# CHS REHAB SERVICE STUDENT MANUAL

## Table of Contents

## I. REHAB SERVICES

<table>
<thead>
<tr>
<th>Policy/Checklist</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Placement Policy</td>
<td>3</td>
</tr>
<tr>
<td>Orientation Documentation Form/Confidentiality Statement</td>
<td>5</td>
</tr>
<tr>
<td>Dress and Appearance Guidelines</td>
<td>6</td>
</tr>
<tr>
<td>Dress Code</td>
<td>9</td>
</tr>
<tr>
<td>Student Attendance Policy</td>
<td>10</td>
</tr>
<tr>
<td>Outpatient Assessment and Documentation Guidelines Policy</td>
<td>14</td>
</tr>
<tr>
<td>MRU Assessment and Documentation Policy</td>
<td>17</td>
</tr>
<tr>
<td>Student/ CI Expectations</td>
<td>19</td>
</tr>
<tr>
<td>Clinical Instructor Check List</td>
<td>21</td>
</tr>
<tr>
<td>Weekly Review Sheet</td>
<td>22</td>
</tr>
<tr>
<td>Standards of behavior</td>
<td>23</td>
</tr>
<tr>
<td>School Contact/Liaison Information</td>
<td>34</td>
</tr>
<tr>
<td>Pathway for Placing Students</td>
<td>36</td>
</tr>
<tr>
<td>Clinical Instructor Evaluation</td>
<td>37</td>
</tr>
<tr>
<td>Student Rating Form</td>
<td>38</td>
</tr>
<tr>
<td>CBISA</td>
<td>39</td>
</tr>
<tr>
<td>PIR Specialty Contact List</td>
<td>40</td>
</tr>
</tbody>
</table>

## II. FACILITY SPECIFIC INFORMATION

<table>
<thead>
<tr>
<th>Material</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department Orientation Policy</td>
<td>42</td>
</tr>
<tr>
<td>Department Specific Orientation Checklist</td>
<td>43</td>
</tr>
<tr>
<td>Orientation Checklist for PT</td>
<td>48</td>
</tr>
<tr>
<td>Orientation Checklist for PTA</td>
<td>50</td>
</tr>
<tr>
<td>Orientation Checklist for OT</td>
<td>52</td>
</tr>
<tr>
<td>Orientation Checklist for COTA</td>
<td>54</td>
</tr>
<tr>
<td>Orientation Checklist for SLP</td>
<td>56</td>
</tr>
<tr>
<td>OT SAR Student Schedule</td>
<td>59</td>
</tr>
<tr>
<td>COTA SAR Student Schedule</td>
<td>62</td>
</tr>
<tr>
<td>PT SAR Student Schedule</td>
<td>64</td>
</tr>
<tr>
<td>PTA SAR Student Schedule</td>
<td>67</td>
</tr>
<tr>
<td>SLP SAR Student Schedule</td>
<td>69</td>
</tr>
<tr>
<td>PT Outpatient Student Schedule</td>
<td>71</td>
</tr>
<tr>
<td>OT SAR Supplemental Material</td>
<td>73</td>
</tr>
</tbody>
</table>
III. **PT/OT/ST STANDARDS OF PRACTICE AND CODE OF ETHICS**

- PT Code of Ethics p. 107
- OT Code of Ethics p. 109
- OT Core Attitudes p. 117
- OT Code Guidelines p. 122
- SLP Code of Ethics p. 130
- SLP Scope of Practice p. 135
PURPOSE:
To provide a uniform policy and procedure in contract administration, risk management coordination and administration for Allied Health Student Activities within Catholic Health (CH) for the placement of Allied Health students.

APPLIES TO:
This policy applies to all areas/departments where Allied Health students have clinical experiences (Exclusive of Medical Students).

POLICY:
All student contracts will be centrally reviewed and maintained by the legal department to ensure compliance with regulatory and contractual guidelines to include health requirements.

PROCEDURE:
1. The programs that will require a license will need NYS approval for the clinical experience. Schools located outside the State of New York must call the NYS Office of Professions for approval for the clinical experience. Once approval has been obtained, the school must send verification to Clinical Education that the clinical experience has been approved.
2. All educational institutions placing students within CH will have a valid contract in place and current liability insurance. All contracts must be submitted to the Clinical Education Department. Clinical Education will send contract to Legal for review. Clinical Education will notify the school of contract status.
3. School/University coordinators will coordinate placements with the Clinical Education Department, who will then forward to the specific departmental leaders as appropriate.
4. All students must have a designated preceptor or clinical instructor. This may be a school faculty member. Associates may serve as preceptors with faculty oversight.
5. Clinical instructors and students will receive orientation to the practice site via the Allied Health Student Education Manual. Documentation of this orientation will be recorded on form HRF 29. The school will keep the document in the student’s file until she/he graduates from the program. Instructor license and/or certification will be kept on file as appropriate. Further orientation may be provided based on need.
6. All students’ behavioral and/or disciplinary actions will be immediately reported by the area/department manager to the Vice President, Clinical Education for follow-up in accordance with contract.
7. All students must meet the health requirements of Catholic Health including flu immunizations.
8. All schools must complete the on-line request for clinical placement along with the faculty information sheet and the clinical rotation spreadsheet.
<table>
<thead>
<tr>
<th>ORIGINATION DATE:</th>
<th>12/01/2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>REPLACES (If applicable):</td>
<td>NA</td>
</tr>
<tr>
<td>Date/ Initials</td>
<td>Date/ Initials</td>
</tr>
<tr>
<td>REVISED:</td>
<td>4/9/09 MKV</td>
</tr>
<tr>
<td>REVIEWED:</td>
<td>5/26/17 MJM</td>
</tr>
<tr>
<td>REVISED:</td>
<td>5/26/17 DS</td>
</tr>
<tr>
<td>CSC/OPC APPROVALS:</td>
<td>6/29/16, 5/31/17</td>
</tr>
<tr>
<td>REFERENCES:</td>
<td></td>
</tr>
</tbody>
</table>
Catholic Health
Allied Health Student
Orientation Documentation Form HRF 29

Instructor/Student Name_____________________________ Date _________

CH Facility __________________________________________________________

Educational Institution: ______________________________________________________________________

I have reviewed/read the Allied Health Student Educational Manual. I understand that I/My students are accountable for the information contained there in.

Printed Name ____________________________________

Signature ________________________________________

Confidentiality Statement

As a student within Catholic Health, I have been informed about my duties and responsibilities toward the confidential nature of patient information.

I understand that any discussion about a patient will be kept to the normal course of business and may not be discussed anywhere outside my Department at any time.

I further understand that I am subject to immediate dismissal without notice for the unauthorized possession, use, copying or reading of hospital records, or disclosure of confidential information to unauthorized persons, or the misuse and/or release of any information systems security code to unauthorized persons.

I have read all of the above and fully understand it.

________________________________________
Printed Name

__________________________________________ _____________
Signature Date

Forms:  HRF 29 Allied Health Student Orientation
Reviewed 5.3.09
PURPOSE:
Catholic Health (CH) is committed to presenting a professional business appearance to both internal and external customers. The purpose of this policy is to provide a common standard of dress for Catholic Health associates that ensures proper appearance and safety. Rather than prevent individual choice, the guidelines are intended to provide a reasonable range of choice within an acceptable overall standard. It is the responsibility of each individual to give careful consideration when determining appropriate attire.

Catholic Health’s definition of appropriate attire is based on the following concepts:

1.) Catholic Health’s image reflects the pride its associates take in their work.
2.) Customers draw conclusions about the quality of CH services based on what they see.
3.) CH associates want to create an image of quality services from the first moment a customer has contact with a CH entity.

APPLIES TO: All associates of Catholic Health, including contractors, vendors, students and volunteers.

POLICY:
Uniforms and Work Attire

1.) CH identification badges must be worn at all times while at work. The badge must be worn above the waist, so it is visible and easy to read by others. The badge must include the associate’s name and job title.

2.) The wearing of adornments such as pins, patches, buttons, jewelry, body jewelry, body paint, tattoos, etc. is prohibited when they are deemed by the organization to be unsafe or have the potential to create an inflammatory, intimidating or stressful environment for other staff, or the people we serve. This applies also to articles worn on the ID Badge. Garments with written statements or symbols are not to be worn unless specified as part of the department’s dress or uniform guidelines.

3.) Appropriate footwear is to be worn. Shoes are to be clean and in good repair. Sandals and flip flops are prohibited. Clinical patient care givers must wear socks or hosiery of some type.

4.) All clothing/uniforms must be neat, clean, in good repair, and properly fitted and selected for the type of work performed. The style of clothing must not be unduly revealing. Proper undergarments are to be worn. The following are considered to be casual attire inappropriate to the work setting: denim (unless required by the nature of the work being performed), sloppy or disheveled clothing, printed t-shirts, spandex, leggings, hooded sweatshirts, and shorts. Clothing must be worn in appropriate lengths and sizes. Bare midriffs, tight clothing, sheer or other overly-revealing clothing are unacceptable.

5.) Hats, caps or other head coverings are prohibited unless required for performance of job duties, religious or medical reasons, as communicated by department leadership.

6.) Proper personal hygiene and grooming must be consistently maintained. Makeup, cologne, and perfume must not be distracting. Fingernails should be clean and well groomed.
Unless you are working in an office with no patient/food contact, you may not wear artificial nails. Wearing of artificial nails is prohibited for those that work in patient care areas (regardless if the associate has direct patient care) and any other area identified that would impact the standards set by Infection Control as it increases the chance that harmful bacteria will be transmitted to patients and cause infection, even after handwashing. Artificial nails include, but are not limited to, binding tips, wrapping, tapes, gels, sculptured and acrylics. Natural nails shall not extend ¼ inch from the fingertip.

7.) Facilities/departments may establish HR approved specific dress, footwear, hairstyle and related standards within the definition of this policy and in accordance with safety and hygiene standards and Human Resources Department approval. Standards must be appropriate for the job duties and responsibilities and must not discriminate against any individual or group of individuals. Facility and/or department standards will be reviewed with associates by their supervisors.

8.) Failure to comply with corporate and/or affiliate specific dress code policies may result in corrective action.

9.) Business casual attire is acceptable attire at all levels of the organizations, unless business reasons dictate otherwise. Jeans/denim may be acceptable for pre-approved events (e.g. on a Friday with a donation to charity) as determined by leadership.

10.) Requests for accommodations to Dress & Appearance Guidelines based on religion or disability should be submitted to the Human Resources Department. If an associate is unable to follow this policy due to a medical reason, documentation must be provided to Associate Health for assessment and final approval by HR.

11.) Any associate failing to comply with this policy may be subject to disciplinary action up to and including termination as identified in Conduct Principles and Corrective Action Policy, HR-011-PC.

**Personal Protective Work Attire**

Certain areas and circumstances require the use of personal protective work attire and will be provided to associates at the expense of the facility.

**Change Time and Laundry**

Facility provided uniforms/garments: For associates in specified areas, facility provided garments/uniforms will be provided to associates. The laundering service for these garments is provided by an approved vendor and a clean supply of uniforms will be available for each associate daily. Associates are expected to be changed into their uniforms and be ready to begin work by the start of their scheduled shifts. Associates are expected to change out of the facility uniforms at the end of their shift. Worn uniforms are to be placed in a specified laundry bin located in the department. Worn garments will be laundered at the expense of the facility. Associates are not allowed to take uniforms home for laundering or personal use.

**Associate purchased uniforms/garments**

Associates who purchase their own uniforms are expected to arrive at work in a uniform that is consistent with uniform and color code for their department. Laundering of these uniforms is the responsibility of and at the financial expense of the associate. Associates will not be compensated for time away from work needed to correct their attire or grooming.

**Supervisor’s Responsibility**

Supervisors have the final responsibility to see that associates that report to them comply with this policy. Professional appearance is subject to review and non-compliance will result in disciplinary action. The supervisor should consult with a representative of Human Resources if there are questions, concerns, serious problems and/or if a misunderstanding arises in complying with this policy.
# POLICY AND PROCEDURE

<table>
<thead>
<tr>
<th>TITLE:</th>
<th>Dress and Appearance Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>POLICY #:</td>
<td>HR-018-PC</td>
</tr>
<tr>
<td>Page</td>
<td>3 of 3</td>
</tr>
</tbody>
</table>

## ORIGINATION DATE: 12/1/2001

**REPLACES (If applicable):** N/A

<table>
<thead>
<tr>
<th>Reviewed</th>
<th>Date/ Initials</th>
<th>Date/ Initials</th>
<th>Date/ Initials</th>
<th>Date/ Initials</th>
<th>Date/ Initials</th>
<th>Date/ Initials</th>
<th>Date/ Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/23/03</td>
<td>DS</td>
<td>4/9/09</td>
<td>DS</td>
<td>7/6/10</td>
<td>DS</td>
<td>7/29/11</td>
<td>DS</td>
</tr>
<tr>
<td>10/12/15</td>
<td>EJT</td>
<td>12/20/16</td>
<td>EJT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10/10/15</td>
<td>DS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## REFERENCES:

No Forms
Partners In Rehab & AthletiCare
Dress Code

All personnel are to have a neat, well-groomed appearance on the job.

This is required to:

❖ provide a competent, professional appearance
❖ promote infection control guidelines
❖ identify our status to patients/residents, physicians, visitors and other employees.

The following dress code is in effect on the CHS Rehab Facilities.

General Guidelines

❖ Hair should be clean and neat during hands-on patient/resident contact. Long hair should be tied back. No unusual hair colors/styles, in keeping with the professional style.
❖ Extremes in cosmetics and non-essential jewelry are inappropriate (particularly if involved in patient/resident contact). Body piercing is prohibited except for religious or cultural reasons.
❖ Fingernails should be clean and not overly long. Acrylic fingernails are inappropriate if treating patients/residents.
❖ All footwear must be clean. If involved in hands-on care, shoes must be closed toe. Hosiery is required for hands-on caregivers (regardless of wearing slacks, pants, skirts, skorts, capri pants, etc.).
❖ CHS identification is to be worn at all times in an easily readable position.
❖ No T-shirt tops with logos, emblems, etc. are to be worn.
❖ No jeans, sweats, spandex, or form-fitting slacks are to be worn.
❖ Shorts at knee or mid-knee are appropriate if stockings or tights are worn with a flat shoe. Sneakers and socks cannot be worn with shorts (shorts must be of dress fabric quality, i.e. no khakis).
❖ Sleeveless shirts must have a collar. Tank-type sleeveless shirts are inappropriate (unless consistently covered by jacket).
❖ Other: 1) Ties for men, per facility.
        2) Lab coats, per facility.

** Be advised that your site may have a specific dress code as well.**
This document is not intended to create, nor is it to be construed to constitute a contract between CHS and any of its employees for either employment or the provision of any benefit. This policy supersedes any and all policies of any CHS organizations and any descriptions of such policies in any handbook of such organization. Personnel failing to comply with this policy may be subject to disciplinary action up to and including termination.

### POLICY AND PROCEDURE

<table>
<thead>
<tr>
<th>TITLE:</th>
<th>Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>RESPONSIBLE DEPARTMENT:</td>
<td>Human Resources</td>
</tr>
<tr>
<td>POLICY #:</td>
<td>HR-003-PC</td>
</tr>
<tr>
<td>PREPARED BY:</td>
<td>Human Resources</td>
</tr>
<tr>
<td>SIGNATURE:</td>
<td></td>
</tr>
</tbody>
</table>

**Purpose:** The purpose of this policy is to promote exemplary attendance, to communicate clearly and uniformly with employees regarding punctuality and absenteeism, and to balance the needs of employees with the needs of patients, mindful of our mission.

**Applies To:** Interns of Catholic Health System’s Continuing Care Division.

**General Statement of Policy:**

1. Interns are expected and required to be in regular attendance and be prepared to commence work activities at designated work locations, days and assigned hours. Interns are also expected to remain at work for the entire period excluding rest and meal periods. Late arrival, early departure and other personal absences are disruptive and should be avoided whenever possible. The reason for each absence, tardy, or early departure has no ability to excuse the occurrence. This is a no-fault policy since the Clinical Instructor treats all occurrences the same without determining the significance of each occurrence.

2. The policy of Catholic Health System (CHS) is to make a fair and reasonable allowance for interns’ absences, recognizing that a reasonable amount of absence for both bonafide sickness or emergency situations is often beyond the control of the intern. Conversely, CHS and its patients are entitled to a reasonable degree of regularity in the attention of our interns to their responsibilities.

**Note:** With respect to the exercise of corrective action in regard to NYS disability absences, patterns of absence, or when an employee’s overall lost time is sufficient enough to present a question about the employee’s continued suitability for employment; corrective action shall be taken. Corrective action shall only be taken after department manager and supervisory personnel consult with a Human Resources representative. Departmental management shall impress upon the employee the unfair burden that is placed on the Hospital and the employee’s co-workers when an employee is involved in periodic extended absences and, that the failure to improve his/her attendance, will result in disciplinary action even if the absences are largely or entirely the result of illness or injury.

### DEFINITION OF TERMS:

1. **Absence:** Failure to report to work as scheduled; working less than one-half of the scheduled work shift.

2. **Partial Absence:** Late arrival to work or early departure, if not specifically approved by the Unit/Department Head, constitutes an unexcused partial absence.
   a. Partial absence of greater than 10 minutes - three (3) such occasions are considered equivalent to one (1) unapproved absence.

**No Forms**
3. Absent from work without notifying supervisor (NO CALL/NO SHOW) – Failing to personally notify the supervisor regarding an inability to report for work as scheduled. Notice should be given as early as possible, however minimum acceptable notice is as follows in the absence of a departmental policy to the contrary: If such notice is not possible due to the scheduled opening time of the department, the employee shall notify the department as soon as the department is open. Where the employee cannot physically make the call, the employee is exempted from providing notice.

a. Attendance - Counseling

(1) Attendance and punctuality patterns are established early and tend to persist; therefore, new Interns should be oriented concerning their responsibility for regular and timely attendance.

(2) Clinical Instructors are encouraged to promptly handle all absenteeism and tardiness problems at their earliest stages. Toward this end it is suggested that, regarding absenteeism and tardiness, a Counseling Session be initiated. Counseling is not a part of the formal corrective action process. Counseling sessions should be informative in nature and used for the following purposes:

   a) To bring to the employee’s attention that a potential problem exists regarding his/her attendance or punctuality record;
   
   b) To demonstrate an active interest in the employee’s health and well being by listening to any problems adversely affecting attendance or punctuality;
   
   c) To let the employee know what is expected of him/her in the future with respect to attendance and punctual attendance;
   
   d) To support any future corrective action, if necessary.

(3) Clinical Instructors, liaisons, and the school’s ACCE / AFWE have discretion and latitude in deciding when a counseling session is necessary.

b. Absenteeism: The following progressive counseling will occur for instances of absenteeism in any clinical rotation.

   (1) For the first two (2) occurrences, at the discretion of the Clinical instructor and ACCE / AFWE, no action is necessary

   (2) Third (3rd) occurrence- The intern is required to make up the time during his/her clinical rotation

   (3) Fourth / Fifth occurrence – The intern will be required to extend the internship by 1 week

   (4) Sixth Occurrence- The intern will meet with the clinical instructor, clinical liaison and ACCE / AFWE of the academic institution to determine appropriate action to take, up to, and including termination of the clinical experience.

   (5) An intern absent from work without notifying his/her clinical instructor (NO CALL/ NO SHOW), and without an explanation satisfactory to the organization, will be
required to meet with the Clinical instructor, clinical liaison and ACCE / AFWE of clinical institution.

A second incident of NO CALL/NO SHOW will result in immediate termination.

(6) If an intern is absent from work without notifying his/her clinical instructor for two consecutive scheduled work shifts without an explanation satisfactory to the organization, the intern will be considered to have voluntarily abandoned his/her internship and will be automatically terminated.
### PURPOSE

It is the policy of the Rehabilitation Department for documentation on each outpatient evaluated and/or treated.

### APPLIES TO

This policy and procedure shall apply to all members of the Rehabilitation Department.

### POLICY

All outpatient medical records will be completed utilizing the APTA Connect documentation system. All of the Medical Records (Initial Evaluations, Progress Reports, and Discharge Reports) will begin with and contain patient name, referring physician, primary care physician, patient account number, date of report, diagnosis, start of care date and number of visits.

