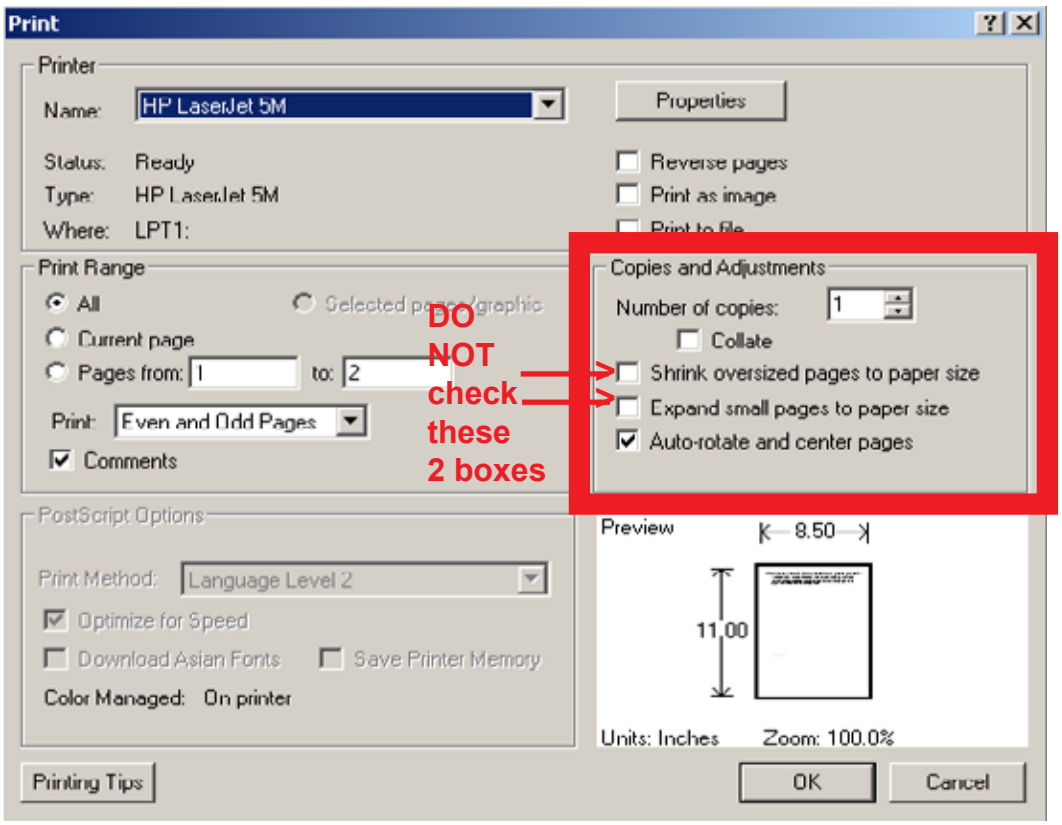
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand



DOH 600-033 (6/2006)

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Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Expired Occupational Therapy Assistant Credential Application Packet

1. 683-041 ..... Contents List/SSN Information/Deposit Slip ..... 1 page
2. 683-042 ..... Instructions—Application for Expired Occupational Therapy Assistant ..... 2 pages
3. 683-043 ..... Application for Expired Occupational Therapy Assistant ..... 2 pages
4. OT/OTA Mentor Policy/Procedure (REV 12/2002) ..... 2 pages
5. 683-031 ..... Occupational Therapy Re-entry/Mentorship Instructions and Checklist ..... 2 pages
6. 683-027 ..... WA State Occupational Therapy Practice Board Re-entry Site / Supervisor Data Sheet .... 1 page
7. 683-029 ..... Washington State Occupational Therapy Practice Board Re-entry Applicant Data Sheet 3 pages
8. 683-044 ..... Re-entry Re-entry Initial Self Assessment ..... 6 pages
9. 683-045 ..... Re-entry Outcome Assessment–Applicant ..... 4 pages
10. 683-046 ..... Re-entry Outcome Assessment–Supervisor ..... 4 pages
11. 683-028 ..... Summary of Re-entry Education Plan & Agreement Form ..... 1 page
12. Resource List ..... 1 page

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.

* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

Occupational Therapy Assistant
(Expired)

DEPOSIT SLIP

NAME (Please Print)

DATE

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$

☐ **Check**
☐ **Money Order**

DOH 683-041 (REV 6/2006)

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Washington State Department of Health
PO Box 47867
Olympia, WA 98504-7867
360/236-4700

Application For Expired Occupational Therapy Assistant Credential Activation

- Instructions -

When your application for expired credential activation is received by the Department of Health, you will be sent an acknowledgment letter noting receipt, and any outstanding documentation needed to complete the process. This is the only notice you will receive while your application is pending. Applicants are discouraged from calling to check on the status of an application until receipt of this acknowledgment. Your cooperation is requested to permit program staff to prepare your file and re-activate your license at the earliest possible time.

