



**Occupational Therapy Skills Checklist**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please list any special certifications you have (Example: Hand Certification, NDT, NBCOT, etc.):

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Please indicate how many years of work experience you have in each of the following categories, (Example: 6 months, 1 year, 3 years, 5 years, 10 years) If you have no experience in a category indicate a '0'.

**General Work Setting Experience**

Work Setting	Experience	Work Setting	Experience
Day Care Center		Hospital – Outpatient	
Pediatric Rehab Hospital		Hospital – Rehab	
Elementary School		Hospital – Psychiatric	
Headstart Program		Outpatient Facility	
General Acute Care		Skilled Nursing Facility	
Home Healthcare		PPS	
Hospital - Inpatient		RUGS	
		FIMS	

Other:

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**Specialty Experience:**

	Experience Level		Experience Level
Conduct Inservice Education		Geriatrics	
Computerized Notes/Reporting		Burn Management	
Senior Therapist		Cardiac Rehab	
Student Supervisor		Cognitive Retraining	
Research		Feeding Techniques	
Evaluation – Driving		Developmentally Disabled	
Evaluation – Work Capacity		Group Dynamics	
Evaluation Sensory		Education of Patient	
Evaluation – Home Accessibility		Education of Family	
Feldenkrais		AIDS/HIV	
Continuous Passive Machine		Arthritis	

Other:

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Pediatric Experience:

	Experience Level		Experience Level
Treatment – NICU		Discharge Planning	
Treatment – Sensory Integration		AIDS/HIV	
Treatment - Neurodevelopmental		Arthritis	
Orthotics			

Other:

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Special Education/School System Experience:

	Experience Level		Experience Level
Mental Retardation		Early Intervention	
Cerebral Palsy		Spina Bifida	
Learning Disabled		IEP Development	
POHI		Infant (Less than 2 yrs)	
SMI		Toddler (2-5 yrs)	
EI		Visually Impaired	
PMH – (Profoundly Mentally Handicapped)		EH – (Emotionally Handicapped)	

Other:

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Adult Population Experience:

	Experience Level		Experience Level
Injury – Orthopedic		Amputation Lower Extremity	
Injury – Hand		Injury – Spinal Cord	
Injury – Reattachment		Rehabilitation – Cognitive	
Injury – Tendon Repair		Rehabilitation - Cardiovascular	
Injury – Nerve Injury		Head Trauma	
Amputation – Upper Extremity		Coma Management	

Other:

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Vocational Rehabilitation:

	Experience Level		Experience Level
Work Hardening		Joint Mobilization	
Assessment - Perceptual		Fluidotherapy	
Assessment – Cognitive		Biofeedback	
Myofacial Release		Tens	

Other:

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Psychiatric Experience:

	Experience Level		Experience Level
Community Re-Entry Disorders – Acute		Substance Abuse	
Disorders – Chronic		Group Treatment	
Standardized Assessment		Crisis Intervention	

Other:

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Experience with Adaptive Equipment:

	Experience Level		Experience Level
Pre-Discharge Planning		Wheel Chair-Seating	
Home Environment Evaluation		Assessment	
Assistance with Daily Living		Fabrication	
Wheel Chair - Ordering			

Other:

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Orthotic and Prosthetic Experience:

	Experience Level		Experience Level
Orthoplast		Prosthetics – Above Knee	
Static Splinting		Prosthetics – Below Knee	
Serial – Inhibitory		Prosthetics – Upper Extremity	

Other:

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I verify that this statement of my work experience is accurate to the best of my knowledge.

Shamrock Medical Staffing, Inc. may utilize this information to make appropriate placements for me. I also give permission for Shamrock Medical Staffing, Inc. to release this survey to potential customers, upon request, during the assignment process.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date