### RESPONSIBILITIES

- Director review and approve policy
- Librarian distribute setup/services as needed

### REVIEW LEVEL

Two Years

### PROCEDURE

- **Coverage (Calls-ins, vacations):** If the therapist or therapist assistant calls in sick or is on vacation, it is the responsibility of the therapist/assistant covering to document any progress notes that are due on that day(s).

- **Daily Documentation (Charge Capture/Flow Sheet):** The patient’s treatment program and response to treatment will be documented following each treatment session. This will be done on the visit/charge capture note and flow sheet, which will be part of the permanent Medical Record. The therapist or therapist assistant is responsible for completing this documentation each day prior to the end of his/her shift. The time spent on each component of the treatment should be recorded on the visit/charge capture and flow sheet daily. Both subjective and objective measurements should be documented daily. Medicare patients must have appropriate minutes documented daily. The documentation must support the skilled intervention provided on a daily basis. **This may be recorded under the parameter section of the flow sheet.**

- **Discontinuance of Treatments:** Patients will be discontinued from treatment under the following conditions:
  1) By order of the referring physician.
  2) If the patient is symptom free and has attained his/her goals. **The physician will be notified by fax or mail.**
  3) If, in the professional opinion of the therapist, the patient is not making progress and has reached maximal therapeutic benefit, **and the referring physician has been notified and agrees that the treatment be discontinued.**
  4) The patient has not shown/returned for scheduled appointments. The patient is then contacted by phone or sent a “Missed Appointment Letter,” **and the physician has been notified**
  5) A Discharge Summary will be completed, and a copy will be mailed / faxed to the referring physician.

- **Errors**
  1) **Clinicians are responsible for completely reading all word documents prior to signing them to prevent major errors.**
2) If major errors occur, or if a note is accidently signed prior to completion, the clinician will edit the title for the visit folder to indicate an error was made and another document will be generated and fully completed with the visit folder indicating that the corrected note is also in the folder.

3) Goals
   a. Short term and long term goals will be established with the patient and documented in the initial evaluation. These goals will be addressed and/or revised in subsequent progress notes upon reassessment, or as needed. Goals should be functional and specific to the patient.
   b. An estimated duration (in days/weeks) will be given to the short and long term goals.

4) Initial Visit: The patient must complete medical history sheet and functional outcome tool prior to Initial Evaluation. Once the therapist has evaluated the patient- the objective information, the evaluation procedure and possible treatment programs will be discussed with the patient. The patient and therapist are required to sign the consent form concerning information that has been presented. (This statement is now to be deleted: One copy is given to the patient and one copy is retained in the patient's Medical Record.)

5) The Initial Evaluation should follow the CHS Rehab format in APTA Connect and contain a minimum the following information:
   a. Subjective data including: chief complaint, pain level, date and mode of injury, diagnosis and referral.
   b. Prior level of function
   c. Whether the patient was hospitalized, had surgery, or had inpatient Rehabilitation in the last 30 - 60 days, or has gone into a higher level of care due to recent decline in status and has the potential to return to the lower level of care.
   d. Indication whether there was a prior injury to involved region.
   e. Objective information (which will vary according to diagnosis): general appearance (posture, gait, edema, ecchymosis, etc.), ROM, strength, functional mobility (transfers, assistive devices, ADL's), neurological (DTR's, sensation), special tests, palpation.
   f. Assessment including: rehab potential and short and long term goals (including duration) and co-morbidities that would increase the rehab time frame to obtain goals.
   g. Plan including: frequency, estimated duration and specific planned treatment program. Treatment program (Plan of Care) must list all modalities and therapeutic techniques that may be applied.
   h. Evaluations are to be completed within 24 hours of the initial visit.

6) Insurance Information (See Compensation and Medicare Policy and Procedure.

7) Outpatient/Physician Correspondence
   a. The referring and primary physician will be sent a copy of each Initial Evaluation, subsequent Progress Notes and Discharge Summary.
   b. The referring physician will be contacted by phone regarding any questions/concerns/problems with patients and/or their treatments.

8) Progress Notes/Reassessment
   a. The patient’s progress and response to treatment is documented at least every 30 days from the date of Initial Evaluation (Progress Notes must be completed prior to the 30 days if there is a substantial change in patient status and/or treatment plan). The appropriate functional outcome tool will be completed by the patient and documented in connect by the clinician.
   b. Progress Notes will be completed in APTA Connect.
   c. Goals will be addressed/revised as necessary.
   d. When a Progress Note/Reassessment is due on a patient but the patient has not attended in a week or more due to cancellations, no-shows, sickness, etc., a Progress Note based on last visit subjective and objective information will be submitted with documentation why patient has been absent. Once the patient has returned for therapy, a full Progress Note will be completed upon reassessment of the patient if there has been a major change in status.

9) Photographs – If photographs are taken, the pictures will be scanned into the chart.

10) Referrals
    a. It is the policy of the Rehabilitation Department to evaluate and treat only patients who have a valid prescription from a physician, dentist, NP, Podiatrist, or physician’s assistant. According to
the Physician Practice Act, the referral is acceptable only if the physician is licensed in New York State. **Out of state prescriptions should be co-signed by a NYS licensed physician.**

b. The patient is required to present all required referrals/authorization numbers required by insurance providers at the time of treatment.

11) **Release of Information Policies**

- **Removal of Records from the Department:** Therapy Medical Records shall not be removed from the department, except as necessary in the transaction of business of the hospital. A file stating when removed, by whom, where and when returned shall be kept.

- **Confidentiality:** Information and the Medical Record concerning the condition of a patient is confidential and should be discussed only to the extent necessary to provide for the care and treatment of the patient. It should not be discussed in casual conversation either in or out of the hospital. It should not be discussed with visitors or with other patients and only to the extent necessary with family members. Unauthorized use, possession, copying or reading of hospital records or disclosure of information contained is such records to unauthorized persons is grounds for discipline, including discharge.

- **Telephone Requests:** Information must never be given over the telephone except in an emergency or to persons herein authorized to receive information by telephone. Authorization for compensation treatment must be obtained via telephone. This department is authorized to give diagnosis, doctor and expected duration of treatment.

- **Requests for Therapy Itemized Statements:** Requests for an itemized statement of date of therapy treatment and charges will be honored only by the patient receiving the treatment. These will be generated by the Business Office unless other arrangements have been made. A simplified report, including dates of treatment, is available in APTA Connect.

- **Correspondence Requests:** All correspondence requesting therapy medical records shall be directed to the Health Information Department. A medical release form will be signed by the patient prior to release of any information.

- **Patient's Request for Information:** Requests by patients for access and copies of their medical record shall be referred to the Health Information Department. A Medical Release Form will be signed by the patient prior to release of any information.

- **Rehabilitation Nurses/Worker's Compensation Case Managers:** Requests for on-site visits by such persons shall be granted, provided a prior appointment has been set by the attending therapist. It is in the patient’s best interest to communicate, and therefore, private conference time should be arranged. No additional, written releases will be necessary provided the Rehabilitation Nurse/Case Manager has proper identification.

- **Record Retention:** All patient’s medical records will be retained in their original or legally reproduced form for a period of at least six years from the date of discharge or three years after the patient's age of majority (18 years), whichever is longer, or at least six years after death.
PURPOSE
Partners in Rehab will utilize the approved Catholic Health System documentation forms and documentation will be standardized for Catholic Health.

APPLIES TO
The Partners in Rehab Staff.

POLICY
Timely, accurate and objective documentation of patient evaluation, treatment programs, responses to treatment, progress reports and discharge summaries are considered essential components of quality care. It is the professional and ethical responsibility of all therapists to assure that this task is accomplished. Failure to adhere to these standards is considered to be professional misconduct.

RESPONSIBILITIES
Director review and approve policy
Librarian distribute setup/services as needed

REVIEW LEVEL
Two Years

PROCEDURE
1. Initial Evaluation-See Policy: Guidelines for the Inpatient Interdisciplinary Assessment Form

2. Progress Notes - Progress notes for the Medical Rehabilitation Unit will be completed daily and placed in the multidisciplinary section of the medical record.

3. Discharge Notes - A Discharge Summary will be completed and placed in the medical record within 24 hours of patient's discharge. Patients are sometimes discharged unexpectedly due to changes in their medical status; therefore the last progress note would serve as a discharge summary for that patient.

4. Attendance Record - Documentation of patient’s treatment time will be recorded on daily progress note. If for some reason the patient does not attend their therapy session, an explanation will be provided in the medical record. Documentation errors will have one line through the error and the therapists/assistants will write error and initial it.

5. Other Forms
   - FIM-See Comprehensive Care Conference Treatment Plan Policy
   - IRFPAI- See Inpatient Rehab Facility Patient Assessment Policy
   - Documentation on the Patient Education Record will be completed by the therapists and assistants. These records should be kept in the chart.

6. Photographs - If photographs are taken, the pictures will be placed in the chart along with the release.

7. Scheduling - All patients schedules are coordinated by OT, PT, and SLP upon admission and then changed as needed.

8. Billing - Each therapist is responsible for daily billing of patients in Soarian Clinicals.
### ORIGINATION/EFFECTIVE DATE: 2/03

<table>
<thead>
<tr>
<th>Date/ Initials</th>
<th>Date/ Initials</th>
<th>Date/ Initials</th>
<th>Date/ Initials</th>
<th>Date/ Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>REVIEWED:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>REVISED:</td>
<td>12/07</td>
<td>2/20/13</td>
<td></td>
<td>BAR</td>
</tr>
</tbody>
</table>

### REFERENCES:
- **FEDERAL LAW:**
- **NYS LAW:**
- **JCAHO STANDARD:**
ALLIED HEALTH STUDENT CLINICAL AFFILIATION

STUDENT EXPECTATIONS:

Each student will be expected to:

1. At all times, demonstrate professional conduct by being punctual, properly attired and displaying respect for patients, family members and other team members. Each student will be required to read and sign the “confidentiality form” to insure an understanding of responsibility when discussing patient status or other issues.

2. Become familiar with the rehab facility policies, procedures and protocols, including the mission statement, infection control procedures, PI and safety guidelines, incident reporting, etc…

3. Review and be familiar with the Allied Health Student Manual and CHS Rehab Services Student Manual.

4. Take responsibility for professional development by:
   a) Initiating and maintaining communication with the clinical instructor and other team members.
   b) Being properly prepared for daily activities, including treatment sessions, progress notes, care plan meetings, family conferences, patient schedules, etc…
   c) Complete Clinical Performance Instrument (midterm and final).
   d) Presenting one inservice or one case study to staff during the affiliation (topic/subject to be discussed with clinical instructor).
   e) Report any issues/concerns related to affiliation to the CI.

EXPECTATIONS OF CLINICAL INSTRUCTOR:

The clinical instructor will be expected to:

1. Provide an appropriate level of guidance and supervision based on discussion with the student of learning style, goals and current level of proficiency.

2. Be available for consultation/feedback with the student on a regular, daily basis and as needed.

3. Facilitate development of clinical skills (specifically, evaluation and treatment of the neurologically impaired patient), problem-solving skills, clinical judgment and oral and written communication skills

4. Maintain communication with the student at all times.

5. Report any issues/concerns related to the affiliation to the supervision/CCCE immediately.

6. Responsible for student orientation completion and forwarding materials to Mary Kay Vause (Director of Staff Development).

CHS Clinical Instructor Checklist

1. Start a file for each student and keep copies of all of the following information: (copies must be saved for a period of no less than three years)

2. Obtain the following information from the student
   - PPD results within past year
   - Results of physical within the past year
   - Malpractice insurance (for OT/PT)
   - Signed student orientation/confidentiality form (part II)
   Note: Copies of the above information must also be submitted to HR at sub-acute sites

3. Student must review the applicable sections of the student manual as it pertains to their discipline. Please be sure all students review/complete the following:
   - Acknowledgement of receipt of student handbook form (part II)
   - Policy and procedure section (part II)
   - Department specific orientation checklist (part III)
   - Discipline specific orientation checklist (part III)
   - Mandatory test (part I)
   - Student/CI expectations checklist (part II)

4. Mid point evaluations, final evaluations and/or weekly review sheets (PT will be able to complete CPI online)

5. Student Survey (part II). Have student complete it and send it to Rick Szabala at Athletic Care at the MACC.

6. Complete Community Service Report (see your manager for site specific instructions in how to complete)

7. Complete the student recruitment rating form and send to Michalina Ryan at St Francis of Buffalo
Weekly Student Clinical Affiliation Review

Student Name:_______________________   Date:___________
Week of Clinical Affiliation:______________

1. Clinical responsibilities completed over the past week:

2. Strengths gained over the past week:

3. Areas in need of improvement:

4. List any positive/negative experiences over the past week:

5. Goals for the following week:

6. Overall summary of progress/experience:

CI signature:_________________  Student signature:__________________
Standards of Behavior

OUR MISSION, VALUES AND PRACTICE

Our Mission

Committed to a common mission, Western New York’s Catholic health providers continue the healing ministry of Jesus. Seeking to improve the health of individuals and communities, we provide high quality service that is holistic, compassionate, and respectful of human dignity. Central to this endeavor is the service of persons who are poor and disadvantaged.

Our Values

√ Reverence for the Dignity of Each Person
√ Compassion
√ Justice for All, Especially Those who are Poor and Disadvantaged
√ Excellence

Our Practice

Guided by our Mission and our Values, Values in Practice creates an environment where….

√ people want to work
√ clinicians want to practice
√ people want to receive care
INTRODUCTION

Our Mission proclaims that we “continue the healing ministry of Jesus.” It proclaims that “we provide high quality service that is holistic, compassionate, and respectful of human dignity.”

Our Core Values determine the quality of care we give to all our patients, residents and visitors, as well as the behaviors we manifest to our co-workers.

Values in Practice enables Catholic Health System physicians, staff, and volunteers to manifest these expected behaviors in our everyday work. Assessment of behaviors is included in the annual Employee Performance Evaluation.

“I just love working here. It helps me become the person God intended me to be.”

The Standards of Behavior Team:

Sister Eileen O’Connor, R.S.M., Mission Integration, Kenmore Mercy Hospital – Team Leader
Ken Bodzinski, Information Technology, CHS
Coleen Cook, Information Technology, CHS
Ruth Dickson, Home Care, CHS
Sister Donna Lord, G.N.S.H., Spiritual Care, Kenmore Mercy Hospital
Anna McDonagh, Nursing, Mercy Hospital of Buffalo
Lois McNamara, Nursing, McAuley Residence
Pam Nicastro, Human Resources, Kenmore Mercy Hospital
Lynn Overbeck, Volunteer Services, Kenmore Mercy Hospital and Sisters of Charity Hospital
Janet Overdorf, Food and Nutrition Services, Mercy Hospital of Buffalo
Patty Pokracki, Lab, Sisters of Charity Hospital
Sister Mary Powers, D.C., Spiritual Care, Long Term Care – Sisters of Charity Hospital
Sandi Scaccia, Nursing, St. Joseph Hospital
Veronica Valazza, Nursing, Kenmore Mercy Hospital
OUR FIRST VALUE

Reverence for the Dignity of Each Person

Shows sincere interest in each person; expresses appreciation; apologizes for misunderstandings, inconveniences or mistakes; is widely trusted; adheres to provisions of Patient Bill of Rights.

(from Employee Performance Evaluation)

Attitude

- Maintain positive, helpful, kind behavior toward all.
- Treat each person as if he/she is the most important concern.
- Apologize when someone’s expectations have not been met, even when you are not at fault.

Service

- Greet every person you meet in a warm and friendly way.
- Provide as much privacy as the environment allows.
- Be respectful regarding the use of name and choice of care, according to the person’s culture and individual needs.

“\textit{The entire staff was caring, kind, and treated me with the utmost dignity. Please acknowledge the entire staff and continue to employ such caring and patient caregivers.}”

Environment

- Create an environment in which all persons feel safe, valued and welcome.
- Take pride in your facility. Keep property and resources clean, neat and safe.
- Report and/or clean up spills immediately.
OUR SECOND VALUE

Compassion

Spends the extra effort to put people at ease; extends hospitality graciously; builds rapport well; brings out the best in people; listens with empathy to understand others’ thoughts, feelings and concerns; treats all persons whom we serve, and with whom we work, with respect and compassion; shares wins and successes; shares credit for accomplishments with others.

(from Employee Performance Evaluation)

Attitude

- Embrace others’ needs as if they were one’s own.
- Listen respectfully and acknowledge people’s feelings. When appropriate, offer a solution.
- Notice people going the extra mile. Let them know you appreciate it.

Service

- Take patients and visitors where they need to go.
- Handle patients, visitors and staff with courtesy and gentleness.
- Consider care of the patient’s family as much a part of mission as care of the patient.

Environment

- Speak quietly in patient care areas, halls, elevators and stairs.
- Pick up litter.
- Leave the closer parking spaces for patients and visitors.

“Thank you so much to Spiritual Care chaplains for sitting with me, talking, listening, and praying with me while I was in the hospital. You offered me so much comfort, and I am grateful that you were there for me.”
OUR THIRD VALUE

Justice for All, Especially Those Who are Poor and Disadvantaged

Treats others justly and respectfully; respects diversity; recognizes and appreciates the need and the circumstances of persons who are poor; responds with empathy to those less fortunate; is seen as one who cares about and actively takes initiative to conserve the resources or our earth; stands up for what is believed to be right, even in the face of adversity; adheres to provisions of the Patient Bill of Rights.

(from Employee Performance Evaluation)

Attitude

- Show respect for and acceptance of all persons without prejudice.
- Create a supportive environment where people can freely express themselves.
- Behave in a professional, collaborative manner, regardless of personal opinions or feelings.

Service

- Listen carefully to patients; notice when they may be expressing or implying special needs – food, housing, clothing – and make appropriate referrals.
- If unable to answer a question, find ways to get the answer for the person in need.
- Actively participate in service projects and programs which promote the good of the community.

Environment

- Ensure that the work environment meets the needs of all people.
- Treat others justly and respectfully by providing private areas for discussing patient issues and family needs. Never discuss patient or co-worker affairs in common areas such as elevators, hallways, stairs or cafeteria.
- Use equipment and supplies responsibly. Recycle whenever possible.
OUR FOURTH VALUE

Excellence

Grounded in the spiritual roots of our healthcare ministry; supports work/life balance for self and others; seeks opportunities to acquire new skills; is open and direct in providing feedback and suggestions to others; maintains a sense of humor; brings out the best in others; realizes the importance of one’s work in contributing to the Mission.

(from Employee Performance Evaluation)

Attitude

- Foster a climate where patients and employees feel valued and appreciated.
- Commend co-workers for doing things well.
- Speak positively about your facility and the Catholic Health System.

Service

- Do each task, make personal contact, complete each assignment correctly the first time.
- Find ways to acquire new skills. Participate in CHS University programs when possible.
- Do more than is expected. Help the other person. Do not say, “That’s not my job.”

Environment

- Dress and behave professionally. Keep appearance tidy and clean. Wear ID badge appropriately.
- Use workplace materials in an appropriate manner.
- Share ideas to generate improvement and involvement in the department.

“I noticed that he went right over and gladly answered all the patient’s questions. He helped her to be less frightened about her upcoming procedure. As a co-worker, I was proud of his response to a need.”
SERVICE

Fundamentals of Service

- **Acknowledge** every patient, resident, visitor, co-worker with a smile and a greeting.
- **Introduce** yourself before offering service. Be sure photo ID is visible.
- **Explain** to the patient or resident the *duration* of the procedure (“Mrs. B., this will take about 25 minutes.”) Or, when appropriate, the *nature* of the procedure (“Mr. G., this is what I am going to do…”)
- **Follow through** regarding questions, concerns or tasks until the need is met.
- **Thank** the patient or resident for choosing this facility.