To ensure that you have submitted the necessary fees and documentation, we encourage you to use the following checklist: **(Total fees due $165.00)**

- ☐ Pay **$50.00** Late Penalty Fee. **(All fees are non-refundable)**
- ☐ Pay **$65.00** Current Occupational Therapist Assistant Renewal Fee. **(All fees are non-refundable)**
- ☐ Pay **$N/A** Substance Abuse Monitoring Surcharge. **(All fees are non-refundable)**
- ☐ Pay **$50.00** Expired Credential Reissuance Fee. **(All fees are non-refundable)**
- ☐ ***Box #1 Demographic Information.***

  Name: Please list your current name with middle initial.

  Residential Address: Please identify the address to which you wish all correspondence, including your credential, delivered. This will become your address of record for all Department of Health transactions until we are notified of a change.

  Telephone Number: Enter current telephone number where you may be reached during normal business hours.

  Social Security Number: Required for license under 42 USC 666 and Chapter 26.23 RCW.

  Additional Data: This information is required to update the Department's Database, and confirm information from your previous (initial) application.

- ☐ ***Box #2 Previous Credentialing.*** List **all** credentials you have held since last being credentialed in Washington State. List in chronological order, most current first. Include your last active credential in Washington State. If you need additional space, attach on a separate piece of paper. If you are or have been credentialed

in another state, verification of that credential must be sent directly from that state to the Department of Health, Occupational Therapy Program before the Occupational Therapy Assistant credential will be reactivated.

- ☐ **Box #3 Professional Experience.** In chronological order, list all professional work experience since your Washington State credential has expired. If you need additional space, attach on a separate piece of paper.
- ☐ **Box #4 AIDS Education and Training Attestation.** Required by WAC 246-12-040.
- ☐ **Box #5 Criminal and Disciplinary Action Attestation.** Required by WAC 246-12-040. **The Department does criminal background checks on all applicants.**
- ☐ **Box #6 Continuing Education Attestation.** Required by WAC 246-12-040.
- ☐ **Box #7 Applicant's Attestation.** Required to be signed and dated in order to process the application.

Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

FOR OFFICE USE ONLY
ISSUANCE DATE
LICENSE #

Application For Expired Occupational Therapy Assistant Credential Activation

LICENSE #

Please Type or Print Clearly—Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application. All applications must be accompanied by the applicable, nonrefundable fee. Make remittance payable to the Department of Health.

1. Demographic Information

APPLICANT'S NAME LAST	FIRST	MIDDLE INITIAL

MAILING ADDRESS

CITY	STATE	ZIP	COUNTY

NOTE: Your credentialing document will show this address and all correspondence from the Department will be sent to this address until you notify us of a change.

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS.)	RESIDENCE TELEPHONE	SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW)
( )	( )	— —

GENDER	BIRTHDATE (MONTH/DAY/YEAR)	PLACE OF BIRTH (CITY/STATE)
☐ Female ☐ Male		

Have you ever been known by any other name? ☐ Yes ☐ No

If yes, other name(s):

2. Previous Credentialing (Since Last Being Credentialed in Washington State)

STATE/JURISDICTION	PROFESSION	CREDENTIAL			METHOD OF CREDENTIALING	CURRENTLY IN FORCE
		TYPE	YEAR ISSUED	NUMBER		
						☐ No ☐ Yes
						☐ No ☐ Yes
						☐ No ☐ Yes
						☐ No ☐ Yes

3. Professional Experience

NATURE OF EXPERIENCE OR PRACTICE AND LOCATION	DATES OF EXPERIENCE	
	FROM (MO/YR)	TO (MO/YR)

4. AIDS Education and Training Attestation

I certify I have completed the minimum of: seven (7) hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and the psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my certification may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS	DATE

5. Criminal and Disciplinary Action Attestation

I certify that no action has been taken by any state or federal jurisdiction or hospital, which would prevent or restrict my right to practice my profession.

I further certify that I have not voluntarily given up any credential or privilege or have not been restricted in the practice of my profession in lieu of or to avoid formal action.

The Department does criminal background checks on all applicants.

APPLICANT'S INITIALS	DATE

6. Continuing Education/Continuing Competency Attestation (If Applicable)

I certify that I have met all continuing education and competency requirements for the past two years.

