



Occupational Therapist Skills Checklist

Please enter your full legal name as it appears on your Social Security Card.

Date:

First Name:

Last Name:

Last 4 digits of your SS#:

Job Description: Occupational Therapist

Is responsible for planning and conducting individualized occupational therapy programs to help patients develop, regain, or maintain their ability to perform daily activities. Teaches patients skills/techniques and how to use adaptive equipment for participating in activities. Studies, evaluates, and records patients' activities and progress. Requires a bachelor's degree and is certified as an occupational therapist. Familiar with standard concepts, practices, and procedures within a particular field. Relies on limited experience and judgment to plan and accomplish goals. Performs a variety of tasks. A certain degree of creativity and latitude is required. Typically reports to a manager.

KEY: For each criteria

Score 1: Two plus years Expert Experience

Score 2: One-Two Years Current Experience

Score 3: Less than one year or Intermittent Experience

Score 4: Theory, no experience

| CRITERIA | SCORE | | | |
|---|-------|---|---|---|
| | 1 | 2 | 3 | 4 |
| ORTHOPEDICS | | | | |
| Arthritis Programs | | | | |
| Energy Conservation | | | | |
| Joint Protection | | | | |
| Hand Injury | | | | |
| Hip Fractures | | | | |
| Mobilization Techniques | | | | |
| Therapeutic Exercises | | | | |
| Total Hip/Knee Replacement | | | | |
| Total Joint Replacement / Upper Extremity | | | | |
| NEUROLOGIC | | | | |
| CVA | | | | |
| Stroke Rehabilitation | | | | |
| Head Trauma | | | | |
| Peripheral Nerve Injury | | | | |
| Spinal Cord Injury | | | | |
| Functional Splinting | | | | |
| Adaptive Equipment | | | | |
| Wheel Chair Evaluation | | | | |
| PSYCHIATRIC | | | | |
| Acute Disorders | | | | |
| Chronic Disorders | | | | |
| Community Re-entry | | | | |
| Crisis Intervention | | | | |

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|--|--|
| Group Treatment | |
| Standardized Assessment Tools | |
| Substance Abuse | |
| PEDIATRICS | |
| Discharge Planning Referral & Resources | |
| Developmental Testing | |
| Orthotics | |
| Neuro – Developmental Testing | |
| Equipment Assessment | |
| Activities of Daily Living | |
| Wheelchair Positioning Device | |
| Sensory Integrative Testing | |
| Visual Perceptual Skills Training | |
| MODEL TIES / PROCEDURES | |
| Biofeedback | |
| Feeding Techniques | |
| Muscle Stimulation | |
| Oral Motor Facilities | |
| Fluidotherapy | |
| Paraffin Bath | |
| Therapeutic Pool | |
| Energy Conservation | |
| Joint Mobilization | |
| ADAPTIVE EQUIPMENT | |
| Assessment | |
| Fabrication | |
| Functional Activities | |
| ALDS | |
| Home Environment | |
| Pre-Discharge Planning | |
| Splinting | |
| Wheelchair | |
| VOCATIONAL TRAINING | |
| Cognitive Assessment | |
| Functional Capacity Evaluation | |
| Job Task Analysis | |
| Perceptual Assessment | |
| Work Hardening | |
| BTE | |
| Valpar | |
| PROSTHETICS / ORTHOTICS / FUNCTIONAL TRAINING | |
| UE Prosthetics | |
| Above Knee Prosthetics | |
| Below Knee Prosthetics | |
| Serial / Inhibitory Casting | |
| Static Splints | |
| Myofascial Release (MFR) | |
| Orthoplast | |
| Upper Extremity Prosthetics | |
| Dynamic Splints | |
| OTHER | |
| AIDS / HIV | |

| | | | | |
|--|----------|----------|----------|----------|
| Amputees | | | | |
| Burn Management | | | | |
| Cardiac Rehabilitation | | | | |
| Education – Patient | | | | |
| Education - Family | | | | |
| Workers Comp | | | | |
| AGE SPECIFIC CARE | | | | |
| Please indicate the frequency with which you provide care for each age group in this specialty area. | 1 | 2 | 3 | 4 |
| Infant (Birth to 1 year) | | | | |
| Toddler (1-3 years) | | | | |
| Pre-school (3-6 years) | | | | |
| School Age (6-12 years) | | | | |
| Adolescent (12-18 years) | | | | |
| Young Adult (18-30 years) | | | | |
| Mature Adult (30-60 years) | | | | |
| Elderly (>60 years) | | | | |

JCAHO: I acknowledge and understand JCAHO's list of "Do Not Use Abbreviations" : _____

JCAHO: I acknowledge and understand JCAHO's "National Patient Safety Goals" : _____

The information I have given is true and accurate to the best of my knowledge. I have read and fully understand the job description. By signing below or submitting electronically, I attest that the information provided within this skills checklist represents a full and complete disclosure of information, and is true and correct to the best of my knowledge and belief. I hereby authorize Sagent Healthstaff to release this skills checklist to client facilities for employment purposes.

I agree with the above statements. :

Signature: (please type your full name) :

Date: