



School Setting Self Assessment

Directions

Please circle a value for each question to provide us and the interested facilities with an assessment of your clinical experience. These values confirm your strengths within your specialty and assist the facility in the selection process of the healthcare professional.

Frequency		Experience	
1	Observed Only or Never Done	1	No Experience
2	Rarely Done (<6 times/year)	2	Some Experience (Requires Assistance)
3	Occasionally Done (1-2 times/month)	3	Experienced (Performs without Assistance)
4	Frequently Done (daily or weekly)	4	Very Experienced (Performs Well)

Print Name

SS#

Date

Knowledge of	Frequency				Experience			
Federal laws	1	2	3	4	1	2	3	4
State laws	1	2	3	4	1	2	3	4
IDEA	1	2	3	4	1	2	3	4
IEP	1	2	3	4	1	2	3	4
LRE	1	2	3	4	1	2	3	4
Section 504	1	2	3	4	1	2	3	4
Tech Act	1	2	3	4	1	2	3	4
Role of educationally relevant therapy	1	2	3	4	1	2	3	4
Disabilities frequency experience	1	2	3	4	1	2	3	4
Cerebral palsy	1	2	3	4	1	2	3	4
Spina bifida	1	2	3	4	1	2	3	4
Muscular dystrophy	1	2	3	4	1	2	3	4
Down syndrome	1	2	3	4	1	2	3	4
Mentally handicapped	1	2	3	4	1	2	3	4
Developmental delay	1	2	3	4	1	2	3	4
Autism	1	2	3	4	1	2	3	4
Asperger syndrome	1	2	3	4	1	2	3	4
Emotionally handicapped	1	2	3	4	1	2	3	4
Learning disabled	1	2	3	4	1	2	3	4
ADD/ADHD	1	2	3	4	1	2	3	4
TBI	1	2	3	4	1	2	3	4
SCI	1	2	3	4	1	2	3	4

Assessments	Frequency				Experience			
Functional school/educational therapy assessment	1	2	3	4	1	2	3	4
Adaptive equipment	1	2	3	4	1	2	3	4
Wheelchair	1	2	3	4	1	2	3	4



Initials _____

Frequency		Experience	
1 Observed Only or Never Done		1 No Experience	
2 Rarely Done (<6 times/year)		2 Some Experience (Requires Assistance)	
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Interventions/Strategies	Frequency				Experience			
Early intervention: Birth to 3 years for head start program assessment	1	2	3	4	1	2	3	4
Pull-out	1	2	3	4	1	2	3	4
In-class direct	1	2	3	4	1	2	3	4
Individual	1	2	3	4	1	2	3	4
Small groups	1	2	3	4	1	2	3	4
Classroom modifications	1	2	3	4	1	2	3	4
Classroom/home programs	1	2	3	4	1	2	3	4
Curriculum accommodations	1	2	3	4	1	2	3	4
Consultation	1	2	3	4	1	2	3	4
Orthotics/prosthetics	1	2	3	4	1	2	3	4
Tone management	1	2	3	4	1	2	3	4
Activity enhancement	1	2	3	4	1	2	3	4
Inservice education	1	2	3	4	1	2	3	4

Skills	Frequency				Experience			
Computer	1	2	3	4	1	2	3	4
Assistive technology	1	2	3	4	1	2	3	4
Classroom positioning	1	2	3	4	1	2	3	4
Gait training on school campus	1	2	3	4	1	2	3	4
Transfer training	1	2	3	4	1	2	3	4
Perceptual motor	1	2	3	4	1	2	3	4
Oral motor feeding	1	2	3	4	1	2	3	4
Architectural barriers	1	2	3	4	1	2	3	4
Pre-vocational	1	2	3	4	1	2	3	4
Adaptive PE	1	2	3	4	1	2	3	4
Splinting	1	2	3	4	1	2	3	4
ADL training	1	2	3	4	1	2	3	4
Sensory techniques	1	2	3	4	1	2	3	4
School bus transportation	1	2	3	4	1	2	3	4
Fine motor	1	2	3	4	1	2	3	4
Wheelchair mobility	1	2	3	4	1	2	3	4

Other	Frequency				Experience			
Infection control practices	1	2	3	4	1	2	3	4
Hand washing	1	2	3	4	1	2	3	4



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Initials _____

Ages	Frequency				Experience			
Infant (birth to 1 year)	1	2	3	4	1	2	3	4
Toddler (ages 1-3 years)	1	2	3	4	1	2	3	4
Preschooler (ages 3-5 years)	1	2	3	4	1	2	3	4
Childhood (ages 6-12 years)	1	2	3	4	1	2	3	4
Adolescents (ages 12-21 years)	1	2	3	4	1	2	3	4
Young Adults (ages 21-39 years)	1	2	3	4	1	2	3	4

Please list any Additional Skills:	
1.	2.
3.	4.
Additional training:	
1.	2.
3.	4.
Additional equipment:	
1.	2.
3.	4.

Fax to: 1-888-298-3146

The information on this and all preceding pages is true and correct.

Signature

Date