APPLICANT'S INITIALS	DATE

7. Applicant's Attestation

I, _____ , certify that I am the person described and identified in
NAME OF APPLICANT

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

_____
SIGNATURE OF APPLICANT

_____
DATE

Official Use Only

Washington State Records Center

Health Professions Quality Assurance
Program Policy and Procedure

Board: Occupational Therapy

Subject: Re-Entry/Mentorship

Reference: WAC 246-847-055 Initial application for individuals who have not practiced within the past four years

WAC 246-847-068 Expired License (3)

WAC 246-847-125 Applicants currently licensed in other states or territories

Effective Date: October 1, 2004

Subersedes: May 6, 1998, October 10, 1994

1. The purpose of the re-entry educational program is to provide occupational therapists and occupational therapy assistants who have neither practiced nor been licensed in any other United States jurisdiction for a specified period of time, a method of re-entry to the practice of occupational therapy in accordance with WACs 246-847-055, 246-847-068, 246-847-125. Re-entry can be achieved after a re-entry applicant satisfies to the Board that he or she: (a) has updated his or her general knowledge of occupation therapy theory and practice and, (b) possesses the professional skills necessary to practice occupational therapy at the entry level.

   1.1. An initial applicant who has not been actively engaged in the practice of occupation therapy within the past four years must comply with WAC 246-847-055.

   1.2. A reactivation applicant who has not been in active practice in another United States jurisdiction within the past three years must comply with WAC 246-847-068(3)(a)(b).

2. A re-entry educational program has three phases: self-assessment, study, and clinical experience.

   2.1. Self-assessment of professional knowledge and skills is conducted by the re-entry applicant in collaboration with his or her proposed clinical experience supervisor using forms and following instructions provided by the Board. The self-assessment results in an educational plan for study and clinical experience, which is also developed in collaboration with the proposed clinical experience supervisor. The plan is submitted to the Board for approval.

   2.2. The Board reviews the educational plan, determines whether the goals are reasonable and the proposed activities meet the goals. In a timely manner the Board notifies the re-entry applicant of approval or the need to revise the educational plan. The clinical experience generally begins after the study phase of the educational plan is complete or well underway.

2.3. The qualified clinical experience supervisor is a therapist or an assistant who has been licensed and in continuous practice in the State of Washington for at least two years. Re-entry applicants at the therapist level are supervised by a therapist; re-entry applicants at the assistant level may be supervised by an assistant. [NOTE: Although the educational plan of the assistant level re-entry applicant may be supervised by a licensed assistant, the re-entry applicant's clinical work must be supervised by a licensed occupational therapist as provided for in WAC 246-847-010.

2.3.1. Supervision of the re-entry applicant by the supervisor shall mean documented face to face meetings between the supervisor and the re-entry applicant at intervals as determined necessary by the supervising occupational therapist to (a) establish, review, or revise the client's treatment objectives and (b) ensure completion of education goals. The supervisor must be on-site unless otherwise approved by the Board.

2.3.2. In accordance with RCW 18.59.040(3), when the re-entry applicant is fulfilling clinical experience activities, the re-entry applicant is designated by a title that clearly indicates he or she is a trainee.

3. Once all educational plan activities have been completed and all goals have been achieved, the re-entry applicant and clinical experience supervisor submit their educational plan final reports to the Board for review. The educational plan supervisor forwards to the Board a copy of the Certificate of Completion of an Occupational Therapy Re-Entry Educational Program and the re-entry applicant may be considered for licensure.

4. The Board delegates to the Board Chair and/or Vice Chair to expedite the initial re-entry plan review approval. The re-entry applicant may be considered for licensure only when an official Board quorum decision is made at a regularly scheduled closed session meeting.

5. The educational plan final reports and the license application must be submitted within two years of approval of the education plan.

Washington State Department of Health

Occupational Therapy Re-entry/Mentorship Instructions and Checklist

If, upon review of your application for occupational therapy assistant licensure, the Board deems it necessary for you to complete a re-entry/mentorship program, these are the steps that must be followed:

1. Complete the following **four** items and forward them to the Board. Your plan will be reviewed by a Board member who will approve it or recommend changes within two weeks. If a specialist review or consultation with the Board is required, up to 30 working days may be required for the initial review.

   - ☐ **Re-entry Applicant Data Sheet** (to be completed by the applicant)
   - ☐ **Re-entry Site and Supervisor Data Sheet** (to be completed by the supervisor)
   - ☐ **OT or OTA Re-entry Initial Self Assessment** (to be completed by the applicant)
   - ☐ **Summary of Re-entry Educational Plan & Agreement Form** (to be completed by the supervisor *and* applicant)

2. If changes are recommended, the recommendations are sent to the applicant who makes changes and re-submits the materials. If the application is approved, the applicant and supervisor receive notice that the applicant is considered to be a student in a Board-approved program, and the clinical experience can begin. The following **two** forms are to be completed during the clinical experience.

   - ☐ **OT or OTA Re-entry Outcome Assessment Form: Report of Supervised Clinical Experience—Applicant** (to be completed by the applicant)
   - ☐ **OT or OTA Re-entry Outcome Assessment Form: Report of Supervised Clinical Experience—Supervisor** (to be completed by the supervisor)

3. The plan for the clinical experience should be based on an applicant's thoughtful self-assessment of skills with input from the proposed clinical supervisor. The board provides a self-assessment form for the applicant's use. The applicant may add other items to the self-assessment if he/she wishes. However, at minimum, all items on the Board-provided forms must be completed. The applicant and the supervisor sign an agreement to formalize their working relationship and planned supervision for the re-entry clinical experience.

4. Clinical Experience begins after Board approval of the plan. Board approval of the re-entry plan is based on appraisal of the thoroughness of the applicant's self-assessment and the degree to which the plan appears to provide opportunity to remediate weak areas.

5. When the Board receives the final clinical experience outcome reports from the applicant and the supervisor, it determines whether the documentation provides evidence that entry level skill competence in the setting has been attained.

6. You will be informed of the Board's decision at the earliest possible date.

If you have any further questions regarding this process, you may contact:

The Occupational Therapy Practice Board
P.O. Box 47867
Olympia, WA 98504-7867

Customer Service Center
Phone: (360) 236-4700
FAX: (360) 664-9077

Washington State Department of Health

Washington State Occupational Therapy Practice Board
Re-entry Site and Supervisor Data Sheet

To be completed by the Supervisor:

APPLICANT'S NAME	LAST	FIRST	MIDDLE INITIAL
MAILING ADDRESS			
CITY	STATE	ZIP CODE	COUNTY
TELEPHONE NUMBER: HOME ( )	WORK ( )	SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW) – –	
LICENSE NUMBER		EXPIRATION DATE	
RE-ENTRY CANDIDATE'S NAME			

Employment

Beginning with current employment, list all Occupational Therapy related work experience for the last five years. (Attach additional information if necessary.)

BEGIN DATE	END DATE	EMPLOYER/ACTIVITIES	ADDRESS/PHONE NUMBER	TITLE

Please Describe

1. **Current Job Responsibilities:**

2. **Clinical Experience Site:**

I agree to supervise the above-named re-entry candidate during his/her re-entry program. I am a Washington licensed Occupational Therapist, and have been in continuous practice for at least two years.

SUPERVISOR'S SIGNATURE _____ DATE _____

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Washington State Department of Health

Washington State Occupational Therapy Practice Board
Re-entry Applicant Data Sheet

To be completed by the Applicant:

APPLICANT'S NAME	LAST	FIRST	MIDDLE INITIAL
MAILING ADDRESS			
CITY	STATE	ZIP CODE	COUNTY
TELEPHONE NUMBER: HOME ( )	WORK ( )	SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW) — —	

Professional Training

Beginning with the most recent, list all professional education including college, university, technical or professional training pertaining to the practice of occupational therapy taken prior to passing the AOTCB or NBCOT certification examination.

BEGIN DATE	END DATE	NAME & LOCATION OF INSTITUTION	DEGREE/CERTIFICATE & DATE RECEIVED

Fieldwork

Beginning with the most recent, list all Fieldwork II sites/addresses.

BEGIN DATE	END DATE	NAME & LOCATION OF INSTITUTION

Coursework

Beginning with the most recent, list all courses taken since AOTCB or NBCOT certification (you must submit evidence of satisfactory completion of coursework.)

BEGIN DATE	END DATE	NAME & LOCATION OF INSTITUTION

Employment

Beginning with the most recent, list all activities and account for all periods of time from AOTCB or NBCOT certification to the present time (attach additional information if necessary).

BEGIN DATE	END DATE	EMPLOYER/ACTIVITIES	ADDRESS/PHONE NUMBER	TITLE

Membership In Professional Organizations

List names and addresses of any professional organizations in which you hold or have held membership.

DATE JOINED	NAME & LOCATION OF ORGANIZATION

Supervisor Information

(Your supervisor must hold a current Washington OT/OTA license, and have been in continuous practice for a period of at least two years)

A Re-entry Program CANNOT be approved without this information.

