledge and confidence to actively participate with in the team.⁵²

These data agreed with Curtis, Helion, and Dohmson's³¹ critical incidence study which identified categories of important behaviors by clinical instructors as reported by students in four accredited athletic training education programs. Students were asked to report behaviors by instructors that were useful as well as detrimental to their learning. Mentoring, professional acceptance, nurturing and modeling were identified from the data, with mentoring being the most frequent.³¹

Whether the ACI is acting as a role model, mentor or just providing an accepting and nurturing environment for the student to learn, their presence is clearly important in student development and professional socialization. In order to maximize these functions, ACIs need to be mindful of the relationship they develop with athletic training students under their supervision. In order to be a good mentor, Pitney and Ehlers reported the importance of being accessible and approachable. Also important is developing a relationship with the student based on similar values and trust. The third area of importance was facilitating the students' development of the knowledge, skills and behaviors necessary for successful professional practices.³⁷ Not every ACI will develop this type of close personal relationship with each athletic training student, but these behaviors are important to remember when interacting with students. All ACIs should act in ways to intentionally improve students' behaviors and professional socialization.

Practice versus Game Coverage

Practice coverage was considered the second most important activity in the learning of professional socialization. The data support the fact that, just as in the

nursing profession,^{49, 52} athletic training students need clinical experience to become successful practicing athletic trainers.^{69, 71} Students can have the best classroom teachers and master all the relevant clinical skills in the laboratory, but still not be qualified clinicians.⁸ Students need to spend time in clinical settings to develop decision-making skills and competence in the affective domain.⁸ Clinical experiences allow students to incorporate real world experiences into their learning which enhances their development of a professional identity.^{1, 8, 49}

It is interesting that while both practice and game coverage were considered important to learning, practice coverage was considered more important. Perhaps this has to do with the nature of each activity. Practice opportunities far out number game opportunities in any given athletic season, therefore subjects had more exposure to practices which may have influenced their perceptions of importance. Subjects may have learned more during practice coverage simply because they spent more time covering practices. Practices also may lend themselves to an enhanced educational opportunity because of the intensity of the experience. Depending on the situation perhaps students are encouraged to more actively participate as athletic trainers during practices. The clinical instructor and students may feel less pressure during a practice and be able to take advantage of a greater number of teachable moments during the experience. Often times the focus shifts away from education during a game environment. Because of pressures during a game to perform skills students may be less likely to engage in these professional behaviors. Likewise there is less time for interaction between the student

and ACI during a game for corrective feedback. These parameters make a game situation a less conducive environment for student learning.

Subjects were asked to rate the importance of supervised practice and supervised game coverage while completing the survey. The presence of an ACI during these experiences may have affected the subject's perceptions of both practice and game coverage. The effects of practice and game coverage can not be separated from the presence of the ACI in these data. Only supervised experiences were examined as those are the only experiences defined as educational by the JRC-AT.

When considering the importance of practice and game coverage there is essentially no data with which to compare these results. There is little research in athletic training education that has examined different clinical experience activities. Two studies have investigated students' learning activities during practice coverage³⁴ and a comparison of high school practice coverage, college practice coverage and a clinical/ industrial/ corporate rotation.³⁹ No one has compared practice coverage to game coverage as of this time. Miller³⁴ reported that athletic training students were only engaged in active learning 30% of the time spent in clinical experience. Berry³⁹ reported that students spent more time actively engaged while in a clinical / industrial/ corporate setting than in the college/ university or high school setting. While these studies are interesting it would be useful to also investigate different clinical activities such as practices, games, treatment times, etc to further understand how to best develop clinical experiences for our students. Another limitation of these studies is that observing practice was considered waiting time which was not included as active learning.^{34, 39}

Observing practice can be a valuable learning experience in that the student is learning about the biomechanical and physiological demands of the athletes as well as watching for injuries.

Peer Learning

While subjects perceived peer practice of clinical proficiencies to be an important component of clinical experience, they reported it to be less important than ACI instruction and practice coverage for professional socialization. This is interesting as peer practice is commonly accepted to involve individuals working collaboratively to enhance performance. Peer learning is thought to improve student reflection, promote a deeper understanding of cognitive theories,⁵⁵⁻⁵⁷ assist students in applying theory to clinical practice,⁵⁶⁻⁵⁸ problem solving,⁵⁶⁻⁵⁸ practical skills,⁷² self-direction¹⁵ and confidence.⁷³ These concepts are all important to the development and socialization of an independent practitioner since professional socialization is the development of the knowledge, skills, attitudes, roles and values of a successful practitioner.

Peer learning is primarily used to allow students to work together to share experiences and learn and grow from each other. From a professional development standpoint, peer learning can be important as it provides opportunity for the student to practice being a colleague.^{57, 58, 74} Athletic trainers, like other health care providers, rarely work in isolation. Peer learning allows the student to practice being part of the health care team. By learning to collaborate with peers, students will be better socialized into the profession.⁷⁴ This practice helps the student develop a sense of professional identity.⁵⁷⁻⁵⁹

There are disadvantages to peer practice which may support the subjects' assertions of the secondary importance of peer practice for socialization. When working solely with peers there are no experts involved to inform them of the proper role of an athletic trainer in various situations. Peer learning can result in incorrect learning when no one in the group has a correct understanding of the theory or skill at hand.⁵⁶ Peer learning can also reveal the difference in understanding between the group members.⁵⁵ Peer learning relies upon previous experiences and for a novice it may not be the best relationship.⁵⁵ These disadvantages taken together may have contributed to the perception that peer practice is less important for professional socialization. However it is important to remember that while peer learning was considered less important than ACI interaction and practice coverage it was still rated as important overall. Peer practice received a mean Likert score of 3.72 on a six point scale. A score of 3.0 is an important barometer as it would indicate a neutral feeling towards the activities' importance for professional socialization. Table 23 provides the mean Likert score for each activity's importance rating.

Table 23. Average Likert Scale rating for each activity's importance for professional socialization on a six point scale with 1 being least important and six being most important.

Activity	Average score
Peer Practice	3.72
Game Coverage	3.83
Practice Coverage	4.10
ACI Interaction	4.37

Demographic Effects

When considering the demographics, again there was no difference between clinical education and field experience. These analyses may have been affected by the low sample size as some demographic groups had very small numbers. When looking at the ranked data there were two statistical differences. ACI interaction was considered less important by athletic trainers who began their experiences later in the program. This difference may be related to the knowledge base and confidence level of these students who have had more class work before entering the clinical setting. They feel less dependent upon the ACI mentoring. However, given that the later experience group (n=8) was much smaller than the earlier experience groups, it is possible that it is a sample size issue rather than a real effect.

Another activity specific difference was related to supervision. Subjects who rated their supervision as above average ranked game coverage as less important than those who rated their supervision quality as excellent. There were no differences in average and below average supervision with any other group. Again this may be a sample artifact as the above average group was larger than any of the other supervision groups. These data may be mimicking the overall sense of the sample related to game coverage.

Response Rate and Generalizability of the Findings

The primary limitation to this study was the response rate, although there is a national trend of decreasing response rates in survey research.⁷⁵⁻⁷⁸ According to a meta analysis conducted by Sheehan⁷⁵ the mean response rate for email based surveys in 2000

was 24%. Four of the email surveys examined by Sheehan⁷⁵ published from 1986-2000 had single digit response rates. Reasons for this decline in response rates were increase in the number of surveys potential subjects receive,^{75, 76} length of survey and issue salience.⁷⁵ The instrument used in this study collected both rated and ranked importance data of the four activities for each of the 31 competencies chosen. It was designed to take 25 minutes to complete. Each time attempts were made to decrease the length the reliability was adversely affected. Also, there is an increasing trend of using survey research both in the academy and in business. As subjects get tired of receiving surveys they are less likely to respond. Also, some subjects may feel their responses are not impacting the way athletic trainers practice. These issues lessen their likelihood of participating.^{75, 76}

Another possible reason for the low response rate was computer problems. The first week of data collection the server which hosted the instrument was offline for 10 days. Many participants may have attempted to complete the survey and were unable to do so. These subjects may have been unwilling to attempt the survey again even after reminders were sent acknowledging the server issues. When the server was repaired and returned online the instrument had reverted to an earlier version which didn't include contact emails addresses. Thus there was no way for the researcher to contact non-responders to measure the possibility of non response bias.

With a 13% response rate there is a potential for non-response bias, which may limit the generalizability of the data. A low response rate is an indication of a possible sample bias not a definite sample bias. It is possible that even given a low response rate,

the data are indicative of the sample as a whole^{77, 78}. One study in occupational health research investigated the correlation between response rate and effect size. Their hypothesis was as more subjects responded the effect size would decrease as the sample normalized itself toward the mean. If a response rate was very small then only subjects very interested in the topic at hand would reply, thereby increasing the effect size. Although there was a negative correlation between response rate and effect size, it was not significant ($p=.09-.73$). Their conclusion was that nonresponse bias is less of an issue than previously thought. There are limitations to the study in that the variables (role ambiguity, role strain, job satisfaction) of their meta-analysis were not particularly sensitive. They also used previously published data for the analysis, so studies with extremely low response rates were unavailable for analysis. Nevertheless, the results provide some data to support that even given a low response rate nonresponse bias is not a given and may in fact have very little effect on the generalizability of the results⁷⁷.

Many journals do not require a response rate to be mentioned.^{76, 79} Those journals that do require a report of response rate allow individual reviewers to determine the quality of the study, but given the trend of decreasing response rates no minimum would be stated. Each article submitted for publication would be considered on an individual basis. There are instances of manuscripts being published with less than a four percent response rate.¹⁹ It was concluded that manuscripts submitted with less than a 20% response rate had less chance of being published.⁷⁹

Implications for Athletic Training Education

The findings of this study are relevant to athletic training education even given the limitations noted above. It is recognized that the affective domain competencies used to represent professional socialization are in the process of being reformulated to represent core values of the profession from the educational competencies used to design athletic training education programs. The reformulation of these competencies should not decrease the importance of these data and conclusions. The affective competencies were chosen to provide a framework for subjects to reflect upon their professional socialization. Professional socialization is still inherent in athletic training education even without these competencies. The proposed core values include aspects of professional socialization as do the new clinical proficiencies. Areas such as legal and ethical practice, understanding the scope of practice, demonstrating compassion and altruism and utilizing a team approach are all areas included in professional socialization. Professional socialization is important in providing students and new professionals with a sense of their role as an athletic trainer. Even if this is not explicit within the educational competencies it is necessary for successful clinical practice and to decrease the attrition of professionals. In short, if students are not socialized into the profession they will most likely leave it. Professional socialization can be considered a developmental process that begins during entry-level education.^{48, 50} Athletic training education researchers should devote some time and energy to investigating how athletic training students are socialized into the profession in order to facilitate the transformation from student to practitioner.

Based on reported data athletic training educators need to focus on the recruitment, development and retention of high quality ACIs. While recruiting ACIs, clinical coordinators need to focus on the educational philosophy of the ACI, and not base the selection on convenience. ACIs should be purposefully chosen based on their abilities to facilitate student learning and serve as a good quality role model, not because they are nearby and need assistance in covering their athletic responsibilities.^{23,34,53} ACIs need to understand their function as a role model and educator for these young professionals. The mindset of all individuals involved in clinical experiences needs to be how student learning and socialization can be enhanced. The idea of students as a labor force needs to be removed from the situation.²³ Students may provide some service to the ACI and the clinical site, but the services provided need to serve an educational purpose.

Athletic training educators also need to focus on developing good quality ACIs. Many individuals have an interest in educating students and serving as an ACI, but do not have the knowledge or skills necessary to do so.^{23, 35} ACI training needs to focus not just on the documentation of the experience, but also should be true professional development for ACIs. Focusing on dealing with common student issues, motivating students to engage in the setting, designing a good learning environment, teaching critical thinking skills and balancing clinical responsibilities with student supervision are just some suggestions of topics that need to be addressed. A small amount of theory should be addressed, but the focus should be on strategies the ACI can utilize during clinical experiences. Athletic training educators should communicate with ACIs and students to

facilitate the development of a better learning environment for students and higher quality ACIs.²³

Student supervision is another important component of being a high quality ACI. How can an ACI be a role model and mentor to students if not providing audio and visual supervision? Subjects indicated that one on one instruction with an ACI was the most important activity in their professional socialization, which indicated that student supervision is vital for student learning. Therefore, ACIs need to provide audio and visual supervision for students to provide a high quality learning experience.

Athletic training educators should apply the findings of this study when designing clinical experiences for their students. Peer practice, ACI interaction, practice coverage and game coverage are all important to students' development into successful practicing clinicians. Educators should focus on a balanced approach to clinical experiences to maximize student socialization into the profession. Athletic training students should experience both practice and game coverage in a traditional athletic training setting. They should be encouraged to participate in peer practice. And finally, perhaps the most important part of an athletic training students' professional socialization is interacting with practicing professionals. Using these professionals as role models and mentors is the most important activity for athletic training students to undertake.

REFERENCES

1. Dunn SV, Ehrich L, Mylonnas A, Hanford BC. Students' perceptions of field experience in professional development: A comparative study. *Journal of Nursing Education*. 2000;39:393-?
2. Edmond CB. A new paradigm for practice education. *Nurse Education Today*. 2001;21:251-259.
3. Laudicina RJ, Beck SJ. Laboratory managers' perceptions of the impact of teaching on the clinical laboratory. *Clinical Laboratory Science*. 2000;13:180-186.
4. Talbot M. Professional modeling: A questionnaire study of junior doctors' attitudes to aspects of experiential learning on the hospital working round. *Medical Education*. 2000;34:312-315.
5. Maudsley G, Strivens J. Promoting professional knowledge, experiential learning and critical thinking for medical students. *Medical Education*. 2000;34:535-544.
6. Ford-Gilboe M, Laschinger HS, Laforet-Fliesser Y, Ward-Griffin C, Foran S. The effect of a clinical practicum on undergraduate nursing students' self-efficacy for community based family nursing practice. *Journal of Nursing Education*. 1997;36:212-219.
7. Pitney WA. The professional socialization of certified athletic trainers in high school settings: A grounded Theory investigation. *Journal of Athletic Training*. 2002;37:286-292.
8. Koehneke P, Editor MGD. Educating student clinicians versus student technicians. *Athletic Therapy Today*. 1997;March:52-53.
9. NATA Education Council. National Athletic Trainers' Association Education Council Clinical Education Definitions [Web page]. Available at: <http://www.cewl.com/clined/clindef.html>. Accessed 2/14/2003, 2003.
10. Moss R. The athletic trainer's coming of age. *Scholastic Coach*. 1991;April:66-68.
11. American Association of Orthopaedic Surgeons. *Athletic training and sports medicine*. 2nd ed. Rosemont, IL: AAOS; 1991.

12. Arnheim D, Prentice W. *Principles of athletic training*. 10th ed. Boston, MA: McGraw-Hill; 2000.
13. Dolan J. *Treatment and prevention of athletic injuries*. Danville, IL: The Interstate; 1955.
14. Delforge GD, Behnke RS. The History and Evolution of Athletic Training Education in the United States. *Journal of Athletic Training*. 1999;34:53-61.
15. Legwold G. "Pinky" Newell: The man who dropped the bucket and sponge. *Physician and Sportsmedicine*. 1983;April:179-182, 187-190.
16. Morehouse L, Rasch P. *Sports medicine for trainers*. 2nd ed. Philadelphia: WB Saunders; 1963.
17. McLean J. Does the National Athletic Trainers' Association need a certification examination? *Journal of Athletic Training*. 1969;4 *Journal of Athletic Training* reprint 1999;34:292-293.
18. Kauth B. The athletic training major. *Journal of Physical Education, Recreation and Dance*. 1984;October:11-13,80-83.
19. Miller S. Athletic Training Education at the crossroads. In: Bell G, ed. *Professional Preparation in Athletic Training*. Champaign, IL: Human Kinetics; 1982.
20. Miller S. Approval of athletic training curriculums at colleges and universities. *Journal of Athletic Training*. 1970;5: *Journal of Athletic Training* Reprint 1999;1934:1962-1963.
21. Grace P. Milestones in athletic trainer certification. *Journal of Athletic Training*. 1999;34:285-291.
22. Commission on Higher Education Accreditation. Board of Directors Report. *The CHEA Chronicle*. August 17 2003
2002;5:<http://www.chea.org/Chronicle/index.cfm>.
23. Weidner TG, Henning JM. Historical Perspective of athletic training clinical education. *Journal of Athletic Training*. 2002;37:S222-S228.
24. Starkey C. Reforming athletic training education. *Journal of Athletic Training*. 1997;32:113-114.

25. Joint Review Committee on Education Programs in Athletic Training. Standards and Guidelines for an accredited educational program for the athletic trainer. *Commission on the Accreditation of Allied Health Education Programs*. 2001. Available at: http://www.caahep.org/standards/at_01.htm. Accessed 2/14/2003, 2003.
26. Harden RM, Crosby JR, Davis MH. AMEE guide no. 14: Outcome based-education: Part 1 -- An introduction to outcome-based education. *Medical Teacher*. 1999;21:7-14.
27. Smith SR, Dollase R. AMEE guide no. 14: Outcome based education: Part 2-- planning, implementing, and evaluating a competency based curriculum. *Medical Teacher*. 1999;21(1):15-22.
28. Osta K. *NATA Revised Strategic Plan*. St. Lois MO: National Athletic Trainers' Association; 23 June 2003 2003.
29. Joint Review Committee on Education Programs in Athletic Training. JRC-AT Update: January 2005 (Educators' Conference). Available at: http://www.jrc-at.org/ppt/presentation_2005_ed_conference.pdf. Accessed 03/13/2005, 2005.
30. Weidner TG, Pipkin J. Clinical supervision of athletic training students at colleges and universities needs improvement. *Journal of Athletic Training*. 2002;37:S241-S247.
31. Curtis N, Helion JG, Domsohn M. Student athletic trainer perceptions of clinical supervisor behaviors: A critical incident study. *Journal of Athletic Training*. 1998;33(3):249-253.
32. Meyer LP. Athletic training clinical instructors as situational leaders. *Journal of Athletic Training*. 2002;37(4S):S261-S265.
33. Stemmans CL, Gangstead SK. Athletic training students initiate behaviors less frequently when supervised by novice clinical instructors. *Journal of Athletic Training*. 2002;37(4S):S255-S260.
34. Miller MG, Berry DC. An assessment of athletic training students' clinical-placement hours. *Journal of Athletic Training*. 2002;37(4S):S229-S235.
35. Laurent T, Weidner TG. Clinical -Education-Setting standards are helpful in the professional preparation of employed, entry-level certified athletic trainers. *Journal of Athletic Training*. 2002;37:S248-S254.

36. Sammarone-Turocy P, Comfort RE, Perrin DH, Gieck JH. Clinical Experiences are not predictive of outcomes on the NATABOC examination. *Journal of Athletic Training*. 2000;35(1):70-75.
37. Pitney WA, Ehlers GG. A grounded theory study of the mentoring process involved with undergraduate athletic training students. *Journal of Athletic Training*. 2004;39(4):344-351.
38. List of regulated states. *National Athletic Trainers' Association* [Web Page]. Available at: <https://www.nata.org/members/committees/gac/stateregboards.htm>. Accessed 13 March 2005, 2004.
39. Berry DC, Miller M, Berry L. Effects of clinical Field-experience setting on athletic training students' perceived percentage of time spent on active learning. *Journal of Athletic Training*. 2004;39(2):176-184.
40. Brandenburger-Shasby S. *Personnel Preparation of occupational therapists: School based practice* [Doctoral Dissertation- research], University of South Carolina; 2000.
41. Bohlin RM. The affective domain: A model of learner-instruction interactions. Paper presented at: National Convention of the Association for Educational Communications and Technology; February 18-22, 1998, 1998; St. Louis MO.
42. Epstein RM, Hundert EM. Defining and assessing professional competence. *The Journal of the American Medical Association*. 2002;287:226-235.
43. Reilly DE. *Teaching and evaluating the affective domain in nursing programs*: Slack; 1978.
44. Spence LM, Hicocl P, Wiggers T. Minimizing instructor bias in the evaluation of student affect. *Clinical Laboratory Science*. 294 1999;12(5):290.
45. Howe A. Professional development in undergraduate medical curricula- the key to the door of a new culture? *Medical Education*. 2002;36:353-359.
46. Teschendorf B, Nemshick M. Faculty Roles in professional socialization. *Journal of physical therapy education*. Spring 2001 2001;15(1):4-??
47. Krathwohl DR, Bloom BS, Masia BB. *Taxonomy of educational objectives: the classification of educational goals: handbook II affective domain*. New York: David McKay Co.; 1964.

48. Weidman JC, Twale DJ, Stein EL. *Socialization of graduate and professional students in higher education: A perilous passage?* Vol 28. San Francisco: Jossey-Bass; 2001.
49. Coudret NA, Fuchs PL, Roberts CS, Suhrheinrich JA, White AH. Role socialization of graduating student nurses: Impact of a nursing practicum on professional role conception. *Journal of Professional Nursing*. 1994 1994;10:342-349.
50. Thornton R, Nardi PM. The dynamics of role acquisition. *The American Journal of Sociology*. 1975;80:870-885.
51. Schemp PG, Graber KC. Teacher socialization from a dialectical perspective: Pretraining through induction. *Journal of Teaching in Physical Education*. 1992 1992;11:329-348.
52. Secrest JA, Norwood B, Keatley VM. "I was actually a nurse": the meaning if professionalism for baccalaureate nursing students. *Journal of Nursing Education*. 2003;42(2):77-82.
53. Maudsley G. Roles and responsibilities of the problem based learning tutor in the undergraduate medical curriculum. *British Medical Journal*. 1999;318:657-661.
54. Sladyk K, Sheckley B. Clinical reasoning and reflective practice: Implications of fieldwork activities. *Occupational Therapy in Health Care*. 2000;13(1):11-22.
55. DeLisi R. From marbles to instant messenger: implications of Piaget's ideas about peer learning. *Theory Into Practice*. 2002;41(1):5-12.
56. Ladyshevsky RK. Peer-assisted learning in clinical education: a review of terms and learning principles. *Journal of Physical Therapy Education*. 2000;14:15-22.
57. Lincoln MA, McAllister LL. Peer learning in clinical education. *Medical Teacher*. 1993;15:17-25.
58. Eisen M-J. Peer-based professional development viewed through the lens of transformative learning. *Holistic Nurse Practitioner*. 2001;16(1):30-42.
59. Hart G. Peer consultation and review. *Australian Journal of Advanced Nursing*. 1990;7:40-46.
60. Duquette C. Conflicting perceptions of participants in field-based teacher education programs. *McGill Journal of Education*. 1997 1997;32:263-272.

61. Admi H. Nursing students' stress during the initial clinical experience. *Journal of Nursing Education*. September 1997 1997;36:323-327.
62. Nardi PM. *Doing Survey Research: A guide to quantitative methods*. Boston: Allyn and Bacon; 2003.
63. Sammarone-Turocy P. Survey research in athletic training: Scientific method of development and implementation. *Journal of Athletic Training*. 2002;37(4S):S174-179.
64. Green SA. Power Analysis in Repeated Measures Analysis of Variance with Heterogeneously Corrected Trials. *ERIC Document*. April 1990 1990(ED 320 932):1-41.
65. Barcikowski R, Robey R. Sample Size Selection in single Group Repeated Measures Analysis. *ERIC Document*. April 1985 1985.
66. Joint Review Committee on Education Programs in Athletic Training. Tracking graduates of graduate athletic training programs. *NATA News*. 2004.
67. Joint Review Committee on Education Programs in Athletic Training. Tracking graduates of entry-level education programs. *NATA News*. 2004.
68. Cahill HA. A qualitative analysis of student nurses' experiences of mentorship. *Journal of Advanced Nursing*. 1996;24:791-799.
69. Pitney W, Ilsley P, Rintala J. The professional socialization of athletic trainers in the National Collegiate Athletic Association division I context. *Journal of Athletic Training*. 2002;37(1):63-70.
70. Darby BA. Mentoring relationships and beginning nursing practice: A study of professional socialization. Paper presented at: Annual Meeting of the American Education Research Association; April 1996, 1996; New York, NY.
71. Knight KL. Clinical Education: We aren't there yet but we're making progress! *Athletic Therapy Today*. 2002;7.
72. Costello J. Learning from each other: Peer teaching and learning in student nurse training. *Nurse Education Today*. 1989;9:203-206.
73. Yates P, Cunningham J, Moyle W, Wollin J. Peer mentorship in clinical education: outcomes of a pilot programme for first year students. *Nurse Education Today*. 1997;17:508-514.

74. Nemshick M, Shepard K. Physical therapy clinical education in a 2:1 student-instructor education model. *Physical Therapy*. 1996;76:968-981.
75. Sheehan K. Email survey response rate: A review. *JCMC*. 2001;6(2).
76. Boser JA, Green K. Research on mail surveys: Response rates and methods in relation to population group over time. Paper presented at: Annual Meeting of the Mid-South Educational Research Association, 1997; Memphis, TN.
77. Schalm RL, Kelloway EK. The relationship between response rate and effect size in occupational health psychology research. *Journal of Occupational Health Psychology*. 2001;6(2):160-163.
78. Dey EL. Working with low survey response rates: The efficacy of weighting adjustments. *Research in Higher Education*. 1997;38(2):215-227.
79. Johnson T, Owens L. Survey Response Rate Reporting In The Professional Literature. *American Association for Public Opinion Research - Section on Survey Research Methods*. [Internet site]. Available at: http://www.srl.uic.edu/publist/Conference/rr_reporting.pdf#search=%27survey%20response%20rates%20required%20for%20publication%20survey%20response%20rates%27. Accessed 02/02, 2005.

APPENDIX A

2001 EC EDUCATIONAL COMPETENCIES
AFFECTIVE DOMAIN

RISK MANAGEMENT AND INJURY PREVENTION

1 - Accepts the moral, professional, and legal responsibilities to conduct safe programs to minimize injury and illness risk factors for individuals involved in physical activity.

2 - Acknowledges the importance of developing and implementing a thorough, comprehensive injury and illness prevention program.

3 - Understands the need for cooperation among administrators, athletic personnel, certified athletic trainers, parents/guardians, other health care professionals, and athletes and others engaged in physical activity in the implementation of effective injury and illness prevention programs.

4 - Appreciates and respects the role of athletic personnel and supervisors in injury and illness prevention programs.

5 - Accepts moral, professional, and legal responsibility of conducting appropriate pre-participation examinations.

6 - Accepts and respects the established guidelines for scheduling physical activity to prevent exposure to unsafe environmental conditions.

7 - Appreciates the importance of the body's thermoregulatory mechanisms for acclimation and conditioning, fluid and electrolyte replacements, proper practice and competition attire, and weight loss.

8 - Values the importance of collecting data on temperature, humidity, and other environmental conditions that can affect the human body when exercising in adverse weather conditions.

9 - Appreciates and respects the concepts and theories pertaining to strength, flexibility, and endurance programs or routines.

10 - Understands the values and benefits of correctly selecting and using prophylactic taping and wrapping or prophylactic padding.

11 - Appreciates and respects the importance of correct and appropriate fitting in the use of protective equipment.

12 - Appreciates and respects the principles and concepts of home, school, and work place ergonomics.

PATHOLOGY OF INJURIES AND ILLNESSES

1 - Appreciates that an understanding of pathology is essential to care for athletes and others involved in physical activity.

2 - Recognizes that physician consultation is a moral and ethical necessity in the diagnosis and treatment of pathologic conditions.

3 - Accepts the moral and ethical responsibility of maintaining current knowledge of the pathologic conditions of athletes and others involved in physical activity.

4 - Promotes accountability for moral and ethical decision-making in the treatment of pathologic conditions.

5 - Understands how the use of exercise will improve the non-diseased organ system, thus enhancing overall wellness.

ASSESSMENT AND EVALUATION

1 - Appreciates the importance of a systematic assessment process in the management of injuries and illness.

2 - Appreciates the importance of documentation of assessment findings and results.

3 - Accepts the role of the certified athletic trainer as a primary provider of assessment to the injuries and illnesses of athletes and others involved in physical activity.

4 - Recognizes the initial clinical evaluation by the certified athletic trainer as an assessment and screening procedure, rather than as a diagnostic procedure.

5 - Appreciates the practical importance of thoroughness in a clinical evaluation.

6 - Accepts the professional, ethical, and legal parameters that define the proper role of the certified athletic trainer in the evaluation and appropriate medical referral of injuries and illnesses of athletes and others involved in physical activity.

7 - Values the skills and knowledge necessary to competently assess the injuries and illnesses of athletes and others involved in physical activity.

ACUTE CARE OF INJURIES AND ILLNESSES

1 - Appreciates the medical-legal and ethical protocol governing the referral of injured and ill athletes and other individuals engaged in physical activity.

2 - Appreciates the legal, moral, and ethical parameters that define the scope of first aid and emergency care, and values the proper role of the certified athletic trainer in providing this care.

3 - Appreciates the roles and responsibilities of various community-based emergency care personnel (paramedics, emergency medical technicians, emergency room personnel).

4 - Appreciates the role and function of various medical/paramedical specialties, and values their respective areas of expertise in the definitive treatment of acute injuries and illnesses.

5 - Values the importance of certification in first aid and emergency care and cardiopulmonary resuscitation.

6 - Appreciates the systematic approach to acute injury or illness of the secondary survey components of obtaining a history, inspection/observation, palpation, and using special tests.

8 - Advocates the principles of proper splinting techniques to prevent further injury.

9 - Appreciates the construction of various splinting devices and the appropriate uses for each.

10 - Appreciates state laws, rules, and regulations governing the application of immobilization devices

11 - Values the proper positioning and securing of a person with a suspected spinal injury onto a spine board or body splint, including preparatory positioning prior to placement of the spine board or body splint, as critical for prevention of further trauma.

12 - Appreciates the need for leadership and teamwork when using a spine board or body splint.

13 - Respects short-distance transportation techniques as a crucial means of moving an injured person.

14 - Supports the application of cryotherapy, elevation, and compression as primary care for a non-threatening injury.

15 - Accepts the approved aseptic and sterile methods for cleaning, treating, and bandaging wounds and for disposing of biohazardous waste.

16 - Empathizes with individuals facing the daily challenges of using ambulatory aids.

PHARMACOLOGY

1 - Recognizes that pharmacology applies to the immediate and ongoing care of injury and illness.

2 - Recognizes the importance of pharmacological concepts in health care.

3 - Accepts physician (or other qualified health care provider) and pharmacist consultation as a legal, moral, and ethical necessity in the prescription and dispensation of medication.

4 - Appreciates the use of clinical references such as the PDR and clinical databases to identify medications.

5 - Accepts the laws and regulations that govern the storage, transportation, and dispensation of all drugs.

