

Occupational Therapist And Occupational Therapist Assistant (Cota) Required Skills Checklist

(✓ check as appropriate - A = THEORY, NO PRACTICE, B = ONE-TWO YEARS EXPERIENCE C = TWO PLUS YEARS EXPERIENCE)

Name/Client:	Date:
--------------	-------

A	B	C	Comments
---	---	---	----------

ADULT&GERIATRIC

Orthopedic:

Amputations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Fractures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Hand Injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Hip Fractures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Mobilization Techniques	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Osteoarthritis-Frozen Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Post Operative Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Therapeutic Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Total Joint Replacements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Neurologic:

Adaptive Equipment - Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Alzheimer's/Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Cognitive Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Head Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Neuromuscular Diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Spinal Cord Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Stroke Rehabilitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Prosthetics/Orthotics:

Above Knee Prosthetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Arthritis Programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Below Knee Prosthetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Occupational Therapist And Occupational Therapist Assistant (Cota) Required Skills Checklist

(✓ check as appropriate - A = THEORY, NO PRACTICE, B = ONE-TWO YEARS EXPERIENCE C = TWO PLUS YEARS EXPERIENCE)

Name/Client:	Date:			
	A	B	C	Comments
Myofascial Release (MFR)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Orthoplast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Upper Extremity Prosthetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other:				
Burn Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiac Rehab/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
CCU Procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Geriatric Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ICU Procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pacemakers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
SICU Procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Procedures/Treatments:				
Adaptive Equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Adaptive Equipment Assessment/Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cognitive Techniques	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Community Re-entry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cryotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Debridement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise Programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Feeding Techniques	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Occupational Therapist And Occupational Therapist Assistant (Cota) Required Skills Checklist

(✓ check as appropriate - A = THEORY, NO PRACTICE, B = ONE-TWO YEARS EXPERIENCE C = TWO PLUS YEARS EXPERIENCE)

Name/Client:	Date:			
	A	B	C	Comments
Functional - Dynamic Splinting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gait Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Group Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hydrotherapy - whirlpool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Iontophoresis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint Mobilization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Myofacial Release	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurodevelopment Techniques	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Phonophoresis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Postural Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Soft Tissue Manipulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Splinting - Elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Splinting - Wrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Splinting - Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Splinting - Wrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sterilization Techniques	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
TENS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ultrasound	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Wound Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric:				
Acute Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Community Re-Entry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Occupational Therapist And Occupational Therapist Assistant (Cota) Required Skills Checklist

(✓ check as appropriate - A = THEORY, NO PRACTICE, B = ONE-TWO YEARS EXPERIENCE C = TWO PLUS YEARS EXPERIENCE)

Name/Client:	Date:			
	A	B	C	Comments
Crisis Intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Modalities:				
Biofeedback	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Edema Massage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Feeding Techniques	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fluidotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle Stimulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oral Motor Facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Paraffin Bath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Therapeutic Pool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
PEDIATRIC				
Adaptive Equipment Assessment/Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Burn Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
CCU Procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Congenital Defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Developmental Diseases of Bone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Developmental Testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fractures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ICU Procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Occupational Therapist And Occupational Therapist Assistant (Cota) Required Skills Checklist

(✓ check as appropriate - A = THEORY, NO PRACTICE, B = ONE-TWO YEARS EXPERIENCE C = TWO PLUS YEARS EXPERIENCE)

Name/Client:	Date:			
	A	B	C	Comments
Lower Extremity Prosthetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurodevelopmental Techniques/Deficits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Orthotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Postural Balance Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sensory Integrative Defects/Techniques	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
SICU Procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spinal Cord Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Splinting wrist/hand/lower Extremity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Upper Extremity Prosthetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Visual Perceptual Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Age Specific Experience (✓ check as appropriate)

A= Newborn (birth - 30 days)	D= Preschooler (3-5 years)	G=Young Adults (18-39 years)
B= Infant (30 days - 1 year)	E= School Age Children (5-12 years)	H=Middle Adults (39-64 years)
C = Toddler (1 - 3 years)	F=Adolescents (12 - 18 years)	I=Older Adults (64+)

	A	B	C	D	E	F	G	H	I
Able to communicate and instruct patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to evaluate age-appropriate behavior and skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>