SUPERVISOR'S NAME	TELEPHONE: HOME ( )	WORK ( )
SUPERVISOR'S MAILING ADDRESS		
CITY	STATE	ZIP CODE / COUNTY
SUPERVISOR'S LICENSE NUMBER	EXPIRATION DATE	

Applicant's Attestation

I, _____ , certify that I am the person described and identified in
NAME OF APPLICANT

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

I have carefully read the questions in the foregoing application and have answered them completely, without reservation of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. **Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice as an occupational therapist or occupational therapy assistant in the state of Washington.**

_____

APPLICANT'S SIGNATURE

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Name: _____

Re-Entry Initial Self Assessment: Assessment Skills

*Rating Scale: Mark **S** for satisfactory (meets entry level): **U** for unsatisfactory.*

Assessment	Possess entry-level knowledge	Possess entry-level skill	Goals for enhancing knowledge or skill
1. Gathers necessary information before assessing the patient.			
2. Selects relevant areas to assess.			
3. Selects the correct methods to assess the relevant areas.			
4. Obtains complete information from staff, family members, patient, and records.			
5. Administers the assessment procedures according to standardized or recommended techniques.			
6. Adapts assessment method when usual procedures are not practical.			
7. Interprets assessment data accurately.			
8. Reports the results of assessment and reassessment(s) accurately and completely.			
9. Reassesses the patient's programs and progress at regular intervals.			
10. Presents assessment purposes and procedures to patient, family and significant others in a manner consistent with their level of understanding.			
11. Explains the steps of the activity at the patient's level of understanding.			
12. Establishes and maintains a therapeutic relationship with the patient.			
13. Creates an environment which maximizes patient's responses.			
14. Adheres to treatment precautions and contraindications.			

Initial Self Assessment (Applicant)

Name: _____

Re-Entry Initial Self Assessment: Assessment Skills

*Rating Scale: Mark **S** for satisfactory (meets entry level): **U** for unsatisfactory.*

Assessment	Possess entry-level knowledge	Possess entry-level skill	Goals for enhancing knowledge or skill
15. Responds to changes in the patient's physical and emotional status during administrations of the assessment procedures			
16. Intervenes, when necessary, at signs of fatigue or frustration.			
17. uses praise or other reinforcers to elicit desired behavior.			
18. Sets necessary limits in response to undesirable physical or social behavior.			

Name: _____

Re-Entry Initial Self Assessment: Planning, Documenting and Reporting Skills

*Rating Scale: Mark **S** for satisfactory (meets entry level): **U** for unsatisfactory.*

Assessment	Possess entry-level knowledge	Possess entry-level skill	Goals for enhancing knowledge or skill
1. Establishes relevant and attainable short term goals which reflect the assessment data.			
2. Documents and reports the treatment plan.			
3. Documents and reports treatment.			
4. Establishes relevant and long term goals which reflect the assessment data.			
5. Collaborates with the patient in establishing goals.			
6. Collaborates with other practitioners to stablish overall goals for patients.			
7. Contributes to discussions at case conferences, rounds, inservices, staff, and other pertinent meetings.			
8. Establishes treatment priorities with patient, family, and significant others.			
9. Reviews progress with patients, family and significant others at regular intervals.			
10. Develops and documents dischargs and follow-up programs in accordance with patient's probable discharge environment.			
11. Collaborates with patient, family, significant others, and staff to formulate discharge and follow-up plans.			
12. Terminates treatment when patient has received maximum benefit from services.			
13. Maintain established treatment plan.			
14. Plans treatment baed upon an accurate analysis of activities.			

Initial Self Assessment (Applicant)

Name: _____

Re-Entry Initial Self Assessment: Planning, Documenting and Reporting Skills

*Rating Scale: Mark **S** for satisfactory (meets entry level): **U** for unsatisfactory.*

Assessment	Possess entry-level knowledge	Possess entry-level skill	Goals for enhancing knowledge or skill
15. Determines the logical sequences of treatment activities to attain the established goals.			
16. Selects treatment activities that demonstrate an understanding of occupational therapy theory.			
17. Modifies goals as patient's condition or response to treatment changes.			

Name: _____

Re-Entry Initial Self Assessment: Treatment Skills

*Rating Scale: Mark **S** for satisfactory (meets entry level): **U** for unsatisfactory.*

Assessment	Possess entry-level knowledge	Possess entry-level skill	Goals for enhancing knowledge or skill
1. Contributes to discussions at case conferences, rounds, inservices, staff, and other petinent meetings.			
2. Orients and instructs family, signifiant others, and staff in activities which support the treatment programs.			
3. Prepares the patient for initial and ongoing treatment.			
4. Explains the steps of the activity at the patient's level of understanding.			
5. Establishes and maintains a therapeutic relationship with the patient.			
6. Creates an environment which maximizes patient's responses.			
7. Adheres to treatment precautions and contraindications.			
8. Intervenes, when necessary at signs of fatigue or frustration.			
9. uses praise or other reinforcers to elicit desired behavior.			
10. Sets necessary limits in response to undesirable physical or social behavior.			
11. Incorporates prevention related activities in treatment.			
12. Uses purposeful activities to maximize patient performance.			
13. Uses a variety of possible strategies for achieving treatment goals.			
14. Adapts treatment activities, when necessary, to reach desired goals.			
15. Demonstrates problem-solving skills in patient treatment.			