6 - Supports the moral and ethical behavior of athletic trainers in dealing with the issues of drug use and abuse in sports.

7 - Accepts moral and ethical responsibility for maintaining current knowledge of the medications commonly prescribed to athletes and others involved in physical activity.

8 - Advocates moral and ethical behavior of self and colleagues in dealing with issues of a pharmacological nature.

9 - Promotes accountability for moral and ethical decision-making in pharmacological issues.

THERAPEUTIC MODALITIES

1 - Accepts the professional, ethical, and legal parameters that define the proper role of the certified athletic trainer in the use of therapeutic agents to treat, rehabilitate, and recondition athletes and others involved in physical activity.

2 - Respects the role of attending physicians and other medical and allied health personnel in the use of therapeutic agents to treat, rehabilitate, and recondition athletes and others involved in physical activity.

3 - Advocates the accepted medical protocol regarding the confidentiality of medical information relative to therapeutic modality treatments.

- 4 - Initiates accepted medical protocol regarding therapeutic prescriptions.
- 5 - Promotes the accepted medical protocol regarding health care referral in the rehabilitation and reconditioning process.

THERAPEUTIC EXERCISE

- 1 - Accepts the professional, ethical, and legal parameters that define the proper role of the certified athletic trainer in the treatment, rehabilitation, or reconditioning of athletes and others involved in physical activity.
- 2 - Accepts the moral and ethical obligation to provide rehabilitation or reconditioning to athletes and others involved in physical activity to the fullest extent possible.
- 3 - Respects the proper role of attending physicians and other medical and paramedical personnel in the treatment and rehabilitation or reconditioning of athletes and others involved in physical activity.
- 4 - Respects accepted medical and paramedical protocols regarding the confidentiality of medical information, medical and therapeutic prescriptions, and health care referral as they relate to the rehabilitation or reconditioning process.

GENERAL MEDICAL CONDITIONS AND DISABILITIES

- 1 - Supports the moral and ethical behavior of athletic trainers in issues dealing with diseases of athletics and physical activity.
- 2 - Recognizes the moral and ethical responsibility of taking situational control in the containment of common contagious viral and infectious diseases.
- 3 - Accepts the roles of medical and allied health personnel in the referral, management, and treatment of athletes and others involved in physical activity suffering from general medical conditions.

NUTRITIONAL ASPECTS

- 1 - Appreciates the role of proper nutrition in the health care of athletes and others involved in physical activity.
- 2 - Respects the various recognized position papers that discuss nutrition wellness.
- 3 - Appreciates the long-term effects of disordered eating, bone density loss, and secondary amenorrhea on the skeletal health of the physically active.
- 4 - Recognizes the need for and implements proper referral for eating disorders.

PSYCHOSOCIAL INTERVENTION AND REFERRAL

- 1 - Accepts the professional, ethical, and legal parameters that define the proper role of the certified athletic trainer in providing health care information, intervention, and referral.
- 2 - Accepts the responsibility to provide health care information, intervention, and referral consistent with the certified athletic trainer's professional training.

- 3 - Recognizes the certified athletic trainer's role as a liaison between the physically active, athletic personnel, health care professionals, parents/guardians, and the public.
- 5 - Accepts the moral and ethical responsibility to intervene in situations of suspected or known use and/or abuse of legal and illegal drugs and chemicals.
- 6 - Accepts the moral and ethical responsibility to intervene in situations of mental, emotional, and/or personal/social conflict.
- 7 - Recognizes athletes and other physically individuals as deserving of quality professional health care.
- 8 - Accepts the individual's physical complaint(s) without personal bias or prejudice.
- 9 - Respects the various social and cultural attitudes, beliefs, and values regarding health care practices when caring for patients.
- 10 - Accepts the role of social support during the injury rehabilitation process.

HEALTH CARE ADMINISTRATION

- 1 - Appreciates the roles and responsibilities of medical and allied health care providers, and respects the systems that each provider works within.
- 2 - Appreciates the roles and functions of various medical and paramedical specialties as well as their respective areas of expertise in the acute care of injuries and illnesses to athletes and others involved in physical activity.
- 3 - Values the need for sideline emergency care supplies and equipment as deemed necessary for all athletic training settings.
- 4 - Appreciates the importance of an emergency action plan that is tailored for a specific venue or setting.
- 5 - Accepts the value of a common medical language and terminology to communicate within and between the health professions.
- 6 - Accepts the professional, ethical, and legal parameters that define the proper role of the certified athletic trainer in the administration and implementation of health care delivery systems.
- 7 - Appreciates the roles and relationship between the NATA, NATABOC/NOCA, NCCA, and JRC-AT/CAAHEP.
- 8 - Recognizes and accepts the need for organizing and conducting health care programs for athletes and other physically active individuals on the basis of sound administrative policies and procedures.
- 9 - Accepts the responsibility for completing the necessary paperwork and maintaining the records associated with the administration of health care programs.
- 10 - Respects the roles and cooperation of medical personnel, administrators, and other staff members in the organization and administration of athletic training service programs.
- 11 - Recognizes and accepts the importance of good public relations with the media (radio, TV, press), the general public, other medical and allied health care personnel, and legislators.
- 12 - Recognizes the certified athletic trainer's role as a liaison between athletes, physically active individuals, caretakers, employers, physicians, coaches, other health

care professionals, and any individual who may be involved with the care provided by the certified athletic trainer.

PROFESSIONAL DEVELOPMENT AND RESPONSIBILITIES

- 1 - Accepts the professional responsibility to satisfy certified athletic trainers' continuing education requirements.
- 2 - Appreciates the need for and the process and benefits of athletic training regulatory acts (registration, licensure, certification).
- 3 - Realizes that the state regulatory acts regarding the practice of athletic training vary from state to state.
- 4 - Understands the consequences of noncompliance with regulatory athletic training practice acts.
- 5 - Accepts the professional, historical, ethical, and organizational structures that define the proper roles and responsibilities of the certified athletic trainer in providing health care to athletes and others involved in physical activity.
- 6 - Defends the moral and ethical responsibility to intervene in situations that conflict with NATA standards.
- 7 - Accepts the function of professional organization position statements that relate to athletic training practice.
- 8 - Advocates the NATA as an allied health professional organization dedicated to the care of athletes and others involved in physical activity.
- 9 - Respects the role and responsibilities of the other health care professions.
- 10 - Appreciates the dynamic nature of issues and concerns as they relate to the health care of athletes and others involved in physical activity.
- 11 - Defends the responsibility to interpret and promote athletic training as a professional discipline among allied-health professional groups and the general public.
- 12 - Accepts the responsibility to enhance the professional growth of athletic training students, colleagues, and peers through a continual sharing of knowledge skills, values, and professional recognition.

(C) 1999, National Athletic Trainers' Association. All rights reserved.

APPENDIX B

LETTER AND SURVEY SENT TO ATHLETIC TRAINING EDUCATORS

Dear Athletic training educator,

You are being invited to participate in the development of a survey to measure the perceptions of entry level athletic trainers' perceptions in the role of clinical experience in the development of the affective domain. Please rank the affective domain competencies below according to their importance in the practice of athletic training. (1 being the most important) Rank each practice domain separately.

Thank you for your time and consideration. If you have any questions please feel free to contact me at 336-278-5883 or email sstevens2@elon.edu. When finished please return the completed document in the self-addressed envelope provided.

Thanks again,

Sue Stevens

2001 EC Educational Competencies Affective Domain

RISK MANAGEMENT AND INJURY PREVENTION

	Accepts the moral, professional, and legal responsibilities to conduct safe programs to minimize injury and illness risk factors for individuals involved in physical activity.
	Acknowledges the importance of developing and implementing a thorough, comprehensive injury and illness prevention program.
	Understands the need for cooperation among administrators, athletic personnel, certified athletic trainers, parents/guardians, other health care professionals, and athletes and others engaged in physical activity in the implementation of effective injury and illness prevention programs.
	Appreciates and respects the role of athletic personnel and supervisors in injury and illness prevention programs.
	Accepts moral, professional, and legal responsibility of conducting appropriate pre-participation examinations.
	Accepts and respects the established guidelines for scheduling physical activity to prevent exposure to unsafe environmental conditions.
	Appreciates the importance of the body's thermoregulatory mechanisms for acclimation and conditioning, fluid and electrolyte replacements, proper practice and competition attire, and weight loss.
	Values the importance of collecting data on temperature, humidity, and other environmental conditions that can affect the human body when exercising in adverse weather conditions.
	Appreciates and respects the concepts and theories pertaining to strength, flexibility, and endurance programs or routines.

	Understands the values and benefits of correctly selecting and using prophylactic taping and wrapping or prophylactic padding.
	Appreciates and respects the importance of correct and appropriate fitting in the use of protective equipment.
	Appreciates and respects the principles and concepts of home, school, and work place ergonomics.

PATHOLOGY OF INJURIES AND ILLNESSES

	Appreciates that an understanding of pathology is essential to care for athletes and others involved in physical activity.
	Recognizes that physician consultation is a moral and ethical necessity in the diagnosis and treatment of pathologic conditions.
	Accepts the moral and ethical responsibility of maintaining current knowledge of the pathologic conditions of athletes and others involved in physical activity.
	Promotes accountability for moral and ethical decision-making in the treatment of pathologic conditions.
	Understands how the use of exercise will improve the non-diseased organ system, thus enhancing overall wellness.

PHARMACOLOGY

	Recognizes that pharmacology applies to the immediate and ongoing care of injury and illness.
	Recognizes the importance of pharmacological concepts in health care.
	Accepts physician (or other qualified health care provider) and pharmacist consultation as a legal, moral, and ethical necessity in the prescription and dispensation of medication.
	Appreciates the use of clinical references such as the PDR and clinical databases to identify medications.
	Accepts the laws and regulations that govern the storage, transportation, and dispensation of all drugs.
	Supports the moral and ethical behavior of athletic trainers in dealing with the issues of drug use and abuse in sports.
	Accepts moral and ethical responsibility for maintaining current knowledge of the medications commonly prescribed to athletes and others involved in physical activity.
	Advocates moral and ethical behavior of self and colleagues in dealing with issues of a pharmacological nature.
	Promotes accountability for moral and ethical decision making in pharmacological issues.

THERAPEUTIC MODALITIES

	Accepts the professional, ethical, and legal parameters that define the proper role of the certified athletic trainer in the use of therapeutic agents to treat, rehabilitate, and recondition athletes and others involved in physical activity.
	Respects the role of attending physicians and other medical and allied health personnel in the use of therapeutic agents to treat, rehabilitate, and recondition athletes and others involved in physical activity.
	Advocates the accepted medical protocol regarding the confidentiality of medical information relative to therapeutic modality treatments.
	Initiates accepted medical protocol regarding therapeutic prescriptions.
	Promotes the accepted medical protocol regarding health care referral in the rehabilitation and reconditioning process.

ASSESSMENT AND EVALUATION

	Appreciates the importance of a systematic assessment process in the management of injuries and illness.
	Appreciates the importance of documentation of assessment findings and results.
	Accepts the role of the certified athletic trainer as a primary provider of assessment to the injuries and illnesses of athletes and others involved in physical activity.
	Recognizes the initial clinical evaluation by the certified athletic trainer as an assessment and screening procedure, rather than as a diagnostic procedure.
	Appreciates the practical importance of thoroughness in a clinical evaluation.
	Accepts the professional, ethical, and legal parameters that define the proper role of the certified athletic trainer in the evaluation and appropriate medical referral of injuries and illnesses of athletes and others involved in physical activity.
	Values the skills and knowledge necessary to competently assess the injuries and illnesses of athletes and others involved in physical activity.

ACUTE CARE OF INJURIES AND ILLNESSES

	Appreciates the medical legal and ethical protocol governing the referral of injured and ill athletes and other individuals engaged in physical activity.
	Appreciates the legal, moral, and ethical parameters that define the scope of first aid and emergency care, and values the proper role of the certified athletic trainer in providing this care.
	Appreciates the roles and responsibilities of various community based emergency care personnel (paramedics, emergency medical technicians, emergency room personnel).
	Appreciates the role and function of various medical/paramedical specialties, and values their respective areas of expertise in the definitive treatment of acute injuries and illnesses.
	Values the importance of certification in first aid and emergency care and

	cardiopulmonary resuscitation.
	Appreciates the systematic approach to acute injury or illness of the secondary survey components of obtaining a history, inspection/observation, palpation, and using special tests.
	Advocates the principles of proper splinting techniques to prevent further injury.
	Appreciates the construction of various splinting devices and the appropriate uses for each.
	Appreciates state laws, rules, and regulations governing the application of immobilization devices
	Values the proper positioning and securing of a person with a suspected spinal injury onto a spine board or body splint, including preparatory positioning prior to placement of the spine board or body splint, as critical for prevention of further trauma.
	Appreciates the need for leadership and teamwork when using a spine board or body splint.
	Respects short distance transportation techniques as a crucial means of moving an injured person.
	Supports the application of cryotherapy, elevation, and compression as primary care for a non threatening injury.
	Accepts the approved aseptic and sterile methods for cleaning, treating, and bandaging wounds and for disposing of biohazardous waste.
	Empathizes with individuals facing the daily challenges of using ambulatory aids.

THERAPEUTIC EXERCISE

	Accepts the professional, ethical, and legal parameters that define the proper role of the certified athletic trainer in the treatment, rehabilitation, or reconditioning of athletes and others involved in physical activity.
	Accepts the moral and ethical obligation to provide rehabilitation or reconditioning to athletes and others involved in physical activity to the fullest extent possible.
	Respects the proper role of attending physicians and other medical and paramedical personnel in the treatment and rehabilitation or reconditioning of athletes and others involved in physical activity.
	Respects accepted medical and paramedical protocols regarding the confidentiality of medical information, medical and therapeutic prescriptions, and health care referral as they relate to the rehabilitation or reconditioning process.

GENERAL MEDICAL CONDITIONS AND DISABILITIES

	Supports the moral and ethical behavior of athletic trainers in issues dealing with diseases of athletics and physical activity.
	Recognizes the moral and ethical responsibility of taking situational control in the containment of common contagious viral and infectious diseases.
	Accepts the roles of medical and allied health personnel in the referral,

	management, and treatment of athletes and others involved in physical activity suffering from general medical conditions.
--	---

NUTRITIONAL ASPECTS

	Appreciates the role of proper nutrition in the health care of athletes and others involved in physical activity.
	Respects the various recognized position papers that discuss nutrition wellness.
	Appreciates the long term effects of disordered eating, bone density loss, and secondary amenorrhea on the skeletal health of the physically active.
	Recognizes the need for and implements proper referral for eating disorders.

PSYCHOSOCIAL INTERVENTION AND REFERRAL

	Accepts the professional, ethical, and legal parameters that define the proper role of the certified athletic trainer in providing health care information, intervention, and referral.
	Accepts the responsibility to provide health care information, intervention, and referral consistent with the certified athletic trainer's professional training.
	Recognizes the certified athletic trainer's role as a liaison between the physically active, athletic personnel, health care professionals, parents/guardians, and the public.
	Accepts the moral and ethical responsibility to intervene in situations of suspected or known use and/or abuse of legal and illegal drugs and chemicals.
	Accepts the moral and ethical responsibility to intervene in situations of mental, emotional, and/or personal/social conflict.
	Recognizes athletes and other physically individuals as deserving of quality professional health care.
	Accepts the individual's physical complaint(s) without personal bias or prejudice.
	Respects the various social and cultural attitudes, beliefs, and values regarding health care practices when caring for patients.
	Accepts the role of social support during the injury rehabilitation process.

HEALTH CARE ADMINISTRATION

	Appreciates the roles and responsibilities of medical and allied health care providers, and respects the systems that each provider works within.
	Appreciates the roles and functions of various medical and paramedical specialties as well as their respective areas of expertise in the acute care of injuries and illnesses to athletes and others involved in physical activity.
	Values the need for sideline emergency care supplies and equipment as deemed necessary for all athletic training settings.
	Appreciates the importance of an emergency action plan that is tailored for a specific venue or setting.
	Accepts the value of a common medical language and terminology to communicate within and between the health professions.

	Accepts the professional, ethical, and legal parameters that define the proper role of the certified athletic trainer in the administration and implementation of health care delivery systems.
	Appreciates the roles and relationship between the NATA, NATABOC/NOCA, NCCA, and JRC-AT/CAAHEP.
	Recognizes and accepts the need for organizing and conducting health care programs for athletes and other physically active individuals on the basis of sound administrative policies and procedures.
	Accepts the responsibility for completing the necessary paperwork and maintaining the records associated with the administration of health care programs.
	Respects the roles and cooperation of medical personnel, administrators, and other staff members in the organization and administration of athletic training service programs.
	Recognizes and accepts the importance of good public relations with the media (radio, TV, press), the general public, other medical and allied health care personnel, and legislators.
	Recognizes the certified athletic trainer's role as a liaison between athletes, physically active individuals, caretakers, employers, physicians, coaches, other health care professionals, and any individual who may be involved with the care provided by the certified athletic trainer.

PROFESSIONAL DEVELOPMENT AND RESPONSIBILITIES

	Accepts the professional responsibility to satisfy certified athletic trainers' continuing education requirements.
	Appreciates the need for and the process and benefits of athletic training regulatory acts (registration, licensure, certification).
	Realizes that the state regulatory acts regarding the practice of athletic training vary from state to state.
	Understands the consequences of noncompliance with regulatory athletic training practice acts.
	Accepts the professional, historical, ethical, and organizational structures that define the proper roles and responsibilities of the certified athletic trainer in providing health care to athletes and others involved in physical activity.
	Defends the moral and ethical responsibility to intervene in situations that conflict with NATA standards.
	Accepts the function of professional organization position statements that relate to athletic training practice.
	Advocates the NATA as an allied health professional organization dedicated to the care of athletes and others involved in physical activity.
	Respects the role and responsibilities of the other health care professions.
	Appreciates the dynamic nature of issues and concerns as they relate to the health care of athletes and others involved in physical activity.

	Defends the responsibility to interpret and promote athletic training as a professional discipline among allied health professional groups and the general public.
	Accepts the responsibility to enhance the professional growth of athletic training students, colleagues, and peers through a continual sharing of knowledge skills, values, and professional recognition.

APPENDIX C

RESULTS FROM SURVEY SENT TO ATHLETIC TRAINING EDUCATORS

RISK MANAGEMENT AND INJURY PREVENTION

10	Accepts the moral, professional, and legal responsibilities to conduct safe programs to minimize injury and illness risk factors for individuals involved in physical activity.
21	Acknowledges the importance of developing and implementing a thorough, comprehensive injury and illness prevention program.
14	Understands the need for cooperation among administrators, athletic personnel, certified athletic trainers, parents/guardians, other health care professionals, and athletes and others engaged in physical activity in the implementation of effective injury and illness prevention programs.
26	Appreciates and respects the role of athletic personnel and supervisors in injury and illness prevention programs.
27	Accepts moral, professional, and legal responsibility of conducting appropriate pre-participation examinations.
24	Accepts and respects the established guidelines for scheduling physical activity to prevent exposure to unsafe environmental conditions.
21	Appreciates the importance of the body's thermoregulatory mechanisms for acclimation and conditioning, fluid and electrolyte replacements, proper practice and competition attire, and weight loss.
36	Values the importance of collecting data on temperature, humidity, and other environmental conditions that can affect the human body when exercising in adverse weather conditions.
14	Appreciates and respects the concepts and theories pertaining to strength, flexibility, and endurance programs or routines.
30	Understands the values and benefits of correctly selecting and using prophylactic taping and wrapping or prophylactic padding.
34	Appreciates and respects the importance of correct and appropriate fitting in the use of protective equipment.
48	Appreciates and respects the principles and concepts of home, school, and work place ergonomics.

PATHOLOGY OF INJURIES AND ILLNESSES

5	Appreciates that an understanding of pathology is essential to care for athletes and others involved in physical activity.
11	Recognizes that physician consultation is a moral and ethical necessity in the diagnosis and treatment of pathologic conditions.
13	Accepts the moral and ethical responsibility of maintaining current knowledge of the pathologic conditions of athletes and others involved in physical activity.
14	Promotes accountability for moral and ethical decision-making in the treatment of pathologic conditions.
17	Understands how the use of exercise will improve the non-diseased organ system, thus enhancing overall wellness.

PHARMACOLOGY

15	Recognizes that pharmacology applies to the immediate and ongoing care of injury and illness.
17	Recognizes the importance of pharmacological concepts in health care.
19	Accepts physician (or other qualified health care provider) and pharmacist consultation as a legal, moral, and ethical necessity in the prescription and dispensation of medication.
31	Appreciates the use of clinical references such as the PDR and clinical databases to identify medications.
24	Accepts the laws and regulations that govern the storage, transportation, and dispensation of all drugs.
14	Supports the moral and ethical behavior of athletic trainers in dealing with the issues of drug use and abuse in sports.
20	Accepts moral and ethical responsibility for maintaining current knowledge of the medications commonly prescribed to athletes and others involved in physical activity.
20	Advocates moral and ethical behavior of self and colleagues in dealing with issues of a pharmacological nature.
22	Promotes accountability for moral and ethical decision making in pharmacological issues.

THERAPEUTIC MODALITIES

5	Accepts the professional, ethical, and legal parameters that define the proper role of the certified athletic trainer in the use of therapeutic agents to treat, rehabilitate, and recondition athletes and others involved in physical activity.
10	Respects the role of attending physicians and other medical and allied health personnel in the use of therapeutic agents to treat, rehabilitate, and recondition athletes and others involved in physical activity.
12	Advocates the accepted medical protocol regarding the confidentiality of medical information relative to therapeutic modality treatments.
17	Initiates accepted medical protocol regarding therapeutic prescriptions.

16	Promotes the accepted medical protocol regarding health care referral in the rehabilitation and reconditioning process.
----	---

ASSESSMENT AND EVALUATION

14	Appreciates the importance of a systematic assessment process in the management of injuries and illness.
20	Appreciates the importance of documentation of assessment findings and results.
9	Accepts the role of the certified athletic trainer as a primary provider of assessment to the injuries and illnesses of athletes and others involved in physical activity.
16	Recognizes the initial clinical evaluation by the certified athletic trainer as an assessment and screening procedure, rather than as a diagnostic procedure.
19	Appreciates the practical importance of thoroughness in a clinical evaluation.
17	Accepts the professional, ethical, and legal parameters that define the proper role of the certified athletic trainer in the evaluation and appropriate medical referral of injuries and illnesses of athletes and others involved in physical activity.
17	Values the skills and knowledge necessary to competently assess the injuries and illnesses of athletes and others involved in physical activity.

ACUTE CARE OF INJURIES AND ILLNESSES

41	Appreciates the medical legal and ethical protocol governing the referral of injured and ill athletes and other individuals engaged in physical activity.
17	Appreciates the legal, moral, and ethical parameters that define the scope of first aid and emergency care, and values the proper role of the certified athletic trainer in providing this care.
28	Appreciates the roles and responsibilities of various community based emergency care personnel (paramedics, emergency medical technicians, emergency room personnel).
15	Appreciates the role and function of various medical/paramedical specialties, and values their respective areas of expertise in the definitive treatment of acute injuries and illnesses.
32	Values the importance of certification in first aid and emergency care and cardiopulmonary resuscitation.
14	Appreciates the systematic approach to acute injury or illness of the secondary survey components of obtaining a history, inspection/observation, palpation, and using special tests.
39	Advocates the principles of proper splinting techniques to prevent further injury.
41	Appreciates the construction of various splinting devices and the appropriate uses for each.
38	Appreciates state laws, rules, and regulations governing the application of immobilization devices
21	Values the proper positioning and securing of a person with a suspected spinal injury onto a spine board or body splint, including preparatory positioning prior

	to placement of the spine board or body splint, as critical for prevention of further trauma.
21	Appreciates the need for leadership and teamwork when using a spine board or body splint.
46	Respects short distance transportation techniques as a crucial means of moving an injured person.
34	Supports the application of cryotherapy, elevation, and compression as primary care for a nonthreatening injury.
33	Accepts the approved aseptic and sterile methods for cleaning, treating, and bandaging wounds and for disposing of biohazardous waste.
60	Empathizes with individuals facing the daily challenges of using ambulatory aids.

THERAPEUTIC EXERCISE

10	1 - Accepts the professional, ethical, and legal parameters that define the proper role of the certified athletic trainer in the treatment, rehabilitation, or reconditioning of athletes and others involved in physical activity.
4	Accepts the moral and ethical obligation to provide rehabilitation or reconditioning to athletes and others involved in physical activity to the fullest extent possible.
11	Respects the proper role of attending physicians and other medical and paramedical personnel in the treatment and rehabilitation or reconditioning of athletes and others involved in physical activity.
15	Respects accepted medical and paramedical protocols regarding the confidentiality of medical information, medical and therapeutic prescriptions, and health care referral as they relate to the rehabilitation or reconditioning process.

GENERAL MEDICAL CONDITIONS AND DISABILITIES

9	Supports the moral and ethical behavior of athletic trainers in issues dealing with diseases of athletics and physical activity.
8	Recognizes the moral and ethical responsibility of taking situational control in the containment of common contagious viral and infectious diseases.
7	Accepts the roles of medical and allied health personnel in the referral, management, and treatment of athletes and others involved in physical activity suffering from general medical conditions.

NUTRITIONAL ASPECTS

7	Appreciates the role of proper nutrition in the health care of athletes and others involved in physical activity.
14	Respects the various recognized position papers that discuss nutrition wellness.
9	Appreciates the long term effects of disordered eating, bone density loss, and secondary amenorrhea on the skeletal health of the physically active.
10	Recognizes the need for and implements proper referral for eating disorders.

PSYCHOSOCIAL INTERVENTION AND REFERRAL

9	Accepts the professional, ethical, and legal parameters that define the proper role of the certified athletic trainer in providing health care information, intervention, and referral.
6	Accepts the responsibility to provide health care information, intervention, and referral consistent with the certified athletic trainer's professional training.
16	Recognizes the certified athletic trainer's role as a liaison between the physically active, athletic personnel, health care professionals, parents/guardians, and the public.
24	Accepts the moral and ethical responsibility to intervene in situations of suspected or known use and/or abuse of legal and illegal drugs and chemicals.
28	Accepts the moral and ethical responsibility to intervene in situations of mental, emotional, and/or personal/social conflict.
26	Recognizes athletes and other physically individuals as deserving of quality professional health care.
22	Accepts the individual's physical complaint(s) without personal bias or prejudice.
24	Respects the various social and cultural attitudes, beliefs, and values regarding health care practices when caring for patients.
25	Accepts the role of social support during the injury rehabilitation process.

HEALTH CARE ADMINISTRATION

21	Appreciates the roles and responsibilities of medical and allied health care providers, and respects the systems that each provider works within.
19	Appreciates the roles and functions of various medical and paramedical specialties as well as their respective areas of expertise in the acute care of injuries and illnesses to athletes and others involved in physical activity.
28	Values the need for sideline emergency care supplies and equipment as deemed necessary for all athletic training settings.
11	Appreciates the importance of an emergency action plan that is tailored for a specific venue or setting.
45	Accepts the value of a common medical language and terminology to communicate within and between the health professions.
6	Accepts the professional, ethical, and legal parameters that define the proper role of the certified athletic trainer in the administration and implementation of health care delivery systems.
42	Appreciates the roles and relationship between the NATA, NATABOC/NOCA, NCCA, and JRC-AT/CAAHEP.
26	Recognizes and accepts the need for organizing and conducting health care programs for athletes and other physically active individuals on the basis of sound administrative policies and procedures.
26	Accepts the responsibility for completing the necessary paperwork and maintaining the records associated with the administration of health care programs.

25	Respects the roles and cooperation of medical personnel, administrators, and other staff members in the organization and administration of athletic training service programs.
41	Recognizes and accepts the importance of good public relations with the media (radio, TV, press), the general public, other medical and allied health care personnel, and legislators.
21	Recognizes the certified athletic trainer's role as a liaison between athletes, physically active individuals, caretakers, employers, physicians, coaches, other health care professionals, and any individual who may be involved with the care provided by the certified athletic trainer.

PROFESSIONAL DEVELOPMENT AND RESPONSIBILITIES

23	Accepts the professional responsibility to satisfy certified athletic trainers' continuing education requirements.
19	Appreciates the need for and the process and benefits of athletic training regulatory acts (registration, licensure, certification).
33	Realizes that the state regulatory acts regarding the practice of athletic training vary from state to state.
36	Understands the consequences of noncompliance with regulatory athletic training practice acts.
16	Accepts the professional, historical, ethical, and organizational structures that define the proper roles and responsibilities of the certified athletic trainer in providing health care to athletes and others involved in physical activity.
34	Defends the moral and ethical responsibility to intervene in situations that conflict with NATA standards.
37	Accepts the function of professional organization position statements that relate to athletic training practice.
19	Advocates the NATA as an allied health professional organization dedicated to the care of athletes and others involved in physical activity.
29	Respects the role and responsibilities of the other health care professions.
33	Appreciates the dynamic nature of issues and concerns as they relate to the health care of athletes and others involved in physical activity.
10	Defends the responsibility to interpret and promote athletic training as a professional discipline among allied health professional groups and the general public.
23	Accepts the responsibility to enhance the professional growth of athletic training students, colleagues, and peers through a continual sharing of knowledge skills, values, and professional recognition.

APPENDIX D

SURVEY INSTRUMENT FOR PILOT ONE

Dear Certified Athletic Trainer,

You are being invited to participate in a web based survey entitled **Entry-level athletic trainers' perceptions on the role of clinical experience in the development of the affective domain**. This survey is a pilot study which will be considered as part of my doctoral dissertation. The purpose of the study is to measure the reliability of my proposed instrument. You must have graduated from Elon's CAAHEP accredited entry-level athletic training education program, passed the NATABOC entry-level certification exam between April 1999 and April 2002 and be employed as an athletic trainer in a recognized practice setting (ie. College/university, high school, clinic, industry, professional sports) to participate in this study. A graduate assistantship in one of these practice settings is acceptable.

The survey consists of demographic questions and questions relating to the importance of structured clinical education and unstructured field experience on the development of selected affective domain competencies. The time commitment is approximately 15 minutes.

To participate you need access to the internet. You will access the link provided below, answer all questions honestly and submit. All of your responses will be confidential. Filling out the survey and submitting your responses serves as your informed consent for participation. Your participation is entirely voluntary and you may withdrawal at any time by discontinuing the survey without submitting the data. This survey and consent letter have been approved by the University of North Carolina at Greensboro Institutional Review Board, which insures that research involving people follows federal regulations.

I intend to submit the results of this study for publication in an aggregate form only. If you would like a copy of the projects results please email me with your request for information. Also if you have any questions regarding this project feel free to contact me either by email or at 336-278-5883. If you have any questions about your rights as a participant in this project please call Dr. Beverly Maddox-Britt at 336-334-5878.