Key Terms at Key Times

- **Be helpful:** “Is there anything I can do for you? I have time.”
- **Talk with the patient or resident:** “I’m ….. (closing this curtain) …in order to (provide you with privacy).”
- **Reassure:** “We want you and your family to be at ease while you’re here. Please feel free to ask any questions you may have.”
- **Notice a need:** “Let me help you find your way.”
- **Ask:** “Have we done everything to control your pain?”
  “Do you need help getting to the bathroom?”
- **Apologize:** “I’m sorry we did not meet your expectations.”
- **Empathize:** “I can understand that this was an inconvenience for you.”
- **Fix it when possible:** “Let me see what I can do to help you with this.”
- **Follow up:** “I checked on ……..; this is what I found out for you………”

“The help from home care has been excellent. Staff were caring, compassionate, experienced.”
ETIQUETTE

Telephone

- Answer phones within three rings. Use a courteous, friendly tone of voice, identifying yourself and your department. Ask: “How may I help you?”
- Ask permission when placing the caller on hold; apologize for delays. If holding for more than a minute or two, ask the caller if it would be better to leave a message or call back. Thank the caller for holding when you return to the line.
- Assist callers in locating the correct person or department.
- Before hanging up the phone, ask: “Is there anything else I can do for you. I have time.”
- Answer phone messages by the end of the next business day.
- When absent, leave “out of the office” voice mail message.

E-Mail

- Answer e-mails by the end of the next business day.
- When absent, leave “out of office” e-mail message.
- Be specific with e-mails, requesting a response if necessary.

“’The volunteers were so helpful when I came, unsure of where I should be. They actually escorted me to my destination, which helped put me at ease.’”

Teamwork

- Support co-workers; avoid gossip and spreading rumors.
- Keep a positive attitude.
- Attempt to resolve conflicts fairly, quickly, and peacefully.
- Welcome new employees and offer help as appropriate.
- Seek opportunities to improve skills needed for the job.
- Be respectful and sensitive to different cultures of co-workers.
- Look for ways to compliment co-workers for a job well done.
BEHAVIOR

On-Stage Behavior: When in the hearing of patients, residents, families, or visitors, staff present a professional, friendly manner, making sure that patients’ needs are a priority, and that personal conversations and jokes are reserved for Off-Stage situations.

- Communicate what is being done to or for the patient or resident.
- Never discuss personal or workplace issues in the presence of patients, residents, families, or visitors.
- Protect patients’, residents’ and families’ privacy and confidentiality.
- When patients or residents need to wait, let them know they are not forgotten. Check back frequently.
- Answer call lights promptly, before the fifth tone.
- Before leaving the patient, resident, family or co-worker, ask: “Is there anything else I can do for you? I have time.”

“Thanks to the lovely people who took my blood tests and EKG. The nurses and anesthesiologist were so comforting and gentle as I was prepared for surgery. I cannot commend enough the nurses and aides on the floor for their capabilities and compassionate attitude”

Off-Stage Behavior: Conversations can be more relaxed and informal when staff are away from patients, residents, families, visitors or when in meeting rooms, staff rooms, or enjoying celebrations.
SAFETY/RECOVERY

Safety -Stewardship

- Understand safety and disaster codes and how to respond appropriately.
- Report to supervisor any suspicious situations.
- Promptly report faulty equipment.
- Turn off lights and appliances in non-patient areas when not in use – offices, storage areas and meeting rooms.
- Observe designated eating, smoking, and parking areas.
- Follow patient safety goals. Report occurrences in a timely fashion.

Service Recovery

Often, despite our best efforts, patients, residents, families, or co-workers may be dissatisfied with our service. As far as we can, we handle complaints or difficulties at once, at the point of service. We strive to make every person’s experience as pleasant as possible. We follow Service Recovery policies and protocols.

- Anticipate and correct problems before they become complaints.
- Acknowledge mistakes when they occur, without placing blame.
- Apologize for not meeting expectations, even when it is not your fault.

Key Phrases

√ I’m SORRY we did not meet your expectations.
√ I’m GLAD you told me about it.
√ What can I do to make things BETTER for you now?
You are the Catholic Health System

Yours is the voice people hear when you answer the telephone.

Yours are the eyes they look into when they’re frightened and lonely.

Yours are the voices people hear when they ride the elevators, when they try to sleep, and when they try to forget their problems.

You are what they hear on their way to their appointments that could affect their destinies and what they hear after they leave those appointments.

Yours are the comments people hear when you think they can’t.

Yours is the intelligence and caring that people hope they’ll find here.

When you’re considerate, so is the Catholic Health System.

When you’re helpful, so is the Catholic Health System.

And when you’re compassionate and respectful, so is the Catholic Health System.

Visitors, patients, residents and co-workers will never know the real you – unless you let them see it.

All they will know is what they see, hear and experience.

And so the Catholic Health System has a stake in your attitude and in the collective attitude of everyone who works here.

We are all judged by your performance.

All of us are the care you give, the attention you pay, the courtesies you extend.

*Thank you for all you are doing for patients, residents, families, co-workers, and for the Catholic Health System.*
School Contact / Liaison Information

Kim M. Kotz PT, ACCE
Villa Maria College
Physical Therapy Assistant Program
240 Pine Ridge Road
Buffalo, NY 14225
Phone: 716-896-0700
Fax: 716-896-0705
kkotz@villa.edu
Liaison: Matt Clemens, PT
        ATC North: 447-6521

Kim M. Kotz PT, ACCE
Villa Maria College
Physical Therapy Assistant Program
240 Pine Ridge Road
Buffalo, NY 14225
Phone: 716-896-0700
Fax: 716-896-0705
kkotz@villa.edu
Liaison: Matt Clemens, PT
        ATC North: 447-6521

Jo A. Schweitzer, MS, OTR
Academic Fieldwork Coordinator
University at Buffalo
Stockton Kimball Tower - Rm. 515
3435 Main St - Bldg. 37
Buffalo, NY 14214
Phone: 716-829-3141 ext. 136
Email: Schweitz@buffalo.edu
Liaison: Lindsey Schultz
        Mt. St. Mary’s: 298-2249

Julie Wylegala, PT (Doug Frye)
Director of Clinical Education
University at Buffalo
Stockton Kimball Tower - Rm. 515
3435 Main St - Bldg. 37
Buffalo, NY 14214
Phone: 716-829-3141 ext. 151
Email: wylegala@buffalo.edu
Liaison: Anne Schukraft
        ATC North: 447-6521

Deb Battistella, OTR
Occupational Therapy Department
Erie Community College
122 Kittinger Hall
6205 Main Street
Williamsville, NY 14221
Phone: 716-851-1312
Email: merlodm@ecc.edu
Liaison: Kira Eimiller
        SOCH outpt: 833-8891

Deb Battistella, OTR
Occupational Therapy Department
Erie Community College
122 Kittinger Hall
6205 Main Street
Williamsville, NY 14221
Phone: 716-851-1312
Email: merlodm@ecc.edu
Liaison: Kira Eimiller
        SOCH outpt: 833-8891

Patricia Nowakowski PT (Colleen Corcoran)
Academic Coordinator of Clinical Education
D’Youville College
320 Porter Ave.
Buffalo, NY 14201
Phone: 716-829-7828
nowakow@dyc.edu
corcoran@dyc.edu
Liaison: Jeff Castiglione, PT
        ATC Amherst 833-8891

Patricia Nowakowski PT (Colleen Corcoran)
Academic Coordinator of Clinical Education
D’Youville College
320 Porter Ave.
Buffalo, NY 14201
Phone: 716-829-7828
nowakow@dyc.edu
corcoran@dyc.edu
Liaison: Jeff Castiglione, PT
        ATC Amherst 833-8891

Theresa Kolodziej, PT (Jessica Wiatrowski)
Academic Coordinator of Clinical Evaluation
Daemen College
4380 Main Street
Amherst, NY 14226
Phone: 716-839-8412 (566-7863)
Email: Tkolodzi@daemen.edu
jwiatrow@daemen.edu
Liaison: Angel Lesanti, PT
        SCL 862-1362

Theresa Kolodziej, PT (Jessica Wiatrowski)
Academic Coordinator of Clinical Evaluation
Daemen College
4380 Main Street
Amherst, NY 14226
Phone: 716-839-8412 (566-7863)
Email: Tkolodzi@daemen.edu
jwiatrow@daemen.edu
Liaison: Angel Lesanti, PT
        SCL 862-1362

Donna Brzykcy
Academic Fieldwork Coordinator for OT
D’Youville College
320 Porter Ave. KAB 333
Buffalo, NY 14201
Phone: 716-829-8346
Email: brzykcyd@dyc.edu
Liaison: Aaron Deckert OTR/L
        TMR 447-6506

Donna Brzykcy
Academic Fieldwork Coordinator for OT
D’Youville College
320 Porter Ave. KAB 333
Buffalo, NY 14201
Phone: 716-829-8346
Email: brzykcyd@dyc.edu
Liaison: Aaron Deckert OTR/L
        TMR 447-6506

Deborah Matuch
Niagara County Community College
Physical Therapy Assistant Program
3111 Saunders Settlement Road
Sanborn, NY 14132-9460
Phone: 614-6422
Liaison: Jennifer Banks
        MSM 298-30228
Chris Caputi, PT, DPT, Cert MDT  
Genesee Community College  
Physical Therapy Assistant Program  
One College Road  
Batavia, NY 14020  
Phone: 585-343-0055 ext 6408  
Email: cdcaputi@genessee.edu  
Liaison: Luke Norman, PT  
ATC North: 447-6037

Melissa Sidor, CCC-SLP  
SUNY Fredonia  
Speech Department  
W115 Thompson Hall  
Fredonia, NY 14063  
Phone: 716-673-3203  
Fax: 716-673-3235  
E-mail: melissa.sidor@fredonia.edu  
Liaison: Kara Trippi SLP  
PIR WS 558-5168

Dona-Hue Ritter-Schmidt, MS, CCC-SLP  
University of Buffalo  
Speech Department  
88 Biomedical Education Building  
Buffalo, NY  
Phone: 716-829-2797 ext 506  
E-mail: dhrs@buffalo.edu  
Liaison: Erin Reedy SLP  
KMH 447-6561

Karen Jones  
Clinic Director  
Buffalo State College  
Speech, Language, and Hearing Clinic  
Caudell Hall  
1300 Elmwood Ave  
Buffalo, NY 14222  
Phone: 716-878-3083  
E-mail:joneskb@buffalostate.edu  
Liaison: Angela DeLarco SLP  
SCH 862-6187

Kathleen Buccieri  
Director of Clinical Education  
Ithaca College  
Phone: 585-292-5060 ext 12  
Fax: 585-292-6431  
k Buccieri@ithaca.edu  
Liaison: Tom Coleman PT  
PIR WS 677-5022

Richard Szabala, Co Chair Student  
Affiliation Committee  
MACC 828-2455

Michalina Ryan, Co Chair  
Student Affiliation Committee  
FBM 209-0752
PATHWAY FOR PLACING STUDENTS WITHIN THE CATHOLIC HEALTH SYSTEM

1. School contacts the Liaison
2. Liaison checks spreadsheet for availability
3. Liaison contacts therapists (CI)
4. Therapist (CI) decides whether or not he/she wants to take the student
5. Liaison contacts school with CI’s name
6. School sends information on student to liaison
7. Liaison sends information on student to the CI
8. Liaison sends welcome packet to student
9. Student contacts CI

IF THE SCHOOL CONTACTS FACILITY/THERAPIST FIRST:

1. School calls/writes the facility or therapist
2. Therapist will call Michalina Ryan (862-2555) or Rick Szabala (828-2455) with information
3. Michalina or Rick contacts the liaison
4. Liaison contacts the school
5. Continue with steps #2-9 above
Clinical instructor:

Partners in Rehab/Athleticare -- STUDENT SURVEY

Thank you for allowing the Catholic Health to help further your education. We would appreciate you taking the time to complete this survey to allow us to be better educators for future students.

Please complete the following questionnaire using the following scale:

- 1 = strongly disagree
- 2 = disagree
- 3 = neutral
- 4 = agree
- 5 = strongly agree

For questions answered with 1, 2, or 3 please document reasons on lines below for your answer.

1. The CI was accessible to you when needed.
   -  
   -  
   -  
   -  
   -  

2. The CI provided clear, open, and concise communication.
   -  
   -  
   -  
   -  
   -  

3. The CI taught in an interactive manner that encouraged problem solving.
   -  
   -  
   -  
   -  
   -  

4. The CI made the formal evaluation process constructive.
   -  
   -  
   -  
   -  
   -  

5. The clinical education site’s objectives for this learning experience were clearly communicated.
   - 1
   - 2
   - 3
   - 4
   - 5

6. The CI served as a positive role model to you.
   - 1
   - 2
   - 3
   - 4
   - 5

7. The CI encouraged you to self-assess
   - 1
   - 2
   - 3
   - 4
   - 5

8. The CI integrated their knowledge into student clinical teaching
   - 1
   - 2
   - 3
   - 4
   - 5

9. The CI provided responsibilities that were within your scope of knowledge and skills
   - 1
   - 2
   - 3
   - 4
   - 5

10 Overall, how would you rate this Clinical Affiliation.
   - poor
   - fair
   - good
   - very good
   - excellent

Please provide any additional comments or suggestions on how we could improve our clinical experiences:
______________________________________________________________
______________________________________________________________
______________________________________________________________

Please return this via interoffice envelope to Rick Szabala at Athleticare South PT Dept @ MACC
CATHOLIC HEALTH
Student Rating Form

<table>
<thead>
<tr>
<th>STUDENT INFORMATION</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Apply to Catholic Health</td>
</tr>
<tr>
<td>School</td>
<td>Interest</td>
</tr>
<tr>
<td>Date of Graduation</td>
<td>Clinical Instructor</td>
</tr>
<tr>
<td>Contact Number</td>
<td>Contact Number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RATINGS</th>
<th>1 = Poor</th>
<th>2 = Fair</th>
<th>3 = Good</th>
<th>4 = Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance/Tardiness</td>
<td>□</td>
<td>□</td>
<td>3</td>
<td>□</td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety Habits/ Judgment</td>
<td>□</td>
<td>□</td>
<td>3</td>
<td>□</td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of Work/ Projects</td>
<td>□</td>
<td>□</td>
<td>3</td>
<td>□</td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follows Policies/ Procedures</td>
<td>□</td>
<td>□</td>
<td>3</td>
<td>□</td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Willingness to Learn</td>
<td>□</td>
<td>□</td>
<td>3</td>
<td>□</td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>□</td>
<td>□</td>
<td>3</td>
<td>□</td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team Interaction</td>
<td>□</td>
<td>□</td>
<td>3</td>
<td>□</td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reliability/ Dependability</td>
<td>□</td>
<td>□</td>
<td>3</td>
<td>□</td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organization</td>
<td>□</td>
<td>□</td>
<td>3</td>
<td>□</td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Response to Constructive Criticism</td>
<td>□</td>
<td>□</td>
<td>3</td>
<td>□</td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient/ Family Interaction</td>
<td>□</td>
<td>□</td>
<td>3</td>
<td>□</td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluation/ POC/ Interventions</td>
<td>□</td>
<td>□</td>
<td>3</td>
<td>□</td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Judgment/ Reasoning</td>
<td>□</td>
<td>□</td>
<td>3</td>
<td>□</td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

OVERALL RATING

ADDITIONAL COMMENTS

Clinical Instructor Signature | Date
**CBISA**

Basic Information Needed for “Reporter” Entry of Clinical Instructor

<table>
<thead>
<tr>
<th><strong>Clinical Instructor:</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Enter name</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Discipline of intern:</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• PT, PTA, OT, COTA, SLP</td>
<td></td>
</tr>
</tbody>
</table>

| **Name of Student**       |                     |

| **Name of School**        |                     |

| **Dates of Student Rotation** |                     |

| **Number of Weeks**        |                     |

| **Number of Hours:**       |                     |
| • Student time spent with CI per week |                     |

| **Facility/Department to Receive Credit** |                     |

Basic Information Needed for “Reporter” Entry of Liaison

<table>
<thead>
<tr>
<th><strong>Liaison Only:</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Enter name</td>
<td></td>
</tr>
</tbody>
</table>

| **Number of Students Served:** |                     |
|                               | Placed or attending presentation |

| **Title of Presentation to School** |                     |

| **Time Spent on Presentation**     |                     |

| **Time Spent on Liaison Duties**   |                     |
| • Phone calls, contact with school, paperwork, etc. |                     |