Initial Self Assessment (Applicant)

Name:_____

Re-Entry Initial Self Assessment: Administrative Skills and Work

*Rating Scale: Mark **S** for satisfactory (meets entry level): **U** for unsatisfactory.*

Assessment	Possess entry-level knowledge	Possess entry-level skill	Goals for enhancing knowledge or skill
1. Manages time effectively.			
2. Adjusts priorities according to the needs of the program, department, and others.			
3. Complies with the institution's policies and procedures.			
4. Participates responsibly in the supervisory relationship.			
5. Adjusts to change and modifies own behavior according to the demands of the situation.			
6. Assumes responsibility for professinal behavior and growth.			
7. Demonstrates an understanding of professional standards and code of ethics.			
8. Maintains work area, equipment, and supplies in a manner conducive to efficiency and safety.			
9. Demonstrates an understanding of the implications of treatment costs and financial support on occupational therapy services.			

APPLICANT SIGNATURE DATE

SUPERVISOR SIGNATURE DATE

Initial Self Assessment (Applicant)

Name: _____

Re-Entry Outcome Assessment Form: Report of Supervised Clinical Experience–Applicant

*Rating Scale: Mark **S** for satisfactory (meets entry level): **U** for unsatisfactory.*

Assessment	Self-Assessment of Performance	Comments
1. Gathers necessary information before assessing the patient.		
2. Selects relevant areas to assess.		
3. Selects the correct methods to assess the relevant areas.		
4. Obtains complete information from staff, family members, patient and records.		
5. Administers the assessment procedures according to standardized or recommended techniques.		
6. Adapts assessment method when usual procedures are not practical.		
7. Interprets assessment data accurately.		
8. Reports the results of assessment and reassessment(s) accurately and completely.		
9. Reassesses the patient's programs and progress at regular intervals.		
10. Presents assessment purposes and procudures to patient, family, and significant others in a manner consistent with their level of understanding.		
11. Explains the steps of the activity at the patient's level of understanding.		
12. Establishes and maintains a therapeutic relationship with the patient.		
13. Creates an environment which maximizes patient's responses.		
14. Adheres to treatment precautions and contraindication.		
15. Responds to changes in the patient's physical and emotional status during administration of the assessment procedures.		

Name: _____

Re-Entry Outcome Assessment Form: Report of Supervised Clinical Experience–Applicant

*Rating Scale: Mark **S** for satisfactory (meets entry level): **U** for unsatisfactory.*

Assessment	Self-Assessment of Performance	Comments
16. Intervenes, when necessary, at signs of fatigue or frustration.		
17. Uses praise or other reinforcers to elicit desired behavior.		
18. Sets necessary limits in response to undesirable physical or social behavior.		

Planning, Documenting, and Reporting

1. Establishes relevant and attainable short term goals which reflect the assessment data.		
2. Documents and reports the treatment plan.		
3. Documents and reports treatment.		
4. Establishes relevant and attainable long term goals which reflect the assessment data.		
5. Collaborates with the patient in establishing goals.		
6. Collaborates with other practitioners to establish overall goals for patients.		
7. Contributes to discussions at case conferences, rounds, inservices, staff, and other pertinent meetings.		
8. Establishes treatment priorities with patient, family, and significant others.		
9. Reviews progress with patients, family, and significant others at regular intervals.		
10. Develops and documents discharge and follow-up programs in accordance with patient's probable discharge environment.		
11. Collaborates with patient, family, significant others, and staff to formulate discharge and follow-up plans.		

Name: _____

Re-Entry Outcome Assessment Form: Report of Supervised Clinical Experience–Applicant

*Rating Scale: Mark **S** for satisfactory (meets entry level): **U** for unsatisfactory.*

Assessment	Self-Assessment of Performance	Comments
12. Terminates treatment when patient has received maximum benefit from services.		
13. Maintains established treatment plan.		
14. Plans treatment based upon an accurate analysis of activities.		
15. Determines the logical sequences of treatment activities to attain the established goals.		
16. Selects treatment activities that demonstrate an understanding of occupational therapy theory.		
17. Modifies goals as a patient's condition or response to treatment changes.		