Thank you for your time and consideration,

Sue Stevens

Sstevens2@elon.edu

336-278-5883

Click this link to be taken to the survey

<http://www.elon.edu/irweb/adomain/adomain.html>

Entry level athletic trainers' perceptions about the role of field experience in the development of the affective domain

Directions

Clinical Education is when you are learning, practicing, or being assessed on a clinical proficiency by an Approved Clinical Instructor.¹ Please rate how important **clinical education** was in your development of the following selected competencies.

Affective domain education competency ²	Not important	Somewhat important	Important	Very important	Extremely important
Accepts the moral, professional, and legal responsibilities to conduct safe programs to minimize injury and illness risk factors for individuals involved in physical activity					
Understands the need for cooperation among administrators, athletic personnel, certified athletic trainers, parents/guardians, other health care professionals, and athletes and others engaged in physical activity in the implementation of effective injury and illness prevention programs.					
Appreciates and respects the concepts and theories pertaining to strength, flexibility, and endurance					

programs or routines.					
Appreciates that an understanding of pathology is essential to care for athletes and others involved in physical activity.					
Recognizes that physician consultation is a moral and ethical necessity in the diagnosis and treatment of pathologic conditions.					
Accepts the moral and ethical responsibility of maintaining current knowledge of the pathologic conditions of athletes and others involved in physical activity.					
Recognizes that pharmacology applies to the immediate and ongoing care of injury and illness.					
Recognizes the importance of pharmacological concepts in health care.					
Accepts moral and ethical responsibility for maintaining current knowledge of the medications commonly prescribed to athletes and others involved in physical activity.					
Accepts the professional, ethical, and legal parameters					

that define the proper role of the certified athletic trainer in the use of therapeutic agents to treat, rehabilitate, and recondition athletes and others involved in physical activity.					
Respects the role of attending physicians and other medical and allied health personnel in the use of therapeutic agents to treat, rehabilitate, and recondition athletes and others involved in physical activity.					
Advocates the accepted medical protocol regarding the confidentiality of medical information relative to therapeutic modality treatments.					
Recognizes the initial clinical evaluation by the certified athletic trainer as an assessment and screening procedure, rather than as a diagnostic procedure.					
Appreciates the importance of a systematic assessment process in the management of injuries and illness.					
Accepts the role of the certified athletic trainer as a primary provider of assessment					

to the injuries and illnesses of athletes and others involved in physical activity.					
Appreciates the legal, moral, and ethical parameters that define the scope of first aid and emergency care, and values the proper role of the certified athletic trainer in providing this care.					
Appreciates the role and function of various medical/paramedical specialties, and values their respective areas of expertise in the definitive treatment of acute injuries and illnesses.					
Appreciates the systematic approach to acute injury or illness of the secondary survey components of obtaining a history, inspection/observation, palpation, and using special tests.					
Accepts the professional, ethical, and legal parameters that define the proper role of the certified athletic trainer in the treatment, rehabilitation, or reconditioning of athletes and others involved in physical activity.					
Accepts the moral and					

ethical obligation to provide rehabilitation or reconditioning to athletes and others involved in physical activity to the fullest extent possible.					
Respects the proper role of attending physicians and other medical and paramedical personnel in the treatment and rehabilitation or reconditioning of athletes and others involved in physical activity.					
Supports the moral and ethical behavior of athletic trainers in issues dealing with diseases of athletics and physical activity.					
Recognizes the moral and ethical responsibility of taking situational control in the containment of common contagious viral and infectious diseases.					
Accepts the roles of medical and allied health personnel in the referral, management, and treatment of athletes and others involved in physical activity suffering from general medical conditions.					
Appreciates the role of proper nutrition in					

the health care of athletes and others involved in physical activity.					
Appreciates the long-term effects of disordered eating, bone density loss, and secondary amenorrhea on the skeletal health of the physically active.					
Recognizes the need for and implements proper referral for eating disorders.					
Accepts the professional, ethical, and legal parameters that define the proper role of the certified athletic trainer in providing health care information, intervention, and referral.					
Accepts the responsibility to provide health care information, intervention, and referral consistent with the certified athletic trainer's professional training.					
Recognizes the certified athletic trainer's role as a liaison between the physically active, athletic personnel, health care professionals, parents/guardians, and					

the public.					
Appreciates the roles and functions of various medical and paramedical specialties as well as their respective areas of expertise in the acute care of injuries and illnesses to athletes and others involved in physical activity.					
Appreciates the importance of an emergency action plan that is tailored for a specific venue or setting.					
Accepts the professional, ethical, and legal parameters that define the proper role of the certified athletic trainer in the administration and implementation of health care delivery systems.					
Appreciates the need for and the process and benefits of athletic training regulatory acts (registration, licensure, certification).					
Accepts the professional, historical, ethical, and organizational structures that define the proper roles and responsibilities of the certified athletic trainer in providing health care to athletes					

and others involved in physical activity.					
Advocates the NATA as an allied health professional organization dedicated to the care of athletes and others involved in physical activity.					
Defends the responsibility to interpret and promote athletic training as a professional discipline among allied health professional groups and the general public.					

Field Experience is unstructured learning or practice of athletic training skills in a real world setting under the supervision of a clinical instructor.¹ The field experience is the time that you are actively working with a sports team covering practices and competitions or pre and post practice treatments. This is an exposure to the daily activities of certified athletic trainers and other medical providers. Please rate how important **field experience** was in your development of the following selected competencies.

Affective domain education competency²	Not important	Somewhat important	Important	Very important	Extremely important
Accepts the moral, professional, and legal responsibilities to conduct safe programs to minimize injury and illness risk factors for individuals involved in physical activity					
Understands the need for cooperation among administrators, athletic personnel, certified athletic trainers, parents/guardians,					

other health care professionals, and athletes and others engaged in physical activity in the implementation of effective injury and illness prevention programs.					
Appreciates and respects the concepts and theories pertaining to strength, flexibility, and endurance programs or routines.					
Appreciates that an understanding of pathology is essential to care for athletes and others involved in physical activity.					
Recognizes that physician consultation is a moral and ethical necessity in the diagnosis and treatment of pathologic conditions.					
Accepts the moral and ethical responsibility of maintaining current knowledge of the pathologic conditions of athletes and others involved in physical activity.					
Recognizes that pharmacology applies to the immediate and ongoing care of injury and illness.					
Recognizes the importance of pharmacological					

concepts in health care.					
Accepts moral and ethical responsibility for maintaining current knowledge of the medications commonly prescribed to athletes and others involved in physical activity.					
Accepts the professional, ethical, and legal parameters that define the proper role of the certified athletic trainer in the use of therapeutic agents to treat, rehabilitate, and recondition athletes and others involved in physical activity.					
Respects the role of attending physicians and other medical and allied health personnel in the use of therapeutic agents to treat, rehabilitate, and recondition athletes and others involved in physical activity.					
Advocates the accepted medical protocol regarding the confidentiality of medical information relative to therapeutic modality treatments.					
Recognizes the initial clinical evaluation by the certified athletic trainer as an					

assessment and screening procedure, rather than as a diagnostic procedure.					
Appreciates the importance of a systematic assessment process in the management of injuries and illness.					
Accepts the role of the certified athletic trainer as a primary provider of assessment to the injuries and illnesses of athletes and others involved in physical activity.					
Appreciates the legal, moral, and ethical parameters that define the scope of first aid and emergency care, and values the proper role of the certified athletic trainer in providing this care.					
Appreciates the role and function of various medical/paramedical specialties, and values their respective areas of expertise in the definitive treatment of acute injuries and illnesses.					
Appreciates the systematic approach to acute injury or illness of the secondary survey components of obtaining a history, inspection/observation, palpation, and using					

special tests.					
Accepts the professional, ethical, and legal parameters that define the proper role of the certified athletic trainer in the treatment, rehabilitation, or reconditioning of athletes and others involved in physical activity.					
Accepts the moral and ethical obligation to provide rehabilitation or reconditioning to athletes and others involved in physical activity to the fullest extent possible.					
Respects the proper role of attending physicians and other medical and paramedical personnel in the treatment and rehabilitation or reconditioning of athletes and others involved in physical activity.					
Supports the moral and ethical behavior of athletic trainers in issues dealing with diseases of athletics and physical activity.					
Recognizes the moral and ethical responsibility of taking situational control in the containment of common contagious					

viral and infectious diseases.					
Accepts the roles of medical and allied health personnel in the referral, management, and treatment of athletes and others involved in physical activity suffering from general medical conditions.					
Appreciates the role of proper nutrition in the health care of athletes and others involved in physical activity.					
Appreciates the long-term effects of disordered eating, bone density loss, and secondary amenorrhea on the skeletal health of the physically active.					
Recognizes the need for and implements proper referral for eating disorders.					
Accepts the professional, ethical, and legal parameters that define the proper role of the certified athletic trainer in providing health care information, intervention, and referral.					
Accepts the responsibility to provide health care information,					

intervention, and referral consistent with the certified athletic trainer's professional training.					
Recognizes the certified athletic trainer's role as a liaison between the physically active, athletic personnel, health care professionals, parents/guardians, and the public.					
Appreciates the roles and functions of various medical and paramedical specialties as well as their respective areas of expertise in the acute care of injuries and illnesses to athletes and others involved in physical activity.					
Appreciates the importance of an emergency action plan that is tailored for a specific venue or setting.					
Accepts the professional, ethical, and legal parameters that define the proper role of the certified athletic trainer in the administration and implementation of health care delivery systems.					
Appreciates the need for and the process and					

benefits of athletic training regulatory acts (registration, licensure, certification).					
Accepts the professional, historical, ethical, and organizational structures that define the proper roles and responsibilities of the certified athletic trainer in providing health care to athletes and others involved in physical activity.					
Advocates the NATA as an allied health professional organization dedicated to the care of athletes and others involved in physical activity.					
Defends the responsibility to interpret and promote athletic training as a professional discipline among allied health professional groups and the general public.					

Demographics (check appropriate answer)

1. How much time did you spend in clinical education and field experience?

100% clinical education



75% clinical education 25% field experience



50% clinical education 50% field experience



25% clinical education 75% field experience



100% field experience



2. Considering your complete education program, how would you rate your clinical instructors' supervisory competence?

Not good <input type="checkbox"/>	Below average <input type="checkbox"/>	Average <input type="checkbox"/>	Above average <input type="checkbox"/>	Excellent <input type="checkbox"/>
--------------------------------------	---	-------------------------------------	---	---------------------------------------

3. When did you begin your clinical education/ field experience?(count from when you entered school not the athletic training program)

First year (freshman) <input type="checkbox"/>	Second year (sophomore) <input type="checkbox"/>	Third year (junior) <input type="checkbox"/>	Fourth year (Senior) <input type="checkbox"/>
--	--	---	---

Thank you for your time and effort in completing this survey.

References

1. National Athletic Trainers' Association Education Council Clinical Education Definitions.
www.cewl.com. Accessed February 22,2003.
1. National Athletic Trainers' Association Education Council. Educational Competencies and Clinical Proficiencies. 2001.

APPENDIX E

RESULTS OF PILOT ONE

Reliability Clinical Education Round 1

***** Method 2 (covariance matrix) will be used for this analysis *****

RELIABILITY ANALYSIS - SCALE (ALPHA)

Correlation Matrix

	CE1	CE2	CE3	CE4	CE5
CE1	1.0000				
CE2	.2831	1.0000			
CE3	.5401	.3669	1.0000		
CE4	.3203	.5983	.0000	1.0000	
CE5	.7777	.5284	.6720	.2491	1.0000
CE6	.9102	.6183	.4537	.6054	.7841
CE7	.3536	-.0400	.7638	-.2831	.1466
CE8	.4410	.2996	.8165	.0000	.5487
CE9	-.3611	.1510	.1800	.3203	-.1901
CE10	.7947	.6974	.4292	.4772	.6181
CE11	.7083	.0849	.2700	.6005	.5962
CE12	.6455	.4385	.8367	.4961	.6426
CE13	.8006	-.0272	.5189	-.1923	.7970
CE14	.8807	.4079	.5189	.1923	.9465
CE15	.3536	-.0400	.7638	-.2831	.6599
CE16	.6651	.7848	.6806	.3700	.9366
CE17	.4196	-.0219	.6275	.0620	.6426
CE18	.7100	-.1316	.4183	-.0620	.7631
CE19	.8807	-.1632	.5189	-.0769	.5978
CE20	-.0589	.5204	.3819	.5095	-.1100
CE21	.8006	-.0272	.5189	-.1923	.4483
CE22	.7083	.0849	.2700	.6005	.5962
CE23	.7660	.3803	.7638	-.0849	.9165
CE24	.5477	.1550	.5916	.4824	.6248
CE25	1.0000	.2831	.5401	.3203	.7777
CE26	.6005	.5983	.7783	-.0769	.7721
CE27	.4167	.8775	.5401	.6005	.4148
CE28	.7660	-.3203	.3819	.1132	.4033
CE29	.0400	-.3536	.2594	.1923	.0747
CE30	.7100	-.1316	.4183	-.0620	.7631
CE31	.9102	.1189	.4537	.3700	.7841

CE32	.5204	.9247	.2594	.6154	.6227
CE33	.8819	.2996	.8165	.0000	.8231
CE34	-.1667	.4812	-.5401	.6005	.0518
CE35	.8839	.3203	.3819	.6794	.6233
CE36	.0400	-.3536	.2594	.1923	.0747
CE37	.6005	.0272	.7783	-.3462	.7721

Correlation Matrix

	CE6	CE7	CE8	CE9	CE10
CE6	1.0000				
CE7	.1485	1.0000			
CE8	.3705	.6236	1.0000		
CE9	-.2334	.0786	.4410	1.0000	
CE10	.9181	.2810	.3504	-.2870	1.0000
CE11	.6651	-.0589	.2205	.0278	.3311
CE12	.6508	.5477	.6831	.3443	.5130
CE13	.5718	.2831	.4237	-.5071	.4136
CE14	.8408	.1132	.4237	-.4270	.6999
CE15	.1485	.4167	.6236	.0786	-.0468
CE16	.7941	.1485	.5557	-.0700	.7233
CE17	.2712	.2282	.6831	.3443	-.0256
CE18	.4881	.0913	.3416	-.3443	.2052
CE19	.6054	.5095	.4237	-.4270	.4772
CE20	.1485	.4167	.3118	.6285	.2810
CE21	.5718	.6794	.4237	-.5071	.6363
CE22	.6651	-.0589	.2205	.0278	.3311
CE23	.6683	.4167	.6236	-.3339	.6088
CE24	.4985	.1936	.4830	.3347	.1814
CE25	.9102	.3536	.4410	-.3611	.7947
CE26	.6054	.5095	.6355	-.2402	.6999
CE27	.6651	.3536	.4410	.2222	.7947
CE28	.4951	.4167	.3118	-.1964	.2810
CE29	-.1009	.1132	.2118	.5071	-.4136
CE30	.4881	.0913	.3416	-.3443	.2052
CE31	.7941	.1485	.3705	-.2334	.5286
CE32	.8072	-.1132	.2118	-.1334	.8590
CE33	.7410	.6236	.6667	-.2940	.7009
CE34	.1750	-.8839	-.4410	.0278	.0993
CE35	.8911	.1667	.3118	-.0786	.7024
CE36	-.1009	.1132	.2118	.5071	-.4136
CE37	.3700	.5095	.6355	-.2402	.2545

Correlation Matrix

	CE11	CE12	CE13	CE14	CE15
CE11	1.0000				
CE12	.6455	1.0000			
CE13	.5204	.3721	1.0000		
CE14	.6005	.4961	.8846	1.0000	
CE15	.3536	.5477	.6794	.5095	1.0000
CE16	.4201	.6508	.5718	.8408	.4951
CE17	.6455	.6500	.5892	.4961	.8672
CE18	.7100	.4000	.9303	.8062	.7303
CE19	.6005	.4961	.8846	.7308	.5095
CE20	-.0589	.5477	-.5095	-.2831	-.1667
CE21	.2402	.3721	.7308	.6154	.2831
CE22	1.0000	.6455	.5204	.6005	.3536
CE23	.3536	.5477	.8775	.9058	.7083
CE24	.8672	.8485	.4385	.4824	.6455
CE25	.7083	.6455	.8006	.8807	.3536
CE26	.0400	.4961	.6154	.7308	.5095
CE27	.1250	.6455	-.0400	.3203	-.0589
CE28	.7660	.5477	.6794	.5095	.4167
CE29	.6005	.4961	.0769	-.0769	.5095
CE30	.7100	.4000	.9303	.8062	.7303
CE31	.9102	.6508	.8072	.8408	.4951
CE32	.2402	.3721	.1923	.6154	-.1132
CE33	.4410	.6831	.8473	.8473	.6236
CE34	.1250	-.2582	-.3203	.0400	-.4714
CE35	.8839	.7303	.5095	.6794	.1667
CE36	.6005	.4961	.0769	-.0769	.5095
CE37	.3203	.4961	.8846	.7308	.9058

Correlation Matrix

	CE16	CE17	CE18	CE19	CE20
CE16	1.0000				
CE17	.4610	1.0000			
CE18	.4881	.7500	1.0000		
CE19	.3700	.4961	.8062	1.0000	
CE20	.1485	-.0913	-.5477	-.2831	1.0000
CE21	.3363	.1550	.4961	.8846	-.1132
CE22	.4201	.6455	.7100	.6005	-.0589
CE23	.8416	.5477	.7303	.7077	-.1667

CE24	.4985	.8485	.6364	.4824	.1936
CE25	.6651	.4196	.7100	.8807	-.0589
CE26	.8408	.2791	.3721	.4615	.1132
CE27	.6651	-.0323	-.1936	.0400	.7660
CE28	.1485	.5477	.7303	.9058	-.1667
CE29	-.1009	.7132	.3721	.1923	.1132
CE30	.4881	.7500	1.0000	.8062	-.5477
CE31	.5882	.6508	.8677	.8408	-.1980
CE32	.8072	-.0620	.0620	.0769	.2831
CE33	.7410	.5123	.6831	.8473	.0000
CE34	.1750	-.2582	-.1936	-.5204	-.0589
CE35	.5446	.4108	.5477	.6794	.1667
CE36	-.1009	.7132	.3721	.1923	.1132
CE37	.6054	.7132	.8062	.7308	-.2831

	CE21	CE22	CE23	CE24	CE25
CE21	1.0000				
CE22	.2402	1.0000			
CE23	.6794	.3536	1.0000		
CE24	.1316	.8672	.4196	1.0000	
CE25	.8006	.7083	.7660	.5477	1.0000
CE26	.6154	.0400	.9058	.1754	.6005
CE27	.2402	.1250	.3536	.2282	.4167
CE28	.6794	.7660	.4167	.6455	.7660
CE29	-.1923	.6005	-.0849	.7894	.0400
CE30	.4961	.7100	.7303	.6364	.7100
CE31	.5718	.9102	.6683	.7670	.9102
CE32	.1923	.2402	.4812	.1316	.5204
CE33	.8473	.4410	.9354	.4830	.8819
CE34	-.6005	.1250	-.2652	-.0913	-.1667
CE35	.5095	.8839	.4583	.7100	.8839
CE36	-.1923	.6005	-.0849	.7894	.0400
CE37	.6154	.3203	.9058	.4824	.6005

Correlation Matrix

	CE26	CE27	CE28	CE29	CE30
CE26	1.0000				
CE27	.6005	1.0000			
CE28	.1132	-.0589	1.0000		
CE29	-.3462	-.2402	.5095	1.0000	

CE30	.3721	-.1936	.7303	.3721	1.0000
CE31	.3700	.1750	.8416	.3700	.8677
CE32	.6154	.8006	-.1132	-.4615	.0620
CE33	.8473	.4410	.6236	.0000	.6831
CE34	-.2402	.1250	-.4714	-.2402	-.1936
CE35	.2831	.4714	.7500	.2831	.5477
CE36	-.3462	-.2402	.5095	1.0000	.3721
CE37	.7308	.0400	.5095	.1923	.8062

	CE31	CE32	CE33	CE34	CE35
CE31	1.0000				
CE32	.3363	1.0000			
CE33	.7410	.4237	1.0000		
CE34	-.0700	.5204	-.4410	1.0000	
CE35	.8911	.5095	.6236	.0589	1.0000
CE36	.3700	-.4615	.0000	-.2402	.2831
CE37	.6054	.0769	.8473	-.5204	.2831

	CE36	CE37
CE36	1.0000	
CE37	.1923	1.0000

N of Cases = 7.0

Inter-item

Correlations	Mean	Minimum	Maximum	Range	Max/Min	Variance
	.3896	-.8839	1.0000	1.8839	-1.1314	.1339

Reliability Coefficients 37 items

Alpha = .9559 Standardized item alpha = .9594

Reliability Field Experience Round one

***** Method 2 (covariance matrix) will be used for this analysis

RELIABILITY ANALYSIS - SCALE (ALPHA)

Correlation Matrix

	FE2	FE3	FE4	FE5	FE6
FE2	1.0000				
FE3	.7660	1.0000			
FE4	.4714	.1667	1.0000		
FE5	.5962	.1466	.8799	1.0000	
FE6	.1750	-.1980	.8911	.7841	1.0000
FE7	.0000	.0000	.6236	.5487	.7410
FE8	.8278	.7024	.6088	.6799	.4451
FE9	.8052	.8911	.4951	.4356	.2353
FE10	.6005	.1132	.6794	.9465	.6054
FE11	.2402	-.1132	.5095	.7970	.5718
FE12	.6651	.4951	.8911	.7841	.5882
FE13	-.0400	-.5095	.5095	.6227	.8072
FE14	.0400	-.2831	.2831	.4234	.6054
FE15	.2582	.0913	-.0913	.2008	.1085
FE16	.7947	.2810	.3746	.6181	.3338
FE17	.5477	.6455	.2582	.2272	.2301
FE18	.2582	.0913	.5477	.2008	.4881
FE19	.7660	.4167	.7500	.9165	.4951
FE20	.7660	1.0000	.1667	.1466	-.1980
FE21	.3203	.1132	.2831	.5978	.3700
FE22	.3114	.3203	.2402	.2113	.3805
FE23	.1909	.0000	.2700	.4752	.4813
FE24	-.1667	-.0589	.4714	.2333	.6651
FE25	.7083	.3536	.4714	.7777	.4201
FE26	.6651	.4951	.1980	.4792	.1765
FE27	.9102	.8416	.1980	.3267	-.0294
FE28	-.4167	-.3536	.3536	-.0518	.5601
FE29	-.2764	-.5330	.5330	.3596	.8444
FE30	.7660	.4167	.1667	.4033	.1485
FE31	.1250	-.0589	.4714	.5962	.6651
FE32	.8807	.5095	.2831	.4234	.1345
FE33	.3151	.1980	.4951	.4356	.6471
FE34	.0700	.1980	.1485	-.1742	.0294
FE35	.0913	-.1936	.1936	.3692	.3068
FE36	-.6455	-.5477	-.0913	-.3614	.1085
FE37	-.5204	-.6794	-.1132	-.0996	.1345

Correlation Matrix

	FE7	FE8	FE9	FE10	FE11
FE7	1.0000				
FE8	.5257	1.0000			
FE9	.3705	.9181	1.0000		
FE10	.4237	.6363	.3363	1.0000	
FE11	.6355	.4772	.1345	.8846	1.0000
FE12	.3705	.6399	.6471	.6054	.3363
FE13	.6355	.2545	-.1009	.6154	.7308
FE14	.6355	.4136	.1009	.4615	.6154
FE15	.3416	.5130	.2712	.3721	.4961
FE16	.0000	.6579	.4451	.6999	.4136
FE17	.4830	.8343	.8437	.1754	.1316
FE18	.0000	.1539	.2712	-.0620	-.3721
FE19	.3118	.7024	.5446	.9058	.6794
FE20	.0000	.7024	.8911	.1132	-.1132
FE21	.6355	.6363	.3363	.7308	.8846
FE22	.5991	.6974	.6183	.1632	.2176
FE23	.7217	.6070	.3208	.5503	.7338
FE24	.8819	.3642	.3151	.0400	.2402
FE25	.4410	.8278	.5601	.8807	.8006
FE26	.3705	.8346	.6471	.6054	.5718
FE27	.0000	.8346	.8529	.3700	.1009
FE28	.4410	-.1325	-.0700	-.3203	-.2402
FE29	.6648	.0799	-.1056	.1931	.3138
FE30	.0000	.7024	.5446	.5095	.2831
FE31	.8819	.5960	.3151	.6005	.8006
FE32	-.2118	.6363	.5718	.4615	.0769
FE33	.7410	.7233	.5882	.3363	.3700
FE34	-.1852	-.0556	.1765	-.3700	-.5718
FE35	.2415	.1814	-.0383	.4385	.4824
FE36	.0000	-.5643	-.4881	-.4961	-.3721
FE37	.0000	-.4772	-.6054	-.0769	.0769

Correlation Matrix

	FE12	FE13	FE14	FE15	FE16
FE12	1.0000				
FE13	.1009	1.0000			
FE14	-.1009	.8846	1.0000		
FE15	-.2712	.4961	.8062	1.0000	

FE16	.3338	.4136	.4772	.5643	1.0000
FE17	.2301	.1316	.4824	.6364	.4353
FE18	.4881	.0620	-.0620	-.4000	.2052
FE19	.8416	.2831	.1132	.0913	.6088
FE20	.4951	-.5095	-.2831	.0913	.2810
FE21	.1345	.6154	.7308	.8062	.4772
FE22	.0476	.4079	.7343	.7455	.4049
FE23	.0000	.7338	.9172	.8874	.4552
FE24	.1750	.5204	.6005	.2582	-.1325
FE25	.4201	.5204	.6005	.7100	.7947
FE26	.1765	.3363	.6054	.8677	.7233
FE27	.3824	-.1345	.1345	.4881	.7233
FE28	.0700	.3203	.2402	-.2582	-.3311
FE29	.1056	.8208	.7001	.1557	.0599
FE30	.1485	.2831	.5095	.7303	.9366
FE31	.1750	.8006	.8807	.7100	.3311
FE32	.3700	.0769	.1923	.3721	.9226
FE33	.2353	.6054	.8072	.6508	.4451
FE34	.2353	-.3363	-.3700	-.4881	-.1391
FE35	.0383	.4824	.4385	.3536	.3265
FE36	-.2712	.0620	-.0620	-.4000	-.5130
FE37	-.3363	.3462	.1923	-.0620	-.1909

Correlation Matrix

	FE17	FE18	FE19	FE20	FE21
FE17	1.0000				
FE18	.1414	1.0000			
FE19	.1936	.0913	1.0000		
FE20	.6455	.0913	.4167	1.0000	
FE21	.4824	-.4961	.5095	.1132	1.0000
FE22	.9303	.1316	.0400	.3203	.5439
FE23	.6275	-.2958	.2700	.0000	.9172
FE24	.5477	.2582	-.0589	-.0589	.3203
FE25	.5477	-.1936	.7660	.3536	.8807
FE26	.7670	-.2712	.4951	.4951	.8408
FE27	.7670	.1085	.4951	.8416	.3700
FE28	.0913	.6455	-.3536	-.3536	-.3203
FE29	.1376	.4282	-.0355	-.5330	.1931
FE30	.6455	.0913	.4167	.4167	.5095
FE31	.5477	-.1936	.3536	-.0589	.8807
FE32	.4824	.3721	.5095	.5095	.1923
FE33	.8437	.2712	.1980	.1980	.5718

FE34	.0383	.6508	-.1485	.1980	-.6054
FE35	.0500	-.1414	.2582	-.1936	.4385
FE36	-.3536	.3000	-.5477	-.5477	-.4961
FE37	-.4385	-.0620	-.2831	-.6794	-.0769

FE22 FE23 FE24 FE25 FE26

FE22	1.0000				
FE23	.7783	1.0000			
FE24	.7077	.5728	1.0000		
FE25	.5095	.7638	.1250	1.0000	
FE26	.7135	.8021	.1750	.9102	1.0000
FE27	.5470	.3208	-.0700	.6651	.7941
FE28	.2831	.0000	.7500	-.4167	-.4201
FE29	.4267	.4606	.7789	.0754	-.0422
FE30	.6005	.5401	-.0589	.7660	.8416
FE31	.7077	.9547	.7083	.7083	.6651
FE32	.3536	.1834	-.2402	.6005	.6054
FE33	.9513	.8021	.8052	.5601	.6471
FE34	-.0476	-.4813	.0700	-.4201	-.3824
FE35	.1550	.4183	.0913	.4108	.3068
FE36	-.1754	-.2958	.2582	-.6455	-.6508
FE37	-.2176	.0000	.0400	-.2402	-.3363

—

Correlation Matrix

FE27 FE28 FE29 FE30 FE31

FE27	1.0000				
FE28	-.4201	1.0000			
FE29	-.3378	.8040	1.0000		
FE30	.8416	-.3536	-.0355	1.0000	
FE31	.1750	.1667	.6030	.3536	1.0000
FE32	.8408	-.3203	-.1448	.9058	.0400
FE33	.4412	.4201	.6333	.5446	.8052
FE34	.0294	.4201	.0422	-.1485	-.4201
FE35	.0383	-.0913	.2477	.2582	.4108
FE36	-.6508	.6455	.4282	-.5477	-.1936
FE37	-.5718	.2402	.3621	-.2831	.0400

FE32 FE33 FE34 FE35 FE36

FE32	1.0000			
FE33	.3363	1.0000		

FE34	.1009	-.0294	1.0000		
FE35	.1316	.2301	.2301	1.0000	
FE36	-.4961	-.1085	.6508	.3536	1.0000
FE37	-.3462	-.1345	.3363	.7455	.8062

FE37

FE37 1.0000

N of Cases = 7.0

Inter-item

Correlations	Mean	Minimum	Maximum	Range	Max/Min	Variance
	.3008	-.6794	1.0000	1.6794	-1.4720	.1506

Reliability Coefficients 36 items

Alpha = .9384 Standardized item alpha = .9393

Reliability Clinical education Round two

***** Method 2 (covariance matrix) will be used for this analysis

*** CE7 has zero variance

*** CE9 has zero variance

Correlation Matrix

	CE_1	CE_2	CE3	CE4	CE5
CE_1	1.0000				
CE_2	.3015	1.0000			
CE3	.5222	.5774	1.0000		
CE4	-.1741	.5774	-.3333	1.0000	
CE5	.8704	.5774	.3333	.3333	1.0000
CE6	.8704	.5774	.3333	.3333	1.0000
CE8	-.1741	.5774	-.3333	1.0000	.3333
CE10	.3015	1.0000	.5774	.5774	.5774
CE11	.5222	.5774	1.0000	-.3333	.3333
CE12	.3015	1.0000	.5774	.5774	.5774
CE13	.5222	.5774	1.0000	-.3333	.3333
CE14	.8528	.7071	.8165	.0000	.8165
CE15	.9045	.0000	.5774	-.5774	.5774
CE16	.4264	.7071	.0000	.8165	.8165

