



## OCCUPATIONAL THERAPIST SKILLS CHECKLIST

|            |                   |           |
|------------|-------------------|-----------|
| First Name | MI                | Last Name |
| E-mail     | Last 4 digits SS# | Date      |

**Instructions:** Please check the appropriate column that best describes your experience level for each knowledge competency and skill. Please use the rating scale below to evaluate yourself based on experiences within the last two years.

**Self Assessed Experience Rating Scale**

1 = No Experience    2 = Minimal Experience    3 = Performs well/Competent    4 = Supervise and Teach

| Skills:   | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| <b>Assessment &amp; Care of Patient With or Requiring</b> |   |   |   |   |
| <b>Orthopedic</b>   |   |   |   |   |
| Hand Injury   |   |   |   |   |
| Arthritis Programs  |   |   |   |   |
| Total Joint Replacement/ Upper Extremities                |   |   |   |   |
| Total Hip/ Knee Replacement                               |   |   |   |   |
| Hip Fractures   |   |   |   |   |
| Mobilization Techniques                                   |   |   |   |   |
| <b>Neurologic</b>   |   |   |   |   |
| Stroke Rehabilitation                                     |   |   |   |   |
| Head Trauma   |   |   |   |   |
| Spinal Cord Injury:                                       |   |   |   |   |
| Functional Splinting                                      |   |   |   |   |
| Adaptive Equipment  |   |   |   |   |
| Wheelchair Evaluation                                     |   |   |   |   |
| <b>Psychiatric</b>  |   |   |   |   |
| Standardized Assessment Tools                             |   |   |   |   |
| Group Treatment   |   |   |   |   |
| Substance Abuse   |   |   |   |   |
| Crisis Intervention                                       |   |   |   |   |
| Acute Disorders   |   |   |   |   |
| Chronic Disorders   |   |   |   |   |

| Skills Continued:                                | 1 | 2 | 3 | 4 |
|--|---|---|---|---|
| Community Re-entry                               |   |   |   |   |
| Depression                                       |   |   |   |   |
| <b>Prosthetics/Orthotics/Functional Training</b> |   |   |   |   |
| Above Knee Prosthetics                           |   |   |   |   |
| Below Knee Prosthetics                           |   |   |   |   |
| Upper Extremity Prosthetics                      |   |   |   |   |
| Orthoplast                                       |   |   |   |   |
| Static Splints                                   |   |   |   |   |
| Dynamic Splints                                  |   |   |   |   |
| Serial/ Inhibitory Casting                       |   |   |   |   |
| <b>Adaptive Equipment</b>                        |   |   |   |   |
| Assessment                                       |   |   |   |   |
| Fabrication                                      |   |   |   |   |
| Wheelchair                                       |   |   |   |   |
| Functional Activities:                           |   |   |   |   |
| Home Environment                                 |   |   |   |   |
| A.D.L.s  |   |   |   |   |
| Pre-discharge Planning                           |   |   |   |   |
| Splinting  |   |   |   |   |
| <b>Vocational Training</b>                       |   |   |   |   |
| Perceptual Assessment                            |   |   |   |   |
| Cognitive Assessment                             |   |   |   |   |
| Work Hardening                                   |   |   |   |   |

| <b>Skills Continued:</b>         | <b>1</b> | <b>2</b> | <b>3</b> | <b>4</b> |
|----------------------------------|----------|----------|----------|----------|
| Functional Capacity Evaluation   |          |          |          |          |
| Pediatrics                       |          |          |          |          |
| Neurodevelopmental Testing       |          |          |          |          |
| Developmental Testing            |          |          |          |          |
| Sensory Integrative Testing      |          |          |          |          |
| Visual Perceptual Skills Testing |          |          |          |          |
| Orthotics                        |          |          |          |          |
| Equipment Assessment:            |          |          |          |          |
| Wheelchair Positioning Device    |          |          |          |          |
| Activities of Daily Living       |          |          |          |          |
| Modalities                       |          |          |          |          |
| Biofeedback                      |          |          |          |          |
| Muscle Stimulation               |          |          |          |          |
| Fluidotherapy                    |          |          |          |          |
| Paraffin Bath                    |          |          |          |          |
| Edema Massage                    |          |          |          |          |
| Feeding Techniques               |          |          |          |          |
| Oral Motor Facilities            |          |          |          |          |
| Therapeutic Pool                 |          |          |          |          |
| TENS                             |          |          |          |          |
| <b>Other</b>                     |          |          |          |          |
| Work Capacity Evaluation         |          |          |          |          |
| Work Hardening :                 |          |          |          |          |
| BTE                              |          |          |          |          |

