

Occupational Therapy Skills

Name: _____

Date: _____

Social Security Number: _____

E-Mail: _____

Instructions: use the following Answer Key to indicate the extent of your previous experience:

Key: for each A. Theory, no practice B. Intermittent experience
Box mark: C. one-two years experience D. two plus years experience

Orthopedic

Arthritis programs

 Energy conservation A B C D

 Joint protection A B C D

Hand injury A B C D

Hip fractures A B C D

Mobilization techniques A B C D

Therapeutic exercise A B C D

Total hip/knee replacement A B C D

Total joint replacement/upper extremities A B C D

Neurological

CVA A B C D

Head trauma A B C D

Peripheral nerve injuries A B C D

Spinal cord injury A B C D

 Adaptive equipment A B C D

 Functional splinting A B C D

 Wheelchair evaluation A B C D

Stroke rehabilitation A B C D

Psychiatric

Acute disorders A B C D

Chronic disorders A B C D

Community re-entry A B C D

Crisis intervention A B C D

Group treatment A B C D

Standardized assessment tools A B C D

Substance abuse A B C D

Prosthetics/Orthotics/Functional Training

Above knee prosthetics	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D
Below knee prosthetics	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D
Dynamic splints	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D
Myofascial release (MFR)	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D
Orthoplast	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D
Serial/inhibitory casting	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D
Static splints	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D
Upper extremity prosthetics	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D

Adaptive Equipment

Assessment	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D
Fabrication	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D
Functional activities	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D
ADLs	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D
Home environment	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D
Pre-discharge planning	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D
Splinting	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D
Wheelchair	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D

Vocational Training

Cognitive assessment	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D
Functional capacity evaluation	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D
Job task analysis	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D
Perceptual assessment	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D
Work hardening	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D
BTE	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D
Valpar	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D

Pediatrics

Developmental testing	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D
Discharge planning (referral & resources)	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D
Equipment assessment	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D
Activities of daily living	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D
Wheelchair positioning device	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D
Neurodevelopmental testing	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D
Orthotics	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D
Sensory integrative testing	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D
Visual perceptual skills testing	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D

Modalities

Biofeedback	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D
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- Edema massage A B C D
- Feeding techniques A B C D
- Fluidotherapy A B C D
- Muscle stimulation A B C D
- Therapeutic pool A B C D

Experience With Age Groups

- Able to adapt care to incorporate normal growth and development. A B C D

- Able to adapt method and terminology of patient instructions to their age, comprehension and maturity level. A B C D

- Can ensure a age environment reflecting specific needs of various age groups. A B C D

Certifications:

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 us the last date of the specific month (e.g., 01/02/2004)

- BCLS Exp. Date: _____
- ACLS Exp. Date: _____
- CPR Exp. Date: _____
- Other: Exp. Date: _____
- Computerized charting systems: Exp. Date: _____