

DOCUMENTS REQUIRED: Occupational Therapist

Employee/Contractor Name:

1. State of Florida License
2. Proof of Liability Insurance
3. CPR Card
4. HIV/AIDS Certificate (ORIGINAL 4 hrs and Update)
5. OSHA Certificate (Update)
6. Domestic Violence Certificate
7. Driver License
8. Auto Insurance
9. Proof of Citizenship/Residency (Voter registration, Resident Card, etc)
10. Social Security Card
11. Physical Examination (less than six (6) months or new request)
12. Criminal Background check (less than 2 years, or 1 money order for \$ 23.00)

Employee Name:

JOB DESCRIPTION  
OCCUPATIONAL THERAPIST

This Agency hereby creates a position for the Occupational Therapist, indicated for functional limitations of activities of daily living that relates to the primary or secondary diagnosis. Such Occupational Therapist shall be governed by the following rules and responsibilities.

RULES

1. He/she must be a graduate of an approved school for Occupational Therapist.
2. He/she must have a current state license for Occupational Therapist.
3. He/she must have a one year of experience in Occupational Therapy.

RESPONSIBILITIES

- A. He/she shall provide Occupational Therapy services as prescribed by a Physician, physician assistant, or advanced registered nurse practitioner, acting within their scope of practice, which can be safely provided in the home.
- B. He/she shall assist the physician, physician assistant, or advanced registered nurse practitioner, acting within their scope of practice, in evaluating the patient's level of function by applying diagnostic and therapeutic procedures.
- C. He/she shall guide the patient in the patient's use of therapeutic creative and self-care activities for the purpose of improving function.
- D. He/she shall observe and record activities and findings in the clinical record and shall report to the physician, physician assistant, or advanced registered nurse practitioner patient's reaction to treatment and any changes in the patient's condition.
- E. He/she shall instruct the patient, patient's family members and other health team personnel in certain phases of occupational Therapy.
- F. Ensure HIPAA guidelines and procedures are maintained.

PHYSICAL REQUIREMENTS:

1. Able to speak, read and write in English.
2. Able read assignments, follow directions,
3. Able to communicate and respond clearly on telephone and respond to patient's spoken needs.
4. The ability to physically transfer, lift or assist patients whose average weight is 160 pounds with or without the aid of mechanical devices.
5. Able to spend 80% of the work standing and/or moving about.
6. Able to walk, climb stairs, stoop, twist, bend and squat to perform essential job functions.

MENTAL REQUIREMENTS:

1. Able to concentrate on detail with frequent interruptions.
2. Able to follow, complete and remember daily routines and requirements.
3. Able to comprehend and utilize professional education materials.
4. Able to cope with the mental and emotional stress of the position.

\_\_\_\_\_  
Administrator

\_\_\_\_\_  
Employee/Contractor

\_\_\_\_\_  
Date

# ORIENTATION CHECKLIST: PROFESSIONAL STAFF

Employee Name: \_\_\_\_\_

## I. GENERAL ORIENTATION

- \_\_\_\_\_ AGENCY ORGANIZATIONAL STRUCTURE
- \_\_\_\_\_ PHILOSOPHY, GOAL & OBJECTIVES, MISSION
- \_\_\_\_\_ TOUR OF FACILITY
  - a) LOCATION OF ADMINISTRATIVE OFFICES
  - b) LOCATION OF EMERGENCY LIGHTS/EXITS
  - c) LOCATION OF FIRE EXTINGUISHERS
  - d) LOCATION OF FIRST AIDE BOX
  - e) EMERGENCY EVACUATION ROUTES
- \_\_\_\_\_ INTRODUCTION TO STAFF/CLIENTS
- \_\_\_\_\_ SCOPE OF SERVICES
- \_\_\_\_\_ EMPLOYMENT POLICIES/JOB DESCRIPTION
- \_\_\_\_\_ COMPLAINTS POLICY/GRIEVANCE FORM
- \_\_\_\_\_ PAYROLL
- \_\_\_\_\_ CORPORATE COMPLIANCE PLAN

