VICTORIA INDEPENDENT SCHOOL DISTRICT

Physical Therapist/Occupational Therapist Evaluation Form

Therapist’s Name ________________________________ Date ____________________
Social Security No. __________________________ Evaluator _____________________

<table>
<thead>
<tr>
<th>Rating Number</th>
<th>Rating Notations</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Exceptional Performance</td>
</tr>
<tr>
<td>3</td>
<td>Above Average Performance</td>
</tr>
<tr>
<td>2</td>
<td>Good Performance</td>
</tr>
<tr>
<td>1</td>
<td>Below Standard Expectation</td>
</tr>
<tr>
<td>No Notation</td>
<td>Not in a Position to Evaluate This Skill</td>
</tr>
</tbody>
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Criterion I: P.T./O.T. Duties and Responsibilities

A. Provides direct P.T./O.T. services

1. Reviews student’s file medical information and physician’s referral. 4 3 2 1

2. Performs tests and measurements and other evaluative procedures to ascertain student’s status and to establish performance baselines. 4 3 2 1

3. Records, evaluates, and interprets findings of evaluative procedures and provides same to the appropriate personnel on a timely and periodic basis. 4 3 2 1

4. Plans, prepares, and establishes appropriate written individual program plans. 4 3 2 1

5. Administers and implements programs according to the student’s needs. 4 3 2 1

6. Demonstrates the necessary knowledge and ability to perform all P.T./O.T. procedures. 4 3 2 1

7. Maintains a record of treatment sessions. 4 3 2 1
### PT/OT Evaluation Form

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<tr>
<th>Expectations</th>
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<td>4 3 2 1</td>
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#### Criterion I: Clinical Skills and Professional Competencies

8. Recognizes any contraindications or necessary precautions prior to treatment.

9. Reassesses and revised programs as necessary as student’s status changes and provides a written progress report on each student on a timely and periodic basis.

### B. Provides indirect P.T./O.T. services and technical assistance

1. Instructs and teaches students, parents, teachers and others as indicated in appropriate intervention strategies.

2. Confers with physicians and other health practitioners as needed to obtain information and make recommendations.

3. Integrates P.T./O.T. programs with other aspects of the student’s program.


5. Supervises P.T./O.T. assistants and P.T./O.T. aides in an appropriate and professional manner according to state laws and regulations.

6. Teaches special skills necessary in the handling and positioning of students; demonstrates the use of adaptive/assistive devices, and the use and care of supportive bracing, orthotic/prosthetic devices.

### Criterion II: Management Skills and Professional Characteristics, Attitudes, and Conduct

1. Understands and practices principles and theories of specialized subject area of professional discipline; is knowledgeable of and adheres to state laws, regulations and district policies.

### Expectations

| 4 3 2 1 |
2. Keeps current on recent developments in field of expertise through professional meetings, journals, and publications, and interaction with others. 4 3 2 1

3. Demonstrates a polite and considerate manner, indicating concern and interest is displayed with students, parents, and other professionals. 4 3 2 1

4. Works together as a team with other professionals involved in the student’s program. Demonstrates ability to work with others in a positive, productive manner by sharing resources, exhibiting willingness to share responsibility, and coordination activities with others. 4 3 2 1

5. Treats information pertaining to the student with confidentiality 4 3 2 1

6. Maintains grooming and personal attire appropriate for professional position. 4 3 2 1

Comments: ________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

________________________________________________________________________

_____________________________ ______________________________
Signature of Evaluator Signature of Therapist

_____________________________ ______________________________
Date Date