

Occupational Therapy Skills Checklist



Your Partner in Staffing™

This profile is for use by Occupational Therapists with more than one year of experience in their discipline and specialty. It will not be a determining factor for the program. Return this checklist to us by fax at 317-780-3745.

www.healthcaredirectstaffing.com

 First name:

 Last name:

____ - ____ - ____
 Social Security number:

Please mark your level of experience

A

Theory, no practice

C

One - two years experience

B

Intermittent experience

D

Two plus years experience

A. Orthopedic

- | | A | B | C | D |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Arthritis programs | | | | |
| a. Energy conservation ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Joint protection ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Hand injury ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Hip fractures ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Mobilization techniques ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Therapeutic exercise ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Total hip/knee replacement ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Total joint replacement/upper extremities -- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

B. Neurological

- | | | | | |
|------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. CVA ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Head trauma ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Peripheral nerve injuries ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Spinal cord injury ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Adaptive equipment ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Functional splinting ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Wheelchair evaluation ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Stroke rehabilitation ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

C. Psychiatric

- | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Acute disorders ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Chronic disorders ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Community re-entry ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Crisis intervention ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Group treatment ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Standardized assessment tools ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Substance abuse ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

D. Prosthetics/Orthotics/Functional Training

- | | | | | |
|--------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Above knee prosthetics ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Below knee prosthetics ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Dynamic splints ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Myofascial release (MFR) ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Orthoplast ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Serial/inhibitory casting ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Static splints ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Upper extremity prosthetics ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

E. Adaptive Equipment

- | | A | B | C | D |
|---------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Assessment ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Fabrication ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Functional activities ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| a. ADLs ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Home environment ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Pre-discharge planning ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Splinting ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Wheelchair ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

F. Vocational Training

- | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Cognitive assessment ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Functional capacity evaluation ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Job task analysis ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Perceptual assessment ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Work hardening | | | | |
| a. BTE ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Valpar ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

G. Pediatrics

- | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Developmental testing ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Discharge planning referral & resources --- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Equipment assessment ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Activities of daily living ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Wheelchair positioning device ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Neurodevelopmental testing ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Orthotics ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Sensory integrative testing ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Visual perceptual skills testing ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

H. Modalities

- | | | | | |
|--------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Biofeedback ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Edema massage ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Feeding techniques ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Fluidotherapy ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Muscle stimulation ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Oral motor facilities ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Paraffin bath ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Therapeutic pool ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

_____ / _____ / _____
First name:

_____ / _____ / _____
Last name:

Please check the boxes below for each age group for which you have expertise in providing age-appropriate nursing care.

AGE SPECIFIC PRACTICE CRITERIA

A. Newborn/Neonate (birth - 30 days)	D. Preschooler (3 - 5 years)	G. Young adults (18 - 39 years)
B. Infant (30 days - 1 year)	E. School age children (5 - 12 years)	H. Middle adults (39 - 64 years)
C. Toddler (1 - 3 years)	F. Adolescents (12 - 18 years)	I. Older adults (64+)

EXPERIENCE WITH AGE GROUPS:

	A	B	C	D	E	F	G	H	I
Able to adapt care to incorporate normal growth and development.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to adapt method and terminology of patient instructions to their age, comprehension and maturity level.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can ensure a safe environment reflecting specific needs of various age groups.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

My experience is primarily in: (Please indicate number of years.)

Practice area: _____ year(s)

Certification: (mo/day/year)

BCLS Exp Date: ____ / ____ / _____

CPR: Exp Date: ____ / ____ / _____

Other (type) _____ Exp Date: ____ / ____ / _____

Computerized charting system: _____ Date: ____ / ____ / _____

I attest that the information I have given is true and accurate to the best of my knowledge and that I am the individual completing this form. I hereby authorize the Company to release this Occupational Therapy Skills Checklist to their Client facilities in relation to consideration of employment as a Traveler with those facilities.

Signature

____ / ____ / _____
Date