Treatment

1. Contributes to discussions at case conferences, rounds, inservices, staff, and other pertinent meetings.		
2. Orients and instructs family, significant others, and staff in activities which support the treatment programs.		
3. Prepares the patient for initial and ongoing teatment.		
4. Explains the steps of the activity at the patient's level of understanding.		
5. Establishes and maintains a therapeutic relationship with the patient.		
6. Creates an environment which maximizes patient's responses.		
7. Adheres to treatment precautions, and contraindications.		
8. Intervenes, when necessary, at signs of fatigue or frustration.		
9. Uses praise or other reinforcers to elicit desired behavior.		
10. Sets necessary limits in response to undesirable physical or social behavior.		

Name: _____

Re-Entry Outcome Assessment Form: Report of Supervised Clinical Experience–Applicant

*Rating Scale: Mark **S** for satisfactory (meets entry level): **U** for unsatisfactory.*

Treatment	Self-Assessment of Performance	Comments
11. Incorporates prevention related activities in treatment.		
12. Uses purposeful activities to maximize patient performance.		
13. Uses a variety of possible strategies for achieving treatment goals.		
14. Adopts treatment activities, when necessary, to reach desired goals.		
15. Demonstrates problem-solving skills in patient treatment.		

Administrative Skills and Work Behaviors

1. Manages time effectively.		
2. Adjusts priorities according to the needs of the program, department, and others.		
3. Complies with the institution's policies and procedures.		
4. Participates responsibly in the supervisory relationship.		
5. Adjusts to change and modifies own behavior according to the demands of the situation.		
6. Assumes responsibility for professinal behavior and growth.		
7. Demonstrates an understanding of professional standards and code of ethics.		
8. Maintains work area, equipment, and supplies in a manner conducive to efficiency and safety.		
9. Demonstrates an understanding of the implications of treatment costs and financial support on occupational therapy services.		

APPLICANT SIGNATURE _____ DATE _____

SUPERVISOR SIGNATURE _____ DATE _____

Name: _____

Re-Entry Outcome Assessment Form: Report of Supervised Clinical Experience–Supervisor

*Rating Scale: Mark **S** for satisfactory (meets entry level): **U** for unsatisfactory.*

Assessment	Supervisor Assessment of Performance	Supervisor Assessment of Judgment	Supervisor Assessment of Attitude	Comments
1. Gathers necessary information before assessing the patient.				
2. Selects relevant areas to assess.				
3. Selects the correct methods to assess the relevant areas.				
4. Obtains complete information from staff, family members, patient and records.				
5. Administers the assessment procedures according to standardized or recommended techniques.				
6. Adapts assessment method when usual procedures are not practical.				
7. Interprets assessment data accurately.				
8. Reports the results of assessment and reassessment(s) accurately and completely.				
9. Reassesses the patient's programs and progress at regular intervals.				
10. Presents assessment purposes and procudures to patient, family, and significant others in a manner consistent with their level of understanding.				
11. Explains the steps of the activity at the patient's level of understanding.				
12. Establishes and maintains a therapeutic relationship with the patient.				
13. Creates an environment which maximizes patient's responses.				
14. Adheres to treatment precautions and contraindication.				
15. Responds to changes in the patient's physical and emotional status during administration of the assessment procedures.				

Name: _____

Re-Entry Outcome Assessment Form: Report of Supervised Clinical Experience–Supervisor

*Rating Scale: Mark **S** for satisfactory (meets entry level): **U** for unsatisfactory.*

Assessment	Supervisor Assessment of Performance	Supervisor Assessment of Judgment	Supervisor Assessment of Attitude	Comments
16. Intervenes, when necessary, at signs of fatigue or frustration.				
17. Uses praise or other reinforcers to elicit desired behavior.				
18. Sets necessary limits in response to undesirable physical or social behavior.				

Planning, Documenting, and Reporting

1. Establishes relevant and attainable short term goals which reflect the assessment data.				
2. Documents and reports the treatment plan.				
3. Documents and reports treatment.				
4. Establishes relevant and attainable long term goals which reflect the assessment data.				
5. Collaborates with the patient in establishing goals.				
6. Collaborates with other practitioners to establish overall goals for patients.				
7. Contributes to discussions at case conferences, rounds, inservices, staff, and other pertinent meetings.				
8. Establishes treatment priorities with patient, family, and significant others.				
9. Reviews progress with patients, family, and significant others at regular intervals.				
10. Develops and documents discharge and follow-up programs in accordance with patient's probable discharge environment.				
11. Collaborates with patient, family, significant others, and staff to formulate discharge and follow-up plans.				

