Revised January 2010

LOUISIANA PHYSICAL THERAPY BOARD

Rating Form For Permittees

Permittee Name: _____ Supervising PT: _____

Place of Employment: _____

_____ Number of patient care hours worked under my supervision

from _____ to _____

Please return this form to the LSBPTE by the end of the third month and the sixth month of supervised clinical period or at the end of your supervision of this permittee so that the permittee's file may be reviewed at the next Board meeting following completion of the of the supervised clinical period.

Please check each of the following items, indicating the level applicable for the individual. If comments are needed, please indicate in space provided on the form.

Key: S= Satisfactory N= Needs Improvement U= Unsatisfactory

Key Area	3 months	6 months	Comments
Safety			
1. Demonstrates awareness of contraindications and precautions for treatment.			
2. Requests assistance when needed.			
3. Uses acceptable techniques for safe handling of patients.			
Professionalism			
1. Accepts responsibility for own actions.			
2. Treats others with positive regard, dignity, respect and compassion.			
3. Manages conflict in constructive ways.			
4. Maintains patient privacy and modesty. (i.e. proper draping)			
5. Accepts criticism without defensiveness.			
Ethical / Legal			
1. Abides by state and federal laws and regulations.			
2. Reports violations of laws governing the practice of physical therapy.			
3. Seeks only such remuneration as is deserved and reasonable for services provided.			
4. Abides by relevant ethical codes and standards of practice.			
Communication			
1. Verbal communication skills permit patients/staff to understand what was said on the first attempt.			
2. Written communication is concise, grammatically correct and accurate in content and is correctly spelled and punctuated.			

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Key Area	3 months	6 months	Comments
3. Correctly interprets written communications.			
4. Listens actively and attentively to understand what is being communicated.			
Documentation			
1. Documents relevant information related to the delivery of physical therapy care including • evaluation, • plan of care, • treatment, • response to treatment, • discharge planning, • family conferences and • communication with others involved in delivering care.			
2. Produces documentation that follows guidelines and format required by the practice setting.			
Evaluation			
1. Selects valid and relevant physical therapy tests and measures to perform an appropriate evaluation of the patient consistent with their diagnosis.			
2. Establishes goals and desired functional outcomes that specify expected time duration.			
3. Establishes a physical therapy plan of care in collaboration with other team members involved in the delivery of care.			
4. Selects intervention strategies to achieve the desired patient outcomes.			
5. Establishes a plan for patient discharge in a timely manner.			
6. Evaluates changes in patients' status and alter the plan of care in response to patients' status.			
Treatment Skills			
1. Performs effective, efficient and technically competent interventions for patients.			
2. Performs interventions consistent with the plan of care.			
3. Provides interventions in a manner minimizing risk to self, the patient and others involved in the delivery of patient care.			
4. Adapts interventions to meet the individual needs and response of the patient.			

NOTICE!! These skills (*) MUST BE REVIEWED – If these skills are not available at your facility, arrangements must be made to have these skills taught and checked off at another facility approved by the Board.

OPTIONS TO VIEW COMPETENCY

Please use this key to indicate the technique used to validate competence.

D = Demonstration O = Observation N=Discussion (a maximum of 3 by **O** and/or **N**)

Key: 1= Needs Improvement 2= Below Average 3=Qualified 4=Well Qualified 5= Excellent

		Techni-que Used	Date of Review	1	2	3	4	5	Comments
Test and Measures									
1. Range of motion	*								
2. Manual muscle strength	*								
3. Pain	*								
4. Posture	*								
5. Prosthetic requirements	*								
6. Orthotic requirements	*								
7. Sensation	*								
8. Equipment needs	*								
9. Self care and home management	*								
10. Gait	*								
11. Neuromuscular tone	*								
12. Functional activities	*								
13. Arousal, mentation and cognition	*								
Interventions									
1. Hot / cold packs	*								
2. Ultrasound	*								
3. Electrotherapeutic modalities	*								
4. Functional training	*								
5. Manuel therapy techniques	*								
6. Patient-related instructions	*								
7. Therapeutic exercise	*								
8. Prosthetic training	*								
9. Orothotic training	*								
10. Infection control procedures	*								
11. Wound care/management	*								
12. Use of assistive devices	*								

Signature of Supervisor Date

Please check one of the following recommendations:

( ) I recommend the permittee be considered for licensure
( ) I recommend extension of the probationary period
( ) I do not recommend the permittee for licensure

Signature of Permit Holder Date

I ( ) agree / ( ) disagree with the above assessment of my clinical skills as a physical therapist.

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