<p>| <strong>Facility/Department to Receive Credit</strong> |                     |</p>
<table>
<thead>
<tr>
<th>First</th>
<th>Last</th>
<th>Specialty/Certification</th>
<th>Office Location</th>
<th>Contact #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lynette</td>
<td>Calder</td>
<td>CWS</td>
<td>Home Care CHARTC</td>
<td>706-2373</td>
</tr>
<tr>
<td>Lorri</td>
<td>Chiaramonte</td>
<td>Wound Care</td>
<td>PIR-WS</td>
<td>677-5022</td>
</tr>
<tr>
<td>Michael</td>
<td>George</td>
<td>Wound Care</td>
<td>SJC-OP</td>
<td>891-2703</td>
</tr>
<tr>
<td>Sheila</td>
<td>Kriegar</td>
<td>CWS, WCC</td>
<td>Home Care CHARTC</td>
<td>706-2373</td>
</tr>
<tr>
<td>Ken</td>
<td>Krug</td>
<td>CWS</td>
<td>Home Care CHARTC</td>
<td>706-4039</td>
</tr>
<tr>
<td>Barb</td>
<td>Stafford</td>
<td>Wound Care</td>
<td>SFW</td>
<td>633-5400</td>
</tr>
<tr>
<td>Kirstin</td>
<td>Barnard</td>
<td>Cert. MDT McKenzie</td>
<td>MSMH</td>
<td>298-2249</td>
</tr>
<tr>
<td>Joseph</td>
<td>Baumgarden</td>
<td>Cert. MDT McKenzie</td>
<td>ATN</td>
<td>447-6037</td>
</tr>
<tr>
<td>Matthew</td>
<td>Clemens</td>
<td>Cert. MDT McKenzie</td>
<td>ATN</td>
<td>447-6037</td>
</tr>
<tr>
<td>Tom</td>
<td>Coleman</td>
<td>Cert. MDT McKenzie</td>
<td>PIR-WS</td>
<td>677-5022</td>
</tr>
<tr>
<td>Rich</td>
<td>Duderwick</td>
<td>Cert. MDT McKenzie</td>
<td>PIR-WS</td>
<td>677-5022</td>
</tr>
<tr>
<td>Joseph</td>
<td>Lorenzetti</td>
<td>Cert. MDT McKenzie</td>
<td>ATN</td>
<td>447-6037</td>
</tr>
<tr>
<td>David</td>
<td>May</td>
<td>Cert. MDT McKenzie</td>
<td>SOCH-OP</td>
<td>862-1170</td>
</tr>
<tr>
<td>Amy</td>
<td>Murdock</td>
<td>Cert. MDT McKenzie</td>
<td>MSMH</td>
<td>298-2249</td>
</tr>
<tr>
<td>Melissa</td>
<td>Ramsey</td>
<td>Cert. MDT McKenzie</td>
<td>EA</td>
<td>828-3700</td>
</tr>
<tr>
<td>Ron</td>
<td>Schenk</td>
<td>Cert. MDT McKenzie</td>
<td>PIR-WS</td>
<td>677-5022</td>
</tr>
<tr>
<td>Anne</td>
<td>Schukraft</td>
<td>Cert. MDT McKenzie</td>
<td>ATN</td>
<td>447-6037</td>
</tr>
<tr>
<td>Lindsey</td>
<td>Schultz</td>
<td>Cert. MDT McKenzie</td>
<td>MSMH</td>
<td>298-2249</td>
</tr>
<tr>
<td>Edyta</td>
<td>Sullivan</td>
<td>Cert. MDT McKenzie</td>
<td>MACC</td>
<td>828-2455</td>
</tr>
<tr>
<td>David</td>
<td>West</td>
<td>MDT-Spine</td>
<td>TMR</td>
<td>447-6600</td>
</tr>
<tr>
<td>Brian</td>
<td>Wyles</td>
<td>Cert. MDT McKenzie</td>
<td>Home Care CHARTC</td>
<td>706-2373</td>
</tr>
<tr>
<td>Michael</td>
<td>Bauer</td>
<td>OCS, OMPT</td>
<td>Home Care CHARTC</td>
<td>706-2373</td>
</tr>
<tr>
<td>Pat</td>
<td>Brady</td>
<td>Orthopedics, Spine</td>
<td>SOCH</td>
<td>862-1170</td>
</tr>
<tr>
<td>Jeff</td>
<td>Castiglione</td>
<td>CSCS, Spine</td>
<td>PIR-TR</td>
<td>684-0649</td>
</tr>
<tr>
<td>Tom</td>
<td>Coleman</td>
<td>Orthopedics, Spine</td>
<td>PIR-WS</td>
<td>677-5022</td>
</tr>
<tr>
<td>Rich</td>
<td>Duderwick</td>
<td>Orthopedics, Spine</td>
<td>PIR-WS</td>
<td>677-5022</td>
</tr>
<tr>
<td>Tara</td>
<td>Gawel</td>
<td>OCS</td>
<td>MACC</td>
<td>828-2455</td>
</tr>
<tr>
<td>Kira</td>
<td>Kremer</td>
<td>OCS</td>
<td>SOCH</td>
<td>862-1170</td>
</tr>
<tr>
<td>Joe</td>
<td>Lorenzetti</td>
<td>MTC</td>
<td>ATN</td>
<td>447-6037</td>
</tr>
<tr>
<td>Tim</td>
<td>Nosbisch</td>
<td>McKenzie Cert, CSES, OCS, NDT</td>
<td>Home Care CHARTC</td>
<td>706-2373</td>
</tr>
<tr>
<td>Ron</td>
<td>Schenk</td>
<td>OCS, Orthopedics, Spine</td>
<td>PIR-WS</td>
<td>677-5022</td>
</tr>
<tr>
<td>Rick</td>
<td>Szabala</td>
<td>OCS</td>
<td>MACC</td>
<td>828-2455</td>
</tr>
<tr>
<td>David</td>
<td>West</td>
<td>OCS, OMPT</td>
<td>TMR</td>
<td>447-6600</td>
</tr>
<tr>
<td>Diane</td>
<td>Brennan</td>
<td>SCS</td>
<td>Transit Road</td>
<td>684-0649</td>
</tr>
<tr>
<td>Tim</td>
<td>Nosbisch</td>
<td>CSES</td>
<td>Home Care CHARTC</td>
<td>706-2373</td>
</tr>
<tr>
<td>Joseph</td>
<td>Baumgarden</td>
<td>Cert. MDT</td>
<td>ATN</td>
<td>447-6037</td>
</tr>
<tr>
<td>Lorri</td>
<td>Chiaramonte</td>
<td>Cert. MDT</td>
<td>PIR-WS</td>
<td>677-5022</td>
</tr>
<tr>
<td>Connie Jo</td>
<td>Bish-Ziegelhorfer</td>
<td>LSVT Certified</td>
<td>PIR-WS</td>
<td>677-5022</td>
</tr>
<tr>
<td>Jordyn</td>
<td>Dolce</td>
<td>LSVT Certified</td>
<td>PIR-WS</td>
<td>677-5022</td>
</tr>
<tr>
<td>Rosalie</td>
<td>Herrmann</td>
<td>LSVT Certified</td>
<td>PIR-WS</td>
<td>677-5022</td>
</tr>
<tr>
<td>Amy</td>
<td>Johnson</td>
<td>LSVT Certified</td>
<td>OLV</td>
<td>819-5312</td>
</tr>
<tr>
<td>Katie</td>
<td>Kennedy</td>
<td>LSVT Certified</td>
<td>SCL</td>
<td>862-1353</td>
</tr>
<tr>
<td>Nancy</td>
<td>Lawler</td>
<td>LSVT Certified</td>
<td>SOCH</td>
<td>862-1170</td>
</tr>
<tr>
<td>Dave</td>
<td>May</td>
<td>LSVT Certified</td>
<td>SOCH-OP</td>
<td>862-1170</td>
</tr>
<tr>
<td>Marie</td>
<td>Packard</td>
<td>LSVT Certified</td>
<td>OLV</td>
<td>819-5312</td>
</tr>
<tr>
<td>Kara</td>
<td>Trippi</td>
<td>LSVT Certified</td>
<td>PIR-WS</td>
<td>677-5022</td>
</tr>
<tr>
<td>Mark</td>
<td>Basile</td>
<td>GCS</td>
<td>KMH-ACUTE</td>
<td>447-6020</td>
</tr>
<tr>
<td>Jenna</td>
<td>Parrish</td>
<td>Certified Lymphedema</td>
<td>SOCH</td>
<td>862-1386</td>
</tr>
<tr>
<td>Brenda</td>
<td>Hamilton</td>
<td>Certified Lymphedema</td>
<td>Home Care CHARTC</td>
<td>706-4540</td>
</tr>
<tr>
<td>Lindsey</td>
<td>Schultz</td>
<td>Certified Lymphedema</td>
<td>Mt. St. Mary's Outpt</td>
<td>298-2249</td>
</tr>
<tr>
<td>Leslie</td>
<td>McKnight</td>
<td>Certified Lymphedema</td>
<td>Home Care CHARTC</td>
<td>598-1530</td>
</tr>
</tbody>
</table>
Rehab Certified Specialists

<table>
<thead>
<tr>
<th>First Last</th>
<th>Specialty/Certification</th>
<th>Office Location</th>
<th>Contact #</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Neurodevelopmental Treatment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Connie Jo Bish-Ziegelhorfer</td>
<td>NCS, NDT, Vestibular</td>
<td>PIR-WS</td>
<td>677-5022</td>
</tr>
<tr>
<td>Andrea Brockman</td>
<td>NDT</td>
<td>BMH MRU</td>
<td>828-2860</td>
</tr>
<tr>
<td>Emily Madeja</td>
<td>NDT</td>
<td>BMH MRU</td>
<td>828-2860</td>
</tr>
<tr>
<td>Tim Nosbisch</td>
<td>NDT</td>
<td>Home Care CHARTC</td>
<td>706-2373</td>
</tr>
<tr>
<td>Sylvia Wischer</td>
<td>Adult NDT Certified, CAPS</td>
<td>OLV</td>
<td>819-5034</td>
</tr>
<tr>
<td><strong>Hand Certified</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amy Barrett</td>
<td>CHT</td>
<td>ATN</td>
<td>447-6037</td>
</tr>
<tr>
<td>Cynthia Brooks</td>
<td>CHT</td>
<td>SOCH</td>
<td>862-1170</td>
</tr>
<tr>
<td>Michelle Knoop</td>
<td>CHT</td>
<td>MACC</td>
<td>828-2455</td>
</tr>
<tr>
<td>Donna Niswander</td>
<td>CHT</td>
<td>ATN</td>
<td>447-6037</td>
</tr>
<tr>
<td>Lindsey Schultz</td>
<td>CHT</td>
<td>MSMH</td>
<td>298-2249</td>
</tr>
<tr>
<td><strong>Vital Stim</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tim Bagovich</td>
<td>Vital Stim Cert</td>
<td>KMH-ACUTE</td>
<td>447-6020</td>
</tr>
<tr>
<td>Angela DeLarco</td>
<td>Vital Stim Cert</td>
<td>SOCH-ACUTE</td>
<td>862-1170</td>
</tr>
<tr>
<td>Jordyn Dolce</td>
<td>Vital Stim Cert</td>
<td>PIR-WS</td>
<td>677-5022</td>
</tr>
<tr>
<td>Maggie Edbauer</td>
<td>Vital Stim Cert</td>
<td>Home Care CHARTC</td>
<td>706-2373</td>
</tr>
<tr>
<td>Wendy Giglio</td>
<td>Vital Stim Cert</td>
<td>BMH-ACUTE</td>
<td>828-3541</td>
</tr>
<tr>
<td>Sarah Hillmey</td>
<td>Vital Stim Cert</td>
<td>BMH-MRU</td>
<td>828-2893</td>
</tr>
<tr>
<td>Melissa Hogan</td>
<td>Vital Stim Cert</td>
<td>BMH-ACUTE</td>
<td>828-3541</td>
</tr>
<tr>
<td>Elizabeth Kobialka</td>
<td>Vital Stim Cert</td>
<td>Home Care CHARTC</td>
<td>706-2373</td>
</tr>
<tr>
<td>Nancy Lawler</td>
<td>Vital Stim Cert</td>
<td>SOCH</td>
<td>862-1170</td>
</tr>
<tr>
<td>Ashley Marcyan</td>
<td>Vital Stim Cert</td>
<td>MSMH</td>
<td>298-2249</td>
</tr>
<tr>
<td>Shannon Niver</td>
<td>Vital Stim Cert</td>
<td>BMH-ACUTE</td>
<td>828-3541</td>
</tr>
<tr>
<td>Erica O'Neil</td>
<td>Vital Stim Cert</td>
<td>MSMH</td>
<td>298-2249</td>
</tr>
<tr>
<td>Renee Otis</td>
<td>Vital Stim Cert</td>
<td>Home Care CHARTC</td>
<td>706-2373</td>
</tr>
<tr>
<td>Erin Reedy</td>
<td>Vital Stim Cert</td>
<td>KMH-ACUTE</td>
<td>447-6020</td>
</tr>
<tr>
<td>Barbara Shaw</td>
<td>Vital Stim Cert</td>
<td>KMH-ACUTE</td>
<td>447-6020</td>
</tr>
<tr>
<td>Juli Greene</td>
<td>Vital Stim Cert</td>
<td>FBM</td>
<td>209-0754</td>
</tr>
<tr>
<td>Jennifer DellaPenta</td>
<td>Vital Stim Cert</td>
<td>FBM</td>
<td>209-0754</td>
</tr>
<tr>
<td>Kara Trippi</td>
<td>Vital Stim Cert</td>
<td>PIR-WS</td>
<td>677-5022</td>
</tr>
<tr>
<td><strong>Other Specialty Areas</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kristin Bernard</td>
<td>Vestibular</td>
<td>MSMH</td>
<td>298-2249</td>
</tr>
<tr>
<td>Connie Jo Bish-Ziegelhorfer</td>
<td>NCS, NDT, Vestibular</td>
<td>PIR-WS</td>
<td>677-5022</td>
</tr>
<tr>
<td>Colleen Bondanza</td>
<td>Vestibular</td>
<td>MACC</td>
<td>828-2455</td>
</tr>
<tr>
<td>Diane Brennan</td>
<td>Vestibular</td>
<td>Transit Road</td>
<td>684-0649</td>
</tr>
<tr>
<td>Lorri Chiaramonte</td>
<td>Vestibular, Prosthetics</td>
<td>PIR-WS</td>
<td>677-5022</td>
</tr>
<tr>
<td>Matthew Clemens</td>
<td>Vestibular</td>
<td>ATN</td>
<td>447-6037</td>
</tr>
<tr>
<td>Lori Cyrek</td>
<td>Vestibular</td>
<td>SOCH NICU</td>
<td>862-1101</td>
</tr>
<tr>
<td>Janet Finley</td>
<td>Vestibular, Aquatic Therapy</td>
<td>MACC</td>
<td>828-2455</td>
</tr>
<tr>
<td>Tara Gawel</td>
<td>Aquatic Therapy</td>
<td>MACC</td>
<td>828-2455</td>
</tr>
<tr>
<td>David May</td>
<td>Vestibular</td>
<td>SOCH-OP</td>
<td>862-1170</td>
</tr>
<tr>
<td>Amy Murdock</td>
<td>Vestibular</td>
<td>MSMH</td>
<td>298-2249</td>
</tr>
<tr>
<td>Debbie Quennel-Kavcic</td>
<td>Vestibular</td>
<td>EA</td>
<td>828-3700</td>
</tr>
<tr>
<td>Anne Schukraft</td>
<td>Vestibular</td>
<td>ATN</td>
<td>447-6037</td>
</tr>
<tr>
<td>Christina VanWyk</td>
<td>Vestibular</td>
<td>SOCH</td>
<td>862-1172</td>
</tr>
<tr>
<td><strong>Temporomandibular Disorders</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joe Lorenzetti</td>
<td></td>
<td>ATN</td>
<td>447-6037</td>
</tr>
<tr>
<td>Ron Schenk</td>
<td></td>
<td>PIR-WS</td>
<td>677-5022</td>
</tr>
<tr>
<td><strong>Women's Health/Pelvic Floor Dysfunction</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kathy Aebischer</td>
<td></td>
<td>MACC</td>
<td>828-8455</td>
</tr>
<tr>
<td>Catherine Kiggins</td>
<td></td>
<td>SOCH</td>
<td>862-1170</td>
</tr>
<tr>
<td><strong>Craniosacral/Myofascial Release</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nancy Ogorek</td>
<td></td>
<td>PIR-WS</td>
<td>677-5022</td>
</tr>
</tbody>
</table>

updated August 2017
PURPOSE: To ensure all employees receive a departmental orientation of sufficient content to prepare them for their specific duties and responsibilities and to meet regulatory requirements.

Applies to: This policy applies to all employees providing service within the Catholic Health System to include agency, employed physicians, and temporary personnel.

GENERAL STATEMENT OF POLICY AND PROCEDURE:

1. All new employees will be oriented to their departments. Orientation will include at a minimum:
   - Organization structure, chain of command and communication
   - Physical layout of department/organization
   - Introduction to key personnel
   - Department specific safety and infection control
   - Unit specific patient safety competencies
   - Department specific competencies in accordance with HR policy # HR-063-PC.

2. Department Directors and/or Managers are responsible for the completion of departmental orientation. A record of departmental orientation will be maintained at the departmental level in accordance with HR policy # HR-063-PC.

3. Departmental orientation will be of such a length to meet the individual employee needs, not to exceed the introductory period and in accordance with collective bargaining agreements.

4. Departmental Orientation is evaluated on a continuous basis making adjustments for changes in practice and scopes of services.

Origination/Effective Date: 7/15/02
Reviewed 10/1/02
Revised 10/1/02MV
References: Federal Law, NYS Law, JCAHO Standards
### DEPARTMENT SPECIFIC ORIENTATION CHECKLIST
Rehabilitation Services

<table>
<thead>
<tr>
<th>Due within 1 week of start date</th>
<th>Date</th>
<th>Manager/Supervisor Signature</th>
<th>Comment Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee sign off</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Indicate NA, (Not applicable) for all that do not apply.**

<table>
<thead>
<tr>
<th><strong>Values in Practice (VIP)</strong></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Verbalizes understanding of core values in relationship to standards of behavior</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Personnel Policies:

| | | |
| 1. Verbalizes understanding of hours of work, holiday commitment, weekend rotation and other department specific items. | | |
| 2. Verbalizes understanding of appropriate “Call-in” procedure. | | |
| 3. Receives and reviews the Dress Code Policy including any specific dept requirements. | | |
| 4. Verbalizes understanding of unit routine including breaks/lunch. Including clocking in and out for lunch, and documentation for no lunch required by the department | | |
| 5. Verbalizes Understanding of: telephone use (including how to answer the telephone) intercoms and/or pagers, and cell phones. | | |
| 6. Verbalizes Understanding of location of department specific policy and procedure manual | | |
| 7. Verbalizes Understanding of security as it relates to personal belongings | | |
| 8. Received and reviewed Attendance Policy | | |

Please sign off and date the completion of the checklist.

Date:
Manager/Supervisor Signature:
Comment Section:
# Department Specific Orientation Checklist

<table>
<thead>
<tr>
<th>Physical Layout of Unit:</th>
<th>Date</th>
<th>Manager/Supervisor Signature</th>
<th>Comment Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction to unit personnel.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Introduction to floor plan, patient rooms.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Miscellaneous: location and use of:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Kitchen/pantry/refrigerator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Ice machine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Laundry disposal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Linen room</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Visitor’s lounge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Conference room</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Cafeteria and restrooms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Department Specific</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Assigned locker/desk area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Front Office</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Gym/treatment area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety &amp; Emergency Procedure:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Demonstrates proper/safe handling of equipment.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Able to locate fire extinguishers and fire alarms.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Observes proper no smoking rules for staff and patients.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Demonstrates knowledge of fire and disaster plans.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Verbalizes procedure for calling fire.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Maintains safe environment for patients and visitors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Verbalizes understanding of emergency shut off procedure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Able to locate code cart</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Verbalizes understanding of procedure for calling a code</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Verbalizes understanding the process for reporting safety concerns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Verbalizes understanding the process for reporting incidents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Verbalizes understanding the process for addressing a violent person (Code Silver)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Verbalizes understanding the process for accessing MSDS’s</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Verbalizes understanding the process of chemical spill containment and location of containment material</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Able to locate Emergency Code Flip Chart</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Able to locate Department Meeting Point</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
DEPARTMENT SPECIFIC
ORIENTATION CHECKLIST
Rehabilitation Services

<table>
<thead>
<tr>
<th>18. Able to locate Evacuation Map</th>
</tr>
</thead>
<tbody>
<tr>
<td>19. Verbalizes understanding of Mass Casualty response responsibilities</td>
</tr>
<tr>
<td>20. Able to locate red outlets</td>
</tr>
<tr>
<td>21. Able to locate Negative Pressure Isolation Room and respirators</td>
</tr>
<tr>
<td>22.</td>
</tr>
<tr>
<td>23.</td>
</tr>
<tr>
<td>24.</td>
</tr>
<tr>
<td>25.</td>
</tr>
</tbody>
</table>

**Able to locate department specific equipment**
(List all appropriate equipment)

Able to safely and competently use:

1. Moist Heat/ Cold Packs/Ice Massage
2. E-Stim
3. Iontophoresis
4. Ultrasound
5. Traction
6. Whirlpools
7. Assistive Devices
8. Therapeutic Exercise Equipment
9. Parallel Bars and Stairs
10. Bracing/Splinting/taping material
11. Vibrators
12. Positioning/ADL Equipment
13. Wheelchairs
14. |
<table>
<thead>
<tr>
<th>15.</th>
<th>Age specific (as applicable)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Received copy of Competency-Based Job Description Orientation/Annual Performance Evaluation Form</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Job Specific competencies:**

1. Received copy of Competency-Based Job Description Orientation/Annual Performance Evaluation Form

2. Received copy and start pursuing New Hire Competencies

3. Received copy and start pursuing Current year competencies

**Upon completion maintain in department file and forward to Human Resources with 90 day evaluation**

FORM # HR 19
## Physical Therapist:
- Understands the role of a PT as a member of the interdisciplinary team

## Documentation:
Demonstrates ability to accurately convey Information using:

### Initial Evaluation
- Inpatient
- MRU
- Outpatient

### Progress Note
- Inpatient
- MRU
- Outpatient

### Discharge Summary

### Other forms
- Patient/Family education sheets
- FIM/IRF PAI Forms

### Miscellaneous
- Uses appropriate abbreviations
- Writes legibly

### Demonstrates ability to establish patient driven goals
- Functional goals
- Measurable goals
- Progressive
<table>
<thead>
<tr>
<th>Treatment Plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Addresses goals and shows treatment progression</td>
</tr>
<tr>
<td>- Demonstrates or describes how to alter treatment based on patients:</td>
</tr>
<tr>
<td>- Psychosocial, development, cultural or age specific needs</td>
</tr>
<tr>
<td>- Medical status</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Billing and Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Able to properly fill out charge sheet</td>
</tr>
<tr>
<td>- Demonstrates understanding of insurance regulations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Initiative</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Understands Productivity standards</td>
</tr>
<tr>
<td>- Discusses with Supervisor changes in the schedule and work site as needed for pt. care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Self/Professional Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Participates in Peer Review</td>
</tr>
<tr>
<td>- Understands Continuing Education Policy</td>
</tr>
<tr>
<td>- Has knowledge of Professional Organizations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates Professional communication with</td>
</tr>
<tr>
<td>- Intradepartmental co-workers</td>
</tr>
<tr>
<td>- Interdepartmental co-workers</td>
</tr>
<tr>
<td>- Patients</td>
</tr>
<tr>
<td>- Physicians/Nursing</td>
</tr>
<tr>
<td>- Understands when to refer pt. for additional services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Participates in PIR Employee Orientation</th>
</tr>
</thead>
</table>

Upon completion maintain in department file and forward to Human Resources with 90 day evaluation.
<table>
<thead>
<tr>
<th>Physical Therapist Assistant:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Understands the role of a PTA as a member of the interdisciplinary team</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Documentation:**
Demonstrates ability to accurately convey Information using:

**Progress Note**
- Inpatient
- MRU
- Outpatient

**Discharge Summary**

**Other forms**
- Patient/Family education sheets
- FIM/IRF PAI Forms

**Miscellaneous**
- Uses appropriate abbreviations
- Writes legibly

**Demonstrates or describes how to alter treatment based on patients:**
- Psychosocial, development, cultural or age specific needs
- Medical status

**Billing and Insurance**
- Able to properly fill out charge sheet
- Demonstrates understanding of insurance regulations
**JOB SPECIFIC ORIENTATION CHECKLIST**