CE17	.7609	.6882	.9272	-.1325	.6623
CE18	.3015	1.0000	.5774	.5774	.5774
CE19	.4545	.9045	.8704	.1741	.5222
CE20	.8528	.7071	.8165	.0000	.8165
CE21	.8182	.3015	.8704	-.5222	.5222
CE22	.8528	.7071	.8165	.0000	.8165
CE23	.8528	.7071	.8165	.0000	.8165
CE24	.8528	.7071	.8165	.0000	.8165
CE25	.6742	.8944	.7746	.2582	.7746
CE26	.6742	.8944	.7746	.2582	.7746
CE27	.4924	.8165	.9428	.0000	.4714
CE28	.4545	.9045	.8704	.1741	.5222
CE29	.4545	.9045	.8704	.1741	.5222
CE30	.8528	.7071	.8165	.0000	.8165
CE31	.8528	.7071	.8165	.0000	.8165
CE32	.4062	.9623	.7778	.3333	.5556
CE33	.4545	.9045	.8704	.1741	.5222
CE34	.8528	.0000	.0000	.0000	.8165
CE35	1.0000	.3015	.5222	-.1741	.8704
CE36	.9045	.0000	.5774	-.5774	.5774
CE37	.9045	.0000	.5774	-.5774	.5774

Correlation Matrix

	CE6	CE8	CE10	CE11	CE12
CE6	1.0000				
CE8	.3333	1.0000			
CE10	.5774	.5774	1.0000		
CE11	.3333	-.3333	.5774	1.0000	
CE12	.5774	.5774	1.0000	.5774	1.0000
CE13	.3333	-.3333	.5774	1.0000	.5774
CE14	.8165	.0000	.7071	.8165	.7071
CE15	.5774	-.5774	.0000	.5774	.0000
CE16	.8165	.8165	.7071	.0000	.7071
CE17	.6623	-.1325	.6882	.9272	.6882
CE18	.5774	.5774	1.0000	.5774	1.0000
CE19	.5222	.1741	.9045	.8704	.9045
CE20	.8165	.0000	.7071	.8165	.7071
CE21	.5222	-.5222	.3015	.8704	.3015
CE22	.8165	.0000	.7071	.8165	.7071
CE23	.8165	.0000	.7071	.8165	.7071
CE24	.8165	.0000	.7071	.8165	.7071
CE25	.7746	.2582	.8944	.7746	.8944

CE26	.7746	.2582	.8944	.7746	.8944
CE27	.4714	.0000	.8165	.9428	.8165
CE28	.5222	.1741	.9045	.8704	.9045
CE29	.5222	.1741	.9045	.8704	.9045
CE30	.8165	.0000	.7071	.8165	.7071
CE31	.8165	.0000	.7071	.8165	.7071
CE32	.5556	.3333	.9623	.7778	.9623
CE33	.5222	.1741	.9045	.8704	.9045
CE34	.8165	.0000	.0000	.0000	.0000
CE35	.8704	-.1741	.3015	.5222	.3015
CE36	.5774	-.5774	.0000	.5774	.0000
CE37	.5774	-.5774	.0000	.5774	.0000

Correlation Matrix

	CE13	CE14	CE15	CE16	CE17
CE13	1.0000				
CE14	.8165	1.0000			
CE15	.5774	.7071	1.0000		
CE16	.0000	.5000	.0000	1.0000	
CE17	.9272	.9733	.6882	.3244	1.0000
CE18	.5774	.7071	.0000	.7071	.6882
CE19	.8704	.8528	.3015	.4264	.8992
CE20	.8165	1.0000	.7071	.5000	.9733
CE21	.8704	.8528	.9045	.0000	.8992
CE22	.8165	1.0000	.7071	.5000	.9733
CE23	.8165	1.0000	.7071	.5000	.9733
CE24	.8165	1.0000	.7071	.5000	.9733
CE25	.7746	.9487	.4472	.6325	.9234
CE26	.7746	.9487	.4472	.6325	.9234
CE27	.9428	.8660	.4082	.2887	.9366
CE28	.8704	.8528	.3015	.4264	.8992
CE29	.8704	.8528	.3015	.4264	.8992
CE30	.8165	1.0000	.7071	.5000	.9733
CE31	.8165	1.0000	.7071	.5000	.9733
CE32	.7778	.8165	.1925	.5443	.8389
CE33	.8704	.8528	.3015	.4264	.8992
CE34	.0000	.5000	.7071	.5000	.3244
CE35	.5222	.8528	.9045	.4264	.7609
CE36	.5774	.7071	1.0000	.0000	.6882
CE37	.5774	.7071	1.0000	.0000	.6882

Correlation Matrix

	CE18	CE19	CE20	CE21	CE22
CE18	1.0000				
CE19	.9045	1.0000			
CE20	.7071	.8528	1.0000		
CE21	.3015	.6364	.8528	1.0000	
CE22	.7071	.8528	1.0000	.8528	1.0000
CE23	.7071	.8528	1.0000	.8528	1.0000
CE24	.7071	.8528	1.0000	.8528	1.0000
CE25	.8944	.9439	.9487	.6742	.9487
CE26	.8944	.9439	.9487	.6742	.9487
CE27	.8165	.9847	.8660	.7385	.8660
CE28	.9045	1.0000	.8528	.6364	.8528
CE29	.9045	1.0000	.8528	.6364	.8528
CE30	.7071	.8528	1.0000	.8528	1.0000
CE31	.7071	.8528	1.0000	.8528	1.0000
CE32	.9623	.9864	.8165	.5222	.8165
CE33	.9045	1.0000	.8528	.6364	.8528
CE34	.0000	.0000	.5000	.4264	.5000
CE35	.3015	.4545	.8528	.8182	.8528
CE36	.0000	.3015	.7071	.9045	.7071
CE37	.0000	.3015	.7071	.9045	.7071

	CE23	CE24	CE25	CE26	CE27
CE23	1.0000				
CE24	1.0000	1.0000			
CE25	.9487	.9487	1.0000		
CE26	.9487	.9487	1.0000	1.0000	
CE27	.8660	.8660	.9129	.9129	1.0000
CE28	.8528	.8528	.9439	.9439	.9847
CE29	.8528	.8528	.9439	.9439	.9847
CE30	1.0000	1.0000	.9487	.9487	.8660
CE31	1.0000	1.0000	.9487	.9487	.8660
CE32	.8165	.8165	.9467	.9467	.9428
CE33	.8528	.8528	.9439	.9439	.9847
CE34	.5000	.5000	.3162	.3162	.0000
CE35	.8528	.8528	.6742	.6742	.4924
CE36	.7071	.7071	.4472	.4472	.4082
CE37	.7071	.7071	.4472	.4472	.4082

-

Correlation Matrix

	CE28	CE29	CE30	CE31	CE32
CE28	1.0000				
CE29	1.0000	1.0000			
CE30	.8528	.8528	1.0000		
CE31	.8528	.8528	1.0000	1.0000	
CE32	.9864	.9864	.8165	.8165	1.0000
CE33	1.0000	1.0000	.8528	.8528	.9864
CE34	.0000	.0000	.5000	.5000	.0000
CE35	.4545	.4545	.8528	.8528	.4062
CE36	.3015	.3015	.7071	.7071	.1925
CE37	.3015	.3015	.7071	.7071	.1925

	CE33	CE34	CE35	CE36	CE37
CE33	1.0000				
CE34	.0000	1.0000			
CE35	.4545	.8528	1.0000		
CE36	.3015	.7071	.9045	1.0000	
CE37	.3015	.7071	.9045	1.0000	1.0000

N of Cases = 4.0

Inter-item

Correlations	Mean	Minimum	Maximum	Range	Max/Min	Variance
	.6237	-.5774	1.0000	1.5774	-1.7321	.1181

Reliability Coefficients 35 items

Alpha = .9810 Standardized item alpha = .9831

Reliability Field experience Round two

***** Method 2 (covariance matrix) will be used for this analysis

* * * FE2 has zero variance
 * * * FE3 has zero variance
 * * * FE5 has zero variance
 * * * FE11 has zero variance

Correlation Matrix

	FE1	FE4	FE6	FE7	FE8
FE1	1.0000				
FE4	1.0000	1.0000			
FE6	1.0000	1.0000	1.0000		
FE7	.3333	.3333	.3333	1.0000	
FE8	.8165	.8165	.8165	.8165	1.0000
FE9	.3333	.3333	.3333	1.0000	.8165
FE10	.5774	.5774	.5774	.5774	.7071
FE12	.5774	.5774	.5774	.5774	.7071
FE13	-.3333	-.3333	-.3333	.3333	.0000
FE14	.5774	.5774	.5774	.5774	.7071
FE15	-.3333	-.3333	-.3333	.3333	.0000
FE16	1.0000	1.0000	1.0000	.3333	.8165
FE17	1.0000	1.0000	1.0000	.3333	.8165
FE18	1.0000	1.0000	1.0000	.3333	.8165
FE19	1.0000	1.0000	1.0000	.3333	.8165
FE20	.5774	.5774	.5774	.5774	.7071
FE21	-.3333	-.3333	-.3333	.3333	.0000
FE22	.5774	.5774	.5774	.5774	.7071
FE23	1.0000	1.0000	1.0000	.3333	.8165
FE24	1.0000	1.0000	1.0000	.3333	.8165
FE25	1.0000	1.0000	1.0000	.3333	.8165
FE26	.8704	.8704	.8704	.5222	.8528
FE27	1.0000	1.0000	1.0000	.3333	.8165
FE28	-.3333	-.3333	-.3333	.3333	.0000
FE29	.5774	.5774	.5774	.5774	.7071
FE30	-.3333	-.3333	-.3333	.3333	.0000
FE31	.5774	.5774	.5774	.5774	.7071
FE32	1.0000	1.0000	1.0000	.3333	.8165
FE33	.5774	.5774	.5774	.5774	.7071
FE34	-.1741	-.1741	-.1741	.8704	.4264
FE35	.0000	.0000	.0000	.8165	.5000
FE36	-.5222	-.5222	-.5222	.5222	.0000
FE37	-.3333	-.3333	-.3333	.3333	.0000

Correlation Matrix

	FE9	FE10	FE12	FE13	FE14
FE9	1.0000				
FE10	.5774	1.0000			
FE12	.5774	.0000	1.0000		
FE13	.3333	-.5774	.5774	1.0000	

FE14	.5774	1.0000	.0000	-.5774	1.0000
FE15	.3333	.5774	-.5774	-.3333	.5774
FE16	.3333	.5774	.5774	-.3333	.5774
FE17	.3333	.5774	.5774	-.3333	.5774
FE18	.3333	.5774	.5774	-.3333	.5774
FE19	.3333	.5774	.5774	-.3333	.5774
FE20	.5774	1.0000	.0000	-.5774	1.0000
FE21	.3333	-.5774	.5774	1.0000	-.5774
FE22	.5774	.0000	1.0000	.5774	.0000
FE23	.3333	.5774	.5774	-.3333	.5774
FE24	.3333	.5774	.5774	-.3333	.5774
FE25	.3333	.5774	.5774	-.3333	.5774
FE26	.5222	.9045	.3015	-.5222	.9045
FE27	.3333	.5774	.5774	-.3333	.5774
FE28	.3333	.5774	-.5774	-.3333	.5774
FE29	.5774	1.0000	.0000	-.5774	1.0000
FE30	.3333	.5774	-.5774	-.3333	.5774
FE31	.5774	1.0000	.0000	-.5774	1.0000
FE32	.3333	.5774	.5774	-.3333	.5774
FE33	.5774	.0000	1.0000	.5774	.0000
FE34	.8704	.3015	.3015	.5222	.3015
FE35	.8165	.7071	.0000	.0000	.7071
FE36	.5222	-.3015	.3015	.8704	-.3015
FE37	.3333	-.5774	.5774	1.0000	-.5774

Correlation Matrix

	FE15	FE16	FE17	FE18	FE19
FE15	1.0000				
FE16	-.3333	1.0000			
FE17	-.3333	1.0000	1.0000		
FE18	-.3333	1.0000	1.0000	1.0000	
FE19	-.3333	1.0000	1.0000	1.0000	1.0000
FE20	.5774	.5774	.5774	.5774	.5774
FE21	-.3333	-.3333	-.3333	-.3333	-.3333
FE22	-.5774	.5774	.5774	.5774	.5774
FE23	-.3333	1.0000	1.0000	1.0000	1.0000
FE24	-.3333	1.0000	1.0000	1.0000	1.0000
FE25	-.3333	1.0000	1.0000	1.0000	1.0000
FE26	.1741	.8704	.8704	.8704	.8704
FE27	-.3333	1.0000	1.0000	1.0000	1.0000
FE28	1.0000	-.3333	-.3333	-.3333	-.3333
FE29	.5774	.5774	.5774	.5774	.5774

FE30	1.0000	-.3333	-.3333	-.3333	-.3333
FE31	.5774	.5774	.5774	.5774	.5774
FE32	-.3333	1.0000	1.0000	1.0000	1.0000
FE33	-.5774	.5774	.5774	.5774	.5774
FE34	.5222	-.1741	-.1741	-.1741	-.1741
FE35	.8165	.0000	.0000	.0000	.0000
FE36	.1741	-.5222	-.5222	-.5222	-.5222
FE37	-.3333	-.3333	-.3333	-.3333	-.3333

	FE20	FE21	FE22	FE23	FE24
FE20	1.0000				
FE21	-.5774	1.0000			
FE22	.0000	.5774	1.0000		
FE23	.5774	-.3333	.5774	1.0000	
FE24	.5774	-.3333	.5774	1.0000	1.0000
FE25	.5774	-.3333	.5774	1.0000	1.0000
FE26	.9045	-.5222	.3015	.8704	.8704
FE27	.5774	-.3333	.5774	1.0000	1.0000
FE28	.5774	-.3333	-.5774	-.3333	-.3333
FE29	1.0000	-.5774	.0000	.5774	.5774
FE30	.5774	-.3333	-.5774	-.3333	-.3333
FE31	1.0000	-.5774	.0000	.5774	.5774
FE32	.5774	-.3333	.5774	1.0000	1.0000
FE33	.0000	.5774	1.0000	.5774	.5774
FE34	.3015	.5222	.3015	-.1741	-.1741
FE35	.7071	.0000	.0000	.0000	.0000
FE36	-.3015	.8704	.3015	-.5222	-.5222
FE37	-.5774	1.0000	.5774	-.3333	-.3333

Correlation Matrix

	FE25	FE26	FE27	FE28	FE29
FE25	1.0000				
FE26	.8704	1.0000			
FE27	1.0000	.8704	1.0000		
FE28	-.3333	.1741	-.3333	1.0000	
FE29	.5774	.9045	.5774	.5774	1.0000
FE30	-.3333	.1741	-.3333	1.0000	.5774
FE31	.5774	.9045	.5774	.5774	1.0000
FE32	1.0000	.8704	1.0000	-.3333	.5774
FE33	.5774	.3015	.5774	-.5774	.0000
FE34	-.1741	.0909	-.1741	.5222	.3015

FE35	.0000	.4264	.0000	.8165	.7071
FE36	-.5222	-.4545	-.5222	.1741	-.3015
FE37	-.3333	-.5222	-.3333	-.3333	-.5774

	FE30	FE31	FE32	FE33	FE34
FE30	1.0000				
FE31	.5774	1.0000			
FE32	-.3333	.5774	1.0000		
FE33	-.5774	.0000	.5774	1.0000	
FE34	.5222	.3015	-.1741	.3015	1.0000
FE35	.8165	.7071	.0000	.0000	.8528
FE36	.1741	-.3015	-.5222	.3015	.8182
FE37	-.3333	-.5774	-.3333	.5774	.5222

	FE35	FE36	FE37
FE35	1.0000		
FE36	.4264	1.0000	
FE37	.0000	.8704	1.0000

N of Cases = 4.0

Inter-item

Correlations	Mean	Minimum	Maximum	Range	Max/Min	Variance
	.3460	-.5774	1.0000	1.5774	-1.7321	.2606

Reliability Coefficients 33 items

Alpha = .9411 Standardized item alpha = .9458

APPENDIX F

COVER LETTER FOR PILOT TWO

Dear Athletic Training Student,

You are being invited to participate in a web based survey entitled **Entry-level athletic trainers' perceptions on the role of clinical experience in the development of the affective domain**. This survey is a pilot study which will be considered as part of my doctoral dissertation. The purpose of the study is to measure the reliability of my proposed instrument using a test-retest method. You will be asked to complete the web based survey now by following the enclosed URL. If you choose to complete this survey you will receive another email in approximately one week inviting you to complete the survey again

You must be a current student in a CAAHEP accredited entry-level athletic training education program to participate in this study.

The survey consists of demographic questions and others relating to the importance of structured clinical education and unstructured field experience on the development of selected affective domain competencies. The survey should take you no longer than approximately 25 minutes to complete.

To participate you need access to the internet. You will access the link provided below, answer all questions honestly and submit your responses. All of your responses will be confidential. Filling out the survey and submitting your responses serves as your informed consent for participation. Your participation is entirely voluntary and you may withdraw at any time by discontinuing the survey without submitting the data. This survey and consent letter have been approved by the University of North Carolina at Greensboro Institutional Review Board, which insures that research involving human subjects follows federal regulations. If you have any questions about your rights as a participant in this project please call Dr. Beverly Maddox-Britt at 336-334-5878.

I intend to submit the results of this study for publication in an aggregate form only. If you would like a copy of the project results please email me with your request for information. Also if you have any questions regarding this project feel free to contact me either by email or at 336-278-5883. If you have any questions about your rights as a participant in this project please call Dr. Beverly Maddox-Britt at 336-334-5878.

Thank you for your time and consideration,

Sue Stevens

Sstevens2@elon.edu

336-278-5883

Click this link to be taken to the survey

http://www.elon.edu/irweb/Athletics/athletics_ss.html

APPENDIX G

RESULTS OF PILOT TWO

Round One Reliability Analysis of Rated Data by Activity

***** Method 2 (covariance matrix) will be used for this analysis *****

Correlation Matrix

	PEER_1	PEER_2	PEER3	PEER_31	PEER_30
PEER_1	1.0000				
PEER_2	.8819	1.0000			
PEER3	.9401	.9683	1.0000		
PEER_31	.8336	.6039	.7464	1.0000	
PEER_30	.6133	.4222	.5154	.8833	1.0000
PEER_27	.5320	.7253	.6920	.4947	.5821
PEER_28	.3678	.1651	.2890	.7591	.9321
PEER_29	.9401	.8350	.8561	.8210	.7201
PEER_4	.7055	.7083	.8315	.6651	.3642
PEER_5	.6355	.6705	.7681	.7231	.6363
PEER_6	.7434	.4566	.6190	.8459	.7443
PEER_7	.5557	.7264	.7464	.4338	.3478
PEER_8	.1956	.5267	.4807	.0854	.0955
PEER_9	.9912	.8546	.9185	.8754	.6885
PEER_10	.6831	.8795	.8601	.3932	.1988
PEER_11	.7009	.8278	.8119	.4938	.4474
PEER_12	.1372	.0389	.0884	.5118	.7623
PEER_13	.6483	.7264	.7464	.6397	.6886
PEER_14	.9700	.7516	.8520	.8548	.6264
PEER_15	.6133	.7368	.7201	.4799	.5197
PEER_16	.5868	.7922	.7296	.4725	.5603
PEER_17	.5964	.4508	.5094	.7860	.9584
PEER_18	.7144	.6076	.6333	.7373	.8584
PEER_19	.4237	.2502	.3499	.7231	.9147
PEER_20	.7600	.8761	.8206	.3680	.2226
PEER_21	.6133	.7368	.7201	.4799	.5197
PEER_22	.4631	.6651	.6419	.3824	.4451
PEER_23	.7715	.9186	.9139	.5145	.3244
PEER_24	.5893	.3118	.3989	.6549	.7434
PEER_25	.6960	.6295	.6650	.7894	.9110
PEER_26	.3576	.7349	.6123	.0355	-.0201
	PEER_27	PEER_28	PEER_29	PEER_4	PEER_5

PEER_27	1.0000				
PEER_28	.4792	1.0000			
PEER_29	.5940	.4371	1.0000		
PEER_4	.5745	.2989	.5117	1.0000	
PEER_5	.8279	.6177	.5462	.8807	1.0000
PEER_6	.4035	.7226	.6390	.6369	.6974
PEER_7	.8748	.2993	.4553	.8122	.8997
PEER_8	.8154	.1156	.1261	.5914	.7280
PEER_9	.5569	.4394	.9685	.6743	.6411
PEER_10	.7843	.0269	.5849	.8004	.7520
PEER_11	.9017	.3038	.6707	.6888	.8033
PEER_12	.3038	.8649	.2211	.0207	.3611
PEER_13	.9593	.6059	.6643	.6651	.8997
PEER_14	.4170	.4128	.8989	.6746	.5900
PEER_15	.9359	.4212	.6142	.6093	.8113
PEER_16	.9775	.4295	.6418	.5260	.7687
PEER_17	.6760	.9025	.7017	.3246	.6497
PEER_18	.7446	.7320	.8060	.3780	.6486
PEER_19	.5864	.9683	.4865	.3203	.6635
PEER_20	.6881	-.0240	.7226	.5745	.5381
PEER_21	.9359	.4212	.6142	.6093	.8113
PEER_22	.9593	.4015	.4553	.6161	.8408
PEER_23	.8091	.1277	.6963	.8165	.7845
PEER_24	.3762	.7152	.5983	.2494	.4494
PEER_25	.8226	.7993	.7932	.4585	.7492
PEER_26	.7686	-.1761	.3458	.4865	.5194

PEER_6 PEER_7 PEER_8 PEER_9 PEER_10

PEER_6	1.0000				
PEER_7	.5016	1.0000			
PEER_8	.1246	.9006	1.0000		
PEER_9	.7500	.5312	.1662	1.0000	
PEER_10	.3718	.9152	.7873	.6439	1.0000
PEER_11	.5489	.9320	.7637	.6885	.9170
PEER_12	.4225	.0545	.0230	.1894	-.2008
PEER_13	.6393	.8971	.7375	.6689	.7728
PEER_14	.8344	.4774	.0650	.9683	.5751
PEER_15	.5582	.9181	.7784	.6141	.8336
PEER_16	.4006	.8452	.7800	.5965	.7915
PEER_17	.7600	.4545	.2200	.6587	.2794
PEER_18	.7587	.5672	.2994	.7587	.4706
PEER_19	.7761	.4288	.2308	.4837	.1550

PEER_20	.4035	.7481	.5478	.7264	.9011
PEER_21	.5582	.9181	.7784	.6141	.8336
PEER_22	.4328	.9485	.9006	.4623	.8203
PEER_23	.4588	.9004	.7243	.7456	.9882
PEER_24	.8761	.3275	.0000	.6133	.1811
PEER_25	.7286	.6236	.3917	.7497	.5022
PEER_26	-.0570	.7806	.8542	.3228	.8767

PEER_11 PEER_12 PEER_13 PEER_14 PEER_15

PEER_11	1.0000				
PEER_12	.0412	1.0000			
PEER_13	.9320	.3594	1.0000		
PEER_14	.6264	.1140	.5852	1.0000	
PEER_15	.9803	.1751	.9668	.5463	1.0000
PEER_16	.9128	.3154	.9384	.4531	.9380
PEER_17	.5822	.7293	.7860	.6049	.6718
PEER_18	.7511	.5040	.8508	.7128	.8047
PEER_19	.4693	.7970	.7231	.4667	.5886
PEER_20	.9017	-.2591	.7059	.6824	.8161
PEER_21	.9803	.1751	.9668	.5463	1.0000
PEER_22	.9320	.2069	.9485	.3696	.9668
PEER_23	.9328	-.1270	.8146	.6735	.8517
PEER_24	.4956	.4850	.5894	.6859	.5575
PEER_25	.7542	.5846	.8999	.6696	.8139
PEER_26	.7787	-.2312	.6316	.1784	.7250

PEER_16 PEER_17 PEER_18 PEER_19 PEER_20

PEER_16	1.0000				
PEER_17	.6771	1.0000			
PEER_18	.7701	.9496	1.0000		
PEER_19	.5556	.9529	.8432	1.0000	
PEER_20	.7482	.3496	.6050	.1518	1.0000
PEER_21	.9380	.6718	.8047	.5886	.8161
PEER_22	.9384	.5871	.6806	.5465	.7059
PEER_23	.8150	.3865	.5669	.2451	.9147
PEER_24	.4150	.8434	.8660	.8238	.3762
PEER_25	.8217	.9658	.9742	.8756	.5506
PEER_26	.7901	.0914	.2737	-.0487	.7686

PEER_21 PEER_22 PEER_23 PEER_24 PEER_25

PEER_21	1.0000
---------	--------

PEER_22	.9668	1.0000			
PEER_23	.8517	.8146	1.0000		
PEER_24	.5575	.3930	.2728	1.0000	
PEER_25	.8139	.7341	.5984	.7734	1.0000
PEER_26	.7250	.7806	.8276	-.1264	.3276

PEER_26

PEER_26 1.0000

RELIABILITY ANALYSIS - SCALE (ALPHA)

N of Cases = 7.0

Item Means	Mean	Minimum	Maximum	Range	Max/Min	Variance
	4.1843	3.4286	5.0000	1.5714	1.4583	.2016

Item Variances	Mean	Minimum	Maximum	Range	Max/Min	Variance
	3.0553	1.0000	4.8095	3.8095	4.8095	.8567

Inter-item

Correlations	Mean	Minimum	Maximum	Range	Max/Min	Variance
	.6149	-.2591	1.0000	1.2591	-3.8590	.0646

Intraclass Correlation Coefficients

Two-Way Mixed Effects Model (Consistency Definition)

Measure	ICC		95% Confidence Interval		F-Value	Sig.
	Value	Lower Bound	Upper Bound			
Single Rater	.6101	.3796	.8860		49.5053	.0000
Average of Raters*	.9798	.9499	.9959		49.5053	.0000

Degrees of freedom for F-tests are 6 and 180. Test Value = 0.

* Assumes absence of People*Rater interaction.

Reliability Coefficients 31 items

Alpha = .9798 Standardized item alpha = .9802

Correlation Matrix

	ACI1	ACI2	ACI3	ACI4	ACI5
ACI1	1.0000				
ACI2	.8807	1.0000			
ACI3	.8321	.8660	1.0000		
ACI4	.6999	.7947	.9177	1.0000	
ACI5	.4615	.6005	.6934	.9226	1.0000
ACI6	.4234	.5962	.7184	.9065	.9465
ACI7	.7970	.8555	.9878	.9683	.7970
ACI8	.6999	.7947	.9177	1.0000	.9226
ACI9	.3203	.4167	.5774	.7947	.8807
ACI10	.5095	.7660	.8165	.9366	.9058
ACI11	.6363	.8278	.5735	.6579	.6363
ACI12	.3721	.7100	.6708	.5643	.3721
ACI13	.4615	.6005	.6934	.9226	1.0000
ACI14	.5095	.7660	.8165	.9366	.9058
ACI15	.0000	.0000	.2673	.4292	.5189
ACI16	-.1632	-.1132	.0000	-.0900	-.1632
ACI17	.5095	.7660	.8165	.9366	.9058
ACI18	-.1834	.0000	.0945	.1517	.1834
ACI19	.1345	.4201	.4851	.7233	.8408
ACI20	-.0620	.2582	.2236	.5643	.8062
ACI21	-.0620	.2582	.2236	.5643	.8062
ACI22	.2545	.5629	.5735	.8158	.9226
ACI23	.0769	.2402	.2774	.6363	.8846
ACI24	-.0620	.2582	.2236	.5643	.8062
ACI25	-.3363	-.0700	.0000	-.0556	-.1009
ACI26	-.4615	-.3203	-.2774	-.2545	-.1923
ACI27	.0400	.4167	.4330	.5629	.6005
ACI28	-.3536	-.3114	-.1961	-.0900	.0272
ACI29	.6974	.7024	.4056	.1675	-.0900
ACI30	-.2831	-.0589	.0000	.2810	.5095
ACI31	.1345	.4201	.4851	.7233	.8408
	ACI6	ACI7	ACI8	ACI9	ACI10
ACI6	1.0000				
ACI7	.8065	1.0000			
ACI8	.9065	.9683	1.0000		
ACI9	.9592	.6740	.7947	1.0000	
ACI10	.9165	.8799	.9366	.7660	1.0000
ACI11	.6799	.6181	.6579	.5960	.7024

ACI12	.4819	.6426	.5643	.2582	.7303
ACI13	.9465	.7970	.9226	.8807	.9058
ACI14	.9165	.8799	.9366	.7660	1.0000
ACI15	.5040	.3360	.4292	.5401	.3819
ACI16	-.2113	-.0352	-.0900	-.3114	-.0400
ACI17	.9165	.8799	.9366	.7660	1.0000
ACI18	.1188	.1188	.1517	.0000	.2700
ACI19	.7841	.5881	.7233	.6651	.8416
ACI20	.7631	.3614	.5643	.7100	.7303
ACI21	.7631	.3614	.5643	.7100	.7303
ACI22	.9065	.6799	.8158	.7947	.9366
ACI23	.7970	.4234	.6363	.8006	.6794
ACI24	.7631	.3614	.5643	.7100	.7303
ACI25	.0218	-.0218	-.0556	-.0700	.1485
ACI26	.0996	-.2740	-.2545	.2402	-.1132
ACI27	.5962	.4926	.5629	.4167	.7660
ACI28	-.0881	-.1585	-.0900	-.1132	-.0400
ACI29	-.0146	.3205	.1675	-.1171	.1325
ACI30	.4033	.1100	.2810	.3536	.4167
ACI31	.7841	.5881	.7233	.6651	.8416

	ACI11	ACI12	ACI13	ACI14	ACI15
ACI11	1.0000				
ACI12	.5130	1.0000			
ACI13	.6363	.3721	1.0000		
ACI14	.7024	.7303	.9058	1.0000	
ACI15	.0000	.0000	.5189	.3819	1.0000
ACI16	-.3824	.1754	-.1632	-.0400	.5503
ACI17	.7024	.7303	.9058	1.0000	.3819
ACI18	-.1517	.2958	.1834	.2700	.7071
ACI19	.4451	.4881	.8408	.8416	.6806
ACI20	.5130	.3000	.8062	.7303	.4183
ACI21	.5130	.3000	.8062	.7303	.4183
ACI22	.6579	.5643	.9226	.9366	.4292
ACI23	.4772	.0620	.8846	.6794	.5189
ACI24	.5130	.3000	.8062	.7303	.4183
ACI25	-.1391	.4881	-.1009	.1485	.4537
ACI26	.0318	.0620	-.1923	-.1132	.0000
ACI27	.3642	.7100	.6005	.7660	.5401
ACI28	-.3824	-.1316	.0272	-.0400	.7338
ACI29	.6141	.4353	-.0900	.1325	-.4552
ACI30	.0468	.0913	.5095	.4167	.7638
ACI31	.4451	.4881	.8408	.8416	.6806

	ACI16	ACI17	ACI18	ACI19	ACI20
ACI16	1.0000				
ACI17	-.0400	1.0000			
ACI18	.9080	.2700	1.0000		
ACI19	.2854	.8416	.6417	1.0000	
ACI20	-.1316	.7303	.2958	.8677	1.0000
ACI21	-.1316	.7303	.2958	.8677	1.0000
ACI22	-.0900	.9366	.3035	.9181	.9234
ACI23	-.2176	.6794	.1834	.8072	.9303
ACI24	-.1316	.7303	.2958	.8677	1.0000
ACI25	.7848	.1485	.8021	.3824	.1085
ACI26	-.2176	-.1132	-.1834	-.1345	.0620
ACI27	.4812	.7660	.7638	.9102	.7100
ACI28	.8654	-.0400	.9080	.4519	.1754
ACI29	-.1909	.1325	-.3219	-.2557	-.3265
ACI30	.5204	.4167	.8101	.8416	.7303
ACI31	.2854	.8416	.6417	1.0000	.8677

	ACI21	ACI22	ACI23	ACI24	ACI25
ACI21	1.0000				
ACI22	.9234	1.0000			
ACI23	.9303	.8590	1.0000		
ACI24	1.0000	.9234	.9303	1.0000	
ACI25	.1085	.1391	-.1345	.1085	1.0000
ACI26	.0620	-.0318	-.0769	.0620	.3363
ACI27	.7100	.7947	.5204	.7100	.6651
ACI28	.1754	.0675	.1632	.1754	.6183
ACI29	-.3265	-.0930	-.3824	-.3265	-.1180
ACI30	.7303	.6088	.6794	.7303	.4951
ACI31	.8677	.9181	.8072	.8677	.3824

	ACI26	ACI27	ACI28	ACI29	ACI30
ACI26	1.0000				
ACI27	-.0400	1.0000			
ACI28	-.2176	.4812	1.0000		
ACI29	-.0675	-.1171	-.5249	1.0000	
ACI30	-.1132	.7660	.8006	-.5629	1.0000
ACI31	-.1345	.9102	.4519	-.2557	.8416

ACI31

ACI31 1.0000

RELIABILITY ANALYSIS - SCALE (ALPHA)

N of Cases = 7.0

Item Means	Mean	Minimum	Maximum	Range	Max/Min	Variance
	5.2949	4.7143	5.7143	1.0000	1.2121	.0693

Item Variances	Mean	Minimum	Maximum	Range	Max/Min	Variance
	.8418	.2381	2.3333	2.0952	9.8000	.2388

Inter-item

Correlations	Mean	Minimum	Maximum	Range	Max/Min	Variance
	.4435	-.5629	1.0000	1.5629	-1.7764	.1537

Intraclass Correlation Coefficients
Two-Way Mixed Effects Model (Consistency Definition)

Measure	ICC		95% Confidence Interval		F-Value	Sig.
	Value	Lower Bound	Upper Bound			
Single Rater	.3820	.1870	.7588	20.1614	.0000	
Average of Raters*	.9504	.8770	.9898	20.1614	.0000	

Degrees of freedom for F-tests are 6 and 180. Test Value = 0.

