



OT / COTA Skills Checklist

Name _____

(Last) (First) (Middle Initial) **Profession:** _____ OT _____ COTA

NBCOT ID # _____ Exam Date: _____ **Please Check**

your Experience Level: 1 = No Experience, 2 = Some Experience, 3 = Very Experienced

| Work Settings: | 1 | 2 | 3 |
|---|----------|----------|----------|
| General Acute Care | | | |
| Home Health | | | |
| Outpatient Clinic | | | |
| Pediatric Rehab | | | |
| Psychiatric Hospital | | | |
| Acute Rehab Hospital | | | |
| Rehab Unit in Hospital | | | |
| School System | | | |
| Skilled Nursing Facility | | | |
| Industrial Medicine | | | |
| | | | |
| Orthopedics: | 1 | 2 | 3 |
| Arthritis Program | | | |
| General Ortho (Knee, Shoulder, Ankle) | | | |
| Hand Injury | | | |
| Pediatric Rehab | | | |
| Hip Fractures | | | |
| Acute Rehab Hospital | | | |
| Mobilization Techniques | | | |
| Total Joint Replacement (Upper Extremities) | | | |
| Skilled Nursing Facility | | | |
| Industrial Medicine | | | |
| | | | |
| Neuro: | 1 | 2 | 3 |
| Cerebral Vascular Accident (CVA) | | | |
| Cognitive Retraining | | | |
| Head Trauma | | | |
| Spinal Cord Injury | | | |
| Parkinson's Disease | | | |
| Traumatic Brain Injury | | | |
| | | | |
| Pediatrics: | 1 | 2 | 3 |
| Cerebral Palsy | | | |
| Developmental Screening | | | |

Validated by: _____

Date: _____



| | | | |
|---------------------------------|----------|----------|----------|
| Early Intervention | | | |
| Learning Disabilities | | | |
| Neurodevelopmental Testing | | | |
| Sensory Integrative Testing | | | |
| Spina Bifida | | | |
| Visual Perception Testing | | | |
| Autism | | | |
| Down's Syndrome | | | |
| Mental Retardation | | | |
| | | | |
| Modalities: | 1 | 2 | 3 |
| Biofeedback | | | |
| Edema Massage | | | |
| Feeding Techniques | | | |
| Fluidotherapy | | | |
| Oral Motor Facilitation | | | |
| Muscle Stimulation | | | |
| Paraffin Bath | | | |
| TENS | | | |
| Therapeutic Massage | | | |
| Therapeutic Pool | | | |
| | | | |
| Prosthetics / Orthotics: | 1 | 2 | 3 |
| Dynamic Splints | | | |
| Functional Splinting | | | |
| Orthotics | | | |
| LE Prosthetics | | | |
| Serial/Inhibitory Casting | | | |
| Static Splints | | | |
| UE Prosthetics | | | |
| | | | |

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| Other: | 1 | 2 | 3 |
|----------------------------------|----------|----------|----------|
| Activities of Daily Living (ADL) | | | |
| Adaptive Equipment | | | |
| Amputees | | | |
| Burn Management | | | |
| Driving Evaluation | | | |
| Dysphagia | | | |
| Energy Conservation | | | |
| Family Education | | | |
| Gait Analysis | | | |
| Geriatrics | | | |
| Group Dynamics | | | |
| Home Accessibility | | | |
| Job Task Analysis | | | |
| Oncology | | | |
| Pain Management | | | |
| Perceptual Motor Testing | | | |
| Pulmonary Rehab | | | |
| Range of Motion | | | |
| Sensation Testing | | | |
| Wheelchair Evaluation | | | |
| Wheelchair Ordering | | | |
| Wheelchair Position Testing | | | |
| Work Capacity Evaluation | | | |
| Work Hardening (BTE) | | | |

Signature _____

Date _____

Validated by: _____

Date: _____



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