## II. CLINICAL ORIENTATION

- \_\_\_\_\_ CLIENT RIGHTS AND RESPONSIBILITIES
- \_\_\_\_\_ ADMISSION/DISCHARGE CRITERIA/THERAPY SERVICES
- \_\_\_\_\_ MEDICAL EMERGENCIES
- \_\_\_\_\_ PSYCHIATRIC EMERGENCIES
- \_\_\_\_\_ DOCUMENTATION REQUIREMENTS/TIME FRAMES
- \_\_\_\_\_ CLINICAL RECORDS

## III. CONFIDENTIALITY/HIPAA GUIDELINES

- \_\_\_\_\_ CLIENT/FAMILY/SIGNIFICANT OTHER
- \_\_\_\_\_ PROGRAM/STAFF
- \_\_\_\_\_ INFORMATION

## IV. SAFETY/RISK MANAGEMENT/INFECTION CONTROL

- \_\_\_\_\_ ACCIDENTAL/INCIDENT REPORTING
- \_\_\_\_\_ OSHA
- \_\_\_\_\_ UNIVERSAL PRECAUTION
- \_\_\_\_\_ BIOHAZARDOUS/INFECTION WASTE
- \_\_\_\_\_ HIV UPDATE
- \_\_\_\_\_ TB UPDATE
- \_\_\_\_\_ EMERGENCY PREPAREDNESS
- \_\_\_\_\_ FIRE DRILL
- \_\_\_\_\_ CARE OF ENVIRONMENT

I HAVE READ AND UNDERSTAND THE POLICIES AND PROCEDURES OF THE AGENCY AND HAVE HAD THE OPPORTUNITY TO HAVE ALL OF MY QUESTIONS/CONCERNS ADDRESSED TO MY COMPLETE SATISFACTION.

I AGREE TO ABIDE AND UPHOLD ALL POLICIES AND PROCEDURE, AND HAVE BEEN ADVISE THAT FAILURE TO DO SO MAY RESULT IN TERMINATION OF EMPLOYMENT.

I ALSO AGREE THAT AS A CONDITION OF EMPLOYMENT THAT I WILL PROVIDE THE AGENCY WITH A FOURTEEN (14) DAY WRITTEN NOTICE OF INTENT TO TERMINATE EMPLOYMENT.

\_\_\_\_\_  
EMPLOYEE SIGNATURE/TITLE

\_\_\_\_\_  
DATE

## OCCUPATIONAL THERAPY COMPETENCY (page 1)

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

TASKS/BEHAVIORS COMPLETED	DATE PERFORMED OR COMPETENT	INITIALS OF EMPLOYEE OR CONTRACTOR	COMMENTS
Referral process			
ASSESSMENT OF:			
Level of Function			
Physical Assessment/ Rehab. Program			
Independent Living/ ADL's training			
Therapeutic exercise to right/left hand			
Patient/Family Education			
Perceptual motor training			
Fine motor coordination			
Neuro-developmental training			
Sensory treatment			
Orthotics/Spiriting			
Adaptive equipments/Body image training			
Pain Management			
Discharge plan discussed with patient on admission/Review of all Literature			
Communication with PCC/Case Manager			
Timely paperwork submission/review of Regulations			

TASKS/BEHAVIORS COMPLETED	DATE PERFORMED OR COMPETENT	INITIALS OF EMPLOYEE OR CONTRACTOR	COMMENTS
Timely notification for patient visits/use of calendar			
All paperwork due by the last day of the 3 <sup>rd</sup> week by 5pm or by 9:00 am the Monday after the last day of the 3 <sup>rd</sup> week to process billing.			
Review of documentation/revisit			
Review of documentation admission			
Notification of patient of discharge 2 wks prior & document			
Evaluation for additional services			
COMMENTS			

SIGNATURE OF ORIENTEE \_\_\_\_\_

SIGNATURE OF PRECEPTOR \_\_\_\_\_