* Assumes absence of People*Rater interaction.

Reliability Coefficients 31 items

Alpha = .9504 Standardized item alpha = .9611

RELIABILITY ANALYSIS - SCALE (ALPHA)

Correlation Matrix

	PRACT1	PRACT2	PRACT3	PRACT4	PRACT5
PRACT1	1.0000				
PRACT2	.7670	1.0000			
PRACT3	.0000	.5916	1.0000		

PRACT4	.3218	.6455	.3819	1.0000	
PRACT5	-.1345	-.4824	-.5189	-.1132	1.0000
PRACT6	.0000	.2415	.4082	.6236	.4237
PRACT7	.1485	.4196	.3819	.8542	.2831
PRACT8	-.3363	-.1316	.2594	.3114	.6154
PRACT9	-.3208	.0000	.5303	.2700	.3669
PRACT10	.3208	.4183	.1768	.8101	.3669
PRACT11	.3363	.4385	.0000	.4812	-.3462
PRACT12	.1750	.5477	.8101	.3536	-.0400
PRACT13	-.0556	.1814	.4292	.4449	.4136
PRACT14	-.2269	.2958	.7500	.5728	.0000
PRACT15	-.3824	.0383	.6806	.1980	.1345
PRACT16	.0000	.5916	1.0000	.3819	-.5189
PRACT17	-.2269	.2958	.7500	.5728	.0000
PRACT18	.1189	.5892	.5503	.9408	-.2176
PRACT19	-.0556	.1814	.4292	.4449	.4136
PRACT20	-.1765	.3068	.9075	.0248	-.3363
PRACT21	.2269	.2958	.5000	.0000	.2594
PRACT22	.1009	.4385	.2594	.8775	-.0769
PRACT23	-.0476	.3721	.3669	.8006	-.0272
PRACT24	-.1750	.0913	.5401	.2652	.3203
PRACT25	-.2301	.4000	.8874	.4841	-.4385
PRACT26	.5601	.0913	-.2700	-.3536	.3203
PRACT27	-.3151	-.0913	.5401	-.2652	.2402
GAME28	-.7179	-.2582	.5728	-.0208	.0849
PRACT29	-.4985	.0500	.4437	.3712	-.4385
PRACT30	-.7670	-.3000	.5916	-.1936	-.1316
PRACT31	.2567	.7607	.7201	.9035	-.3203

PRACT6 PRACT7 PRACT8 PRACT9 PRACT10

PRACT6	1.0000				
PRACT7	.9354	1.0000			
PRACT8	.8473	.7077	1.0000		
PRACT9	.8660	.6751	.9172	1.0000	
PRACT10	.8660	.9451	.5503	.5000	1.0000
PRACT11	-.2118	.0849	-.1923	-.3669	.0000
PRACT12	.6614	.5598	.6005	.7638	.3819
PRACT13	.8761	.7727	.9226	.9105	.6070
PRACT14	.8165	.7638	.7783	.8839	.5303
PRACT15	.7410	.5446	.8072	.9625	.3208
PRACT16	.4082	.3819	.2594	.5303	.1768
PRACT17	.8165	.7638	.7783	.8839	.5303
PRACT18	.5991	.8006	.4079	.3892	.6486

PRACT19	.8761	.7727	.9226	.9105	.6070
PRACT20	.3705	.1980	.3363	.6417	.0000
PRACT21	.6124	.3819	.5189	.7071	.3536
PRACT22	.4237	.6794	.3462	.1834	.5503
PRACT23	.4494	.6605	.4079	.2594	.5189
PRACT24	.8819	.6776	.8006	.9547	.5728
PRACT25	.4830	.4841	.4385	.6275	.2092
PRACT26	.0000	-.1473	-.0400	.0000	.0000
PRACT27	.4410	.1473	.6005	.7638	.0000
GAME28	.4677	.2708	.7077	.8101	.0000
PRACT29	.0000	.1452	.1316	.1046	-.1046
PRACT30	.2415	.0323	.4385	.6275	-.2092
PRACT31	.5879	.7660	.3203	.3819	.6365

PRACT11 PRACT12 PRACT13 PRACT14 PRACT15

PRACT11	1.0000				
PRACT12	-.0400	1.0000			
PRACT13	-.0318	.7947	1.0000		
PRACT14	.0000	.8101	.8584	1.0000	
PRACT15	-.3363	.8052	.8346	.9075	1.0000
PRACT16	.0000	.8101	.4292	.7500	.6806
PRACT17	.0000	.8101	.8584	1.0000	.9075
PRACT18	.5439	.4812	.5399	.7338	.3805
PRACT19	-.0318	.7947	1.0000	.8584	.8346
PRACT20	-.3363	.8052	.4451	.6806	.7941
PRACT21	-.5189	.8101	.6438	.5000	.6806
PRACT22	.7308	.2402	.4136	.5189	.1345
PRACT23	.5439	.2831	.3824	.5503	.2140
PRACT24	-.5204	.7500	.8278	.8101	.9102
PRACT25	.1754	.7303	.5804	.8874	.7670
PRACT26	-.2402	.1667	.1325	-.2700	-.0700
PRACT27	-.6005	.7083	.5629	.5401	.8052
GAME28	-.3114	.5598	.6088	.7638	.8911
PRACT29	.4824	.0913	.0725	.4437	.2301
PRACT30	-.4385	.4108	.3265	.5916	.7670
PRACT31	.4270	.6111	.4857	.7201	.3967

PRACT16 PRACT17 PRACT18 PRACT19 PRACT20

PRACT16	1.0000			
PRACT17	.7500	1.0000		
PRACT18	.5503	.7338	1.0000	
PRACT19	.4292	.8584	.5399	1.0000

PRACT20	.9075	.6806	.2140	.4451	1.0000
PRACT21	.5000	.5000	.0000	.6438	.6806
PRACT22	.2594	.5189	.9247	.4136	-.1009
PRACT23	.3669	.5503	.8654	.3824	.0476
PRACT24	.5401	.8101	.3114	.8278	.6651
PRACT25	.8874	.8874	.7132	.5804	.7670
PRACT26	-.2700	-.2700	-.4812	.1325	-.0700
PRACT27	.5401	.5401	-.1132	.5629	.8052
GAME28	.5728	.7638	.2402	.6088	.7179
PRACT29	.4437	.4437	.6047	.0725	.2301
PRACT30	.5916	.5916	.0620	.3265	.7670
PRACT31	.7201	.7201	.9436	.4857	.3967

PRACT21 PRACT22 PRACT23 PRACT24 PRACT25

PRACT21	1.0000				
PRACT22	-.2594	1.0000			
PRACT23	-.1834	.9247	1.0000		
PRACT24	.8101	.0400	.1132	1.0000	
PRACT25	.2958	.4824	.4961	.5477	1.0000
PRACT26	.5401	-.5204	-.6794	.1250	-.4108
PRACT27	.8101	-.3203	-.1132	.7500	.4108
GAME28	.3819	.0849	.2402	.6776	.7100
PRACT29	-.4437	.6359	.7132	-.0913	.6500
PRACT30	.2958	-.1316	.0620	.5477	.6500
PRACT31	.1800	.8006	.8115	.3611	.7303

PRACT26 PRACT27 GAME28 PRACT29 PRACT30

PRACT26	1.0000				
PRACT27	.1667	1.0000			
GAME28	-.3536	.7660	1.0000		
PRACT29	-.8900	-.0685	.4841	1.0000	
PRACT30	-.4108	.7303	.9360	.4750	1.0000
PRACT31	-.4167	.0278	.2161	.5173	.0913

PRACT31

PRACT31	1.0000
---------	--------

RELIABILITY ANALYSIS - SCALE (ALPHA)

N of Cases = 7.0

Item Means	Mean	Minimum	Maximum	Range	Max/Min	Variance
	4.8341	3.8571	5.2857	1.4286	1.3704	.0940

Item Variances	Mean	Minimum	Maximum	Range	Max/Min	Variance
	.9155	.4762	2.4762	2.0000	5.2000	.1977

Inter-item

Correlations	Mean	Minimum	Maximum	Range	Max/Min	Variance
	.3729	-.8900	1.0000	1.8900	-1.1235	.1539

Intraclass Correlation Coefficients

Two-Way Mixed Effects Model (Consistency Definition)

Measure	ICC		95% Confidence Interval		F-Value	Sig.
	Value	Lower Bound	Upper Bound			
Single Rater	.3634	.1743	.7446		18.6979	.0000
Average of Raters*	.9465	.8674	.9891		18.6979	.0000

Degrees of freedom for F-tests are 6 and 180. Test Value = 0.

* Assumes absence of People*Rater interaction.

Reliability Coefficients 31 items

Alpha = .9465 Standardized item alpha = .9485

RELIABILITY ANALYSIS - SCALE (ALPHA)

Correlation Matrix

	GAME1	GAME2	GAME3	GAME4	GAME5
GAME1	1.0000				
GAME2	.4201	1.0000			
GAME3	-.8402	-.5000	1.0000		
GAME4	.5423	.0000	-.3873	1.0000	
GAME5	.1715	-.6124	.0000	.7906	1.0000
GAME6	.0379	.2705	-.2705	.4889	.2209
GAME7	.4954	-.3216	-.3216	.9135	.9191

GAME8	-.1588	.0000	.3780	.5855	.4629
GAME9	-.4167	.0000	.5410	.2794	.2209
GAME10	.7647	.4201	-.8402	.7593	.3430
GAME11	.3430	.9186	-.3062	-.0791	-.6250
GAME12	-.6860	-.6124	.6124	.1581	.5000
GAME13	-.0450	-.6433	.3216	.6644	.9191
GAME14	-.1588	.0000	.3780	.5855	.4629
GAME15	-.5941	.0000	.7071	.0000	.0000
GAME16	-.3430	.0000	.6124	.3162	.2500
GAME17	-.1085	-.7746	.3873	.4000	.7906
GAME18	.4118	.4201	-.4201	.7593	.3430
GAME19	-.2425	-.5774	.5774	.4472	.7071
GAME20	-.5119	-.7833	.7833	.0674	.5330
GAME21	-.6002	-.9186	.6124	.0791	.6250
GAME22	.5664	.4758	-.4758	.4914	.0971
GAME23	.3757	-.2236	-.2236	.5196	.5477
GAME24	-.2941	-.8402	.4201	.4339	.8575
GAME25	-.4201	.5000	.5000	-.3873	-.6124
GAME26	-.2425	-.5774	.0000	-.4472	.0000
GAME27	-.4287	-.9186	.6124	-.0791	.5000
GAME28	-.6860	-.3062	.9186	-.0791	.1250
GAME29	.0333	.0000	.2379	-.1229	-.0971
GAME30	-.8402	-.5000	1.0000	-.3873	.0000
GAME31	.7939	.7559	-.7559	.5855	.0000

GAME6 GAME7 GAME8 GAME9 GAME10

GAME6	1.0000				
GAME7	.2030	1.0000			
GAME8	.5112	.3647	1.0000		
GAME9	.5610	.0290	.9202	1.0000	
GAME10	.6439	.5855	.1588	-.0379	1.0000
GAME11	-.0552	-.3283	.0000	-.0552	.1715
GAME12	.1104	.2626	.4629	.4417	-.3430
GAME13	.0290	.7931	.6078	.3770	.0450
GAME14	.5112	.3647	1.0000	.9202	.1588
GAME15	.3825	-.2274	.8018	.9564	-.2970
GAME16	.2209	.1313	.9258	.8835	-.1715
GAME17	-.3492	.6644	.2928	.0698	-.2169
GAME18	.4167	.5855	.4763	.1894	.6471
GAME19	-.1562	.5571	.6547	.4685	-.2425
GAME20	-.3767	.2799	.3948	.3296	-.5850
GAME21	-.1104	.3283	.2315	.2209	-.4287
GAME22	-.1073	.4336	.0899	-.2360	.4331

GAME23	-.3629	.7192	.0000	-.3629	.1879
GAME24	.1894	.5855	.4763	.4167	-.0588
GAME25	.0000	-.6433	.3780	.5410	-.4201
GAME26	-.1562	-.1857	-.6547	-.4685	-.2425
GAME27	-.5522	.2626	.0000	-.0552	-.6002
GAME28	-.0552	-.1313	.6944	.7730	-.6002
GAME29	-.7937	.0255	-.0899	-.2789	-.4331
GAME30	-.2705	-.3216	.3780	.5410	-.8402
GAME31	.3067	.3647	.1429	-.1022	.7939

GAME11 GAME12 GAME13 GAME14 GAME15

GAME11	1.0000				
GAME12	-.5000	1.0000			
GAME13	-.5252	.6565	1.0000		
GAME14	.0000	.4629	.6078	1.0000	
GAME15	.0000	.4330	.2274	.8018	1.0000
GAME16	.1250	.5000	.5252	.9258	.8660
GAME17	-.5534	.6325	.9135	.2928	.0000
GAME18	.4287	.1715	.3153	.4763	.0000
GAME19	-.3536	.7071	.9285	.6547	.4082
GAME20	-.5330	.7462	.7838	.3948	.3693
GAME21	-.8125	.8750	.7222	.2315	.2165
GAME22	.6313	-.0971	.1275	.0899	-.3365
GAME23	.0000	.2739	.5754	.0000	-.4743
GAME24	-.8575	.6860	.8557	.4763	.2970
GAME25	.6124	.0000	-.3216	.3780	.7071
GAME26	-.7071	.0000	-.1857	-.6547	-.4082
GAME27	-.6875	.6250	.6565	.0000	.0000
GAME28	-.1250	.6250	.4596	.6944	.8660
GAME29	.3885	.0971	.1786	-.0899	-.1682
GAME30	-.3062	.6124	.3216	.3780	.7071
GAME31	.6944	-.4629	-.1216	.1429	-.2673

GAME16 GAME17 GAME18 GAME19 GAME20

GAME16	1.0000				
GAME17	.3162	1.0000			
GAME18	.3430	.1085	1.0000		
GAME19	.7071	.8944	.2425	1.0000	
GAME20	.5330	.8765	-.1463	.9045	1.0000
GAME21	.2500	.7906	-.1715	.7071	.8528
GAME22	.0971	.1229	.8329	.1374	-.1657
GAME23	.0000	.6928	.5636	.5164	.3503

GAME24	.3430	.7593	-.0588	.7276	.7313
GAME25	.6124	-.3873	.0000	.0000	.0000
GAME26	-.7071	.0000	-.7276	-.3333	.0000
GAME27	.1250	.8696	-.3430	.7071	.9061
GAME28	.8750	.3953	-.0857	.7071	.7462
GAME29	.1943	.4300	.1666	.4121	.4142
GAME30	.6124	.3873	-.4201	.5774	.7833
GAME31	.0000	-.2928	.7939	-.2182	-.5922

GAME21 GAME22 GAME23 GAME24 GAME25

GAME21	1.0000				
GAME22	-.3400	1.0000			
GAME23	.2739	.7448	1.0000		
GAME24	.8575	-.3665	.1879	1.0000	
GAME25	-.3062	.0000	-.4472	-.4201	1.0000
GAME26	.3536	-.6868	-.2582	.2425	-.5774
GAME27	.8750	-.2428	.4108	.6860	-.3062
GAME28	.5000	-.2428	-.1369	.4287	.6124
GAME29	.0486	.5849	.6384	-.2332	.2379
GAME30	.6124	-.4758	-.2236	.4201	.5000
GAME31	-.6944	.8093	.3381	-.4763	.0000

 GAME26 GAME27 GAME28 GAME29 GAME30

GAME26	1.0000				
GAME27	.3536	1.0000			
GAME28	-.3536	.4375	1.0000		
GAME29	-.4121	.3885	.2428	1.0000	
GAME30	.0000	.6124	.9186	.2379	1.0000
GAME31	-.6547	-.6944	-.4629	.0899	-.7559

 GAME31

GAME31 1.0000

RELIABILITY ANALYSIS - SCALE (ALPHA)

N of Cases = 6.0

Item Means	Mean	Minimum	Maximum	Range	Max/Min	Variance
	4.5269	3.1667	5.5000	2.3333	1.7368	.2261

Item Variances	Mean	Minimum	Maximum	Range	Max/Min	Variance
----------------	------	---------	---------	-------	---------	----------

.8753 .2667 2.0000 1.7333 7.5000 .2178

Inter-item

Correlations	Mean	Minimum	Maximum	Range	Max/Min	Variance
	.1588	-.9186	1.0000	1.9186	-1.0887	.2219

Intraclass Correlation Coefficients

Two-Way Mixed Effects Model (Consistency Definition)

Measure	ICC		95% Confidence Interval		F-Value	Sig.
	Value	Lower Bound	Upper Bound			
Single Rater	.1636	.0509	.5741	7.0616	.0000	
Average of Raters*	.8584	.6244	.9766	7.0616	.0000	

Degrees of freedom for F-tests are 5 and 150. Test Value = 0.

* Assumes absence of People*Rater interaction.

Reliability Coefficients 31 items

Alpha = .8584 Standardized item alpha = .8541

Round One Reliability Analysis of Ranked Data by activity

***** Method 2 (covariance matrix) will be used for this analysis *****

	RPEER1	RPEER_2	RPEER3	RPEER4	RPEER5
RPEER1	1.0000				
RPEER_2	.5960	1.0000			
RPEER3	.7424	.4282	1.0000		
RPEER4	.8721	.5594	.9548	1.0000	
RPEER5	.9065	.6740	.8113	.9237	1.0000
RPEER6	.7587	.7638	.3568	.4930	.5940
RPEER7	.9105	.7638	.7135	.7888	.8316
RPEER8	.6190	.4523	.8098	.7525	.5784
RPEER9	.3583	.4959	.1264	.1280	.3506
RPEER10	.8241	.7777	.4601	.5756	.6935
RPEER11	.8241	.7777	.4601	.5756	.6935
RPEER12	.3338	.0700	.6214	.5242	.1742
RPEER13	.5286	.0700	.5069	.3977	.3267
RPEER14	-.1357	-.3416	-.3191	-.3528	-.1063
RPEER15	.4474	.1325	.2011	.1539	.1854

RPEER16	.4474	.1325	.2011	.1539	.1854
RPEER17	.7623	.6740	.6418	.6426	.6613
RPEER18	.6786	.6831	.3989	.4410	.5313
RPEER19	.5804	.5477	.5330	.4714	.4686
RPEER20	.6786	.6831	.3989	.4410	.5313
RPEER21	.7623	.6740	.6418	.6426	.6613
RPEER22	.7623	.6740	.6418	.6426	.6613
RPEER23	.2810	-.3536	.5230	.3347	.1466
RPEER24	.4136	-.2402	.0935	.0827	.0996
RPEER25	.6786	.6831	.3989	.4410	.5313
RPEER26	.6402	.5556	.6617	.6455	.7777
RPEER27	.7788	.6030	.8333	.7915	.7347
RPEER28	.4792	.4523	.4812	.4801	.3596
RPEER39	.1574	-.1980	.4278	.3068	.0462
RPEER30	.4049	-.1132	.6611	.5847	.3346
RPEER31	.7506	.6111	.7006	.7603	.6740

RPEER6 RPEER7 RPEER8 RPEER9 RPEER10

RPEER6	1.0000				
RPEER7	.8750	1.0000			
RPEER8	.3454	.6908	1.0000		
RPEER9	.6198	.6198	.1767	1.0000	
RPEER10	.9504	.9504	.5159	.7293	1.0000
RPEER11	.9504	.9504	.5159	.7293	1.0000
RPEER12	.1604	.3208	.6966	-.3409	.1307
RPEER13	.4813	.6417	.5489	.5871	.5881
RPEER14	-.1118	-.1118	-.4119	.5544	.0000
RPEER15	.6070	.6070	.3395	.7345	.6799
RPEER16	.6070	.6070	.3395	.7345	.6799
RPEER17	.8316	.9504	.6878	.7433	.9194
RPEER18	.8944	.8944	.5149	.8315	.9563
RPEER19	.7321	.8367	.6331	.7902	.8235
RPEER20	.8944	.8944	.5149	.8315	.9563
RPEER21	.8316	.9504	.6878	.7433	.9194
RPEER22	.8316	.9504	.6878	.7433	.9194
RPEER23	.0000	.2700	.4619	.1594	.1100
RPEER24	.3669	.3669	.1448	.4115	.4234
RPEER25	.8944	.8944	.5149	.8315	.9563
RPEER26	.5092	.7638	.4858	.7664	.6740
RPEER27	.6908	.9211	.8030	.5845	.7973
RPEER28	.6908	.5757	.2576	.1767	.5159
RPEER39	.1134	.1134	.1194	-.2544	-.0462
RPEER30	.1297	.2594	.3073	-.3063	.0352

RPEER31	.7638	.7638	.4523	.1803	.6567
---------	-------	-------	-------	-------	-------

	RPEER11	RPEER12	RPEER13	RPEER14	RPEER15
--	---------	---------	---------	---------	---------

RPEER11	1.0000				
RPEER12	.1307	1.0000			
RPEER13	.5881	.3824	1.0000		
RPEER14	.0000	-.7174	.2870	1.0000	
RPEER15	.6799	.1391	.9181	.4072	1.0000
RPEER16	.6799	.1391	.9181	.4072	1.0000
RPEER17	.9194	.3267	.7841	.0000	.7623
RPEER18	.9563	.1435	.7174	.1000	.8143
RPEER19	.8235	.3068	.8437	.0935	.8343
RPEER20	.9563	.1435	.7174	.1000	.8143
RPEER21	.9194	.3267	.7841	.0000	.7623
RPEER22	.9194	.3267	.7841	.0000	.7623
RPEER23	.1100	.4951	.8416	.2415	.6088
RPEER24	.4234	.1009	.8072	.4922	.8590
RPEER25	.9563	.1435	.7174	.1000	.8143
RPEER26	.6740	-.0700	.5835	.3416	.4857
RPEER27	.7973	.4855	.7811	-.1030	.6390
RPEER28	.5159	.5489	.4011	-.4119	.3395
RPEER39	-.0462	.6655	.3744	-.3044	.1574
RPEER30	.0352	.7135	.3805	-.3481	.0900
RPEER31	.6567	.5601	.3967	-.4554	.2870

	RPEER16	RPEER17	RPEER18	RPEER19	RPEER20
--	---------	---------	---------	---------	---------

RPEER16	1.0000				
RPEER17	.7623	1.0000			
RPEER18	.8143	.9563	1.0000		
RPEER19	.8343	.9655	.9354	1.0000	
RPEER20	.8143	.9563	1.0000	.9354	1.0000
RPEER21	.7623	1.0000	.9563	.9655	.9563
RPEER22	.7623	1.0000	.9563	.9655	.9563
RPEER23	.6088	.4033	.2415	.4841	.2415
RPEER24	.8590	.4483	.4922	.4824	.4922
RPEER25	.8143	.9563	1.0000	.9354	1.0000
RPEER26	.4857	.7777	.6831	.7303	.6831
RPEER27	.6390	.9536	.8239	.9083	.8239
RPEER28	.3395	.5784	.5149	.5367	.5149
RPEER39	.1574	.1540	.0000	.1763	.0000
RPEER30	.0900	.2113	.0000	.1550	.0000
RPEER31	.2870	.6740	.5693	.5477	.5693

	RPEER21	RPEER22	RPEER23	RPEER24	RPEER25
RPEER21	1.0000				
RPEER22	1.0000	1.0000			
RPEER23	.4033	.4033	1.0000		
RPEER24	.4483	.4483	.6794	1.0000	
RPEER25	.9563	.9563	.2415	.4922	1.0000
RPEER26	.7777	.7777	.3536	.2402	.6831
RPEER27	.9536	.9536	.5330	.3621	.8239
RPEER28	.5784	.5784	.2132	.1448	.5149
RPEER29	.1540	.1540	.5601	.2140	.0000
RPEER30	.2113	.2113	.6005	.2176	.0000
RPEER31	.6740	.6740	.1964	.1334	.5693

	RPEER26	RPEER27	RPEER28	RPEER29	RPEER30
RPEER26	1.0000				
RPEER27	.8040	1.0000			
RPEER28	.2513	.5909	1.0000		
RPEER29	-.0330	.2985	.7464	1.0000	
RPEER30	.1132	.4097	.6657	.9249	1.0000
RPEER31	.4259	.7203	.9213	.6106	.6794

RPEER31

RPEER31	1.0000					
N of Cases = 7.0						
Item Means	Mean	Minimum	Maximum	Range	Max/Min	Variance
	2.8802	2.1429	3.5714	1.4286	1.6667	.1280
Item Variances	Mean	Minimum	Maximum	Range	Max/Min	Variance
	1.4301	.6190	2.6190	2.0000	4.2308	.1736

Intraclass Correlation Coefficients
Two-Way Mixed Effects Model (Consistency Definition)

Measure	ICC		95% Confidence Interval		F-Value	Sig.
	Value	Lower Bound	Upper Bound			
Single Rater	.5112	.2870	.8396	33.4215	.0000	
Average of Raters*	.9701	.9258	.9939	33.4215	.0000	

Degrees of freedom for F-tests are 6 and 180. Test Value = 0.

* Assumes absence of People*Rater interaction.

Reliability Coefficients 31 items

Alpha = .9701 Standardized item alpha = .9707

Correlation Matrix

	RACI1	RACI2	RACI3	RACI4	RACI5
RACI1	1.0000				
RACI2	.6364	1.0000			
RACI3	.8839	.4750	1.0000		
RACI4	.7100	.8672	.5477	1.0000	
RACI5	.3000	.6364	.3889	.7100	1.0000
RACI6	.6617	.6331	.6331	.8040	.3892
RACI7	.3000	.6364	.3889	.7100	1.0000
RACI8	-.3721	.1316	-.1754	.2402	.4961
RACI9	-.2008	.1704	-.0284	.3111	.3614
RACI10	.7100	.8672	.5477	1.0000	.7100
RACI11	.6617	.6331	.6331	.8040	.3892
RACI12	-.2582	.0913	-.5477	.1667	-.2582
RACI13	-.2582	.0913	.0913	.1667	.6455
RACI14	-.4000	-.3536	-.6010	-.1936	-.4000
RACI15	-.1557	-.1376	.0550	.1005	.1168
RACI16	-.3721	-.4824	-.4824	-.3203	-.3721
RACI17	-.2582	.0913	.0913	.1667	.6455
RACI18	-.5130	-.3265	-.3265	-.1325	.2052
RACI19	-.0430	.1217	.3347	.2222	.5594
RACI20	.2052	.1814	.4353	.3311	.2052
RACI21	-.2582	.0913	.0913	.1667	.6455
RACI22	-.2582	.0913	.0913	.1667	.6455
RACI23	-.4000	-.3536	-.1061	-.1936	.3000
RACI24	-.5130	-.3265	-.3265	-.1325	.2052
RACI25	-.5292	-.1871	-.3742	.0000	.2646
RACI26	-.4819	-.2272	-.6248	-.0518	-.2008
RACI27	-.4000	-.3536	-.1061	-.1936	.3000
RACI28	-.4961	-.7455	-.2850	-.5204	-.0620
RACI29	-.4000	-.3536	-.6010	-.1936	-.4000
RACI30	-.3721	-.4824	-.4824	-.3203	-.3721
RACI31	-.4000	-.3536	-.1061	-.1936	.3000

	RACI6	RACI7	RACI8	RACI9	RACI10
RACI6	1.0000				
RACI7	.3892	1.0000			
RACI8	.3621	.4961	1.0000		
RACI9	.5784	.3614	.9465	1.0000	
RACI10	.8040	.7100	.2402	.3111	1.0000
RACI11	1.0000	.3892	.3621	.5784	.8040
RACI12	.2513	-.2582	.3203	.4148	.1667
RACI13	.2513	.6455	.8807	.7777	.1667
RACI14	-.1557	-.4000	.0620	.0803	-.1936
RACI15	.4697	.1168	.7001	.7973	.1005
RACI16	-.3138	-.3721	-.0769	-.0996	-.3203
RACI17	.2513	.6455	.8807	.7777	.1667
RACI18	-.0599	.2052	.6363	.5357	-.1325
RACI19	.4523	.5594	.8006	.7950	.2222
RACI20	.7788	.2052	.6363	.8241	.3311
RACI21	.2513	.6455	.8807	.7777	.1667
RACI22	.2513	.6455	.8807	.7777	.1667
RACI23	-.1557	.3000	.4961	.3614	-.1936
RACI24	-.0599	.2052	.6363	.5357	-.1325
RACI25	.1030	.2646	.8204	.7438	.0000
RACI26	.0313	-.2008	.4234	.4355	-.0518
RACI27	-.1557	.3000	.4961	.3614	-.1936
RACI28	-.5311	-.0620	.0769	-.0747	-.5204
RACI29	-.1557	-.4000	.0620	.0803	-.1936
RACI30	-.3138	-.3721	-.0769	-.0996	-.3203
RACI31	-.1557	.3000	.4961	.3614	-.1936

	RACI11	RACI12	RACI13	RACI14	RACI15
RACI11	1.0000				
RACI12	.2513	1.0000			
RACI13	.2513	-.1667	1.0000		
RACI14	-.1557	.6455	-.2582	1.0000	
RACI15	.4697	.2513	.6030	.3892	1.0000
RACI16	-.3138	.3203	-.2402	.9303	.3621
RACI17	.2513	-.1667	1.0000	-.2582	.6030
RACI18	-.0599	.1325	.5960	.5643	.7788
RACI19	.4523	-.2222	.9444	-.3443	.6868
RACI20	.7788	.1325	.5960	-.1539	.7788
RACI21	.2513	-.1667	1.0000	-.2582	.6030
RACI22	.2513	-.1667	1.0000	-.2582	.6030
RACI23	-.1557	-.2582	.6455	.3000	.6617

RACI24	-.0599	.1325	.5960	.5643	.7788
RACI25	.1030	.3416	.6831	.5292	.8239
RACI26	.0313	.7777	.0518	.3614	.1407
RACI27	-.1557	-.2582	.6455	.3000	.6617
RACI28	-.5311	-.3203	.2402	.3721	.3138
RACI29	-.1557	.6455	-.2582	.3000	-.1557
RACI30	-.3138	.3203	-.2402	.9303	.3621
RACI31	-.1557	-.2582	.6455	.3000	.6617

RACI16 RACI17 RACI18 RACI19 RACI20

RACI16	1.0000				
RACI17	-.2402	1.0000			
RACI18	.6363	.5960	1.0000		
RACI19	-.3203	.9444	.4857	1.0000	
RACI20	-.2545	.5960	.2632	.7947	1.0000
RACI21	-.2402	1.0000	.5960	.9444	.5960
RACI22	-.2402	1.0000	.5960	.9444	.5960
RACI23	.4961	.6455	.9234	.5594	.2052
RACI24	.6363	.5960	1.0000	.4857	.2632
RACI25	.4922	.6831	.9501	.5693	.4072
RACI26	.0747	.0518	.1030	-.0518	.1030
RACI27	.4961	.6455	.9234	.5594	.2052
RACI28	.6154	.2402	.6999	.1334	-.1909
RACI29	.0620	-.2582	-.1539	-.3443	-.1539
RACI30	1.0000	-.2402	.6363	-.3203	-.2545
RACI31	.4961	.6455	.9234	.5594	.2052

RACI21 RACI22 RACI23 RACI24 RACI25

RACI21	1.0000				
RACI22	1.0000	1.0000			
RACI23	.6455	.6455	1.0000		
RACI24	.5960	.5960	.9234	1.0000	
RACI25	.6831	.6831	.7937	.9501	1.0000
RACI26	.0518	.0518	-.2008	.1030	.3188
RACI27	.6455	.6455	1.0000	.9234	.7937
RACI28	.2402	.2402	.8062	.6999	.4922
RACI29	-.2582	-.2582	-.4000	-.1539	.0000
RACI30	-.2402	-.2402	.4961	.6363	.4922
RACI31	.6455	.6455	1.0000	.9234	.7937

RACI26	RACI27	RACI28	RACI29	RACI30	RACI31
RACI26	1.0000				
RACI27	-.2008	1.0000			
RACI28	-.0747	.8062	1.0000		
RACI29	.9237	-.4000	-.0620	1.0000	
RACI30	.0747	.4961	.6154	.0620	1.0000
RACI31	-.2008	1.0000	.8062	-.4000	.4961

RACI31

RACI31	1.0000
--------	--------

N of Cases = 7.0

Item Means	Mean	Minimum	Maximum	Range	Max/Min	Variance
	1.6129	1.1429	2.2857	1.1429	2.0000	.0996

Item Variances	Mean	Minimum	Maximum	Range	Max/Min	Variance
	.8740	.1429	1.9048	1.7619	13.3333	.2586

Intraclass Correlation Coefficients
Two-Way Mixed Effects Model (Consistency Definition)

Measure	ICC		95% Confidence Interval		F-Value	Sig.
	Value	Lower Bound	Upper Bound			
Single Rater	.2357	.0951	.6201	10.5587	.0000	
Average of Raters*	.9053	.7652	.9806	10.5587	.0000	

Degrees of freedom for F-tests are 6 and 180. Test Value = 0.

* Assumes absence of People*Rater interaction.

Reliability Coefficients 31 items

Alpha = .9053 Standardized item alpha = .9065

RPRACT1	RPRACT2	RPRACT3	RPRACT4	RPRACT5
RPRACT1	1.0000			
RPRACT2	.1345	1.0000		
RPRACT3	.8549	.4328	1.0000	
RPRACT4	.8062	.1085	.5622	1.0000

RPRACT5	.5892	-.4610	.1814	.4750	1.0000
RPRACT6	.8590	.0556	.8746	.5130	.3334
RPRACT7	.8006	-.4201	.6088	.6455	.6455
RPRACT8	.3721	-.6508	.1814	-.0500	.6500
RPRACT9	.4079	-.2140	.4772	-.1316	.1754
RPRACT10	.5983	-.0476	.5886	.0219	.4824
RPRACT11	.8590	.0556	.7443	.8721	.3334
RPRACT12	.8006	-.4201	.6088	.6455	.6455
RPRACT13	.7308	-.3363	.5399	.3721	.5892
RPRACT14	.8062	.1085	.8162	.3000	.4750
RPRACT15	.8473	.0000	.8673	.6831	.3416
RPRACT16	.6939	.0934	.7024	.2582	.5594
RPRACT17	.8807	-.0700	.7024	.4841	.7100
RPRACT18	.6363	-.3338	.6141	.1539	.5130
RPRACT19	.4772	-.4451	.2977	.0256	.5643
RPRACT20	.8800	.4991	.9320	.7094	.3068
RPRACT21	.8807	-.0700	.7024	.4841	.7100
RPRACT22	.7308	-.3363	.5399	.3721	.5892
RPRACT23	.4615	-.8072	.0675	.3721	.8062
RPRACT24	.4270	-.4201	.3902	-.1076	.4949
RPRACT25	.3721	-.6508	.1814	-.0500	.6500
RPRACT26	.6227	.1307	.6264	.0803	.3614
RPRACT27	.4237	-.3705	.1239	.1708	.8539
RPRACT28	.2594	-.6806	.0000	.0000	.8367
RPRACT29	.5204	.0700	.4449	.4196	.6455
RPRACT30	.3363	-.3824	.1180	.0813	.8406
RPRACT31	.3363	.0294	.3934	.4610	.2712

RPRACT6 RPRACT7 RPRACT8 RPRACT9 RPRACT10

RPRACT6	1.0000				
RPRACT7	.7947	1.0000			
RPRACT8	.5130	.6455	1.0000		
RPRACT9	.7199	.5095	.7894	1.0000	
RPRACT10	.7199	.5095	.7894	.8654	1.0000
RPRACT11	.8158	.7947	.1539	.2475	.2475
RPRACT12	.7947	1.0000	.6455	.5095	.5095
RPRACT13	.8590	.8006	.8062	.7887	.7887
RPRACT14	.8721	.6455	.6500	.7894	.9428
RPRACT15	.8761	.8819	.3416	.4494	.4494
RPRACT16	.5960	.5556	.5594	.5473	.8115
RPRACT17	.8278	.7500	.7100	.6794	.8775
RPRACT18	.8158	.7947	.8721	.8773	.8773
RPRACT19	.6579	.5960	.9234	.8549	.8549

RPRACT20	.7082	.5446	.0383	.2186	.4541
RPRACT21	.8278	.7500	.7100	.6794	.8775
RPRACT22	.8590	.8006	.8062	.7887	.7887
RPRACT23	.4136	.8006	.8062	.4079	.4079
RPRACT24	.6402	.6111	.9467	.9058	.9058
RPRACT25	.5130	.6455	1.0000	.7894	.7894
RPRACT26	.7623	.4148	.6426	.8278	.9510
RPRACT27	.1752	.4410	.6831	.2996	.5991
RPRACT28	.2146	.5401	.8367	.3669	.5503
RPRACT29	.3311	.4167	.1936	-.0849	.3114
RPRACT30	.1391	.4201	.6508	.2140	.5470
RPRACT31	.1391	.4201	-.1085	-.2854	-.1189

RPRACT11 RPRACT12 RPRACT13 RPRACT14 RPRACT15

RPRACT11	1.0000				
RPRACT12	.7947	1.0000			
RPRACT13	.6363	.8006	1.0000		
RPRACT14	.5130	.6455	.8062	1.0000	
RPRACT15	.8761	.8819	.6355	.6831	1.0000
RPRACT16	.2870	.5556	.5071	.8607	.5879
RPRACT17	.5960	.7500	.8807	.9360	.6614
RPRACT18	.4474	.7947	.8590	.8721	.7009
RPRACT19	.2895	.5960	.9226	.7438	.3504
RPRACT20	.7082	.5446	.3805	.7094	.7859
RPRACT21	.5960	.7500	.8807	.9360	.6614
RPRACT22	.6363	.8006	1.0000	.8062	.6355
RPRACT23	.4136	.8006	.7308	.3721	.4237
RPRACT24	.1766	.6111	.8006	.7961	.4410
RPRACT25	.1539	.6455	.8062	.6500	.3416
RPRACT26	.3296	.4148	.7970	.9237	.4115
RPRACT27	.0000	.4410	.4237	.5123	.1667
RPRACT28	.0000	.5401	.5189	.4183	.2041
RPRACT29	.3311	.4167	.2402	.4196	.4410
RPRACT30	-.0556	.4201	.3363	.4610	.1852
RPRACT31	.3338	.4201	-.1345	.0813	.5557

RPRACT16 RPRACT17 RPRACT18 RPRACT19 RPRACT20

RPRACT16	1.0000				
RPRACT17	.8056	1.0000			
RPRACT18	.7506	.8278	1.0000		
RPRACT19	.4857	.7947	.8421	1.0000	
RPRACT20	.7261	.6683	.4328	.1180	1.0000

RPRACT21	.8056	1.0000	.8278	.7947	.6683
RPRACT22	.5071	.8807	.8590	.9226	.3805
RPRACT23	.3203	.6005	.6363	.6999	.0476
RPRACT24	.6852	.7500	.9492	.9051	.1980
RPRACT25	.5594	.7100	.8721	.9234	.0383
RPRACT26	.6740	.8555	.7623	.8241	.4774
RPRACT27	.7349	.6614	.5257	.5257	.2620
RPRACT28	.5401	.5401	.6438	.6438	.0000
RPRACT29	.5556	.4583	.3311	.1325	.5446
RPRACT30	.7235	.5601	.5286	.4451	.2288
RPRACT31	.3967	.0700	.1391	-.3338	.5199

RPRACT21 RPRACT22 RPRACT23 RPRACT24 RPRACT25

RPRACT21	1.0000				
RPRACT22	.8807	1.0000			
RPRACT23	.6005	.7308	1.0000		
RPRACT24	.7500	.8006	.6138	1.0000	
RPRACT25	.7100	.8062	.8062	.9467	1.0000
RPRACT26	.8555	.7970	.2740	.7777	.6426
RPRACT27	.6614	.4237	.6355	.5879	.6831
RPRACT28	.5401	.5189	.7783	.7201	.8367
RPRACT29	.4583	.2402	.2402	.2222	.1936
RPRACT30	.5601	.3363	.5718	.5835	.6508
RPRACT31	.0700	-.1345	.1009	-.0700	-.1085

RPRACT26 RPRACT27 RPRACT28 RPRACT29 RPRACT30

RPRACT26	1.0000				
RPRACT27	.4115	1.0000			
RPRACT28	.3360	.8165	1.0000		
RPRACT29	.2333	.4410	.5401	1.0000	
RPRACT30	.3267	.9262	.9075	.6651	1.0000
RPRACT31	-.2831	.1852	.2269	.6651	.3824

RPRACT31

RPRACT31	1.0000
----------	--------

N of Cases = 7.0

Item Means	Mean	Minimum	Maximum	Range	Max/Min	Variance
	2.6083	1.8571	3.2857	1.4286	1.7692	.1129

Item Variances	Mean	Minimum	Maximum	Range	Max/Min	Variance
	.9140	.1429	1.8095	1.6667	12.6667	.1210

Intraclass Correlation Coefficients
Two-Way Mixed Effects Model (Consistency Definition)

Measure	ICC		95% Confidence Interval		F-Value	Sig.
	Value	Lower Bound	Upper Bound			
Single Rater	.4810	.2617	.8231	29.7248	.0000	
Average of Raters*	.9664	.9166	.9931	29.7248	.0000	

Degrees of freedom for F-tests are 6 and 180. Test Value = 0.

* Assumes absence of People*Rater interaction.

Reliability Coefficients 31 items

Alpha = .9664 Standardized item alpha = .9694

Correlation Matrix

*** RGAME26 has zero variance

	RGAME1	RGAME2	RGAME3	RGAME4	RGAME5
RGAME1	1.0000				
RGAME2	.7082	1.0000			
RGAME3	.2365	.5582	1.0000		
RGAME4	.8052	.9366	.2483	1.0000	
RGAME5	.6683	.1325	-.0468	.2652	1.0000
RGAME6	.7500	.6689	.7372	.5426	.3713
RGAME7	.5426	.8663	.2152	.8958	.1473
RGAME8	.3151	-.0468	-.3311	.1250	.4714
RGAME9	-.0813	.1814	.5643	-.0323	.0913
RGAME10	.9571	.7506	.4995	.7464	.6111
RGAME11	.4541	.7199	.9703	.4604	.0849
RGAME12	.1189	.2545	-.0900	.3114	-.3203
RGAME13	-.2976	-.2107	-.6788	-.0208	-.5598
RGAME14	-.6779	-.4353	-.3847	-.4196	-.4108
RGAME15	-.5446	-.1766	-.1561	-.2161	-.9444
RGAME16	-.2557	.0789	-.2233	.1171	-.7947
RGAME17	.3218	.5960	-.0468	.6776	-.1667
RGAME18	.1310	.5257	.2478	.4677	-.4410
RGAME20	-.4610	-.0725	-.3334	-.0323	-.8672

RGAME19	.4537	.3035	-.4292	.5401	.0000
RGAME21	.3218	.5960	-.0468	.6776	-.1667
RGAME22	.3218	.5960	-.0468	.6776	-.1667
RGAME23	-.1941	-.0799	-.5648	.0888	-.6030
RGAME24	-.0197	-.2632	-.4280	-.1171	-.3642
RGAME25	-.2301	.1539	.5804	-.0913	-.6455
RGAME27	.1574	.0789	-.4838	.2810	-.3311
RGAME28	.5426	.5385	.0993	.6042	-.0589
RGAME29	-.1604	.0000	-.6070	.1909	-.5401
RGAME30	.3700	.0675	-.3022	.2402	-.0849
RGAME31	.1345	.3824	-.3022	.5204	-.4812

RGAME6 RGAME7 RGAME8 RGAME9 RGAME10

RGAME6	1.0000				
RGAME7	.3151	1.0000			
RGAME8	-.0700	-.1250	1.0000		
RGAME9	.2712	.2582	-.7100	1.0000	
RGAME10	.8911	.4910	.1964	.0913	1.0000
RGAME11	.8408	.3803	-.2402	.4961	.6794
RGAME12	.0476	.0849	.5095	-.7455	.0534
RGAME13	-.5601	.0208	-.1667	-.4841	-.4910
RGAME14	-.6508	-.0323	-.6455	.4000	-.7303
RGAME15	-.3796	-.1964	-.3536	-.3347	-.5556
RGAME16	-.2951	.0468	-.0468	-.5804	-.3311
RGAME17	.0248	.5598	.4714	-.5477	.2222
RGAME18	.1310	.3118	.3118	-.4830	.1470
RGAME20	-.4881	.0323	-.2582	-.4000	-.5477
RGAME19	.0000	.2700	.5401	-.8367	.2546
RGAME21	.0248	.5598	.4714	-.5477	.2222
RGAME22	.0248	.5598	.4714	-.5477	.2222
RGAME23	-.4329	.0355	-.0355	-.6331	-.3685
RGAME24	-.1180	-.3746	.0468	-.6892	-.1325
RGAME25	.2301	-.2282	-.0913	-.1414	-.0430
RGAME27	-.1574	.0468	.2810	-.8343	-.0221
RGAME28	.4376	.2708	.4583	-.6455	.4910
RGAME29	-.4813	.1909	.0000	-.5916	-.3600
RGAME30	.2186	-.1001	.2402	-.7132	.2453
RGAME31	-.1345	.4604	-.0400	-.4961	-.0189

RGAME11 RGAME12 RGAME13 RGAME14 RGAME15

RGAME11	1.0000	
RGAME12	-.0272	1.0000

RGAME13	-.6605	.3114	1.0000		
RGAME14	-.4961	-.4824	.4841	1.0000	
RGAME15	-.2453	.4270	.7464	.3347	1.0000
RGAME16	-.2250	.6999	.7727	.0725	.9051
RGAME17	.0849	.8006	.2652	-.4108	.2222
RGAME18	.2996	.8473	.1559	-.4830	.4410
RGAME20	-.3721	.4824	.8714	.4000	.9433
RGAME19	-.2594	.7338	.5401	-.4183	.2546
RGAME21	.0849	.8006	.2652	-.4108	.2222
RGAME22	.0849	.8006	.2652	-.4108	.2222
RGAME23	-.5292	.5311	.9594	.2477	.8040
RGAME24	-.4049	.4136	.7024	-.0725	.6402
RGAME25	.4824	.4961	-.0913	-.3536	.5594
RGAME27	-.3824	.6999	.7727	-.1814	.5960
RGAME28	.2402	.8775	.1667	-.7100	.2161
RGAME29	-.5503	.5189	.9547	.2958	.7201
RGAME30	-.1923	.5983	.5204	-.3721	.3774
RGAME31	-.1923	.5983	.8006	.0620	.6416

RGAME16 RGAME17 RGAME18 RGAME20 RGAME19

RGAME16	1.0000				
RGAME17	.5960	1.0000			
RGAME18	.7009	.8819	1.0000		
RGAME20	.9431	.4108	.4830	1.0000	
RGAME19	.6070	.7638	.5774	.4183	1.0000
RGAME21	.5960	1.0000	.8819	.4108	.7638
RGAME22	.5960	1.0000	.8819	.4108	.7638
RGAME23	.8986	.4523	.3989	.9083	.6908
RGAME24	.6579	.0993	.1752	.5804	.6070
RGAME25	.5130	.2582	.6831	.3536	.0000
RGAME27	.8158	.5960	.5257	.6892	.9105
RGAME28	.5385	.7660	.7795	.2582	.8101
RGAME29	.8584	.5401	.4082	.8874	.7071
RGAME30	.5399	.3114	.2996	.3721	.7783
RGAME31	.8549	.7077	.5991	.8062	.7783

RGAME21 RGAME22 RGAME23 RGAME24 RGAME25

RGAME21	1.0000				
RGAME22	1.0000	1.0000			
RGAME23	.4523	.4523	1.0000		
RGAME24	.0993	.0993	.7788	1.0000	
RGAME25	.2582	.2582	.1168	.2052	1.0000

RGAME27	.5960	.5960	.8986	.8421	.1539
RGAME28	.7660	.7660	.4086	.4449	.4108
RGAME29	.5401	.5401	.9770	.6438	.0000
RGAME30	.3114	.3114	.6486	.8773	.1316
RGAME31	.7077	.7077	.8876	.5624	.1316

RGAME27 RGAME28 RGAME29 RGAME30 RGAME31

RGAME27	1.0000				
RGAME28	.7024	1.0000			
RGAME29	.8584	.3819	1.0000		
RGAME30	.8549	.7406	.5503	1.0000	
RGAME31	.8549	.6005	.9172	.5962	1.0000

N of Cases = 7.0

Item Means	Mean	Minimum	Maximum	Range	Max/Min	Variance
	2.8429	2.1429	3.5714	1.4286	1.6667	.1370

Item Variances	Mean	Minimum	Maximum	Range	Max/Min	Variance
	.9556	.2857	1.8095	1.5238	6.3333	.1694

Intraclass Correlation Coefficients
Two-Way Mixed Effects Model (Consistency Definition)

Measure	ICC 95% Confidence Interval			F-Value	Sig.
	Value	Lower Bound	Upper Bound		
Single Rater	.2060	.0780	.5829	8.7824	.0000
Average of Raters*	.8861	.7174	.9767	8.7824	.0000

Degrees of freedom for F-tests are 6 and 174. Test Value = 0.

* Assumes absence of People*Rater interaction.

RELIABILITY ANALYSIS - SCALE (ALPHA)
Reliability Coefficients 30 items

Alpha = .8861 Standardized item alpha = .8874

Round Two Reliability Analysis of Rated data by Activity

RELIABILITY ANALYSIS - SCALE (ALPHA)

*** PEER_24 has zero variance

Correlation Matrix

	PEER_1	PEER_2	PEER3	PEER_4	PEER_5
PEER_1	1.0000				
PEER_2	.7559	1.0000			
PEER3	1.0000	.7559	1.0000		
PEER_4	1.0000	.7559	1.0000	1.0000	
PEER_5	.6547	.0000	.6547	.6547	1.0000
PEER_6	.9449	.5000	.9449	.9449	.8660
PEER_7	.9449	.5000	.9449	.9449	.8660
PEER_8	.9449	.5000	.9449	.9449	.8660
PEER_9	.7857	.1890	.7857	.7857	.9820
PEER_10	.9449	.5000	.9449	.9449	.8660
PEER_11	.9820	.8660	.9820	.9820	.5000
PEER_12	.1890	-.5000	.1890	.1890	.8660
PEER_13	.9449	.5000	.9449	.9449	.8660
PEER_14	.1890	-.5000	.1890	.1890	.8660
PEER_15	.7559	1.0000	.7559	.7559	.0000
PEER_16	.9449	.5000	.9449	.9449	.8660
PEER_17	.6547	.0000	.6547	.6547	1.0000
PEER_19	-.9449	-.5000	-.9449	-.9449	-.8660
PEER_20	-.7559	-1.0000	-.7559	-.7559	.0000
PEER_21	-.9820	-.8660	-.9820	-.9820	-.5000
PEER_22	.7559	1.0000	.7559	.7559	.0000
PEER_23	.7559	1.0000	.7559	.7559	.0000
PEER_25	-.1890	.5000	-.1890	-.1890	-.8660
PEER_26	-.7559	-1.0000	-.7559	-.7559	.0000
PEER_27	-.1890	.5000	-.1890	-.1890	-.8660
PEER_28	-.9286	-.9449	-.9286	-.9286	-.3273
PEER_29	-.1429	-.7559	-.1429	-.1429	.6547
PEER_30	-.7559	-1.0000	-.7559	-.7559	.0000
PEER_31	-.3273	-.8660	-.3273	-.3273	.5000

	PEER_6	PEER_7	PEER_8	PEER_9	PEER_10
PEER_6	1.0000				
PEER_7	1.0000	1.0000			
PEER_8	1.0000	1.0000	1.0000		
PEER_9	.9449	.9449	.9449	1.0000	
PEER_10	1.0000	1.0000	1.0000	.9449	1.0000

PEER_11	.8660	.8660	.8660	.6547	.8660
PEER_12	.5000	.5000	.5000	.7559	.5000
PEER_13	1.0000	1.0000	1.0000	.9449	1.0000
PEER_14	.5000	.5000	.5000	.7559	.5000
PEER_15	.5000	.5000	.5000	.1890	.5000
PEER_16	1.0000	1.0000	1.0000	.9449	1.0000
PEER_17	.8660	.8660	.8660	.9820	.8660
PEER_19	-1.0000	-1.0000	-1.0000	-.9449	-1.0000
PEER_20	-.5000	-.5000	-.5000	-.1890	-.5000
PEER_21	-.8660	-.8660	-.8660	-.6547	-.8660
PEER_22	.5000	.5000	.5000	.1890	.5000
PEER_23	.5000	.5000	.5000	.1890	.5000
PEER_25	-.5000	-.5000	-.5000	-.7559	-.5000
PEER_26	-.5000	-.5000	-.5000	-.1890	-.5000
PEER_27	-.5000	-.5000	-.5000	-.7559	-.5000
PEER_28	-.7559	-.7559	-.7559	-.5000	-.7559
PEER_29	.1890	.1890	.1890	.5000	.1890
PEER_30	-.5000	-.5000	-.5000	-.1890	-.5000
PEER_31	.0000	.0000	.0000	.3273	.0000

PEER_11 PEER_12 PEER_13 PEER_14 PEER_15

PEER_11	1.0000				
PEER_12	.0000	1.0000			
PEER_13	.8660	.5000	1.0000		
PEER_14	.0000	1.0000	.5000	1.0000	
PEER_15	.8660	-.5000	.5000	-.5000	1.0000
PEER_16	.8660	.5000	1.0000	.5000	.5000
PEER_17	.5000	.8660	.8660	.8660	.0000
PEER_19	-.8660	-.5000	-1.0000	-.5000	-.5000
PEER_20	-.8660	.5000	-.5000	.5000	-1.0000
PEER_21	-1.0000	.0000	-.8660	.0000	-.8660
PEER_22	.8660	-.5000	.5000	-.5000	1.0000
PEER_23	.8660	-.5000	.5000	-.5000	1.0000
PEER_25	.0000	-1.0000	-.5000	-1.0000	.5000
PEER_26	-.8660	.5000	-.5000	.5000	-1.0000
PEER_27	.0000	-1.0000	-.5000	-1.0000	.5000
PEER_28	-.9820	.1890	-.7559	.1890	-.9449
PEER_29	-.3273	.9449	.1890	.9449	-.7559
PEER_30	-.8660	.5000	-.5000	.5000	-1.0000
PEER_31	-.5000	.8660	.0000	.8660	-.8660

PEER_16 PEER_17 PEER_19 PEER_20 PEER_21

PEER_16	1.0000				
PEER_17	.8660	1.0000			
PEER_19	-1.0000	-.8660	1.0000		
PEER_20	-.5000	.0000	.5000	1.0000	
PEER_21	-.8660	-.5000	.8660	.8660	1.0000
PEER_22	.5000	.0000	-.5000	-1.0000	-.8660
PEER_23	.5000	.0000	-.5000	-1.0000	-.8660
PEER_25	-.5000	-.8660	.5000	-.5000	.0000
PEER_26	-.5000	.0000	.5000	1.0000	.8660
PEER_27	-.5000	-.8660	.5000	-.5000	.0000
PEER_28	-.7559	-.3273	.7559	.9449	.9820
PEER_29	.1890	.6547	-.1890	.7559	.3273
PEER_30	-.5000	.0000	.5000	1.0000	.8660
PEER_31	.0000	.5000	.0000	.8660	.5000

PEER_22 PEER_23 PEER_25 PEER_26 PEER_27

PEER_22	1.0000				
PEER_23	1.0000	1.0000			
PEER_25	.5000	.5000	1.0000		
PEER_26	-1.0000	-1.0000	-.5000	1.0000	
PEER_27	.5000	.5000	1.0000	-.5000	1.0000
PEER_28	-.9449	-.9449	-.1890	.9449	-.1890
PEER_29	-.7559	-.7559	-.9449	.7559	-.9449
PEER_30	-1.0000	-1.0000	-.5000	1.0000	-.5000
PEER_31	-.8660	-.8660	-.8660	.8660	-.8660

PEER_28 PEER_29 PEER_30 PEER_31

PEER_28	1.0000			
PEER_29	.5000	1.0000		
PEER_30	.9449	.7559	1.0000	
PEER_31	.6547	.9820	.8660	1.0000

N of Cases = 3.0

Item Means	Mean	Minimum	Maximum	Range	Max/Min	Variance
	4.0230	2.0000	5.3333	3.3333	2.6667	.7058

Item Variances	Mean	Minimum	Maximum	Range	Max/Min	Variance
	1.3218	.3333	5.3333	5.0000	16.0000	1.4324

Intraclass Correlation Coefficients
Two-Way Mixed Effects Model (Consistency Definition)

Measure	ICC 95% Confidence Interval			F-Value	Sig.
	Value	Lower Bound	Upper Bound		
Single Rater	.0447	-.0141	.7605	2.3576	.1040
Average of Raters*	.5758	-.6724	.9893	2.3576	.1040

Degrees of freedom for F-tests are 2 and 56. Test Value = 0.

* Assumes absence of People*Rater interaction.

