



"Allied Services Division"

Occupational Therapy – Self Assessment

Applicant Name _____

Level of Experience
 0 – No Experience
 1 – Limited
 2 – Fair
 3 – More than Average
 4 – Proficient

General

Experience

Orthopedic

- | | |
|--|-----------|
| 1. Arthritis programs | |
| a. Energy conservation | 0 1 2 3 4 |
| b. Joint protection | 0 1 2 3 4 |
| 2. Hand injury | 0 1 2 3 4 |
| 3. Hip fractures | 0 1 2 3 4 |
| 4. Mobilization techniques | 0 1 2 3 4 |
| 5. Therapeutic exercise | 0 1 2 3 4 |
| 6. Total hip/knee replacement | 0 1 2 3 4 |
| 7. Total joint replacement/upper extremities | 0 1 2 3 4 |

Neurological

- | | |
|------------------------------|-----------|
| 1. CVA | 0 1 2 3 4 |
| 2. Head trauma | 0 1 2 3 4 |
| 3. Peripheral nerve injuries | 0 1 2 3 4 |
| 4. Spinal cord injury | |
| a. Adaptive equipment | 0 1 2 3 4 |
| b. Functional splinting | 0 1 2 3 4 |
| c. Wheelchair evaluation | 0 1 2 3 4 |
| 5. Stroke rehabilitation | 0 1 2 3 4 |

Psychiatric

- | | |
|------------------------|-----------|
| 1. Acute disorders | 0 1 2 3 4 |
| 2. Chronic disorders | 0 1 2 3 4 |
| 3. Community re-entry | 0 1 2 3 4 |
| 4. Crisis intervention | 0 1 2 3 4 |
| 5. Group treatment | 0 1 2 3 4 |

Cont.

Experience

Prosthetics/Orthotics/Functional Training

- | | |
|--------------------------------|-----------|
| 1. Above knee prosthetics | 0 1 2 3 4 |
| 2. Below knee prosthetics | 0 1 2 3 4 |
| 3. Dynamic splints | 0 1 2 3 4 |
| 4. Myofascial release (MFR) | 0 1 2 3 4 |
| 5. Orthoplast | 0 1 2 3 4 |
| 6. Serial/inhibitory casting | 0 1 2 3 4 |
| 7. Static splints | 0 1 2 3 4 |
| 8. Upper extremity prosthetics | 0 1 2 3 4 |

Adaptive Equipment

- | | |
|---------------------------|-----------|
| 1. Assessment | 0 1 2 3 4 |
| 2. Fabrication | 0 1 2 3 4 |
| 3. Functional activities | |
| a. ADLs | 0 1 2 3 4 |
| b. Home environment | 0 1 2 3 4 |
| c. Pre-discharge planning | 0 1 2 3 4 |
| d. Splinting | 0 1 2 3 4 |
| 4. Wheelchair | 0 1 2 3 4 |

Vocational Training

- | | |
|-----------------------------------|-----------|
| 1. Cognitive assessment | 0 1 2 3 4 |
| 2. Functional capacity evaluation | 0 1 2 3 4 |
| 3. Job task analysis | 0 1 2 3 4 |
| 4. Perceptual assessment | 0 1 2 3 4 |
| 5. Work hardening | |
| a. BTE | 0 1 2 3 4 |
| b. Valpar | 0 1 2 3 4 |

- | | | | | | |
|----------------------------------|---|---|---|---|---|
| 6. Standardized assessment tools | 0 | 1 | 2 | 3 | 4 |
| 7. Substance abuse | 0 | 1 | 2 | 3 | 4 |

Pediatrics

- | | | | | | |
|--|---|---|---|---|---|
| 1. Developmental testing | 0 | 1 | 2 | 3 | 4 |
| 2. Discharge planning (referral & Resources) | 0 | 1 | 2 | 3 | 4 |
| 3. Equipment assessment | | | | | |
| a. Activities of daily living | 0 | 1 | 2 | 3 | 4 |
| b. Wheelchair positioning Device | 0 | 1 | 2 | 3 | 4 |
| 4. Neurodevelopmental testing | 0 | 1 | 2 | 3 | 4 |
| 5. Orthotics | 0 | 1 | 2 | 3 | 4 |
| 6. Sensory integrative testing | 0 | 1 | 2 | 3 | 4 |
| 7. Visual perceptual skills testing | 0 | 1 | 2 | 3 | 4 |

Modalities

- | | | | | | |
|--------------------------|---|---|---|---|---|
| 1. Biofeedback | 0 | 1 | 2 | 3 | 4 |
| 2. Edema massage | 0 | 1 | 2 | 3 | 4 |
| 3. Feeding techniques | 0 | 1 | 2 | 3 | 4 |
| 4. Fluidotherapy | 0 | 1 | 2 | 3 | 4 |
| 5. Muscle stimulation | 0 | 1 | 2 | 3 | 4 |
| 6. Oral motor facilities | 0 | 1 | 2 | 3 | 4 |
| 7. Paraffin bath | 0 | 1 | 2 | 3 | 4 |
| 8. Therapeutic pool | 0 | 1 | 2 | 3 | 4 |

AGE SPECIFIC PRACTICE CRITERIA

Please circle the age groups below for each area in which you have expertise.

- Newborn/Neonate (birth – 30 days)
- Infant (30 days – 1 year)
- Toddler (1 – 3 years)
- Preschooler (3 – 5 years)
- School age Children (5 – 12 years)
- Adolescents (12 – 18 years)
- Young adults (18 – 39 years)
- Middle adults (39 – 64)
- Older adults (64+)

My experience is primarily in: _____

Practice area: _____ (Please indicate number of years.) _____

Certification:

Please check the boxes below and indicate the expiration date for each certificate that you have. If you do not know the exact date, please use the lasts date of the specific months (e.g., 08/31/2003).

BCLS Exp. Date: (/ /)
CPR Exp. Date: (/ /)
Other (type): Exp. Date: (/ /)

Computerized chart system: _____