**PHYSICAL THERAPIST ASSISTANT**

Due within 90 days of start date

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Date</th>
<th>Manager/Supervisor Signature</th>
<th>Comment Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee sign off</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Initiative**
- Understands Productivity standards
- Discusses with Supervisor changes in the schedule and work site as needed for pt. care

**Self/Professional Development**
- Participates in Peer Review
- Understands Continuing Education
- Has knowledge of Professional Organizations

**Communication**
Demonstrates Professional communication with:
- Intra departmental co-workers
- Inter departmental co-workers
  - Participates on interdisciplinary teams
- Patients
- Physicians/Nursing
- Understands when to refer patient for additional services

**Participates in PIR Employee Orientation**

Upon completion maintain in department file and forward to Human Resources with 90 day evaluation.
**Occupational Therapist:**

- Understands the role of a OT as a member of the interdisciplinary team

**Documentation:**

Demonstrates ability to accurately convey Information using:

**Initial Evaluation**
- Inpatient
- MRU
- Outpatient

**Progress Note**
- Inpatient
- MRU
- Outpatient

**Discharge Summary**

**Other forms**
- Patient/Family education sheets
- FIM/IRF PAI Forms

**Miscellaneous**
- Uses appropriate abbreviations
- Writes legibly

**Demonstrates ability to establish patient driven goals**
- Functional goals
- Measurable goals
- Progressive
<table>
<thead>
<tr>
<th>Treatment Plan</th>
<th>Date</th>
<th>Manager/Supervisor Signature</th>
<th>Comment Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Addresses goals and shows treatment progression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Demonstrates or describes how to alter treatment based on patients:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Psychosocial, development, cultural or age specific needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Medical status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Billing and Insurance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Able to properly fill out charge sheet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Demonstrates understanding of insurance regulations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initiative</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Understands Productivity standards</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Discusses with Supervisor changes in the schedule and work site as needed for pt. care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self/Professional Development</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Participates in Peer Review</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Understands Continuing Education Policy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Has knowledge of Professional Organizations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrates Professional communication with</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Intradepartmental co-workers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Interdepartmental co-workers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Patients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Physicians/Nursing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Understands when to refer pt. for additional services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participates in PIR Employee Orientation</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Upon completion maintain in department file and forward to Human Resources with 90 day evaluation.
## Job Specific Orientation Checklist

### Certified Occupational Therapy Assistant:

- Understands the role of an COTA as a member of the interdisciplinary team

### Documentation:

Demonstrates ability to accurately convey Information using:

- Progress Note
  - Inpatient
  - MRU
  - Outpatient
- Discharge Summary
- Other Forms
  - Patient/Family education sheets
  - FIM/IRF PAI Forms
  - Splint Forms
- Miscellaneous
  - Uses appropriate abbreviations
  - Writes legibly

### Demonstrates or describes how to alter treatment based on patients:

- Psychosocial, development, cultural or age specific needs
- Medical status

### Billing and Insurance:

- Able to properly fill out charge sheet
- Demonstrates understanding of insurance regulations
### JOB SPECIFIC ORIENTATION CHECKLIST
CERTIFIED OCCUPATIONAL THERAPY ASSISTANT

**Due within 90 days of start date**

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Date</th>
<th>Manager/Supervisor Signature</th>
<th>Comment Section</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Indicate <strong>NA</strong>, (Not applicable) for all that do not apply.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Self/Professional Development</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Communication</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Understands Productivity standards
- Discusses with Supervisor changes in the work site as needed for pt. care

- Peer Review
- Continuing Education

Demonstrates professional communication with:

- Intradepartmental co-workers
- Interdepartmental co-workers
  - Participates on interdisciplinary teams
- Patients
- Physicians/Nursing
- Understands when to refer patient for additional services

Participates in PIR Employee Orientation

Upon completion maintain in department file and forward to Human Resources with 90 day evaluation
<table>
<thead>
<tr>
<th>Speech Language Pathologist:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Understands the role of an SLP as a member of the interdisciplinary team</td>
<td></td>
</tr>
</tbody>
</table>

**Documentation:**

Demonstrates ability to accurately convey Information using:

**Initial Evaluation**
- Inpatient
- MRU
- Outpatient

**Progress Note**
- Inpatient
- MRU
- Outpatient

**Discharge Summary**

**Other Forms**
- Patient/Family education sheets
- FIM/IRF PAI Forms

**Miscellaneous**
- Uses appropriate abbreviations
- Writes legibly

**Demonstrates ability to establish patient driven goals**
- Functional goals
- Measurable goals
- Progressive goals
<table>
<thead>
<tr>
<th><strong>Treatment Plan:</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Addresses goals and shows treatment progression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Demonstrates or describes how to alter treatment based on patients:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Psychosocial, development, cultural or age specific needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Medical status</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Billing and Insurance</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Able to properly fill out charge sheet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Demonstrates understanding of insurance regulations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Initiative</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Understands Productivity standards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Discusses with Supervisor changes in the schedule and work site as needed for pt. care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Self/Professional Development</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Participates in Peer Review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Understands Continuing Education Policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Has knowledge of Professional Organizations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Communication</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates professional communication with:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Intradepartmental co-workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Interdepartmental co-workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Participates on interdisciplinary teams</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Physicians/Nursing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Understands when to refer pt for additional services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<p>| <strong>Participates in PIR Employee Orientation</strong> |  |  |</p>
<table>
<thead>
<tr>
<th>Due within 90 days of start date</th>
<th>Date</th>
<th>Manager/Supervisor Signature</th>
<th>Comment Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee sign off</td>
<td></td>
<td></td>
<td>Indicate <strong>NA</strong>, (Not applicable) for all that do not apply.</td>
</tr>
</tbody>
</table>

**Upon completion maintain in department file and forward to Human Resources with 90 day evaluation**
STUDENT SCHEDULE FOR OTR STUDENTS

Week 1

- Introduction to staff/ Attend Report/Rounding
- Tour of facility and departments
- Observation of evaluations/treatment in clinic
- Review department forms and paperwork/ orientation to resident’s charts
- Student will list his/her goals for fieldwork and strengths/weaknesses
- Student will familiarize with department modalities with assigned therapist
- Review chart and collect data for first treatment plan
- Perform 1-2 chart reviews
- Review facility policies and procedures

Week 2

- First treatment plan due
- Collect data for second treatment plan
- Student will review with therapist medical precautions
- Student will complete new evaluation under therapist’s supervision
- Assist in clinic
- Research topic or diagnosis for paper or idea for clinic project
- Receive first patient- collect data, plan initial evaluation, evaluate patient, under supervisor’s direction, write up evaluation, and complete paperwork
- Perform full ADL with resident in AM
- Attend family meeting

* caseload 1 patient

Week 3

- Begin preparing for topic presentation/ clinic project
- Receive second and third patients
- Work with assigned patients
- Complete second treatment plan
- Choose field trip site if available
- Assist in clinic
- Present at Rounds/ Report
- Review progress note format with therapist and provide input on patient
- Observe feeding in dining room
- Update closet care plans

* caseload 3 patients
**Week 4**

Complete progress notes on assigned patients with therapist’s review
Review discharge note format with therapist and complete a discharge summary (both written and in the computer)
Assist with feeding/ splinting/ positioning evaluations
Review positioning devices, splints, and adaptive feeding equipment
Receive fourth patient
Work with assigned patients
Present at a family meeting

*caseload 4 patients*

**Week 5**

Observe/Perform Home evaluations if applicable
Meet with supervisor and choose patient for case study assignment
Receive fifth patient
Work with assigned patients
Perform Mini Mental Test

*caseload 5 patients*

**Week 6**

Observe/ Perform kitchen assessment
Arrange/attend surgery observation if able
Work with assigned patients
Complete mid-term evaluation

*caseload 5-7 patients*

**Week 7**

Review/ Assist therapist with quarterly/ annual screen
Fabricate splint with therapist
Review Medicare guidelines and RUG scores
Work with assigned patients

*caseload 6-8 patients*

**Week 8**

Assign fieldwork project
Perform quarterly/annual screens independently
Work with assigned patients

*caseload 7-9 patients

**Week 9**

Meet with supervisor to review fieldwork project
Work with assigned patients

*caseload approximately 10 patients

**Week 10**

Fieldwork project due and presented to staff
Work with assigned patients

*caseload 10-12 patients

**Week 11**

Present In-service
Work with assigned patients

*caseload 10-12 patients

**Week 12**

Fill out CI survey and email to liaison
Review final evaluation of student with supervisor
Work with assigned patients

*caseload 10-12 patients
COTA Level II Fieldwork
Student Objectives

Week 1
Orientation to facility.
Familiarize self with facility environment and O.T. department procedures.
Review paperwork and orientation to patient charts.
Shadow O.T. staff.
Attend Rounding / Report.
Fill out student’s goals strengths and weaknesses.

Week 2
Pick topic for in-service.
Review three charts with minimal guidance, and be able to summarize circumstances efficiently.
Assist with 2-3 sessions with supervisor; write observation notes on all patients observed.
Responsible for choosing activities for one patient according to treatment plan and implement them in a session with a supervisor.
Demonstrate the ability to interpret an initial evaluation, determine problem areas and identify at least one activity appropriate for treatment.
Be able to perform AROM UE (goniometer) and identify problem areas.
Complete ADL assessment with supervisor.
Observe family meeting.

Week 3
Able to complete chart review independently.
Independent with partial ADL assessment.
Observe feeding in dining room.
Complete progress notes with supervision.
Given a treatment plan, set treatment priorities and identify a variety of appropriate treatment activities.
Update closet care plan.
Start presenting in Rounding / Report.
Caseload of 2-4 patients.

Week 4
Complete progress notes with minimal to moderate assistance.
Identify 2-3 activities for any given problem.
Treatment of patients with occasional supervision for treatment planning and implementation.
Complete discharge summary and UDA.
Review of positioning devices and splints / AE.
Participate in family meeting.
Caseload of 4-5 patients.
Complete Midterm with supervisor.

**Week 5**

Plan and implement treatment program for patients.
Attend a home assessment if applicable; write down observations and problem areas.
Perform mini mental examination.
Midterm evaluation.

**Week 6**

Independent with ADL assessment and treatment.
Independent with kitchen assessment and treatment.
Complete OT progress notes with occasional need for guidance or minimal assist.
Demonstrate ability to verbally report patient progress comprehensively to supervisor, OTR, team.
Grade activities independently.
Independent with planning, implementing TX.
Caseload of 5-6 patients, independent management of scheduling.

**By End of Affiliation**

Participate responsibly in OTR / COTA communication supervision / relationship.
Full caseload of 6-8 patients.
Accurately write, on time, all progress notes for patients on his / her caseload in the format style that is consistent with this department.
Satisfactory meet behavioral objectives of fieldwork.
Complete Oral presentation (in-service) for Rehab staff.
Complete and review final evaluation.
Fill out CI survey and mail to liaison.
**PT Student Schedule**

**Week 1**

- Tour of facility/ departments
- Introduction to staff/ attend Rounding/ Report
- Review student’s goals for fieldwork and strengths/ weaknesses
- Review facility policies and procedures
- Review department forms and paperwork/ orientation to resident’s charts
- Observe evaluation/ treatments in clinic
- Perform 1-2 chart reviews and collect data for first treatment plan

**Week 2**

- First treatment plan due
- Collect data for second/ third treatment plan
- Assist in clinic
- Pick topic and begin research for presentation
- Receive first patient- collect history, perform evaluation under CI’s direction, write up evaluation, and complete paperwork
- Attend family meeting (if applicable)
- Observe OT/ ST treatments

**Week 3**

- Receive second and third patients
- Complete second and third treatment plan
- Perform 1-2 evaluations
- Treat assigned patients, assist in clinic
- Present at Rounding/ Report
- Review progress note format and provide input on patient
- Continue research for presentation topic
- Review process for updating care plans
- Meet with CI for midterm review
**Week 4**

- Complete progress notes on assigned patients with CI direction
- Review discharge note format and complete a discharge summary and UDA
- Receive 4th and 5th patients
- Complete fourth and fifth treatment plan
- Perform evaluations
- Work with assigned patients
- Continue research for presentation topic
- Choose patient for case study presentation

**Week 5**

- Complete progress notes on assigned patients
- Receive 6th and 7th patients and complete treatment plans
- Work with assigned patients
- Perform evaluations
- Review Medicare guidelines and RUG scores
- Review/ Assist therapist with quarterly/ annual screen
- Present research topic
- Prepare for patient case study presentation

**Week 6**

- Perform quarterly/ annual screens
- Work with assigned patients
- Fill out CI survey and email to liaison
- Review Final evaluation of student with supervisor
- Present patient case study
Physical Therapist Assistant Goals & Expectations

Week 1

- Introduction to facility/staff
- Orientation to student manual
- Review policies and procedures
- Student to familiarize self with department equipment/modalities
- Student to set and discuss personal goals, strengths and weaknesses with clinical instructor
- Review ROM/goniometry, MMT, transfer/gait/stair training, body mechanics, THP, WB restrictions, use of AD/AE and guarding techniques
- Observe PT initial evaluation including chart review
- Review current caseload documentation
- Observe/participate in PT treatments
- Review week 1 and set goals for week 2

Week 2

- Discuss possible topics/date for inservice
- Review documentation and billing procedures
- Overview of Medicare guidelines related to SAR/LTC
- Overview of MDS guidelines
- Student to acquire caseload of 1 client per treatment hour and will carry out treatment plan with assistance from CI
- Student, with assist from CI, will be responsible for documentation/billing for clients on students current caseload
- Complete and review midterm evaluation
- Discuss week 2 and set goals for week 3

Week 3

- Set inservice topic and date
- Student to acquire caseload of 2 clients per treatment hour and will carry out treatment plan with supervision from CI
- Student, with supervision from CI, will be responsible for documentation/billing for clients on students current caseload
• Student to demonstrate the ability to progress treatment activities within the plan of care
• Attend family meeting
• Attend Rouding/ Report
• Accompany PT/OT on home assessment for patient on current caseload
• Discuss week 3 and set goals for week 4

**Week 4**

• Student to acquire CI full caseload and will be responsible for treatments, documentation and billing for each client
• Develop home exercise program (HEP) for clients on current caseload
• Attend Rounding/ Report with participation regarding clients on current caseload
• Present in-service to staff
• Complete and review final evaluation
• Complete CI survey and email to liaison
• Complete site evaluation
**SLP Student Schedule**

### Week 1:
- Tour of facility/departments
- Introduction to staff/attend morning report
- Review externship goals and identify strengths/weaknesses
- Review facility policies/procedures
- Review diet consistencies
- Familiarize with adaptive feeding/swallowing equipment
- Familiarize with testing/therapy materials
- Review department forms/paperwork
- Orientation to patient/resident’s charts
- Observe chart reviews, evaluations, treatment planning, treatments
- Attend subacute discharge planning meeting

### Week 2:
- Review morning report book and identify red flags
- Attend family care plan meeting and/or observe family education
- Perform 1-2 chart reviews, collect data, evaluations with max assist
- Develop 1-2 treatment plans and perform treatments with max assist
- Documentation/billing with max assist (of 1-2 treatments performed)
- Pick topic for inservice and begin research
- Shadow OT/PT treatments in therapy room
- Shadow OT during feed program

### Week 3:
- Present at subacute discharge planning meeting
- Perform 1-2 chart reviews, collect data, evaluations with max-mod assist
- Develop 1-2 treatment plans and perform treatments with max-mod assist
- Documentation/billing with max-mod assist (of 1-2 treatments performed)
- Continue research for inservice topic, with direction as needed
- Review process for care plan updating
- Round dining rooms and identify s/s of aspiration

### Week 4:
- Present at subacute discharge planning meeting
- Perform 2-3 chart reviews, collect data, evaluations with mod assist
- Develop 2-3 treatment plans and perform treatments with mod assist
- Documentation/billing with mod assist (of 2-3 treatments performed)
- Round dining rooms and model safe feeding
- Choose patient for case study report
- Review process for MDS updating
- Review Medicare guidelines and RUG scores
- Assist with annual screens
Week 5:
- Review mid-term evaluation of student with supervisor
- Present at subacute discharge planning meeting
- Perform 4-5 chart reviews, collect data, evaluations with mod-min assist
- Develop 4-5 treatment plans and perform treatments with mod-min assist
- Documentation/billing with mod-min assist (of 4-5 treatments performed)

Weeks 6-7:
- Present at subacute discharge planning meeting
- Perform all chart reviews, collect data, evaluations continue with mod-min assist
- Develop all treatment plans and perform treatments continue with mod-min assist
- Documentation/billing continue with mod-min assist (of all treatments performed)
- Review process for UDA updating

Weeks 8-9
- Present at subacute discharge planning meeting
- Perform all chart reviews, collect data, evaluations with min assist
- Develop all treatment plans and perform treatments with min assist
- Documentation/billing with min assist (of all treatments performed)

Week 10:
- Present at subacute discharge planning meeting
- Perform all chart reviews, collect data, evaluations with min-no assist
- Develop all treatment plans and perform treatments with min-no assist
- Documentation/billing with min-no assist (of all treatments performed)
- Present case study/research project
- In-service nursing staff
- Review final evaluation of student with supervisor
- Fill out student survey and mail to liaison

*Additional observations, as schedule permits:
  - Modified Barium Swallow study
  - Vital Stim treatment
  - PEG tube placement
  - Dementia Program
**PT STUDENT SCHEDULE**

**Week 1**
- Tour of facility/departments
- Introduction to staff
- Review department forms and paperwork/orientation to patient’s charts
- Review student’s goals for internship and review strengths/weaknesses
- Review student manual
- Observe evaluation/treatments in clinic
- Perform 1-2 chart reviews
- Receive first patient – collect history, perform evaluation under CI’s direction, write up evaluation, and complete paperwork
- Perform mock evaluations with CI, reviewing upper and lower extremity screen, developing treatment plan
- Review week1/plan goals for week 2

**Week 2**
- Review current patient load and develop treatment plans for charts for the week
- Assist with patients in the clinic
- Pick topic and begin research for inservice
- Observe other ancillary sources – OT, imaging
- Perform 3-5 evaluations under CI direction
- Review week 2/plan goals for week 3
- Select two articles for article review

**Week 3**
- Review current patient load and develop treatment plans for the week
- Perform 3-5 evaluations under CI direction
- Treat assigned patients, assist in clinic
- Continue research for presentation topic
- Meet with CI for midterm review
- Article review, 2 articles
- Review week 3/plan goals week 4
- Caseload should be approaching 1 client/hour by the end of the week
**Week 4**

Review current patient load and develop treatment plan for week
Complete 30-day progress notes and/or discharge summaries on assigned patients with CI direction
Perform 3-5 evaluations
Work with assigned patients
Attend staff meeting
Continue research for presentation topic
Choose patient for case study presentation
Article review, 2 articles
Review week 4/plan goals week 5

**Week 5**

Complete progress notes/discharge summaries on assigned patients
Work with assigned patients
Perform evaluations 3-5
Present inservice
Prepare for patient case study presentation
Article review, 2 articles
Review week 5/plan goals for week 6

**Week 6**

Review current patient load and develop treatment plan for week
Work with assigned patients
Fill out student survey and mail to liaison
Review Final evaluation of student with supervisor
Present patient case study
Make sure all paperwork is up to date and treatment plans updated for Physical Therapist who takes over the patient load
Exercises for the Shoulder Following Replacement-Reconstruction When the Tuberosities are Intact

The following is a suggested program of exercises for rehabilitation of soft tissue. The program may be altered for special circumstances.

6th Post-op Day

A. Assisted External Rotation:
Lying on back—Elbows flexed to 90° and held close to body. push operated hand outward, good arm supplying the power through the use of a stick.

B. Pendulum Exercises:
Standing—(a) Bending over at waist, circle entire arm clockwise, palm facing forward. (b) Bending over at waist, circle entire arm counter-clockwise, palm facing backward.

8th Post-op Day

C. Assisted Extension:
Standing—Grasping a stick with weight in hand.Operated arm behind.

D. Pulley Exercises:
Standing—Good arm supplies the power to bring the arm of poor.
10th Post-op Day

**ISOMETRICS**

Exercises G through L are designed to maintain muscle tone. It is important to note that in each isometric exercise no motion is allowed, i.e., motion is resisted and prevented by the good arm or an immovable object such as a door jamb or wall.

