Occupational Therapy Skills Checklist

Med Travelers

First name:

Last name:

Social Security number:

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 toll free fax at (800) 218-1650.

Please mark your level of experience

- **A** Theory, no practice
- **B** Intermittent experience
- **C** One - two years experience
- **D** Two plus years experience

	A	B	C	D
A. Orthopedic				
1. Arthritis programs				
a. Energy conservation	☐	☐	☐	☐
b. Joint protection	☐	☐	☐	☐
2. Hand injury	☐	☐	☐	☐
3. Hip fractures	☐	☐	☐	☐
4. Mobilization techniques	☐	☐	☐	☐
5. Therapeutic exercise	☐	☐	☐	☐
6. Total hip/knee replacement	☐	☐	☐	☐
7. Total joint replacement/upper extremities	☐	☐	☐	☐
B. Neurological				
1. CVA	☐	☐	☐	☐
2. Head trauma	☐	☐	☐	☐
3. Peripheral nerve injuries	☐	☐	☐	☐
4. Spinal cord injury	☐	☐	☐	☐
a. Adaptive equipment	☐	☐	☐	☐
b. Functional splinting	☐	☐	☐	☐
c. Wheelchair evaluation	☐	☐	☐	☐
5. Stroke rehabilitation	☐	☐	☐	☐
C. Psychiatric				
1. Acute disorders	☐	☐	☐	☐
2. Chronic disorders	☐	☐	☐	☐
3. Community re-entry	☐	☐	☐	☐
4. Crisis intervention	☐	☐	☐	☐
5. Group treatment	☐	☐	☐	☐
6. Standardized assessment tools	☐	☐	☐	☐
7. Substance abuse	☐	☐	☐	☐
D. Prosthetics/Orthotics/Functional Training				
1. Above knee prosthetics	☐	☐	☐	☐
2. Below knee prosthetics	☐	☐	☐	☐
3. Dynamic splints	☐	☐	☐	☐
4. Myofascial release (MFR)	☐	☐	☐	☐
5. Orthoplast	☐	☐	☐	☐
6. Serial/inhibitory casting	☐	☐	☐	☐
7. Static splints	☐	☐	☐	☐
8. Upper extremity prosthetics	☐	☐	☐	☐

	A	B	C	D
E. Adaptive Equipment				
1. Assessment	☐	☐	☐	☐
2. Fabrication	☐	☐	☐	☐
3. Functional activities	☐	☐	☐	☐
a. ADLs	☐	☐	☐	☐
b. Home environment	☐	☐	☐	☐
c. Pre-discharge planning	☐	☐	☐	☐
d. Splinting	☐	☐	☐	☐
4. Wheelchair	☐	☐	☐	☐
F. Vocational Training				
1. Cognitive assessment	☐	☐	☐	☐
2. Functional capacity evaluation	☐	☐	☐	☐
3. Job task analysis	☐	☐	☐	☐
4. Perceptual assessment	☐	☐	☐	☐
5. Work hardening				
a. BTE	☐	☐	☐	☐
b. Valpar	☐	☐	☐	☐
G. Pediatrics				
1. Developmental testing	☐	☐	☐	☐
2. Discharge planning referral & resources	☐	☐	☐	☐
3. Equipment assessment	☐	☐	☐	☐
a. Activities of daily living	☐	☐	☐	☐
b. Wheelchair positioning device	☐	☐	☐	☐
4. Neurodevelopmental testing	☐	☐	☐	☐
5. Orthotics	☐	☐	☐	☐
6. Sensory integrative testing	☐	☐	☐	☐
7. Visual perceptual skills testing	☐	☐	☐	☐
H. Modalities				
1. Biofeedback	☐	☐	☐	☐
2. Edema massage	☐	☐	☐	☐
3. Feeding techniques	☐	☐	☐	☐
4. Fluidotherapy	☐	☐	☐	☐
5. Muscle stimulation	☐	☐	☐	☐
6. Oral motor facilities	☐	☐	☐	☐
7. Paraffin bath	☐	☐	☐	☐
8. Therapeutic pool	☐	☐	☐	☐

53908

Toll Free Phone (800) 788-4815 Toll Free Fax (800) 218-1650

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.	☐	☐	☐	☐	☐	☐	☐	☐	☐
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 age groups.	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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