Reliability Coefficients 29 items

Alpha = .5758 Standardized item alpha = .7712

RELIABILITY ANALYSIS - SCALE (ALPHA)

*** ACI3 has zero variance
 *** ACI6 has zero variance
 *** ACI7 has zero variance
 *** ACI10 has zero variance
 *** ACI11 has zero variance
 *** ACI13 has zero variance
 *** ACI16 has zero variance

Correlation Matrix

	ACI1	ACI2	ACI4	ACI5	ACI8
ACI1	1.0000				
ACI2	-.0000	1.0000			
ACI4	1.0000	-.0000	1.0000		
ACI5	1.0000	-.0000	1.0000	1.0000	
ACI8	.5000	-.5000	.5000	.5000	1.0000
ACI9	.8660	-.8660	.8660	.8660	.8660
ACI12	.5000	-.5000	.5000	.5000	-.5000
ACI14	.5000	-.5000	.5000	.5000	-.5000
ACI15	-1.0000	1.0000	-1.0000	-1.0000	-.5000
ACI17	1.0000	-1.0000	1.0000	1.0000	.5000
ACI18	-1.0000	1.0000	-1.0000	-1.0000	-.5000
ACI19	.5000	-.5000	.5000	.5000	-.5000
ACI20	.0000	.0000	.0000	.0000	-.8660
ACI21	.3273	-.3273	.3273	.3273	-.6547
ACI22	.5000	-.5000	.5000	.5000	-.5000
ACI23	.5000	-.5000	.5000	.5000	1.0000

ACI24	.0000	.0000	.0000	.0000	-.8660
ACI25	-.9177	.9177	-.9177	-.9177	-.8030
ACI26	.5000	-.5000	.5000	.5000	-.5000
ACI27	-.9820	.9820	-.9820	-.9820	-.6547
ACI28	.0000	.0000	.0000	.0000	-.8660
ACI29	.6934	-.6934	.6934	.6934	-.2774
ACI30	.5000	-.5000	.5000	.5000	-.5000
ACI31	.5000	-.5000	.5000	.5000	-.5000

ACI9	ACI12	ACI14	ACI15	ACI17
------	-------	-------	-------	-------

ACI9	1.0000				
ACI12	.0000	1.0000			
ACI14	.0000	1.0000	1.0000		
ACI15	-.8660	-.5000	-.5000	1.0000	
ACI17	.8660	.5000	.5000	-1.0000	1.0000
ACI18	-.8660	-.5000	-.5000	1.0000	-1.0000
ACI19	.0000	1.0000	1.0000	-.5000	.5000
ACI20	-.5000	.8660	.8660	.0000	.0000
ACI21	-.1890	.9820	.9820	-.3273	.3273
ACI22	.0000	1.0000	1.0000	-.5000	.5000
ACI23	.8660	-.5000	-.5000	-.5000	.5000
ACI24	-.5000	.8660	.8660	.0000	.0000
ACI25	-.9934	-.1147	-.1147	.9177	-.9177
ACI26	.0000	1.0000	1.0000	-.5000	.5000
ACI27	-.9449	-.3273	-.3273	.9820	-.9820
ACI28	-.5000	.8660	.8660	.0000	.0000
ACI29	.2402	.9707	.9707	-.6934	.6934
ACI30	.0000	1.0000	1.0000	-.5000	.5000
ACI31	.0000	1.0000	1.0000	-.5000	.5000

ACI18	ACI19	ACI20	ACI21	ACI22
-------	-------	-------	-------	-------

ACI18	1.0000				
ACI19	-.5000	1.0000			
ACI20	.0000	.8660	1.0000		
ACI21	-.3273	.9820	.9449	1.0000	
ACI22	-.5000	1.0000	.8660	.9820	1.0000
ACI23	-.5000	-.5000	-.8660	-.6547	-.5000
ACI24	.0000	.8660	1.0000	.9449	.8660
ACI25	.9177	-.1147	.3974	.0751	-.1147
ACI26	-.5000	1.0000	.8660	.9820	1.0000
ACI27	.9820	-.3273	.1890	-.1429	-.3273
ACI28	.0000	.8660	1.0000	.9449	.8660

ACI29	-.6934	.9707	.7206	.9078	.9707
ACI30	-.5000	1.0000	.8660	.9820	1.0000
ACI31	-.5000	1.0000	.8660	.9820	1.0000

	ACI23	ACI24	ACI25	ACI26	ACI27
ACI23	1.0000				
ACI24	-.8660	1.0000			
ACI25	-.8030	.3974	1.0000		
ACI26	-.5000	.8660	-.1147	1.0000	
ACI27	-.6547	.1890	.9762	-.3273	1.0000
ACI28	-.8660	1.0000	.3974	.8660	.1890
ACI29	-.2774	.7206	-.3500	.9707	-.5447
ACI30	-.5000	.8660	-.1147	1.0000	-.3273
ACI31	-.5000	.8660	-.1147	1.0000	-.3273

	ACI28	ACI29	ACI30	ACI31
ACI28	1.0000			
ACI29	.7206	1.0000		
ACI30	.8660	.9707	1.0000	
ACI31	.8660	.9707	1.0000	1.0000

N of Cases = 3.0

Item Means	Mean	Minimum	Maximum	Range	Max/Min	Variance
	4.5833	2.6667	5.6667	3.0000	2.1250	.6304

Item Variances	Mean	Minimum	Maximum	Range	Max/Min	Variance
	1.9167	.3333	7.0000	6.6667	21.0000	5.1232

Intraclass Correlation Coefficients
Two-Way Mixed Effects Model (Consistency Definition)

Measure	ICC		95% Confidence Interval		F-Value	Sig.
	Value	Lower Bound	Upper Bound			
Single Rater	.1805	.0233	.9115	6.2872	.0039	
Average of Raters*	.8409	.3636	.9960	6.2872	.0039	

Degrees of freedom for F-tests are 2 and 46. Test Value = 0.

* Assumes absence of People*Rater interaction.

Reliability Coefficients 24 items

Alpha = .8409 Standardized item alpha = .8210

RELIABILITY ANALYSIS - SCALE (ALPHA)

*** PRACT15 has zero variance

*** PRACT18 has zero variance

Correlation Matrix

	PRACT1	PRACT2	PRACT3	PRACT4	PRACT5
PRACT1	1.0000				
PRACT2	.5000	1.0000			
PRACT3	.5000	1.0000	1.0000		
PRACT4	-1.0000	-.5000	-.5000	1.0000	
PRACT5	1.0000	.5000	.5000	-1.0000	1.0000
PRACT6	-1.0000	-.5000	-.5000	1.0000	-1.0000
PRACT7	-.1890	.7559	.7559	.1890	-.1890
PRACT8	.8660	.8660	.8660	-.8660	.8660
PRACT9	-.5000	.5000	.5000	.5000	-.5000
PRACT10	-.5000	.5000	.5000	.5000	-.5000
PRACT11	1.0000	.5000	.5000	-1.0000	1.0000
PRACT12	-.5000	.5000	.5000	.5000	-.5000
PRACT13	.5000	1.0000	1.0000	-.5000	.5000
PRACT14	1.0000	.5000	.5000	-1.0000	1.0000
PRACT16	.5000	-.5000	-.5000	-.5000	.5000
PRACT17	1.0000	.5000	.5000	-1.0000	1.0000
PRACT19	-.8660	.0000	.0000	.8660	-.8660
PRACT20	-.5000	.5000	.5000	.5000	-.5000
PRACT21	-.5000	.5000	.5000	.5000	-.5000
PRACT22	-.5000	.5000	.5000	.5000	-.5000
PRACT23	-1.0000	-.5000	-.5000	1.0000	-1.0000
PRACT24	.5000	1.0000	1.0000	-.5000	.5000
PRACT25	-.8660	-.8660	-.8660	.8660	-.8660
PRACT26	-.6934	.2774	.2774	.6934	-.6934
PRACT27	-.5000	-1.0000	-1.0000	.5000	-.5000
PRACT28	-.7559	.1890	.1890	.7559	-.7559
PRACT29	-.5000	.5000	.5000	.5000	-.5000
PRACT30	-.5000	.5000	.5000	.5000	-.5000
PRACT31	.0000	.8660	.8660	.0000	.0000

	PRACT6	PRACT7	PRACT8	PRACT9	PRACT10
--	--------	--------	--------	--------	---------

PRACT6	1.0000				
PRACT7	.1890	1.0000			
PRACT8	-.8660	.3273	1.0000		
PRACT9	.5000	.9449	.0000	1.0000	
PRACT10	.5000	.9449	.0000	1.0000	1.0000
PRACT11	-1.0000	-.1890	.8660	-.5000	-.5000
PRACT12	.5000	.9449	.0000	1.0000	1.0000
PRACT13	-.5000	.7559	.8660	.5000	.5000
PRACT14	-1.0000	-.1890	.8660	-.5000	-.5000
PRACT16	-.5000	-.9449	.0000	-1.0000	-1.0000
PRACT17	-1.0000	-.1890	.8660	-.5000	-.5000
PRACT19	.8660	.6547	-.5000	.8660	.8660
PRACT20	.5000	.9449	.0000	1.0000	1.0000
PRACT21	.5000	.9449	.0000	1.0000	1.0000
PRACT22	.5000	.9449	.0000	1.0000	1.0000
PRACT23	1.0000	.1890	-.8660	.5000	.5000
PRACT24	-.5000	.7559	.8660	.5000	.5000
PRACT25	.8660	-.3273	-1.0000	.0000	.0000
PRACT26	.6934	.8386	-.2402	.9707	.9707
PRACT27	.5000	-.7559	-.8660	-.5000	-.5000
PRACT28	.7559	.7857	-.3273	.9449	.9449
PRACT29	.5000	.9449	.0000	1.0000	1.0000
PRACT30	.5000	.9449	.0000	1.0000	1.0000
PRACT31	.0000	.9820	.5000	.8660	.8660

PRACT11 PRACT12 PRACT13 PRACT14 PRACT16

PRACT11	1.0000				
PRACT12	-.5000	1.0000			
PRACT13	.5000	.5000	1.0000		
PRACT14	1.0000	-.5000	.5000	1.0000	
PRACT16	.5000	-1.0000	-.5000	.5000	1.0000
PRACT17	1.0000	-.5000	.5000	1.0000	.5000
PRACT19	-.8660	.8660	.0000	-.8660	-.8660
PRACT20	-.5000	1.0000	.5000	-.5000	-1.0000
PRACT21	-.5000	1.0000	.5000	-.5000	-1.0000
PRACT22	-.5000	1.0000	.5000	-.5000	-1.0000
PRACT23	-1.0000	.5000	-.5000	-1.0000	-.5000
PRACT24	.5000	.5000	1.0000	.5000	-.5000
PRACT25	-.8660	.0000	-.8660	-.8660	.0000
PRACT26	-.6934	.9707	.2774	-.6934	-.9707
PRACT27	-.5000	-.5000	-1.0000	-.5000	.5000
PRACT28	-.7559	.9449	.1890	-.7559	-.9449

PRACT29	-.5000	1.0000	.5000	-.5000	-1.0000
PRACT30	-.5000	1.0000	.5000	-.5000	-1.0000
PRACT31	.0000	.8660	.8660	.0000	-.8660

	PRACT17	PRACT19	PRACT20	PRACT21	PRACT22
--	---------	---------	---------	---------	---------

PRACT17	1.0000				
PRACT19	-.8660	1.0000			
PRACT20	-.5000	.8660	1.0000		
PRACT21	-.5000	.8660	1.0000	1.0000	
PRACT22	-.5000	.8660	1.0000	1.0000	1.0000
PRACT23	-1.0000	.8660	.5000	.5000	.5000
PRACT24	.5000	.0000	.5000	.5000	.5000
PRACT25	-.8660	.5000	.0000	.0000	.0000
PRACT26	-.6934	.9608	.9707	.9707	.9707
PRACT27	-.5000	.0000	-.5000	-.5000	-.5000
PRACT28	-.7559	.9820	.9449	.9449	.9449
PRACT29	-.5000	.8660	1.0000	1.0000	1.0000
PRACT30	-.5000	.8660	1.0000	1.0000	1.0000
PRACT31	.0000	.5000	.8660	.8660	.8660

	PRACT23	PRACT24	PRACT25	PRACT26	PRACT27
--	---------	---------	---------	---------	---------

PRACT23	1.0000				
PRACT24	-.5000	1.0000			
PRACT25	.8660	-.8660	1.0000		
PRACT26	.6934	.2774	.2402	1.0000	
PRACT27	.5000	-1.0000	.8660	-.2774	1.0000
PRACT28	.7559	.1890	.3273	.9959	-.1890
PRACT29	.5000	.5000	.0000	.9707	-.5000
PRACT30	.5000	.5000	.0000	.9707	-.5000
PRACT31	.0000	.8660	-.5000	.7206	-.8660

	PRACT28	PRACT29	PRACT30	PRACT31
--	---------	---------	---------	---------

PRACT28	1.0000			
PRACT29	.9449	1.0000		
PRACT30	.9449	1.0000	1.0000	
PRACT31	.6547	.8660	.8660	1.0000

RELIABILITY ANALYSIS - SCALE (ALPHA)

N of Cases = 3.0

Item Means	Mean	Minimum	Maximum	Range	Max/Min	Variance
	4.0920	2.0000	5.3333	3.3333	2.6667	.6738

Item Variances	Mean	Minimum	Maximum	Range	Max/Min	Variance
	1.4253	.3333	5.3333	5.0000	16.0000	2.3404

Intraclass Correlation Coefficients

Two-Way Mixed Effects Model (Consistency Definition)

Measure	ICC		95% Confidence Interval		F-Value	Sig.
	Value	Lower Bound	Upper Bound			
Single Rater	.1668	.0244	.9022	6.8040	.0023	
Average of Raters*	.8530	.4205	.9963	6.8040	.0023	

Degrees of freedom for F-tests are 2 and 56. Test Value = 0.

* Assumes absence of People*Rater interaction.

Reliability Coefficients 29 items

Alpha = .8530 Standardized item alpha = .8514

RELIABILITY ANALYSIS - SCALE (ALPHA)

*** GAME9 has zero variance
 *** GAME10 has zero variance
 *** GAME11 has zero variance
 *** GAME12 has zero variance
 *** GAME18 has zero variance

Correlation Matrix

	GAME1	GAME2	GAME3	GAME4	GAME5
GAME1	1.0000				
GAME2	1.0000	1.0000			
GAME3	.5000	.5000	1.0000		
GAME4	-.5000	-.5000	-1.0000	1.0000	
GAME5	.5000	.5000	1.0000	-1.0000	1.0000
GAME6	-.5000	-.5000	-1.0000	1.0000	-1.0000
GAME7	.0000	.0000	.8660	-.8660	.8660
GAME8	.8660	.8660	.8660	-.8660	.8660
GAME13	.8660	.8660	.8660	-.8660	.8660
GAME14	1.0000	1.0000	.5000	-.5000	.5000

GAME15	.5000	.5000	-.5000	.5000	-.5000
GAME16	.5000	.5000	-.5000	.5000	-.5000
GAME17	.5000	.5000	1.0000	-1.0000	1.0000
GAME19	-.5000	-.5000	.5000	-.5000	.5000
GAME20	-.5000	-.5000	.5000	-.5000	.5000
GAME21	-.5000	-.5000	.5000	-.5000	.5000
GAME22	-.5000	-.5000	.5000	-.5000	.5000
GAME23	-.5000	-.5000	-1.0000	1.0000	-1.0000
GAME24	1.0000	1.0000	.5000	-.5000	.5000
GAME25	-.5000	-.5000	-1.0000	1.0000	-1.0000
GAME26	-1.0000	-1.0000	-.5000	.5000	-.5000
GAME27	-.5000	-.5000	-1.0000	1.0000	-1.0000
GAME28	-.7559	-.7559	.1890	-.1890	.1890
GAME29	-.5000	-.5000	.5000	-.5000	.5000
GAME30	-.5000	-.5000	.5000	-.5000	.5000
GAME31	.1890	.1890	.9449	-.9449	.9449

GAME6 GAME7 GAME8 GAME13 GAME14

GAME6	1.0000				
GAME7	-.8660	1.0000			
GAME8	-.8660	.5000	1.0000		
GAME13	-.8660	.5000	1.0000	1.0000	
GAME14	-.5000	.0000	.8660	.8660	1.0000
GAME15	.5000	-.8660	.0000	.0000	.5000
GAME16	.5000	-.8660	.0000	.0000	.5000
GAME17	-1.0000	.8660	.8660	.8660	.5000
GAME19	-.5000	.8660	.0000	.0000	-.5000
GAME20	-.5000	.8660	.0000	.0000	-.5000
GAME21	-.5000	.8660	.0000	.0000	-.5000
GAME22	-.5000	.8660	.0000	.0000	-.5000
GAME23	1.0000	-.8660	-.8660	-.8660	-.5000
GAME24	-.5000	.0000	.8660	.8660	1.0000
GAME25	1.0000	-.8660	-.8660	-.8660	-.5000
GAME26	.5000	.0000	-.8660	-.8660	-1.0000
GAME27	1.0000	-.8660	-.8660	-.8660	-.5000
GAME28	-.1890	.6547	-.3273	-.3273	-.7559
GAME29	-.5000	.8660	.0000	.0000	-.5000
GAME30	-.5000	.8660	.0000	.0000	-.5000
GAME31	-.9449	.9820	.6547	.6547	.1890

GAME15 GAME16 GAME17 GAME19 GAME20

GAME15	1.0000
--------	--------

GAME16	1.0000	1.0000			
GAME17	-.5000	-.5000	1.0000		
GAME19	-1.0000	-1.0000	.5000	1.0000	
GAME20	-1.0000	-1.0000	.5000	1.0000	1.0000
GAME21	-1.0000	-1.0000	.5000	1.0000	1.0000
GAME22	-1.0000	-1.0000	.5000	1.0000	1.0000
GAME23	.5000	.5000	-1.0000	-.5000	-.5000
GAME24	.5000	.5000	.5000	-.5000	-.5000
GAME25	.5000	.5000	-1.0000	-.5000	-.5000
GAME26	-.5000	-.5000	-.5000	.5000	.5000
GAME27	.5000	.5000	-1.0000	-.5000	-.5000
GAME28	-.9449	-.9449	.1890	.9449	.9449
GAME29	-1.0000	-1.0000	.5000	1.0000	1.0000
GAME30	-1.0000	-1.0000	.5000	1.0000	1.0000
GAME31	-.7559	-.7559	.9449	.7559	.7559

GAME21 GAME22 GAME23 GAME24 GAME25

GAME21	1.0000				
GAME22	1.0000	1.0000			
GAME23	-.5000	-.5000	1.0000		
GAME24	-.5000	-.5000	-.5000	1.0000	
GAME25	-.5000	-.5000	1.0000	-.5000	1.0000
GAME26	.5000	.5000	.5000	-1.0000	.5000
GAME27	-.5000	-.5000	1.0000	-.5000	1.0000
GAME28	.9449	.9449	-.1890	-.7559	-.1890
GAME29	1.0000	1.0000	-.5000	-.5000	-.5000
GAME30	1.0000	1.0000	-.5000	-.5000	-.5000
GAME31	.7559	.7559	-.9449	.1890	-.9449

GAME26 GAME27 GAME28 GAME29 GAME30

GAME26	1.0000				
GAME27	.5000	1.0000			
GAME28	.7559	-.1890	1.0000		
GAME29	.5000	-.5000	.9449	1.0000	
GAME30	.5000	-.5000	.9449	1.0000	1.0000
GAME31	-.1890	-.9449	.5000	.7559	.7559

GAME31

GAME31	1.0000
--------	--------

N of Cases = 3.0

Item Means	Mean	Minimum	Maximum	Range	Max/Min	Variance
	4.2051	2.6667	5.3333	2.6667	2.0000	.6674

Item Variances	Mean	Minimum	Maximum	Range	Max/Min	Variance
	1.1667	.3333	5.3333	5.0000	16.0000	2.0556

Intraclass Correlation Coefficients
Two-Way Mixed Effects Model (Consistency Definition)

Measure	ICC		95% Confidence Interval		F-Value	Sig.
	Value	Lower Bound	Upper Bound			
Single Rater	.0000	-.0296	.5968	1.0000	.3751	
Average of Raters*	.0000	-2.975	.9747	1.0000	.3751	

Degrees of freedom for F-tests are 2 and 50. Test Value = 0.

* Assumes absence of People*Rater interaction.

Reliability Coefficients 26 items

Alpha = .0000 Standardized item alpha = .1440

RELIABILITY ANALYSIS - SCALE (ALPHA)

*** RPEER10 has zero variance
 *** RPEER13 has zero variance
 *** RPEER24 has zero variance
 *** RPEER30 has zero variance

Correlation Matrix

	RPEER1	RPEER_2	RPEER3	RPEER4	RPEER5
RPEER1	1.0000				
RPEER_2	1.0000	1.0000			
RPEER3	1.0000	1.0000	1.0000		
RPEER4	.7559	.7559	.7559	1.0000	
RPEER5	.7559	.7559	.7559	1.0000	1.0000
RPEER6	.7559	.7559	.7559	1.0000	1.0000
RPEER7	1.0000	1.0000	1.0000	.7559	.7559
RPEER8	1.0000	1.0000	1.0000	.7559	.7559

RPEER9	.7559	.7559	.7559	1.0000	1.0000
RPEER11	1.0000	1.0000	1.0000	.7559	.7559
RPEER12	.5000	.5000	.5000	.9449	.9449
RPEER14	-.5000	-.5000	-.5000	.1890	.1890
RPEER15	1.0000	1.0000	1.0000	.7559	.7559
RPEER16	.1890	.1890	.1890	.7857	.7857
RPEER17	1.0000	1.0000	1.0000	.7559	.7559
RPEER18	1.0000	1.0000	1.0000	.7559	.7559
RPEER19	.9449	.9449	.9449	.9286	.9286
RPEER20	1.0000	1.0000	1.0000	.7559	.7559
RPEER21	1.0000	1.0000	1.0000	.7559	.7559
RPEER22	1.0000	1.0000	1.0000	.7559	.7559
RPEER23	1.0000	1.0000	1.0000	.7559	.7559
RPEER25	-.2774	-.2774	-.2774	.4193	.4193
RPEER26	1.0000	1.0000	1.0000	.7559	.7559
RPEER27	.0000	.0000	.0000	.6547	.6547
RPEER28	.5000	.5000	.5000	.9449	.9449
RPEER39	.7559	.7559	.7559	1.0000	1.0000
RPEER31	1.0000	1.0000	1.0000	.7559	.7559

RPEER6 RPEER7 RPEER8 RPEER9 RPEER11

RPEER6	1.0000				
RPEER7	.7559	1.0000			
RPEER8	.7559	1.0000	1.0000		
RPEER9	1.0000	.7559	.7559	1.0000	
RPEER11	.7559	1.0000	1.0000	.7559	1.0000
RPEER12	.9449	.5000	.5000	.9449	.5000
RPEER14	.1890	-.5000	-.5000	.1890	-.5000
RPEER15	.7559	1.0000	1.0000	.7559	1.0000
RPEER16	.7857	.1890	.1890	.7857	.1890
RPEER17	.7559	1.0000	1.0000	.7559	1.0000
RPEER18	.7559	1.0000	1.0000	.7559	1.0000
RPEER19	.9286	.9449	.9449	.9286	.9449
RPEER20	.7559	1.0000	1.0000	.7559	1.0000
RPEER21	.7559	1.0000	1.0000	.7559	1.0000
RPEER22	.7559	1.0000	1.0000	.7559	1.0000
RPEER23	.7559	1.0000	1.0000	.7559	1.0000
RPEER25	.4193	-.2774	-.2774	.4193	-.2774
RPEER26	.7559	1.0000	1.0000	.7559	1.0000
RPEER27	.6547	.0000	.0000	.6547	.0000
RPEER28	.9449	.5000	.5000	.9449	.5000
RPEER39	1.0000	.7559	.7559	1.0000	.7559
RPEER31	.7559	1.0000	1.0000	.7559	1.0000

	RPEER12	RPEER14	RPEER15	RPEER16	RPEER17
RPEER12	1.0000				
RPEER14	.5000	1.0000			
RPEER15	.5000	-.5000	1.0000		
RPEER16	.9449	.7559	.1890	1.0000	
RPEER17	.5000	-.5000	1.0000	.1890	1.0000
RPEER18	.5000	-.5000	1.0000	.1890	1.0000
RPEER19	.7559	-.1890	.9449	.5000	.9449
RPEER20	.5000	-.5000	1.0000	.1890	1.0000
RPEER21	.5000	-.5000	1.0000	.1890	1.0000
RPEER22	.5000	-.5000	1.0000	.1890	1.0000
RPEER23	.5000	-.5000	1.0000	.1890	1.0000
RPEER25	.6934	.9707	-.2774	.8910	-.2774
RPEER26	.5000	-.5000	1.0000	.1890	1.0000
RPEER27	.8660	.8660	.0000	.9820	.0000
RPEER28	1.0000	.5000	.5000	.9449	.5000
RPEER39	.9449	.1890	.7559	.7857	.7559
RPEER31	.5000	-.5000	1.0000	.1890	1.0000

	RPEER18	RPEER19	RPEER20	RPEER21	RPEER22
RPEER18	1.0000				
RPEER19	.9449	1.0000			
RPEER20	1.0000	.9449	1.0000		
RPEER21	1.0000	.9449	1.0000	1.0000	
RPEER22	1.0000	.9449	1.0000	1.0000	1.0000
RPEER23	1.0000	.9449	1.0000	1.0000	1.0000
RPEER25	-.2774	.0524	-.2774	-.2774	-.2774
RPEER26	1.0000	.9449	1.0000	1.0000	1.0000
RPEER27	.0000	.3273	.0000	.0000	.0000
RPEER28	.5000	.7559	.5000	.5000	.5000
RPEER39	.7559	.9286	.7559	.7559	.7559
RPEER31	1.0000	.9449	1.0000	1.0000	1.0000

	RPEER23	RPEER25	RPEER26	RPEER27	RPEER28
RPEER23	1.0000				
RPEER25	-.2774	1.0000			
RPEER26	1.0000	-.2774	1.0000		
RPEER27	.0000	.9608	.0000	1.0000	
RPEER28	.5000	.6934	.5000	.8660	1.0000
RPEER39	.7559	.4193	.7559	.6547	.9449

RPEER31 1.0000 -.2774 1.0000 .0000 .5000

 RPEER39 RPEER31

RPEER39 1.0000
RPEER31 .7559 1.0000

RELIABILITY ANALYSIS - SCALE (ALPHA)

N of Cases = 3.0

Item Means	Mean	Minimum	Maximum	Range	Max/Min	Variance
	2.8395	2.0000	3.6667	1.6667	1.8333	.1912

Item Variances	Mean	Minimum	Maximum	Range	Max/Min	Variance
	2.4074	.3333	4.3333	4.0000	13.0000	.9430

Intraclass Correlation Coefficients

Two-Way Mixed Effects Model (Consistency Definition)

Measure	ICC		95% Confidence Interval		F-Value	Sig.
	Value	Lower Bound	Upper Bound			
Single Rater	.6339	.2904	.9859		47.7554	.0000
Average of Raters*	.9791	.9170	.9995		47.7554	.0000

Degrees of freedom for F-tests are 2 and 52. Test Value = 0.

* Assumes absence of People*Rater interaction.

Reliability Coefficients 27 items

Alpha = .9791 Standardized item alpha = .9811

RELIABILITY ANALYSIS - SCALE (ALPHA)

*** RACI10 has zero variance
*** RACI23 has zero variance
*** RACI27 has zero variance
*** RACI28 has zero variance

Correlation Matrix

	RACI1	RACI2	RACI3	RACI4	RACI5
RACI1	1.0000				
RACI2	1.0000	1.0000			
RACI3	1.0000	1.0000	1.0000		
RACI4	1.0000	1.0000	1.0000	1.0000	
RACI5	1.0000	1.0000	1.0000	1.0000	1.0000
RACI6	1.0000	1.0000	1.0000	1.0000	1.0000
RACI7	1.0000	1.0000	1.0000	1.0000	1.0000
RACI8	1.0000	1.0000	1.0000	1.0000	1.0000
RACI9	-1.0000	-1.0000	-1.0000	-1.0000	-1.0000
RACI11	1.0000	1.0000	1.0000	1.0000	1.0000
RACI12	1.0000	1.0000	1.0000	1.0000	1.0000
RACI13	1.0000	1.0000	1.0000	1.0000	1.0000
RACI14	1.0000	1.0000	1.0000	1.0000	1.0000
RACI15	1.0000	1.0000	1.0000	1.0000	1.0000
RACI16	1.0000	1.0000	1.0000	1.0000	1.0000
RACI17	1.0000	1.0000	1.0000	1.0000	1.0000
RACI18	1.0000	1.0000	1.0000	1.0000	1.0000
RACI19	1.0000	1.0000	1.0000	1.0000	1.0000
RACI20	1.0000	1.0000	1.0000	1.0000	1.0000
RACI21	1.0000	1.0000	1.0000	1.0000	1.0000
RACI22	1.0000	1.0000	1.0000	1.0000	1.0000
RACI24	1.0000	1.0000	1.0000	1.0000	1.0000
RACI25	1.0000	1.0000	1.0000	1.0000	1.0000
RACI26	1.0000	1.0000	1.0000	1.0000	1.0000
RACI29	1.0000	1.0000	1.0000	1.0000	1.0000
RACI30	1.0000	1.0000	1.0000	1.0000	1.0000
RACI31	1.0000	1.0000	1.0000	1.0000	1.0000
	RACI6	RACI7	RACI8	RACI9	RACI11
RACI6	1.0000				
RACI7	1.0000	1.0000			
RACI8	1.0000	1.0000	1.0000		
RACI9	-1.0000	-1.0000	-1.0000	1.0000	
RACI11	1.0000	1.0000	1.0000	-1.0000	1.0000
RACI12	1.0000	1.0000	1.0000	-1.0000	1.0000
RACI13	1.0000	1.0000	1.0000	-1.0000	1.0000
RACI14	1.0000	1.0000	1.0000	-1.0000	1.0000
RACI15	1.0000	1.0000	1.0000	-1.0000	1.0000
RACI16	1.0000	1.0000	1.0000	-1.0000	1.0000

RACI17	1.0000	1.0000	1.0000	-1.0000	1.0000
RACI18	1.0000	1.0000	1.0000	-1.0000	1.0000
RACI19	1.0000	1.0000	1.0000	-1.0000	1.0000
RACI20	1.0000	1.0000	1.0000	-1.0000	1.0000
RACI21	1.0000	1.0000	1.0000	-1.0000	1.0000
RACI22	1.0000	1.0000	1.0000	-1.0000	1.0000
RACI24	1.0000	1.0000	1.0000	-1.0000	1.0000
RACI25	1.0000	1.0000	1.0000	-1.0000	1.0000
RACI26	1.0000	1.0000	1.0000	-1.0000	1.0000
RACI29	1.0000	1.0000	1.0000	-1.0000	1.0000
RACI30	1.0000	1.0000	1.0000	-1.0000	1.0000
RACI31	1.0000	1.0000	1.0000	-1.0000	1.0000

RACI12 RACI13 RACI14 RACI15 RACI16

RACI12	1.0000				
RACI13	1.0000	1.0000			
RACI14	1.0000	1.0000	1.0000		
RACI15	1.0000	1.0000	1.0000	1.0000	
RACI16	1.0000	1.0000	1.0000	1.0000	1.0000
RACI17	1.0000	1.0000	1.0000	1.0000	1.0000
RACI18	1.0000	1.0000	1.0000	1.0000	1.0000
RACI19	1.0000	1.0000	1.0000	1.0000	1.0000
RACI20	1.0000	1.0000	1.0000	1.0000	1.0000
RACI21	1.0000	1.0000	1.0000	1.0000	1.0000
RACI22	1.0000	1.0000	1.0000	1.0000	1.0000
RACI24	1.0000	1.0000	1.0000	1.0000	1.0000
RACI25	1.0000	1.0000	1.0000	1.0000	1.0000
RACI26	1.0000	1.0000	1.0000	1.0000	1.0000
RACI29	1.0000	1.0000	1.0000	1.0000	1.0000
RACI30	1.0000	1.0000	1.0000	1.0000	1.0000
RACI31	1.0000	1.0000	1.0000	1.0000	1.0000

RACI17 RACI18 RACI19 RACI20 RACI21

RACI17	1.0000				
RACI18	1.0000	1.0000			
RACI19	1.0000	1.0000	1.0000		
RACI20	1.0000	1.0000	1.0000	1.0000	
RACI21	1.0000	1.0000	1.0000	1.0000	1.0000
RACI22	1.0000	1.0000	1.0000	1.0000	1.0000
RACI24	1.0000	1.0000	1.0000	1.0000	1.0000
RACI25	1.0000	1.0000	1.0000	1.0000	1.0000
RACI26	1.0000	1.0000	1.0000	1.0000	1.0000

RACI29	1.0000	1.0000	1.0000	1.0000	1.0000
RACI30	1.0000	1.0000	1.0000	1.0000	1.0000
RACI31	1.0000	1.0000	1.0000	1.0000	1.0000

RACI22 RACI24 RACI25 RACI26 RACI29

RACI22	1.0000				
RACI24	1.0000	1.0000			
RACI25	1.0000	1.0000	1.0000		
RACI26	1.0000	1.0000	1.0000	1.0000	
RACI29	1.0000	1.0000	1.0000	1.0000	1.0000
RACI30	1.0000	1.0000	1.0000	1.0000	1.0000
RACI31	1.0000	1.0000	1.0000	1.0000	1.0000

RACI30 RACI31

RACI30	1.0000	
RACI31	1.0000	1.0000

N of Cases = 2.0

Item Means	Mean	Minimum	Maximum	Range	Max/Min	Variance
	1.8148	1.5000	3.5000	2.0000	2.3333	.2144

Item Variances	Mean	Minimum	Maximum	Range	Max/Min	Variance
	1.0000	.5000	2.0000	1.5000	4.0000	.5192

Intraclass Correlation Coefficients
Two-Way Mixed Effects Model (Consistency Definition)

Measure	ICC		95% Confidence Interval		F-Value	Sig.
	Value	Lower Bound	Upper Bound			
Single Rater	.7849	.3806	.9997	99.5232	.0000	
Average of Raters*	.9900	.9431	1.0000	99.5232	.0000	

Degrees of freedom for F-tests are 1 and 26. Test Value = 0.