**E. Assisted Internal Rotation:**
Standing—Grasp wrist of the operated arm with the good hand behind back, slide hands up and down.

**F. Assisted External Rotation:**
Lying on back—Grasp wrist of operated arm with good hand, reach up and overhead, clasp hands, then slide hands down behind neck, while spreading elbows. Reverse by sliding clasped hands upward out from under neck.

**G. External Rotators:**
Lying on back—Elbows flexed to 90° and held close to body, grasp wrist of operated arm with good hand, attempt to move operated hand outward resisting motion with the good hand. Do not allow the operated arm to move.

**H. Internal Rotators:**
Lying on back—Elbow flexed to 90° and held close to body, grasp wrist of operated arm with good hand, attempt to move operated hand inward, resisting any motion with the good hand.

**I. External Rotators:**
Standing—Elbow flexed to 90° and held close to body, attempt to push hand outward against door jamb.

**J. Internal Rotators:**
Standing—Elbow flexed to 90° and held close to body, attempt to push inward.

**K. Pectoralis Major:**
Standing—Elbow flexed to 90° and held close to body, attempt to press elbow.

**L. Middle Deltoid:**
Standing—Elbow flexed to 90° and held close to body, attempt to move elbow out to side and upward.


Active (Strengthening) Exercises (Phase II)

These are begun on the 12th day after surgery. Active elevation is begun with the patient supine and later, when strength permits, with the patient erect. Resistive exercises for the posterior, middle, and anterior deltoid are begun with rubber dental dam, and later with surgical tubing.

12th Post-op Day

M. Forward Elevation (anterior deltoid): Lying on back—Hold hand overhead, with elbow flexed, then gradually lower it, trying to hold it with your muscles at various points in the range. When arm can be lifted overhead in a smooth arc with the elbow straight, progress to same exercise in the sitting position.

N. Forward Elevation (anterior deltoid): Standing—Grasp stick in both hands, push straight up overhead.

O. Forward Elevation (anterior deltoid): Sitting at a table or desk—Slide arm forward and back. Progress by lifting arm upward off of the desk at the end of the push forward.

P. Shoulder Extension (posterior deltoid): With dental dam around door knob and elbow flexed to 90°, pull arm backward. Hold for five seconds.

Q. Forward Elevation (anterior deltoid): With dental dam around door knob and elbow flexed to 90°, push forward. Hold for five

R. External Rotation: Both elbows flexed to 90°, stretch dental dam by pulling hands apart equally. Hold for five seconds.

All exercises should be done in several short sessions daily. They are designed to strengthen the shoulder muscles, to maintain and continue to gain motion. Use of the arm in daily activities is recommended.
S. Forward Elevation: Facing an open door, assist arm up, hook finger tips on top of door. Bend knees slightly to stretch. Use a stool if necessary.

T. Internal Rotation: Behind low back pull hand up as high as possible, using a towel.

U. External Rotation: Standing in a doorway with elbow flexed to 90° and held close to body, place palm on door jamb, slowly turn body away from the arm.

21st Post-op

Discharge from hospital with sling worn between exercise sessions as needed for fatigue.
Basic Total Hip Replacement Precautions

Weight-bearing status:

Continue to use the following guidelines until your doctor tells you otherwise.

Avoid bending past 90 degrees.

Avoid twisting your leg in or out.

Avoid crossing your legs.
Total Hip Replacement Precautions

Continue to use the following guidelines until your doctor tells you otherwise.

In general:

Avoid bending past 90 degrees.
Avoid twisting your leg in or out.
Avoid crossing your legs.

Lying

• Lie on your back while resting in bed. Keep a pillow between your thighs to prevent your knees from touching.

• You must have a pillow between your thighs if you lie on your side.

Transfers

• Scoot to the edge of the bed or chair before standing.

• Keep your involved leg in front of the other when getting up from a chair or bed.

• Avoid low beds.

Sitting

• Sit in chairs higher than knee height.
• Sit in a firm, straight-back chair with arm rests.
• DO NOT sit on soft chairs, rocking chairs, sofas, or stools.

pilow

straight-back chair

arm rest
Walking

- Continue to use your walker, crutches, or cane until your doctor tells you otherwise.
- Wear well-fitting shoes with non-skid soles.
- Get up and move around every hour. Take short, frequent walks.
- Be careful on uneven ground or wet surfaces.
- Maintain your weight-bearing status as instructed until your doctor or therapist tells you otherwise.
- Avoid pivoting on your operated leg. Take small steps when turning.

Toileting

- Use a raised toilet seat at or above knee height.
- Avoid twisting during personal hygiene.

Bathting

- Take sponge baths or purchase a tub bench. You may use a walk-in shower.
- DO NOT bend or reach for the tub controls.
- DO NOT bend or squat to wash your legs and feet. Use long-handled equipment to reach them.
- DO NOT sit in the bottom of a regular bathtub; use a tub seat or bench.

Dressing

- Use long-handled equipment to get dressed.
- Sit down when passing clothing over your feet.
- DO NOT bend over, raise your legs, or cross your legs when you get dressed.
Household chores

- Use long-handled reachers, mops, brooms, or dustpans to do simple chores that would involve bending, stooping, or twisting (such as washing floors, dusting low tables, or making beds).

- DO NOT bend to pick up objects from the floor. Use a long-handled reacher.
- DO NOT run the vacuum cleaner or sweeper.
- Use a rolling cart to transport items.

Riding in a car

- DO NOT drive until your doctor says you may.
- DO NOT enter your car while standing on a curb or step.
- Avoid long car rides. Get up and walk around every two hours.
- Avoid cars with deep bucket seats or low seats. Sit on a pillow to raise the seat height.

Sexual relations

Do not feel that you have to avoid sexual relations. You do need to take certain precautions concerning your position. Discuss this with your doctor or therapist.

- Place commonly used items above knee level or on the top shelf of your refrigerator.
- Slide items along the kitchen counter.
- Sit while preparing food.
Energy Conservation and Work Simplification Techniques

Principles of Energy Conservation
- Balance activity with rest
- Plan ahead
- Set Priorities
- Pace activity
- Learn activity tolerance

Principles of Work Simplification
- Slide, don’t lift
- Eliminate unnecessary motions
- Sit to work whenever possible
- Use proper work heights
- Avoid stooping, bending, and over-reaching
- Store supplies where used

1. Self Care
- Choose combs, brushes, etc., with large handles - they are easier to grip.
- Use pipe insulation from a hardware store, as it can be used to enlarge utensil handles.
- Put on a terry cloth bathrobe if you can’t dry your back.
- Use a bath brush for feet and back - get one with a long handle.
- If you have difficulty manipulating medication containers, ask your physician to write, “Do not put in childproof container.”
- Ease toileting and bathing by using adapted bathroom, i.e., elevated commode, safety rails, tub bench, hand held shower, and grab bars.
2. Clothing

- Select larger clothing than usual, as it is easier to put on and take off.
- Select clothing that opens in the front and opens all the way so that you do not have to step into it.
- Select clothing with large flat buttons.
- Do you have difficulty with small fasteners? Adaptive equipment is available.
- Ease zipper manipulation by using a large paper clip or ring on zipper.
- Buy pants with elastic waistbands.
- Do you have a sore shoulder or hip? Put sore arm/leg in first and take out last.
- Use a long shoe horn if bending over is difficult or not allowed.

3. Bathroom Safety: Most accidents occur in the home, and a large majority of them occur in the bathroom. Assure safety with bathroom mobility by considering the following equipment:

- Non-skid strips in the bottom of the tub.
- Grab bars in the bathtub as they are essential safety items for all.
- Shower chair and hand held shower.
- Raised toilet seat and/or toilet safety rails, as they can provide additional support.

4. Cleaning

- Use tongs to pick up objects from the floor.
- Do not reach when using the dust mop.
- Use light weight, long handled tools.
- Use tea cart to transport cleaning equipment.
• When shower curtain gets dirty, throw it in the washing machine with a towel.
• Carry a light basket with all the cleaning supplies you need.
• Use a professional cleaning service occasionally.
• Put pail on a rolling dolly.

5. Meal Planning, Preparation, Service and Cleanup
• Use surface appliances rather than a low oven when possible.
• Use fireplace matches to light gas oven.
• Gather all supplies and position then where they are to be used before starting the first stop of a job.
• Use tea cart to transport heavy objects and to save steps.
• Slide filled pans along stove and counter tops instead of lifting them.
• Use a pull cart to bring food home from the supermarket rather than carrying shopping bags.
• Use an electric appliance when possible (i.e., blender, mixer, can opener, etc.)
• Use prepared mixes, frozen foods, or packaged foods.
• Plan one dish meals.
• Prepare extra portions for easy reheating later.
• Use lightweight pots and pans with Teflon/Silverstone coating.
• Wear an apron with pockets so that you can carry objects.
• Eliminate unnecessary steps:
  a) Let dishes drain dry.
  b) Use paper dinner napkins instead of linen ones.
  c) Use placemats instead of tablecloths.
  d) Soak pots in hot water and detergent to eliminate vigorous scouring
6. Laundry
- Pin socks together before washing.
- Sort clothes on a table, never on the floor.
- Use sinks that are at a proper work height.
- Sit to iron.
- Use fabric softener to avoid wrinkles.
- Use three baskets to collect dirty clothes to assist in sorting light, medium and dark colors.
- Raise front-loaded washer/dryer on cinder blocks.

7. Communication
- Use bookstand or music stand to hold books.
- Use large print books and magazines, or use a magnifying glass.
- Use writing aids with large handles that are built up with firm tape.
- Use a card holder which is commercially available, or use a scrub brush.
- Ease telephone speaking by using a phone holder.
- Use pencil to dial telephone.

8. Storage
- Store articles where they are used.
- Pull out storage bins for vegetables, etc., to avoid reaching.
- Hang pots on wall, if dust is not a problem.
- Install pull out or swing out shelving.
- Keep measuring utensils in containers where they are used.
9. Shopping
- Call department store ahead of time and reserve a wheelchair.
- Call ahead and make sure items you want are available.
- Keep memo pad and pencil in all rooms to keep shopping list up to date.
- Shop at non-peak hours.
- Have grocery store deliver groceries.

10. Correct Body Mechanics to Save Energy
- Sit and stand correctly by using good posture.
- Lift with your legs while keeping your back straight.
- Avoid reaching.
- Push, don’t pull.
- Use both hands to carry items, when possible.
- Slide, don’t lift.
- Hold objects close to your body when carrying.

11. Pace
- Work and move at a moderate pace:
  a) Fast walking takes 1 ½ times as much energy as slow walking.
  b) Walking up stairs takes 7 times as much energy as walking on level ground.
- Take frequent short rest periods while you are walking to avoid getting tired, instead of a long rest period after you get tired.
- Use slow, flowing motions rather than fast jerky movements. Avoid sudden bursts of activity.
- Plan ahead to avoid rushing. This allows you to work at a relaxed pace.
- Alternate light and heavy work throughout the day and week.
12. Work Heights

- Use work surfaces that are at a level that allows you to work without bending or raising your hand above the elbow.
- Adapt counter space or use a lapboard for wheelchair patients.
- Order desk arm on a wheelchair to allow an individual access to appropriate tables.

13. Breathing Techniques

- Pursed lip breathing – Take in a slow breath through your nose. Then, pucker (purse) your lips like you are going to whistle and let the air fall out slowly through your pursed lips. Remember: Slow, easy, and relaxed in and out to control your breathing.
- Inhalation should be done when you are extending or straightening the trunk, lifting the arms up, or moving your arms away from the body.
- Exhalation should be done when flexing or bending the trunk or bringing your arms toward the body. Exhale by blowing out through pursed lips.
- Remember; never hold your breath during activities and pace yourself by breathing slowly and deeply.
- If you are experiencing shortness of breath, get your head and shoulders down, breathe in through your mouth, and blow out through your mouth. As you catch your breath begin to breathe through your nose and slow your breathing down. Stay in the same position for five minutes or longer.
National Outcomes Measurement System (NOMS)

News

Seven of ASHA’s Functional Communication Measures have been adopted by CMS for Claims-based Outcome Reporting using G-codes.

Starting January 1st, SLPs who treat Medicare Part B beneficiaries must begin reporting patient outcomes on claims forms. The measures, based on the NOMS FCMs, are described as a G-code with a seven-point severity modifier that corresponds to the FCM severity scale. View frequently asked questions related to NOMS and claims-based outcomes reporting.

ASHA’s NOMS is also an Approved Registry for the CMS Physician Quality Reporting System (PQRS)

PQRS is separate from the Medicare claims-based reporting initiative and is only for SLPs who directly bill Medicare Part B for the provision of services to stroke patients. As an approved registry, ASHA will submit NOMS data to CMS on behalf of eligible SLPs. View the participation criteria and frequently asked questions related to PQRS.

Release of the Adult NOMS Functional Communication Measures (FCM)

In 2008, eight of the 15 Functional Communication Measures (FCM) from the Adult NOMS were submitted to the National Quality Forum (NQF) for review. All eight were endorsed and subsequently became part of the public domain. While the FCMs from the Adult NOMS are part of the public domain and can be used for claims-based reporting and/or PQRS, it is important to note that the FCMs are only one component of NOMS, ASHA’s National Outcomes Measurement System. View the eight Adult

Information for Prospective Participants

- Why collect outcomes data?
- Benefits of NOMS
- Examples of NOMS applications
- Collecting NOMS data
- Register to participate in NOMS data collection
- Frequently asked questions

Information for Current Participants

- Adult User Training
- Pre-Kindergarten User Training
- Online Data Collection and Reporting Tool
- Register to participate in the Physician Quality Reporting System (PQRS)

http://www.asha.org/Members/research/NOMS/
What Is NOMS?

ASHA's National Outcomes Measurement System (NOMS) is a voluntary data collection system developed to illustrate the value of speech-language pathology services provided to adults and children with communication and swallowing disorders. SLPs working in healthcare organizations or schools can register their facility or system to participate in the NOMS Adult Healthcare and/or NOMS Pre-Kindergarten Component. In exchange for participating in NOMS data collection, SLPs will have access to their data benchmarked against the national data and system data if applicable.

The key to NOMS is the use of ASHA's Functional Communication Measures (FCMs). FCMs are a series of disorder-specific, seven-point rating scales designed to describe the change in an individual's functional communication and/or swallowing ability over time. Based on an individual's treatment plan/IEP, FCMs are chosen and scored by a certified speech-language pathologist on admission and again at discharge to depict the amount of change in communication and/or swallowing abilities after speech and language intervention and submitted to ASHA's national registry. In addition to scoring the FCMs, SLPs also provide information on patient/client and intervention characteristics (e.g., SLP diagnosis, frequency/intensity of treatment).

Through the use of NOMS, we are now beginning to demonstrate the value of speech-language pathology services and provide our members the needed tools to address the challenging questions posed by policy makers, third party payers, administrators and consumers alike.

To find out more about the benefits of NOMS, frequently asked questions, and how to register your organization for data collection, see the Information for Prospective Participants in the resource box at the top of the page.

National Data Reports and Fact Sheets

The national reports offer an in-depth look and analysis, while the fact sheets provide a snapshot of the data collected in each NOMS component (Adults in Health Care and Pre-Kindergarten).

©1997-2013 American Speech-Language-Hearing Association

http://www.asha.org/Members/research/NOMS/
American Speech-Language-Hearing Association

G-Codes and Severity Modifiers for Claims-Based Outcomes Reporting

Medicare Part B Therapy Services

The Centers for Medicare & Medicaid Services (CMS) established non-payable G-codes for reporting on claims for Medicare Part B beneficiaries receiving therapy services. Each non-payable G-code listed on the claim form must be accompanied with a severity/complexity modifier. The modifier represents the functional impairment on a 7-point severity/complexity scale. The G-codes related to speech-language pathology services and severity modifiers are listed in the tables below.

Speech-Language Pathology Related G-Codes

<table>
<thead>
<tr>
<th>G-Codes</th>
<th>Functional Limitation &amp; Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Swallowing</strong></td>
<td></td>
</tr>
<tr>
<td>G8996</td>
<td>Swallowing functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals</td>
</tr>
<tr>
<td>G8997</td>
<td>Swallowing functional limitation, projected goal status, at initial therapy treatment/outset and at discharge from therapy</td>
</tr>
<tr>
<td>G8998</td>
<td>Swallowing functional limitation, discharge status, at discharge from therapy/endpoint of reporting on limitation</td>
</tr>
<tr>
<td><strong>Motor Speech</strong> (Note: The codes for Motor Speech are not sequentially numbered)</td>
<td></td>
</tr>
<tr>
<td>G8999</td>
<td>Motor speech functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals</td>
</tr>
<tr>
<td>G9186</td>
<td>Motor speech functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy</td>
</tr>
<tr>
<td>G9158</td>
<td>Motor speech functional limitation, discharge status at discharge from therapy/endpoint of reporting on limitation</td>
</tr>
</tbody>
</table>

Spoken Language Comprehension
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G9159</td>
<td>Spoken language comprehension functional limitation, current status at time of initial therapy treatment/episode onset and reporting intervals</td>
</tr>
<tr>
<td>G9160</td>
<td>Spoken language comprehension functional limitation, projected goal status at initial therapy treatment/episode onset and at discharge from therapy</td>
</tr>
<tr>
<td>G9161</td>
<td>Spoken language comprehension functional limitation, discharge status at discharge from therapy/end of reporting on limitation</td>
</tr>
</tbody>
</table>

**Spoken Language Expression**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G9162</td>
<td>Spoken language expression functional limitation, current status at time of initial therapy treatment/episode onset and reporting intervals</td>
</tr>
<tr>
<td>G9163</td>
<td>Spoken language expression functional limitation, projected goal status at initial therapy treatment/episode onset and at discharge from therapy</td>
</tr>
<tr>
<td>G9164</td>
<td>Spoken language expression functional limitation, discharge status at discharge from therapy/end of reporting on limitation</td>
</tr>
</tbody>
</table>

**Attention**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G9165</td>
<td>Attention functional limitation, current status at time of initial therapy treatment/episode onset and reporting intervals</td>
</tr>
<tr>
<td>G9166</td>
<td>Attention functional limitation, projected goal status at initial therapy treatment/episode onset and at discharge from therapy</td>
</tr>
<tr>
<td>G9167</td>
<td>Attention functional limitation, discharge status at discharge from therapy/end of reporting on limitation</td>
</tr>
</tbody>
</table>

**Memory**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G9168</td>
<td>Memory functional limitation, current status at time of initial therapy treatment/episode onset and reporting intervals</td>
</tr>
<tr>
<td>G9169</td>
<td>Memory functional limitation, projected goal status at initial therapy treatment/episode onset and at discharge from therapy</td>
</tr>
<tr>
<td>G9170</td>
<td>Memory functional limitation, discharge status at discharge from therapy/end of reporting on limitation</td>
</tr>
</tbody>
</table>

**Voice**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G9171</td>
<td>Voice functional limitation, current status at time of initial therapy treatment/episode onset and reporting intervals</td>
</tr>
<tr>
<td>G9172</td>
<td>Voice functional limitation, projected goal status at initial therapy treatment/episode onset and at discharge from therapy</td>
</tr>
<tr>
<td>G9173</td>
<td>Voice functional limitation, discharge status at discharge from therapy/end of reporting on limitation</td>
</tr>
</tbody>
</table>
### Other SLP Functional Limitation

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G9174</td>
<td>Other speech language pathology functional limitation, current status at time of initial therapy treatment/episode onset and reporting intervals</td>
</tr>
<tr>
<td>G9175</td>
<td>Other speech language pathology functional limitation, projected goal status at initial therapy treatment/episode onset and at discharge from therapy</td>
</tr>
<tr>
<td>G9176</td>
<td>Other speech language pathology functional limitation, discharge status at discharge from therapy/episode onset of reporting on limitation</td>
</tr>
</tbody>
</table>

### Severity Modifiers

**Note:** Corresponding National Outcomes Measurement System (NOMS) levels are listed here. NOMS can assist with G-code and severity modifier selection.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Impairment Limitation Restriction</th>
<th>NOMS Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>CH</td>
<td>0 percent impaired, limited or restricted</td>
<td>7</td>
</tr>
<tr>
<td>CI</td>
<td>At least 1 percent but less than 20 percent impaired, limited or restricted</td>
<td>6</td>
</tr>
<tr>
<td>CJ</td>
<td>At least 20 percent but less than 40 percent impaired, limited or restricted</td>
<td>5</td>
</tr>
<tr>
<td>CK</td>
<td>At least 40 percent but less than 60 percent impaired, limited or restricted</td>
<td>4</td>
</tr>
<tr>
<td>CL</td>
<td>At least 60 percent but less than 80 percent impaired, limited or restricted</td>
<td>3</td>
</tr>
<tr>
<td>CM</td>
<td>At least 80 percent but less than 100 percent impaired, limited or restricted</td>
<td>2</td>
</tr>
<tr>
<td>CN</td>
<td>100 percent impaired, limited or restricted</td>
<td>1</td>
</tr>
</tbody>
</table>

See also:

- Centers for Medicare & Medicaid Services Guidance for Claims-Based Outcomes Reporting
- Case Scenarios and Sample Claim Form Entries for Outcomes Reporting [PDF]
- Overview of Claims-Based Outcomes Reporting Requirement for Therapy Services

http://www.asha.org/Practice/reimbursement/medicare/G-Codes/
Medicare CPT Coding Rules for Speech-Language Pathology Services

This page contains important Medicare policies related to CPT coding for services rendered by speech-language pathologists, including a complete list of CPT codes and any relevant special coding rules. While these rules are set by the Centers for Medicare & Medicaid Services (CMS), they are often adopted by other third party payers.