| <b>Skills Continued:</b>           | <b>1</b> | <b>2</b> | <b>3</b> | <b>4</b> |
|------------------------------------|----------|----------|----------|----------|
| Valpar                             |          |          |          |          |
| Job Task Analysis                  |          |          |          |          |
| Cardiac Rehabilitation             |          |          |          |          |
| Burn Management                    |          |          |          |          |
| Back Injuries                      |          |          |          |          |
| <b>Equipment and Procedures</b>    |          |          |          |          |
| Developmental Disabilities         |          |          |          |          |
| Home Accessibility                 |          |          |          |          |
| Driving Evaluation                 |          |          |          |          |
| Group Dynamics                     |          |          |          |          |
| Therapeutic Media                  |          |          |          |          |
| Cognitive Retraining               |          |          |          |          |
| Other (specify):                   |          |          |          |          |
|                                    |          |          |          |          |
|                                    |          |          |          |          |
| <b>Experience in Primary Areas</b> |          |          |          |          |
| Hospitals                          |          |          |          |          |
| Clinics                            |          |          |          |          |
| Nursing Homes                      |          |          |          |          |
| Home Health                        |          |          |          |          |
| Certifications                     |          |          |          |          |
| BLS                                |          |          |          |          |
| ACLS                               |          |          |          |          |
| Accrediting Agency:                |          |          |          |          |
| Name of agency                     |          |          |          |          |

| <b>My Experience Is Primary In:</b> | <b>Number of Years:</b> |
|-------------------------------------|-------------------------|
| General Acute Care                  |                         |
| Rehab Clinic                        |                         |
| Rehabilitation Hospital             |                         |
| Children's Hospital                 |                         |
| School System                       |                         |
| Home Health Care                    |                         |
| Outpatient Clinic                   |                         |
| Skilled Nursing Facility            |                         |
| Industrial Medicine                 |                         |
| Psychiatric Hospital                |                         |
| Work Hardening                      |                         |
| Other:                              |                         |

| <b>1. Age Specific Practice Criteria</b>  | <b>1</b> | <b>2</b> | <b>3</b> | <b>4</b> |
|---|----------|----------|----------|----------|
| Adolescents (12 – 18 years)   |          |          |          |          |
| Young Adults (18 – 39 years)  |          |          |          |          |
| Middle Adults (39 – 64 years)   |          |          |          |          |
| Older Adults (64+ years)  |          |          |          |          |
| <b>2. Care of Patient with:</b>   |          |          |          |          |
| Able to adapt care to incorporate normal growth and development   |          |          |          |          |
| Able to adapt method and terminology of patient instructions to their age, comprehension, and maturity level. |          |          |          |          |
| Can ensure a safe environment, reflecting specific needs of various groups.                                   |          |          |          |          |

**Certification:**

Please check the boxes below and indicate the expiration date for each certificate that you hold. If you do not know the exact date, please use the last date of the specific month (i.e. 1/31/2007).

| <b>Certification:</b> | <b>Expiration Date:</b> |
|-----------------------|-------------------------|
| BCLS                  |                         |

I hereby certify all statements and claims as true and that any misrepresentation of the facts on this checklist is sufficient cause for dismissal at any time without prior notice even if I have been already employed.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Full Name (Print)