* Assumes absence of People*Rater interaction.

Reliability Coefficients 27 items

Alpha = .9900 Standardized item alpha = .9936

RELIABILITY ANALYSIS - SCALE (ALPHA)

*** RPRACT10 has zero variance
 *** RPRACT11 has zero variance
 *** RPRACT13 has zero variance
 *** RPRACT17 has zero variance
 *** RPRACT24 has zero variance

Correlation Matrix

	RPRACT1	RPRACT2	RPRACT3	RPRACT4	RPRACT5
RPRACT1	1.0000				
RPRACT2	1.0000	1.0000			
RPRACT3	1.0000	1.0000	1.0000		
RPRACT4	1.0000	1.0000	1.0000	1.0000	
RPRACT5	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT6	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT7	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT8	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT9	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT12	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT14	-1.0000	-1.0000	-1.0000	-1.0000	-1.0000
RPRACT15	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT16	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT18	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT19	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT20	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT21	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT22	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT23	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT25	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT26	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT27	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT28	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT29	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT30	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT31	1.0000	1.0000	1.0000	1.0000	1.0000

	RPRACT6	RPRACT7	RPRACT8	RPRACT9	RPRACT12
RPRACT6	1.0000				
RPRACT7	1.0000	1.0000			
RPRACT8	1.0000	1.0000	1.0000		

RPRACT9	1.0000	1.0000	1.0000	1.0000	
RPRACT12	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT14	-1.0000	-1.0000	-1.0000	-1.0000	-1.0000
RPRACT15	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT16	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT18	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT19	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT20	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT21	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT22	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT23	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT25	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT26	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT27	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT28	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT29	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT30	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT31	1.0000	1.0000	1.0000	1.0000	1.0000

RPRACT14	RPRACT15	RPRACT16	RPRACT18	RPRACT19
----------	----------	----------	----------	----------

RPRACT14	1.0000				
RPRACT15	-1.0000	1.0000			
RPRACT16	-1.0000	1.0000	1.0000		
RPRACT18	-1.0000	1.0000	1.0000	1.0000	
RPRACT19	-1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT20	-1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT21	-1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT22	-1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT23	-1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT25	-1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT26	-1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT27	-1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT28	-1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT29	-1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT30	-1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT31	-1.0000	1.0000	1.0000	1.0000	1.0000

RPRACT20	RPRACT21	RPRACT22	RPRACT23	RPRACT25
----------	----------	----------	----------	----------

RPRACT20	1.0000			
RPRACT21	1.0000	1.0000		
RPRACT22	1.0000	1.0000	1.0000	
RPRACT23	1.0000	1.0000	1.0000	1.0000

RPRACT25	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT26	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT27	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT28	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT29	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT30	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT31	1.0000	1.0000	1.0000	1.0000	1.0000

RPRACT26 RPRACT27 RPRACT28 RPRACT29 RPRACT30

RPRACT26	1.0000				
RPRACT27	1.0000	1.0000			
RPRACT28	1.0000	1.0000	1.0000		
RPRACT29	1.0000	1.0000	1.0000	1.0000	
RPRACT30	1.0000	1.0000	1.0000	1.0000	1.0000
RPRACT31	1.0000	1.0000	1.0000	1.0000	1.0000

RPRACT31

RPRACT31 1.0000

N of Cases = 2.0

Item Means	Mean	Minimum	Maximum	Range	Max/Min	Variance
	2.8654	1.5000	3.5000	2.0000	2.3333	.1512

Item Variances	Mean	Minimum	Maximum	Range	Max/Min	Variance
	1.4808	.5000	2.0000	1.5000	4.0000	.5296

Intraclass Correlation Coefficients

Two-Way Mixed Effects Model (Consistency Definition)

Measure	ICC		95% Confidence Interval		F-Value	Sig.
	Value	Lower Bound	Upper Bound			
Single Rater	.8332	.4586	.9998	130.9190	.0000	
Average of Raters*	.9924	.9566	1.0000	130.9190	.0000	

Degrees of freedom for F-tests are 1 and 25. Test Value = 0.

* Assumes absence of People*Rater interaction.

Reliability Coefficients 26 items

Alpha = .9924 Standardized item alpha = .9931

RELIABILITY ANALYSIS - SCALE (ALPHA)

```

*** RGAME1    has zero variance
*** RGAME2    has zero variance
*** RGAME3    has zero variance
*** RGAME4    has zero variance
*** RGAME7    has zero variance
*** RGAME8    has zero variance
*** RGAME10   has zero variance
*** RGAME11   has zero variance
*** RGAME21   has zero variance
*** RGAME23   has zero variance
*** RGAME26   has zero variance
*** RGAME27   has zero variance
*** RGAME28   has zero variance

```

Correlation Matrix

	RGAME5	RGAME6	RGAME9	RGAME12	RGAME13
RGAME5	1.0000				
RGAME6	-1.0000	1.0000			
RGAME9	1.0000	-1.0000	1.0000		
RGAME12	-1.0000	1.0000	-1.0000	1.0000	
RGAME13	-1.0000	1.0000	-1.0000	1.0000	1.0000
RGAME14	-1.0000	1.0000	-1.0000	1.0000	1.0000
RGAME15	-1.0000	1.0000	-1.0000	1.0000	1.0000
RGAME16	-1.0000	1.0000	-1.0000	1.0000	1.0000
RGAME17	1.0000	-1.0000	1.0000	-1.0000	-1.0000
RGAME18	1.0000	-1.0000	1.0000	-1.0000	-1.0000
RGAME19	1.0000	-1.0000	1.0000	-1.0000	-1.0000
RGAME20	1.0000	-1.0000	1.0000	-1.0000	-1.0000
RGAME22	1.0000	-1.0000	1.0000	-1.0000	-1.0000
RGAME24	-1.0000	1.0000	-1.0000	1.0000	1.0000
RGAME25	-1.0000	1.0000	-1.0000	1.0000	1.0000
RGAME29	-1.0000	1.0000	-1.0000	1.0000	1.0000
RGAME30	-1.0000	1.0000	-1.0000	1.0000	1.0000
RGAME31	1.0000	-1.0000	1.0000	-1.0000	-1.0000

	RGAME14	RGAME15	RGAME16	RGAME17	RGAME18
RGAME14	1.0000				
RGAME15	1.0000	1.0000			

RGAME16	1.0000	1.0000	1.0000		
RGAME17	-1.0000	-1.0000	-1.0000	1.0000	
RGAME18	-1.0000	-1.0000	-1.0000	1.0000	1.0000
RGAME19	-1.0000	-1.0000	-1.0000	1.0000	1.0000
RGAME20	-1.0000	-1.0000	-1.0000	1.0000	1.0000
RGAME22	-1.0000	-1.0000	-1.0000	1.0000	1.0000
RGAME24	1.0000	1.0000	1.0000	-1.0000	-1.0000
RGAME25	1.0000	1.0000	1.0000	-1.0000	-1.0000
RGAME29	1.0000	1.0000	1.0000	-1.0000	-1.0000
RGAME30	1.0000	1.0000	1.0000	-1.0000	-1.0000
RGAME31	-1.0000	-1.0000	-1.0000	1.0000	1.0000

RGAME19 RGAME20 RGAME22 RGAME24 RGAME25

RGAME19	1.0000				
RGAME20	1.0000	1.0000			
RGAME22	1.0000	1.0000	1.0000		
RGAME24	-1.0000	-1.0000	-1.0000	1.0000	
RGAME25	-1.0000	-1.0000	-1.0000	1.0000	1.0000
RGAME29	-1.0000	-1.0000	-1.0000	1.0000	1.0000
RGAME30	-1.0000	-1.0000	-1.0000	1.0000	1.0000
RGAME31	1.0000	1.0000	1.0000	-1.0000	-1.0000

RGAME29 RGAME30 RGAME31

RGAME29	1.0000		
RGAME30	1.0000	1.0000	
RGAME31	-1.0000	-1.0000	1.0000

RELIABILITY ANALYSIS - SCALE (ALPHA)

N of Cases = 2.0

Item Means	Mean	Minimum	Maximum	Range	Max/Min	Variance
	2.6111	2.0000	3.5000	1.5000	1.7500	.4575

Item Variances	Mean	Minimum	Maximum	Range	Max/Min	Variance
	1.1667	.5000	2.0000	1.5000	4.0000	.5882

Intraclass Correlation Coefficients

Two-Way Mixed Effects Model (Consistency Definition)

Measure	ICC		95% Confidence Interval		F-Value	Sig.
	Value	Lower Bound	Upper Bound			

Single Rater	.0308	-.0429	.9885	1.5723	.2268
Average of Raters*	.3640	-2.843	.9994	1.5723	.2268

Degrees of freedom for F-tests are 1 and 17. Test Value = 0.

* Assumes absence of People*Rater interaction.

Reliability Coefficients 18 items

Alpha = .3640 Standardized item alpha = -3.7059

APPENDIX H

INSTITUTIONAL REVIEW BOARD APPROVAL

THE UNIVERSITY OF NORTH CAROLINA

11/8/2004

GREENSBORO

NOV 11 2004

IRB File NUM:

045108**TITLE:** Entry level athletic trainers perceptions about the role of clinical experiences on development in tl**PI:** Stevens.Susan**DEPT:** ESS**CO_PIS:****FACULTY SPONSOR:** Perrin.David**Action Taken:**

eXempt from Full Review

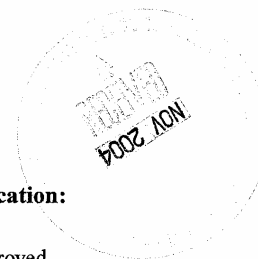
Expedited Review

Full IRB Review

Disposition of Application:

Approved

Disapproved

**MODIFICATIONS AND COMMENTS:**

Paul S. Kelly

 IRB Chair/Designee

APPROVAL DATE*: 11/12/04EXPIRATION DATE*: 11/10/05

*Approval of Research is for up to **ONE** year only. If your research extends beyond one year, the project must be reviewed before the expiration date prior to continuation.

APPENDIX I

COVER LETTER FOR FINAL DATA COLLECTION

Dear Entry Level Athletic Trainer,

You have been invited to participate in a research study entitled, **Entry-level athletic trainers' perceptions about the role of clinical experience in the development of the affective domain**. This survey is will be considered as part of my doctoral dissertation. The purpose of the study is to determine the importance of various common clinical experiences on the development of competence in the affective domain of the educational competencies which are required in all CAAHEP accredited athletic training education programs. These data are important as the Education Council is currently examining and revising the education competencies.

You will be asked to complete the web based survey by following the enclosed URL.

You must be currently employed as an athletic trainer in one of the recognized practice areas to participate in this study.

The survey consists of demographic questions and others relating to the importance of structured clinical education and unstructured field experience on the development of selected affective domain competencies. The survey should take you no longer than approximately 25 minutes to complete.

To participate you need access to the internet. You will access the link provided below, answer all questions honestly and submit your responses. You are being asked for your email address to be removed from the reminder list only. Your address will be removed from your results by the primary researcher before any data is analyzed. These addresses will be kept in a separate and secure location. All of your responses will be confidential and you will not be identified by name as a subject in this study. Filling out the survey and submitting your responses serves as your informed consent for participation. Your participation is entirely voluntary and you may withdraw at any time by discontinuing the survey without submitting the data. This survey and consent letter have been approved by the University of North Carolina at Greensboro Institutional Review Board, which insures that research involving human subjects follows federal regulations. If you have any questions about your rights as a participant in this project please call Mr. Eric Allen at (336) 256-1482. Any new information that develops during the project will be provided to you if the information might affect your willingness to continue participation in the project.

I intend to submit the results of this study for publication in an aggregate form only. The raw data will be kept in a locked office and destroyed three years after publication of the results. If you would like a copy of the project results please email me with your request

for information. Also if you have any questions regarding this project feel free to contact me either by email or at 336-278-5883.

Thank you for your time and consideration,

Sue Stevens

Sstevens2@elon.edu

336-278-5883

Click this link to be taken to the survey

http://www.elon.edu/irweb/Athletics/athletics_ss.html

APPENDIX J

SURVEY INSTRUMENT FOR PILOT TWO AND FINAL DATA COLLECTION

Entry level athletic trainers' perceptions about the role of clinical experience in the development of the affective domain**Directions**

1. As you complete the survey please keep in mind that this survey is measuring how important different clinical experiences were in your learning of specific learning objectives during your entry-level education program. Even though each of these activities were defined by the education council, clearly some are more important than others in your learning of specific educational competencies. Each bold statement below is taken directly from the NATA Educational Competencies and Clinical Proficiencies.*
2. Reflect back to your athletic training education as you read each bold statement and consider how important each of the activities listed below was in your learning of that bold statement.
 - a. Practicing clinical proficiencies with peers in an AT lab/ clinical course
 - b. Individual instruction/ assessment of clinical proficiencies with an approved clinical instructor
 - c. Practice coverage under the supervision of a clinical instructor
 - d. Game coverage under the supervision of a clinical instructor
3. Rate each activity according to that activity's importance in your mastery of each bold statement. (1=least important, 6= extremely important). For example in the first table, how important was practicing clinical proficiencies with your classmates in ensuring your learning of how to accept the moral, professional and legal responsibility to conduct safe programs to minimize injury...
4. After rating each activity's importance in your learning also rank order each activity in the area below each table. Remember that your ranking of each activity is based on your learning of the specific bold statement in the table above the ranking box.

[Next >](#)

Rank each activity according to its importance in your learning of the above bold statement.
(1=most important, 4=least important)

<input type="checkbox"/>	Practicing clinical proficiencies with peers in an AT lab/ clinical course
<input type="checkbox"/>	Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor
<input type="checkbox"/>	Practice coverage under supervision of a Clinical Instructor
<input type="checkbox"/>	Game coverage under supervision of a Clinical Instructor

Accepts the moral and ethical responsibility of maintaining current knowledge of the pathologic conditions of athletes and others involved in physical activity

	1=Not important	2	3	4	5	6=Extremely important
Practicing clinical proficiencies with peers in an AT lab/ clinical course	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Practice coverage under supervision of a Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Game coverage under supervision of a Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Rank each activity according to its importance in your learning of the above bold statement.
(1=most important, 4=least important)

<input type="checkbox"/>	Practicing clinical proficiencies with peers in an AT lab/ clinical course
<input type="checkbox"/>	Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor
<input type="checkbox"/>	Practice coverage under supervision of a Clinical Instructor
<input type="checkbox"/>	Game coverage under supervision of a Clinical Instructor

Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Practice coverage under supervision of a Clinical Instructor	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Game coverage under supervision of a Clinical Instructor	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Rank each activity according to its importance in your learning of the above bold statement.
(1=most important, 4=least important)

- Practicing clinical proficiencies with peers in an AT lab/ clinical course
- Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor
- Practice coverage under supervision of a Clinical Instructor
- Game coverage under supervision of a Clinical Instructor

Advocates the accepted medical protocol regarding the confidentiality of medical information relative to therapeutic modality treatments

	1=Not important	2	3	4	5	6=Extremely important
Practicing clinical proficiencies with peers in an AT lab/ clinical course	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Practice coverage under supervision of a Clinical Instructor	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Game coverage under supervision of a Clinical Instructor	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Rank each activity according to its importance in your learning of the above bold statement.
(1=most important, 4=least important)

<input type="checkbox"/>	Practicing clinical proficiencies with peers in an AT lab/ clinical course
<input type="checkbox"/>	Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor
<input type="checkbox"/>	Practice coverage under supervision of a Clinical Instructor
<input type="checkbox"/>	Game coverage under supervision of a Clinical Instructor

Appreciates the importance of a systematic assessment process in the management of injuries and illness

	1=Not important	2	3	4	5	6=Extremely important
Practicing clinical proficiencies with peers in an AT lab/ clinical course	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Practice coverage under supervision of a Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Game coverage under supervision of a Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Rank each activity according to its importance in your learning of the above bold statement. (1=most important, 4=least important)

<input type="checkbox"/>	Practicing clinical proficiencies with peers in an AT lab/ clinical course
<input type="checkbox"/>	Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor
<input type="checkbox"/>	Practice coverage under supervision of a Clinical Instructor
<input type="checkbox"/>	Game coverage under supervision of a Clinical Instructor

Accepts the role of the certified athletic trainer as a primary provider of assessment to the injuries and illnesses of athletes and others involved in physical activity

Practice coverage under supervision of a Clinical Instructor	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Game coverage under supervision of a Clinical Instructor	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Rank each activity according to its importance in your learning of the above bold statement. (1=most important, 4=least important)

<input type="checkbox"/>	Practicing clinical proficiencies with peers in an AT lab/ clinical course
<input type="checkbox"/>	Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor
<input type="checkbox"/>	Practice coverage under supervision of a Clinical Instructor
<input type="checkbox"/>	Game coverage under supervision of a Clinical Instructor

Appreciates the role and function of various medical/paramedical specialties, and values their respective areas of expertise in the definitive treatment of acute injuries and illnesses

	1=Not important	2	3	4	5	6=Extremely important
Practicing clinical proficiencies with peers in an AT lab/ clinical course	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Practice coverage under supervision of a Clinical Instructor	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Game coverage under supervision of a Clinical Instructor	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Rank each activity according to its importance in your learning of the above bold statement. (1=most important, 4=least important)

- Practicing clinical proficiencies with peers in an AT lab/ clinical course
- Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor
- Practice coverage under supervision of a Clinical Instructor
- Game coverage under supervision of a Clinical Instructor

Appreciates the systematic approach to acute injury or illness of the secondary survey components of obtaining a history, inspection/observation, palpation, and using special tests

	1=Not important	2	3	4	5	6=Extremely important
Practicing clinical proficiencies with peers in an AT lab/ clinical course	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Practice coverage under supervision of a Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Game coverage under supervision of a Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Rank each activity according to its importance in your learning of the above bold statement. (1=most important, 4=least important)

- Practicing clinical proficiencies with peers in an AT lab/ clinical course
- Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor
- Practice coverage under supervision of a Clinical Instructor
- Game coverage under supervision of a Clinical Instructor

Accepts the professional, ethical, and legal parameters that define the proper role of the certified athletic trainer in the treatment, rehabilitation, or reconditioning of athletes and others involved in physical activity

Practice coverage under supervision of a Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Game coverage under supervision of a Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Rank each activity according to its importance in your learning of the above bold statement. (1=most important, 4=least important)

- Practicing clinical proficiencies with peers in an AT lab/ clinical course
- Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor
- Practice coverage under supervision of a Clinical Instructor
- Game coverage under supervision of a Clinical Instructor

Respects the proper role of attending physicians and other medical and paramedical personnel in the treatment and rehabilitation or reconditioning of athletes and others involved in physical activity

	1=Not important	2	3	4	5	6=Extremely important
Practicing clinical proficiencies with peers in an AT lab/ clinical course	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Practice coverage under supervision of a Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Game coverage under supervision of a Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Rank each activity according to its importance in your learning of the above bold statement. (1=most important, 4=least important)

<input type="checkbox"/>	Practicing clinical proficiencies with peers in an AT lab/ clinical course
<input type="checkbox"/>	Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor
<input type="checkbox"/>	Practice coverage under supervision of a Clinical Instructor
<input type="checkbox"/>	Game coverage under supervision of a Clinical Instructor

Supports the moral and ethical behavior of athletic trainers in issues dealing with diseases of athletics and physical activity

	1=Not important	2	3	4	5	6=Extremely important
Practicing clinical proficiencies with peers in an AT lab/ clinical course	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Practice coverage under supervision of a Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Game coverage under supervision of a Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Rank each activity according to its importance in your learning of the above bold statement. (1=most important, 4=least important)

<input type="checkbox"/>	Practicing clinical proficiencies with peers in an AT lab/ clinical course
<input type="checkbox"/>	Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor
<input type="checkbox"/>	Practice coverage under supervision of a Clinical Instructor
<input type="checkbox"/>	Game coverage under supervision of a Clinical Instructor

Recognizes the moral and ethical responsibility of taking situational control in the containment of common contagious viral and infectious diseases

Practice coverage under supervision of a Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Game coverage under supervision of a Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Rank each activity according to its importance in your learning of the above bold statement. (1=most important, 4=least important)

<input type="checkbox"/>	Practicing clinical proficiencies with peers in an AT lab/ clinical course
<input type="checkbox"/>	Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor
<input type="checkbox"/>	Practice coverage under supervision of a Clinical Instructor
<input type="checkbox"/>	Game coverage under supervision of a Clinical Instructor

Appreciates the role of proper nutrition in the health care of athletes and others involved in physical activity

	1=Not important	2	3	4	5	6=Extremely important
Practicing clinical proficiencies with peers in an AT lab/ clinical course	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Practice coverage under supervision of a Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Game coverage under supervision of a Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Rank each activity according to its importance in your learning of the above bold statement. (1=most important, 4=least important)

<input type="checkbox"/>	Practicing clinical proficiencies with peers in an AT lab/ clinical course
--------------------------	--

Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor

Practice coverage under supervision of a Clinical Instructor

Game coverage under supervision of a Clinical Instructor

Appreciates the long term effects of disordered eating, bone density loss, and secondary amenorrhea on the skeletal health of the physically active

	1=Not important	2	3	4	5	6=Extremely important
Practicing clinical proficiencies with peers in an AT lab/ clinical course	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Practice coverage under supervision of a Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Game coverage under supervision of a Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Rank each activity according to its importance in your learning of the above bold statement. (1=most important, 4=least important)

Practicing clinical proficiencies with peers in an AT lab/ clinical course

Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor

Practice coverage under supervision of a Clinical Instructor

Game coverage under supervision of a Clinical Instructor

Recognizes the need for and implements proper referral for eating disorders

	1=Not important	2	3	4	5	6=Extremely important
--	-----------------	---	---	---	---	-----------------------

Game coverage under supervision of a Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

Rank each activity according to its importance in your learning of the above bold statement. (1=most important, 4=least important)

<input type="checkbox"/>	Practicing clinical proficiencies with peers in an AT lab/ clinical course
<input type="checkbox"/>	Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor
<input type="checkbox"/>	Practice coverage under supervision of a Clinical Instructor
<input type="checkbox"/>	Game coverage under supervision of a Clinical Instructor

Accepts the responsibility to provide health care information, intervention, and referral consistent with the certified athletic trainer's professional training

	1=Not important	2	3	4	5	6=Extremely important
Practicing clinical proficiencies with peers in an AT lab/ clinical course	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Practice coverage under supervision of a Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Game coverage under supervision of a Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Rank each activity according to its importance in your learning of the above bold statement. (1=most important, 4=least important)

<input type="checkbox"/>	Practicing clinical proficiencies with peers in an AT lab/ clinical course
<input type="checkbox"/>	Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor
<input type="checkbox"/>	Practice coverage under supervision of a Clinical Instructor

<input type="checkbox"/> Game coverage under supervision of a Clinical Instructor

Recognizes the certified athletic trainer's role as a liaison between the physically active, athletic personnel, health care professionals, parents/guardians, and the public

	1=Not important	2	3	4	5	6=Extremely important
Practicing clinical proficiencies with peers in an AT lab/ clinical course	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Practice coverage under supervision of a Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Game coverage under supervision of a Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Rank each activity according to its importance in your learning of the above bold statement. (1=most important, 4=least important)

<input type="checkbox"/> Practicing clinical proficiencies with peers in an AT lab/ clinical course
<input type="checkbox"/> Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor
<input type="checkbox"/> Practice coverage under supervision of a Clinical Instructor
<input type="checkbox"/> Game coverage under supervision of a Clinical Instructor

Appreciates the roles and functions of various medical and paramedical specialties as well as their respective areas of expertise in the acute care of injuries and illnesses to athletes and others involved in physical activity

	1=Not important	2	3	4	5	6=Extremely important
--	-----------------	---	---	---	---	-----------------------

Game coverage under supervision of a Clinical Instructor	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
--	-------------------------------------	-------------------------------------	-------------------------------------	-------------------------------------	-------------------------------------	-------------------------------------

Rank each activity according to its importance in your learning of the above bold statement. (1=most important, 4=least important)

<input type="checkbox"/>	Practicing clinical proficiencies with peers in an AT lab/ clinical course
<input type="checkbox"/>	Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor
<input type="checkbox"/>	Practice coverage under supervision of a Clinical Instructor
<input type="checkbox"/>	Game coverage under supervision of a Clinical Instructor

Accepts the professional, ethical, and legal parameters that define the proper role of the certified athletic trainer in the administration and implementation of health care delivery systems

	1=Not important	2	3	4	5	6=Extremely important
Practicing clinical proficiencies with peers in an AT lab/ clinical course	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Practice coverage under supervision of a Clinical Instructor	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Game coverage under supervision of a Clinical Instructor	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Rank each activity according to its importance in your learning of the above bold statement. (1=most important, 4=least important)

<input type="checkbox"/>	Practicing clinical proficiencies with peers in an AT lab/ clinical course
<input type="checkbox"/>	Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor

Practice coverage under supervision of a Clinical Instructor

Game coverage under supervision of a Clinical Instructor

Appreciates the need for and the process and benefits of athletic training regulatory acts (registration, licensure, certification)

	1=Not important	2	3	4	5	6=Extremely important
Practicing clinical proficiencies with peers in an AT lab/ clinical course	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Practice coverage under supervision of a Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Game coverage under supervision of a Clinical Instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Rank each activity according to its importance in your learning of the above bold statement. (1=most important, 4=least important)

Practicing clinical proficiencies with peers in an AT lab/ clinical course

Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor

Practice coverage under supervision of a Clinical Instructor

Game coverage under supervision of a Clinical Instructor

Accepts the professional, historical, ethical, and organizational structures that define the proper roles and responsibilities of the certified athletic trainer in providing health care to athletes and others involved in physical activity

Game coverage under supervision of a Clinical Instructor	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
--	-------------------------------------	-------------------------------------	-------------------------------------	-------------------------------------	-------------------------------------	-------------------------------------

Rank each activity according to its importance in your learning of the above bold statement. (1=most important, 4=least important)

<input type="checkbox"/>	Practicing clinical proficiencies with peers in an AT lab/ clinical course
<input type="checkbox"/>	Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor
<input type="checkbox"/>	Practice coverage under supervision of a Clinical Instructor
<input type="checkbox"/>	Game coverage under supervision of a Clinical Instructor

Defends the responsibility to interpret and promote athletic training as a professional discipline among allied health professional groups and the general public

	1=Not important	2	3	4	5	6=Extremely important
Practicing clinical proficiencies with peers in an AT lab/ clinical course	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Practice coverage under supervision of a Clinical Instructor	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Game coverage under supervision of a Clinical Instructor	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Rank each activity according to its importance in your learning of the above bold statement. (1=most important, 4=least important)

<input type="checkbox"/>	Practicing clinical proficiencies with peers in an AT lab/ clinical course
<input type="checkbox"/>	Individual instruction/ assessment of clinical proficiencies with Approved Clinical Instructor

- Practice coverage under supervision of a Clinical Instructor
- Game coverage under supervision of a Clinical Instructor

1. Using the following definitions, how much time did you spend in clinical education and field experience?

Clinical Education is when you are learning, practicing, or being assessed on a clinical proficiency by an Approved Clinical Instructor.**

Field Experience is unstructured learning or practice of athletic training skills in a real world setting under the supervision of a clinical instructor.** The field experience is the time that you are actively working with a sports team covering practices and competitions or pre and post practice treatments. This is an exposure to the daily activities of certified athletic trainers and other medical providers

- 100% clinical education
- 75% clinical education 25% field experience
- 50% clinical education 50% field experience
- 25% clinical education 75% field experience
- 100% field experience

2. Considering your complete education program, how would you rate your clinical instructors' supervisory competence?

3. When did you begin your clinical education/ field experience?(count from when you entered school not the athletic training program)

- First year (freshman)
- Second year (sophomore)
- Third year (junior)
- Fourth year (Senior)

Thank you for your time and effort in completing this survey.

References

*National Athletic Trainers' Association Education Council. Educational Competencies and Clinical Proficiencies. 2001.

**National Athletic Trainers' Association Education Council Clinical Education Definitions.
<http://www.cewl.com/>. Accessed February 22,2003.

Finish

Powered By
 inquisite™