On this page:

- Designation of Time
- Code Modifiers
- Same-Day Billing Restrictions
- Use of Physical Medicine Codes (97000 Series)
- CPT Codes & Special Medicare Rules for SLPs

See also: Medicare Coding Rules for Audiology Services

Designation of Time

Most CPT/HCPCS codes reported by speech-language pathologists are "untimed" (i.e., they do not include time designations). An untimed code is billed as a session without regard to time. Exceptions for Medicare-covered codes are:

- evaluation for speech-generating device (92607, first hour; 92608, each additional 30 minutes)
- evaluation of auditory rehabilitation status (92626, first hour; 92627, each additional 30 minutes)
- assessment of aphasia (96105, per hour)
- standardized cognitive performance testing (96125, per hour)
- cognitive skills development (97532, each 15 minutes)
- sensory integration (97533, each 15 minutes)

Note: A timed code is billed only if face-to-face time spent in an evaluation is at least 51% of the time
designated in the code’s descriptor. An exception is 96125 where allowable time includes interpretation of test results and preparation of the report.

15 Minute Codes

15-Minute Codes
For CPT codes designated as 15 minutes, multiple coding represents minimum face-to-face treatment, as follows

- 1 unit: 8 minutes to < 23 minutes
- 2 units: 23 minutes to < 38 minutes
- 3 units: 38 minutes to < 53 minutes
- 4 units: 53 minutes to < 68 minutes
- 5 units: 68 minutes to < 83 minutes
- 6 units: 83 minutes to < 98 minutes

Code Modifiers
Untimed CPT codes represent "typical" visit lengths or times to conduct a typical test unless the time is specified in the CPT descriptor. For significantly atypical procedures, a "-22" modifier can be used to indicate that the work is substantially greater than typically required and a "-52" modifier for an abbreviated procedure. Modifier "-22" should not be used frequently because the Medicare contractor could make the determination that the procedure reflects typical service delivery. For claims with the "-22" modifier a description of the need for extended services should accompany the claim. Modifier "-59" is used to establish one procedure as distinct from another procedure billed on the same day.

Part B services provided under plans of care for speech-language pathology or dysphagia services require a GN modifier as a suffix to the CPT code. The requirement applies to physician offices as well as facilities and private practices. Occupational therapy and physical therapy modifiers are GO and GP, respectively. For therapy services that exceed the annual therapy cap, a -KX modifier is required, indicating services are medically necessary and the documentation is available for review.

Same-Day Billing Restrictions
For restrictions on certain CPT code pairs billed on the same day, see Medicare's National Correct Coding Initiative (NCCI) edits.
Use of Physical Medicine Codes (97000 Series)

CMS staff have concluded that speech-language pathologists should not report physical medicine codes 97110 (Therapeutic exercises, each 15 minutes) and 97112 (Neuromuscular reeducation, each 15 minutes). Although CMS has not issued a formal policy statement regarding this issue, agency officials have stated their position, based on the official descriptors and vignettes for the codes. Please note that cognitive therapy (97532) and sensory integration (97533) by speech-language pathologists are covered in all Medicare Local Coverage Determinations (LCDs). Some Medicare contractors may allow exceptions in Local Coverage Determinations.

CPT Codes & Special Medicare Rules for SLPs

**Note:** CMS requires that the "-GN" modifier be added to every code that is rendered under a speech-language pathology or dysphagia plan of treatment. [-GO indicates occupational therapy; -GP indicates physical therapy]

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Descriptor</th>
<th>Special Medicare Rules</th>
</tr>
</thead>
<tbody>
<tr>
<td>31579</td>
<td>Diagnostic laryngoscopy with stroboscopy</td>
<td>Effective Oct. 1, 2011, this code can be billed by independent SLPs without supervision, unless supervision is determined by state law or regional Medicare Administrative Contractors. For more information, see ASHA’s FAQs on this matter.</td>
</tr>
<tr>
<td>92506</td>
<td>Evaluation of speech, language, voice, communication, and/or auditory processing</td>
<td>Evaluation of aural rehabilitation is no longer part of 92506; speech-language pathologists and audiologists should use 92626 and 92627</td>
</tr>
<tr>
<td>92507</td>
<td>Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual</td>
<td>Includes training &amp; modification of voice prosthetics. Medicare directs SLPs to use 92507 for auditory rehabilitation.</td>
</tr>
<tr>
<td>92508</td>
<td>Group, two or more individuals</td>
<td>Generally limited to 4 individuals. Limit of 25% of total SLP tx sessions is applicable to Part B patients in some intermediary Local Coverage Determinations. (For SNF Part A residents, up to 25% of each discipline’s rehabilitation tx minutes per week.)</td>
</tr>
</tbody>
</table>

http://www.asha.org/practice/reimbursement/medicare/SLP_coding_rules.htm
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>92511</td>
<td>Nasopharyngoscopy with endoscope (separate procedure)</td>
<td>Effective Oct. 1, 2011, this code can be billed by independent SLPs without supervision, unless supervision is determined by state law or regional Medicare Administrative Contractors. For more information, see ASHA's FAQs on this matter.</td>
</tr>
<tr>
<td>92520</td>
<td>Laryngeal function studies (i.e., aerodynamic testing and acoustic testing)</td>
<td></td>
</tr>
<tr>
<td>92526</td>
<td>Treatment of swallowing dysfunction and/or oral function for feeding</td>
<td>There is no dysphagia group tx code. Medicare payers may accept 97150 for dysphagia group tx based on section 15/230.A of the Medicare Benefit Policy Manual. Please contact your local intermediary or carrier for further guidance. [3]</td>
</tr>
<tr>
<td>92597</td>
<td>Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech</td>
<td>Under Medicare, applies to tracheoesophageal prostheses, artificial larynges, as well as voice amplifiers. Use 92507 for training and modification of voice prostheses. [4]</td>
</tr>
<tr>
<td>92605</td>
<td>Evaluation for prescription for non-speech generating AAC device, face-to-face with the patient; first hour</td>
<td>CMS instructs SLPs to use 92506 for this service. [5]</td>
</tr>
<tr>
<td>92618</td>
<td>Evaluation [92605], each additional 30 minutes</td>
<td>This is an add-on code for 92605. CMS instructs SLPs to use 92506 for a non-SGD evaluation (see 92605).</td>
</tr>
<tr>
<td>92606</td>
<td>Therapeutic services for use of non-speech generating devices, including programming and modification</td>
<td>CMS requires use of 92507 instead, for these therapy services. [6]</td>
</tr>
</tbody>
</table>

See also: Medicare Guidelines for Group Therapy Treatment
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>92607</td>
<td>Evaluation for prescription of speech-generating AAC device, first hour</td>
<td>SGDs generate synthesized or digital speech. Include -52 modifier if less than one hour.</td>
</tr>
<tr>
<td>92608</td>
<td>Evaluation [92607], each additional 30 minutes</td>
<td>May be reported on ensuing days until the evaluation is completed.</td>
</tr>
<tr>
<td>92609</td>
<td>Therapeutic services for use of speech-generating device, including programming and modification</td>
<td></td>
</tr>
<tr>
<td>92610</td>
<td>Evaluation of oral and pharyngeal swallowing function</td>
<td></td>
</tr>
<tr>
<td>92611</td>
<td>Motion fluoroscopic evaluation of swallowing function by cine or video recording</td>
<td>Should be billed with radiology procedure 74230. 92610 is usually reported prior to this procedure.</td>
</tr>
<tr>
<td>92612</td>
<td>Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording (FEES)</td>
<td>This is the complete endoscopic procedure. Level of physician supervision varies by state. Use 92700 if performed without cine or video recording.</td>
</tr>
<tr>
<td>92613</td>
<td>Physician interpretation and report</td>
<td>Effective January 1, 2013, the term &quot;physician&quot; is deleted. Check with your MAC to determine if SLPs can now use this code. Could be used when the SLP has not performed the endoscopic evaluation but is asked to interpret the report. SLP should not report if he/she performs the endoscopy. See New &amp; Revised CPT Codes.</td>
</tr>
<tr>
<td>92614</td>
<td>Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording</td>
<td>This is not a swallow evaluation; sensory testing only.</td>
</tr>
<tr>
<td>92615</td>
<td>Physician interpretation and report</td>
<td>Effective January 1, 2013, the term &quot;physician&quot; is deleted. Check with your MAC to determine if SLPs can now use this code. Could be used when the SLP has not performed the endoscopic evaluation but is asked to interpret the report. SLP should not report if he/she performs the endoscopy. See New &amp; Revised CPT Codes.</td>
</tr>
<tr>
<td>92616</td>
<td>Flexible fiberoptic endoscopic evaluation of</td>
<td>This is the complete endoscopic procedure for</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>92617</td>
<td>Physician interpretation and report</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Swallowing and sensory testing combined. Level of physician supervision varies by state and/or MAC.</td>
<td></td>
</tr>
<tr>
<td>92626</td>
<td>Evaluation of auditory rehabilitation status, first hour</td>
<td></td>
</tr>
<tr>
<td>92627</td>
<td>Evaluation of auditory rehabilitation status, each additional 15 minutes</td>
<td></td>
</tr>
<tr>
<td>92630</td>
<td>Auditory rehabilitation; pre-lingual hearing loss</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SLPs must use 92507 in lieu of this code[^9]</td>
<td></td>
</tr>
<tr>
<td>92633</td>
<td>Auditory rehabilitation; post-lingual hearing loss</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SLPs must use 92507 in lieu of this code[^10]</td>
<td></td>
</tr>
<tr>
<td>96105</td>
<td>Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour</td>
<td></td>
</tr>
<tr>
<td></td>
<td>There is no published rule regarding time necessary to qualify for subsequent one-hour codes. Recommend use of -52 modifier if less than 30 minute segment.</td>
<td></td>
</tr>
<tr>
<td>96110</td>
<td>Developmental screening, with interpretation and report, per standardized instrument form</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not covered by Medicare. See G0451 at the end of this table.</td>
<td></td>
</tr>
<tr>
<td>96111</td>
<td>Developmental testing, (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report</td>
<td></td>
</tr>
<tr>
<td>96125</td>
<td>Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If billed on the same day as 92506, documentation should explain the need for the cognitive evaluation</td>
<td></td>
</tr>
</tbody>
</table>
Other CPT Codes of Interest to Speech-Language Pathologists

These procedures are generally not considered to be SLP codes although they may be performed by speech-language pathologists or in collaboration with physicians. Some Medicare payers may allow payment of the listed 97000 series codes performed solely by the speech-language pathologist.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Descriptor</th>
<th>Special Medicare Rules</th>
</tr>
</thead>
<tbody>
<tr>
<td>70371</td>
<td>Pharyngeal and speech evaluation, by cine or video</td>
<td>Radiologic procedure. 92506 may be reported with this procedure.</td>
</tr>
<tr>
<td>74230</td>
<td>Swallowing function, with cineradiography/videoradiography</td>
<td>Radiologic procedure; is reported with 92611. 92610 is usually reported prior to this procedure.</td>
</tr>
<tr>
<td>90901</td>
<td>Biofeedback training</td>
<td>Covered for muscle re-education of specific</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Medicare Coding Rules for SLP Services</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>92511</td>
<td>Nasopharyngoscopy with endoscope</td>
<td>Muscle groups[^1][^2]</td>
</tr>
<tr>
<td>97032</td>
<td>Electrical stimulation, manual, each 15 minutes</td>
<td>92526 should be billed instead of 97032</td>
</tr>
<tr>
<td>97110</td>
<td>Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility</td>
<td>See Physical Medicine Codes.</td>
</tr>
<tr>
<td>97112</td>
<td>Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities, each 15 minutes</td>
<td>See Physical Medicine Codes.</td>
</tr>
<tr>
<td>97530</td>
<td>Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes</td>
<td>See Physical Medicine Codes.</td>
</tr>
<tr>
<td>97535</td>
<td>Self-care/home management training (eg, activities of daily living and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes</td>
<td>See Physical Medicine Codes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>May be appropriate when necessary to observe the patient in home environment.</td>
</tr>
<tr>
<td>97537</td>
<td>Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes</td>
<td>See Physical Medicine Codes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>May be appropriate when necessary to observe the patient in work environment.</td>
</tr>
</tbody>
</table>

[^1]: Additional information required.
[^2]: Further details needed.


[13] Sec. 15/230.A of the Medicare Benefit Policy Manual: Group Therapy Services. Contractors pay for outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services provided simultaneously to two or more individuals by a practitioner as group therapy services (97150). The individuals can be, but need not be performing the same activity. The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one patient contact is not required.


[18] CPT Assistant, March 2003, p. 5


[12] Included in many intermediary SLP Local Coverage Determinations.


[14] Medicare Claims Processing Manual, Chapter 5, Section 20.B. The CPT procedure in question must be performed under physician supervision because it does not appear on the CMS list of rehabilitation codes (Section 5/20.B)

©1997-2013 American Speech-Language-Hearing Association

http://www.asha.org/practice/reimbursement/medicare/SLP_coding_rules.htm
Timed and Untimed Codes Frequently Asked Questions

- Can CPT procedure codes for speech-language treatment be billed by units of time?
- Are there any timed codes that SLPs can use?
- Why isn’t ASHA moving toward adding time units?
- Why can’t “complexity” of care be accounted for in the codes?
- Are there any guidelines or data available on what constitutes the typical time allowed for a speech-language pathology session?
- Why don’t SLPs have time units like PT/OT codes?
- Occasionally, I must spend an extremely long period of time rendering an evaluation or treatment session. Is there a way to be reimbursed an extra amount in recognition of the inordinate amount of time?
- If I spend 20 minutes treating a patient and bill the cognitive therapy CPT code 97832 each 15 minutes, can I bill two units?
- Can I bill an untimed code more than once per day?

Can procedure codes be billed by units of time?

Most speech-language pathology codes do not have time units assigned to them, specifically 92506 (speech-language evaluation) and 92507 (speech-language treatment). If no time is noted in the descriptor, each code counts as one session. These codes are listed in ASHA’s “Health Plan Coding and Claims Guide” (available through the ASHA Online Store, Item #0112486). A complete list of the CPT codes for speech-language pathology and audiology services can also be found in the ASHA Medicare Fee Schedule or the ASHA Model Superbill for Speech-Language Pathology Practice [PDF].

Are there any timed codes that SLPs can use?

Yes. They are:

- Evaluation for non-speech generating device (92605, first hour: 92618, each additional 30 minutes)
Timed & Untimed Codes FAQs

- Evaluation for speech-generating device (92607, first hour; 92608, each additional 30 minutes)
- Evaluation of auditory rehabilitation status (92626, first hour; 92627, each additional 30 minutes)
- Assessment of aphasia (96105, per hour)
- Standardized cognitive performance testing (96125, per hour)
- Cognitive skills development (97532, each 15 minutes)
- Sensory integration (97533, each 15 minutes)

Why isn't ASHA moving toward adding time units?

Please be aware that ASHA representatives requested time units be added to the speech-language treatment procedure descriptor in 1994 but the request was not accepted by the American Medical Association's (AMA) CPT Editorial Panel. The Panel noted that "time" was already factored into the formula that values the procedure. At the present time, adding time units is a lengthy multi-step process and has the potential of yielding unfavorable results. For example, if time units were added to the descriptor, the procedure would be "re-valued" and, as such, an even lower reimbursement rate could be assigned. This possibility exists each time a procedure is redefined.

The Medicare formula for determining reimbursement for these codes is undergoing examination and deals with a concept called physician work. At the present time, the physician work component adds value to 92507. Any revision of the procedure descriptor alone would beg the question, "What does a physician do during these treatment procedures?" If the answer is "nothing" then it is very possible that the relative value for that part of the reimbursement formula would be changed to zero and, consequently, the rate would be reduced. ASHA is now in the process of negotiating with CMS and the AMA RUC so that the services of the speech-language pathologist as well as a physician can be reflected in the work component.

Why can't "complexity" of care be accounted for in the codes?

If the treatment code (92507) is revised, the development of additional treatment codes that could address complexity of services would be considered at that time. ASHA would have to present evidence that the services are different in terms of the time it takes to perform the service, the level of technical skill, the physical effort, the required mental effort and judgment, and the stress due to the potential risk to the patient.

Are there any guidelines or data available on what constitutes the typical time allowed for a speech-language pathology session?

ASHA conducted a survey and found that 45-60 minutes was a typical session length, although more recent
feedback from speech-language pathologists indicates that typical sessions are moving closer toward 30 minutes. This survey information is also used by the Centers for Medicare & Medicaid (CMS) and the AMA's relative value process.

Why don't SLPs have time units like the PT/OT codes?

Historically, the physical medicine and rehabilitation procedure codes were assigned time units of 15 minutes while the codes for speech-language pathology were not. Because of the way codes are developed and established, it is difficult to revise descriptors. There are two 15-minute treatment codes available to speech-language pathologists under Medicare - CPT 97532, Development of cognitive skills, each 15 minutes; and 97533, Sensory integrative techniques, each 15 minutes.

Occasionally, I must spend an extremely long period of time rendering an evaluation or treatment session. Is there a way to be reimbursed an extra amount in recognition of the inordinate amount of time?

One of the CPT modifiers is -22, added at the end of the CPT code. This modifier denotes a session or procedure that is unusually long. Many payers will increase reimbursement by 25 to 50 percent when this modifier is included. Be warned that if you submit claims with the -22 modifier too often, the payer may conclude that the long sessions are not "unusual," and cease to honor the modifier.

If I spend 20 minutes treating a patient and bill the cognitive therapy CPT code 97532 (each 15 minutes), can I bill two units?

No. Medicare has established specific minimum and maximum times for 15-minute codes and most payers have adopted this policy. The minimum time for one 15-minute code is 8 minutes. Two units would be a minimum of 15 + 8 minutes = 23 minutes. This rule is extended to multiple units in the following CMS table:

1 unit: 8 minutes to < 23 minutes
2 units: 23 minutes to < 38 minutes
3 units: 38 minutes to < 53 minutes
4 units: 53 minutes to < 68 minutes
5 units: 68 minutes to < 83 minutes
6 units: 83 minutes to < 98 minutes

Can I bill an untimed code more than once per day?
Medicare specifies that evaluation or assessment procedures may be billed only once per discipline, per date of service, per patient (CPT 92506, 92597, 92607, 92611, 92612, 92616). Additionally, treatment codes may be subject to Medicare's Medically Unlikely Edits (MUEs), which specify how many times a code may be billed per date of service. For instance, the MUE for CPT 92507 prevents this code from being billed more than once in a day. Many payers will adopt Medicare policy.

©1997-2013 American Speech-Language-Hearing Association
Reporting SLP Services Using Service-Based CPT Codes

Introduction

Speech-language pathology Current Procedural Terminology (CPT) codes are primarily service-based. There are CPT codes that are reported by speech-language pathologists that are time-based:

- the first hour of a speech-generating device (SGD) evaluation,
- each additional 30 minutes of the SGD evaluation,
- aphasia evaluation, per hour,
- the first hour of an aural rehabilitation evaluation, and
- each additional 15 minutes of the aural rehabilitation evaluation.