Name: _____

Re-Entry Outcome Assessment Form: Report of Supervised Clinical Experience–Supervisor

*Rating Scale: Mark **S** for satisfactory (meets entry level): **U** for unsatisfactory.*

Planning, Documenting, and Reporting	Supervisor Assessment of Performance	Supervisor Assessment of Judgment	Supervisor Assessment of Attitude	Comments
12. Terminates treatment when patient has received maximum benefit from services.				
13. Maintains established treatment plan.				
14. Plans treatment based upon an accurate analysis of activities.				
15. Determines the logical sequences of treatment activities to attain the established goals.				
16. Selects treatment activities that demonstrate an understanding of occupational therapy theory.				
17. Modifies goals as a patient's condition or response to treatment changes.				

Treatment

1. Contributes to discussions at case conferences, rounds, inservices, staff, and other pertinent meetings.				
2. Orients and instructs family, significant others, and staff in activities which support the treatment programs.				
3. Prepares the patient for initial and ongoing teatment.				
4. Explains the steps of the activity at the patient's level of understanding.				
5. Establishes and maintains a therapeutic relationship with the patient.				
6. Creates an environment which maximizes patient's responses.				
7. Adheres to treatment precautions, and contraindications.				
8. Intervenes, when necessary, at signs of fatigue or frustration.				
9. Uses praise or other reinforcers to elicit desired behavior.				
10. Sets necessary limits in response to undesirable physical or social behavior.				

Outcome Assessment (Supervisor)

Name: _____

Re-Entry Outcome Assessment Form: Report of Supervised Clinical Experience–Supervisor

*Rating Scale: Mark **S** for satisfactory (meets entry level): **U** for unsatisfactory.*

Treatment	Supervisor Assessment of Performance	Supervisor Assessment of Judgment	Supervisor Assessment of Attitude	Comments
11. Incorporates prevention related activities in treatment.				
12. Uses purposeful activities to maximize patient performance.				
13. Uses a variety of possible strategies for achieving treatment goals.				
14. Adopts treatment activities, when necessary, to reach desired goals.				
15. Demonstrates problem-solving skills in patient treatment.				

Administrative Skills and Work Behaviors

1. Manages time effectively.				
2. Adjusts priorities according to the needs of the program, department, and others.				
3. Complies with the institution's policies and procedures.				
4. Participates responsibly in the supervisory relationship.				
5. Adjusts to change and modifies own behavior according to the demands of the situation.				
6. Assumes responsibility for professinal behavior and growth.				
7. Demonstrates an understanding of professional standards and code of ethics.				
8. Maintains work area, equipment, and supplies in a manner conducive to efficiency and safety.				
9. Demonstrates an understanding of the implications of treatment costs and financial support on occupational therapy services.				

APPLICANT SIGNATURE _____ DATE _____

SUPERVISOR SIGNATURE _____ DATE _____

Summary of Re-entry Educational Plan & Agreement Form

To be completed by the Applicant and the Supervisor

(Attach additional sheets if necessary)

Goals	PLAN (Include *study* and *clinical* components)	Expected Date of Completion

What is the minimum frequency, duration, and availability of the formal supervised sessions and treatments agreed upon by the applicant and supervisor?

When completed in conjunction with the accompanying documents, this form constitutes a formal agreement between the re-entry applicant and his/her supervisor.

I agree to, and verify the above conditions, and certify that this re-entry plan is valid, and will be adhered to. If any changes are to be made, the Occupational Therapy Practice Board will be notified in advance.

APPLICANT SIGNATURE _____ DATE _____ PROPOSED SUPERVISOR'S SIGNATURE _____ DATE _____

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Resource List

Professional Organizations

Professional Organizations are generally a key resource for member continuing education. You are encouraged to explore the option of membership in your national and state organization.

American Occupational Therapy Association
4720 Montgomery Lane
P.O. Box 31220
Bethesda, MD 20824-1220
(301) 652-2682

Washington Occupational Therapy Association
P.O. Box 4499 Midway Station
Kent, WA 98032
(206) 242-9862

Publishers

American Occupational Therapy Association
4720 Montgomery Lane
P.O. Box 31220
Bethesda, MD 20824-1220
(301) 652-2682

Aspen Publishers
P.O. Box 990
Frederick, MD 21705-9782

F. A. Davis
915 Arch Street
Philadelphia, PA 19103

Haworth Press
10 Alice Street
Binghampton, NY 13904-1580

Mosby Publishers
11830 Westline Industrial Avenue
St. Louis, MO 63146

Slack, Inc.
6900 Grove Road
Thorofare, NJ 08086

Electronic Resources

OT Reliable Source Electronic Bulletin Board Service
American Occupational Therapy Association
4720 Montgomery Lane
P.O. Box 31220
Bethesda, MD 20824-1220
(301) 652-2682

Internet Resource: http://otpt.ups.edu