



Physical Therapy Skills Checklist

Name: _____ Date: _____

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

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 | |
| Sports Medicine | | FIMS | |

Other:

Specialty Experience Pediatric:

| | Experience Level | | Experience Level |
|--------------------------------|------------------|-----------------|------------------|
| Traumatic Brain Injury | | Orthotics | |
| Spinal Cord injury | | Prosthetics | |
| Spasticity Management | | Taping | |
| AIDS/HIV | | Bracing | |
| Arthritis | | Splinting | |
| Neuro Developmental Techniques | | Crutch training | |
| Fractures | | | |

Other:

Industrial/Occupational Rehab:

| | Experience Level | | Experience Level |
|--------------------------------|------------------|------------------------------------|------------------|
| Evaluation - Work Capacity | | Carpal Tunnel | |
| Evaluation – Function Capacity | | Workers Compensation Injury | |
| Ergonomics | | Workers Compensation Documentation | |
| Work Hardening | | | |

Other:

Orthotics/Prosthetics Experience:

| | Experience Level | | Experience Level |
|-------------------------------|------------------|------------------------|------------------|
| Prosthetics – Upper Extremity | | Splinting – Hand | |
| Prosthetics – Above the Knee | | Splinting – UE Static | |
| Prosthetics – Below the Knee | | Splinting – UE Dynamic | |
| Splinting – Wrist | | | |

Other:

Adult Population Experience:

| | Experience Level | | Experience Level |
|-------------------------|------------------|------------------|------------------|
| Injury – Spinal Cord | | Cardiac Rehab | |
| Injury – Head | | Emphysema | |
| Injury – Hand | | COPD | |
| Multiple Sclerosis | | AIDS/HIV | |
| Muscular Dystrophy | | Stroke | |
| Injury – Neck | | Back Injury | |
| Peripheral Nerve Injury | | Knee Replacement | |
| Alzheimer’s Disease | | Hip Fracture | |
| Parkinson’s Disease | | Hip Replacement | |
| Wound Management | | Group Therapy | |

Other:

Special Education/School Experience:

| | Experience Level | | Experience Level |
|---------------------------------|------------------|--------------------------|------------------|
| Developmentally Disabled | | Early Intervention | |
| Learning Disabled | | IEP Development | |
| POHI | | Emotionally Handicapped | |
| Profoundly Mentally Handicapped | | Speech Language Impaired | |

Other:

Modality Experience:

| | Experience Level | | Experience Level |
|------------------------|------------------|--------------------------|------------------|
| Ultrasound | | Myofacial Release | |
| TENS | | Traction – Lumbar | |
| Electrical Stimulation | | Traction – Cervical | |
| Cryotherapy | | Mobilization - Extremity | |
| Massage | | Mobilization - Spinal | |
| Accupressure | | Hydrotherapy | |

Other:

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