

ALLIED HEALTH SPECIALTY SHEET

Occupational Therapist

Please list any limitations or comments you may have on a separate sheet.

IDENTIFYING INFORMATION	Last Name	First name	Middle name	Previous Surname		
	Social Security Number					
LICENSES <i>List all states in which you are or have ever been licensed beginning with your original state license</i>	Original State License	License Number	Exp. Date	State License	License Number	Exp. Date
	State License	License Number	Exp. Date	State License	License Number	Exp. Date

CERTIFICATION NBCOT #: _____ Original date: _____ Renewal Date: _____

CLINICAL SKILLS Please rate your skills in the areas below, using the following values:
 1 = No experience 2 = Some experience (less than 1 yr.) 3 = Experienced (1 yr. or more) 4 = Highly experienced (2 yrs. or more)

<u>Orthopedics</u>	1	2	3	4
Total hip replacements				
Total knee replacements				
UE joint replacements				
Amputation				
Fractures/dislocations				
Traumatic hand injury				
Arthritis				
Back injury				
Multi-trauma				
<u>General Acute Care</u>				
<u>Discharge Planning</u>	1	2	3	4
Home assessment				
Home modification/adaptation				
Driver re-education				
<u>Neurological</u>	1	2	3	4
Traumatic brain injury				
CVA/stroke				
Spinal cord injury				
Coma management				
Peripheral nerve injury				
Reflex sympathetic dystrophy				
Parkinson's				
Multiple sclerosis				
Alzheimer's				
Cumulative trauma disorders				
Gullian Barre Syndrome				
ALS				
Laminectomy				
Craniotomy				
<u>Pediatrics</u>	1	2	3	4
NICU				
Congenital anomalies				
Cerebral palsy				
Spina bifida				
Musculoskeletal disorders				

<u>Pediatrics, Cont.</u>	1	2	3	4
Genetic conditions				
Learning disabilities				
Perceive developmental disorders				
AIDS				
General medical conditions				
Sensory integration				
<u>Orthotics/Prosthetics</u>	1	2	3	4
Static splinting				
Dynamic splinting				
Serial inhibitory casting				
UE prosthetics assess/train				
LE prosthetics assess/train				
<u>Hand Therapy</u>				
Modality Certification	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Certified Hand Therapist	<input type="checkbox"/> Yes <input type="checkbox"/> No			
<u>Techniques</u>	1	2	3	4
<u>Assessments:</u>				
Independent living skills/life mgnt skills				
Physical				
Psychosocial				
ADL				
Cognitive/perceptual				
Sensory				
Therapeutic adaptation				
Positioning				
Restraint reduction				
Home safety				
Modalities				
<u>Treatment:</u>	1	2	3	4
Neurodevelopmental				
Transfer training				
ADL retraining				
Home management				
Post-op client education/precautions				
Positioning				

Juvenile rheumatoid arthritis				
Arthrogryposis				
Multi trauma				
Techniques (Cont.)	1	2	3	4
<u>Treatment (cont.):</u>				
Work simplification/energy conservation				
Sensory re-education				
Sensory integration				
Manual therapy				
Functional mobility retraining				
Prosthetic training				
Valpar				
BTE				
Assistive technology				
Psychosocial integration				

Tone management				
Postural re-education				
Reflex management				
	1	2	3	4
<u>Mental Health</u>				
<u>Medicare Documentation 700 & 701 Forms</u>				
<u>PPS</u>				
<u>MDS Form</u>				