All other codes are procedure-based. That is, the CPT code is reported once regardless of the length of the appointment.

In the past, some payers including Medicare for institutional settings, paid for speech-language pathology services using time units, usually 15-minute units. Thus, a speech-language pathologist might have been able to bill for 3 units of therapy, or 45 minutes. Now, payers are gradually implementing payment policies based on strict CPT (Current Procedural Terminology codebook) descriptors; if there is no time designated in the official descriptor, the code represents a typical session. One reason for the change is the Health Insurance Portability & Accountability Act (HIPAA) that requires providers to comply with coding guidelines of the American Medical Association (AMA) CPT procedure codes and the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes. The number of health plans reviewing, auditing, and changing billing policies regarding eliminating time units has increased dramatically in recent years.

ASHA suggests that speech-language pathologists take a proactive approach using the following strategies and information when you are advised by payers that there are no time components associated with most speech-language pathology and audiology CPT codes.

http://www.asha.org/practice/reimbursement/coding/servicebased.htm
Preamble
The Code of Ethics for the Physical Therapist (Code of Ethics) delineates the ethical obligations of all physical therapists as determined by the House of Delegates of the American Physical Therapy Association (APTA). The purposes of this Code of Ethics are to:
1. Define the ethical principles that form the foundation of physical therapist practice in patient/client management, consultation, education, research, and administration.
2. Provide standards of behavior and performance that form the basis of professional accountability to the public.
3. Provide guidance for physical therapists facing ethical challenges, regardless of their professional roles and responsibilities.
4. Educate physical therapists, students, other health care professionals, regulators, and the public regarding the core values, ethical principles, and standards that guide the professional conduct of the physical therapist.
5. Establish the standards by which the American Physical Therapy Association can determine if a physical therapist has engaged in unethical conduct.

No code of ethics is exhaustive nor can it address every situation. Physical therapists are encouraged to seek additional advice or consultation in instances where the guidance of the Code of Ethics may not be definitive.

This Code of Ethics is built upon the five roles of the physical therapist (management of patients/clients, consultation, education, research, and administration), the core values of the profession, and the multiple realms of ethical action (individual, organizational, and societal).

Physical therapist practice is guided by a set of seven core values: accountability, altruism, compassion/caring, excellence, integrity, professional duty, and social responsibility. Throughout the document the primary core values that support specific principles are indicated in parentheses. Unless a specific role is indicated in the principle, the duties and obligations being delineated pertain to the five roles of the physical therapist. Fundamental to the Code of Ethics is the special obligation of physical therapists to empower, educate, and enable those with impairments, activity limitations, participation restrictions, and disabilities to facilitate greater independence, health, wellness, and enhanced quality of life.

Principles

**Principle #1:** Physical therapists shall respect the inherent dignity and rights of all individuals.
(Core Values: Compassion, Integrity)

1A. Physical therapists shall act in a respectful manner toward each person regardless of age, gender, race, nationality, religion, ethnicity, social or economic status, sexual orientation, health condition, or disability.
1B. Physical therapists shall recognize their personal biases and shall not discriminate against others in physical therapist practice, consultation, education, research, and administration.

**Principle #2:** Physical therapists shall be trustworthy and compassionate in addressing the rights and needs of patients/clients.
(Core Values: Altruism, Compassion, Professional Duty)

2A. Physical therapists shall adhere to the core values of the profession and shall act in the best interests of patients/clients over the interests of the physical therapist.
2B. Physical therapists shall provide physical therapy services with compassionate and caring behaviors that incorporate the individual and cultural differences of patients/clients.
2C. Physical therapists shall provide the information necessary to allow patients or their surrogates to make informed decisions about physical therapy care or participation in clinical research.
2D. Physical therapists shall collaborate with patients/clients to empower them in decisions about their health care.
2E. Physical therapists shall protect confidential patient/client information and may disclose confidential information to appropriate authorities only when allowed or as required by law.

**Principle #3:** Physical therapists shall be accountable for making sound professional judgments.
(Core Values: Excellence, Integrity)

3A. Physical therapists shall demonstrate independent and objective professional judgment in the patient's/client's best interest in all practice settings.
3B. Physical therapists shall demonstrate professional judgment informed by professional standards, evidence (including current literature and established best practice), practitioner experience, and patient/client values.
3C. Physical therapists shall make judgments within their scope of practice and level of expertise and shall communicate with, collaborate with, or refer to peers or other health care professionals when necessary.
3D. Physical therapists shall not engage in conflicts of interest that interfere with professional judgment.
3E. Physical therapists shall provide appropriate direction of and communication with physical therapist assistants and support personnel.
Principle #4: Physical therapists shall demonstrate integrity in their relationships with patients/clients, families, colleagues, students, research participants, other health care providers, employers, payers, and the public.  
(Core Value: Integrity)

4A. Physical therapists shall provide truthful, accurate, and relevant information and shall not make misleading representations.
4B. Physical therapists shall not exploit persons over whom they have supervisory, evaluative or other authority (e.g., patients/clients, students, supervisees, research participants, or employees).
4C. Physical therapists shall discourage misconduct by health care professionals and report illegal or unethical acts to the relevant authority, when appropriate.
4D. Physical therapists shall report suspected cases of abuse involving children or vulnerable adults to the appropriate authority, subject to law.
4E. Physical therapists shall not engage in any sexual relationship with any of their patients/clients, supervisees, or students.
4F. Physical therapists shall not harass anyone verbally, physically, emotionally, or sexually.

Principle #5: Physical therapists shall fulfill their legal and professional obligations.  
(Core Values: Professional Duty, Accountability)

5A. Physical therapists shall comply with applicable local, state, and federal laws and regulations.
5B. Physical therapists shall have primary responsibility for supervision of physical therapist assistants and support personnel.
5C. Physical therapists involved in research shall abide by accepted standards governing protection of research participants.
5D. Physical therapists shall encourage colleagues with physical, psychological, or substance-related impairments that may adversely impact their professional responsibilities to seek assistance or counsel.
5E. Physical therapists who have knowledge that a colleague is unable to perform their professional responsibilities with reasonable skill and safety shall report this information to the appropriate authority.
5F. Physical therapists shall provide notice and information about alternatives for obtaining care in the event the physical therapist terminates the provider relationship while the patient/client continues to need physical therapy services.

Principle #6: Physical therapists shall enhance their expertise through the lifelong acquisition and refinement of knowledge, skills, abilities, and professional behaviors.  
(Core Value: Excellence)

6A. Physical therapists shall achieve and maintain professional competence.
6B. Physical therapists shall take responsibility for their professional development based on critical self-assessment and reflection on changes in physical therapist practice, education, health care delivery, and technology.
6C. Physical therapists shall evaluate the strength of evidence and applicability of content presented during professional development activities before integrating the content or techniques into practice.
6D. Physical therapists shall cultivate practice environments that support professional development, lifelong learning, and excellence.

Principle #7: Physical therapists shall promote organizational behaviors and business practices that benefit patients/clients and society.  
(Core Values: Integrity, Accountability)

7A. Physical therapists shall promote practice environments that support autonomous and accountable professional judgments.
7B. Physical therapists shall seek remuneration as is deserved and reasonable for physical therapist services.
7C. Physical therapists shall not accept gifts or other considerations that influence or give an appearance of influencing their professional judgment.
7D. Physical therapists shall fully disclose any financial interest they have in products or services that they recommend to patients/clients.
7E. Physical therapists shall be aware of charges and shall ensure that documentation and coding for physical therapy services accurately reflect the nature and extent of the services provided.
7F. Physical therapists shall refrain from employment arrangements, or other arrangements, that prevent physical therapists from fulfilling professional obligations to patients/clients.

Principle #8: Physical therapists shall participate in efforts to meet the health needs of people locally, nationally, or globally.  
(Core Value: Social Responsibility)

8A. Physical therapists shall provide pro bono physical therapy services or support organizations that meet the health needs of people who are economically disadvantaged, uninsured, and underinsured.
8B. Physical therapists shall advocate to reduce health disparities and health care inequities, improve access to health care services, and address the health, wellness, and preventive health care needs of people.
8C. Physical therapists shall be responsible stewards of health care resources and shall avoid overutilization or underutilization of physical therapy services.
8D. Physical therapists shall educate members of the public about the benefits of physical therapy and the unique role of the physical therapist.
OCCUPATIONAL THERAPY CODE OF ETHICS (2005)

PREAMBLE

The American Occupational Therapy Association (AOTA) Occupational Therapy Code of Ethics (2005) is a public statement of principles used to promote and maintain high standards of conduct within the profession and is supported by the Core Values and Attitudes of Occupational Therapy Practice (AOTA, 1993). Members of AOTA are committed to promoting inclusion, diversity, independence, and safety for all recipients in various stages of life, health, and illness and to empower all beneficiaries of occupational therapy. This commitment extends beyond service recipients to include professional colleagues, students, educators, businesses, and the community.

Fundamental to the mission of the occupational therapy profession is the therapeutic use of everyday life activities (occupations) with individuals or groups for the purpose of participation in roles and situations in home, school, workplace, community, and other settings. “Occupational therapy addresses the physical, cognitive, psychosocial, sensory and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect health, well being and quality of life” (Definition of Occupational Therapy Practice for the AOTA Model Practice Act, 2004). Occupational therapy personnel have an ethical responsibility first and foremost to recipients of service as well as to society.

The historical foundation of this Code is based on ethical reasoning surrounding practice and professional issues, as well as empathic reflection regarding these interactions with others. This reflection resulted in the establishment of principles that guide ethical action. Ethical action goes beyond rote following of rules or application of principles; rather it is a manifestation of moral character and mindful reflection. It is a commitment to beneficence for the sake of others, to virtuous practice of artistry and science, to genuinely good behaviors, and to noble acts of courage. It is an empathic way of being among others, which is made every day by all occupational therapy personnel.

The AOTA Occupational Therapy Code of Ethics (2005) is an aspirational guide to professional conduct when ethical issues surface. Ethical decision making is a process that includes awareness regarding how the outcome will impact occupational therapy clients in all spheres. Applications of Code principles are considered situation-specific and where a conflict exists, occupational therapy personnel will pursue responsible efforts for resolution.

The specific purpose of the AOTA Occupational Therapy Code of Ethics (2005) is to:

1. Identify and describe the principles supported by the occupational therapy profession
The AOTA *Occupational Therapy Code of Ethics* (2005) defines the set principles that apply to occupational therapy personnel at all levels:

**Principle 1. Occupational therapy personnel shall demonstrate a concern for the safety and well-being of the recipients of their services. (BENEFICENCE)**

**Occupational therapy personnel shall:**

A. Provide services in a fair and equitable manner. They shall recognize and appreciate the cultural components of economics, geography, race, ethnicity, religious and political factors, marital status, age, sexual orientation, gender identity, and disability of all recipients of their services.

B. Strive to ensure that fees are fair and reasonable and commensurate with services performed. When occupational therapy practitioners set fees, they shall set fees considering institutional, local, state, and federal requirements, and with due regard for the service recipient’s ability to pay.

C. Make every effort to advocate for recipients to obtain needed services through available means.

D. Recognize the responsibility to promote public health and the safety and well-being of individuals, groups, and/or communities.

**Principle 2. Occupational therapy personnel shall take measures to ensure a recipient’s safety and avoid imposing or inflicting harm. (NONMALEFICENCE)**

**Occupational therapy personnel shall:**

A. Maintain therapeutic relationships that shall not exploit the recipient of services sexually, physically, emotionally, psychologically, financially, socially, or in any other manner.

B. Avoid relationships or activities that conflict or interfere with therapeutic professional judgment and objectivity.

C. Refrain from any undue influences that may compromise provision of service.
D. Exercise professional judgment and critically analyze directives that could result in potential harm before implementation.

E. Identify and address personal problems that may adversely impact professional judgment and duties.

F. Bring concerns regarding impairment of professional skills of a colleague to the attention of the appropriate authority when or/ if attempts to address concerns are unsuccessful.

Principle 3. Occupational therapy personnel shall respect recipients to assure their rights. (AUTONOMY, CONFIDENTIALITY)

Occupational therapy personnel shall:

A. Collaborate with recipients, and if they desire, families, significant others, and/or caregivers in setting goals and priorities throughout the intervention process, including full disclosure of the nature, risk, and potential outcomes of any interventions.

B. Obtain informed consent from participants involved in research activities and ensure that they understand potential risks and outcomes.

C. Respect the individual’s right to refuse professional services or involvement in research or educational activities.

D. Protect all privileged confidential forms of written, verbal, and electronic communication gained from educational, practice, research, and investigational activities unless otherwise mandated by local, state, or federal regulations.

Principle 4. Occupational therapy personnel shall achieve and continually maintain high standards of competence. (DUTY).

Occupational therapy personnel shall:

A. Hold the appropriate national, state, or any other requisite credentials for the services they provide.

B. Conform to AOTA standards of practice, and official documents.

C. Take responsibility for maintaining and documenting competence in practice, education, and research by participating in professional development and educational activities.
D. Be competent in all topic areas in which they provide instruction to consumers, peers, and/or students.

E. Critically examine available evidence so they may perform their duties on the basis of current information.

F. Protect service recipients by ensuring that duties assumed by or assigned to other occupational therapy personnel match credentials, qualifications, experience, and scope of practice.

G. Provide appropriate supervision to individuals for whom they have supervisory responsibility in accordance with Association official documents, local, state, and federal or national laws and regulations, and institutional policies and procedures.

H. Refer to or consult with other service providers whenever such a referral or consultation would be helpful to the care of the recipient of service. The referral or consultation process shall be done in collaboration with the recipient of service.

Principle 5. Occupational therapy personnel shall comply with laws and Association policies guiding the profession of occupational therapy. (PROCEDURAL JUSTICE)

   Occupational therapy personnel shall:

   A. Familiarize themselves with and seek to understand and abide by institutional rules, applicable Association policies; local, state, and federal/national/international laws.

   B. Be familiar with revisions in those laws and Association policies that apply to the profession of occupational therapy and shall inform employers, employees, and colleagues of those changes.

   C. Encourage those they supervise in occupational therapy-related activities to adhere to the Code.

   D. Take reasonable steps to ensure employers are aware of occupational therapy’s ethical obligations, as set forth in this Code, and of the implications of those obligations for occupational therapy practice, education, and research.

   E. Record and report in an accurate and timely manner all information related to professional activities.

Principle 6. Occupational therapy personnel shall provide accurate information when representing the profession. (VERACITY)
Occupational therapy personnel shall:

A. Represent their credentials, qualifications, education, experience, training, and competence accurately. This is of particular importance for those to whom occupational therapy personnel provide their services or with whom occupational therapy personnel have a professional relationship.

B. Disclose any professional, personal, financial, business, or volunteer affiliations that may pose a conflict of interest to those with whom they may establish a professional, contractual, or other working relationship.

C. Refrain from using or participating in the use of any form of communication that contains false, fraudulent, deceptive, or unfair statements or claims.

D. Identify and fully disclose to all appropriate persons errors that compromise recipients’ safety.

E. Accept responsibility for their professional actions that reduce the public’s trust in occupational therapy services and those that perform those services.

Principle 7. Occupational therapy personnel shall treat colleagues and other professionals with respect, fairness, discretion, and integrity. (FIDELITY)

Occupational therapy personnel shall:

A. Preserve, respect, and safeguard confidential information about colleagues and staff, unless otherwise mandated by national, state, or local laws.

B. Accurately represent the qualifications, views, contributions, and findings of colleagues.

C. Take adequate measures to discourage, prevent, expose, and correct any breaches of the Code and report any breaches of the Code to the appropriate authority.

D. Avoid conflicts of interest and conflicts of commitment in employment and volunteer roles.

E. Use conflict resolution and/or alternative dispute resolution resources to resolve organizational and interpersonal conflicts.

F. Familiarize themselves with established policies and procedures for handling concerns about this Code, including familiarity with national, state, local, district, and territorial procedures for handling ethics complaints. These include policies and procedures created by AOTA, licensing and regulatory bodies, employers, agencies, certification boards, and other organizations having jurisdiction over occupational therapy practice.
Note. This AOTA Occupational Therapy Code of Ethics is one of three documents that constitute the Ethics Standards. The other two are the Core Values and Attitudes of Occupational Therapy Practice (1993) and the Guidelines to the Occupational Therapy Code of Ethics (2000).

Glossary

Autonomy—The right of an individual to self-determination. The ability to independently act on one’s decisions for their own well-being (Beauchamp & Childress, 2001)

Beneficence—Doing good for others or bringing about good for them. The duty to confer benefits to others

Confidentiality—Not disclosing data or information that should be kept private to prevent harm and to abide by policies, regulations, and laws

Dilemma—A situation in which one moral conviction or right action conflicts with another. It exists because there is no one, clear-cut, right answer

Duty—Actions required of professionals by society or actions that are self-imposed

Ethics—a systematic study of morality (i.e., rules of conduct that are grounded in philosophical principles and theory)

Fidelity—Faithfully fulfilling vows and promises, agreements, and discharging fiduciary responsibilities (Beauchamp & Childress, 2001)

Justice—Three types of justice are

  Compensatory—Making reparation for wrongs that have been done
  Distributive justice—The act of distributing goods and burdens among members of society
  Procedural justice—Assuring that processes are organized in a fair manner and policies or laws are followed

Morality—Personal beliefs regarding values, rules, and principles of what is right or wrong. Morality may be culture-based or culture-driven

Nonmaleficence—Not harming or causing harm to be done to oneself or others the duty to ensure that no harm is done

Veracity—A duty to tell the truth; avoid deception
References


Authors

The Commission on Standards and Ethics (SEC):
- S. Maggie Reitz, PhD, OTR/L, FAOTA, Chairperson
- Melba Arnold, MS, OTR/L
- Linda Gabriel Franck, PhD, OTR/L
- Darryl J. Austin, MS, OT/L
- Diane Hill, COTA/L, AP, ROH
- Lorie J. McQuade, MEd, CRC
- Daryl K. Knox, MD
- Deborah Yarett Slater, MS, OT/L, FAOTA, Staff Liaison
With contributions to the Preamble by Suzanne Peloquin, PhD, OTR, FAOTA

Adopted by the Representative Assembly 2005C202


Core Values and Attitudes of Occupational Therapy Practice

Elizabeth Kanny, MA, OT
for Standards and Ethics Commission - Ruth A. Hansen, PhD, OT, FAOTA, Chairperson

Introduction

In 1985, the American Occupational Therapy Association funded the Professional and Technical Role Analysis Study (PATRA). This study had two purposes: to delineate the entry-level practice of OTs and OTAs through a role analysis and to conduct a task inventory of what practitioners actually do. Knowledge, skills, and attitude statements were to be developed to provide a basis for the role analysis. The PATRA study completed the knowledge and skills statements. The Executive Board subsequently charged the Standards and Ethics Commission (SEC) to develop a statement that would describe the attitudes and values that undergird the profession of occupational therapy. The SEC wrote this document for use by AOTA members.

The list of terms used in this statement was originally constructed by the American Association of Colleges of Nursing (AACN) (1986). The PATRA committee analyzed the knowledge statements that the committee had written and selected those terms from the AACN list that best identified the values and attitudes of our profession. This list of terms was then forwarded to SEC by the PATRA Committee to use as the basis for the Core Values and Attitudes paper.

The development of this document is predicated on the assumption that the values of occupational therapy are evident in the official documents of the American Occupational Therapy Association. The official documents that were examined are: (1) "Dictionary Definition of Occupational Therapy" (April 1986), (2) The Philosophical Base of Occupational Therapy (AOTA, Resolution C #531-79), (3) Essentials and Guidelines for an Accredited Educational Program for the Occupational Therapist (AOTA, 1991a), (4) Essentials and Guidelines for an Accredited Educational Program for the Occupational Therapy Assistant (AOTA, 1991b), and (5) Occupational Therapy Code of
Ethics (AOTA, 1988). It is further assumed that these documents are representative of the values and beliefs reflected in other occupational therapy literature.

A value is defined as a belief or an ideal to which an individual is committed. Values are an important part of the base or foundation of a profession. Ideally, these values are embraced by all members of the profession and are reflected in the members’ interactions with those persons receiving services, colleagues, and the society at large. Values have a central role in a profession, and are developed and reinforced throughout an individual's life as a student and as a professional.

Actions and attitudes reflect the values of the individual. An attitude is the disposition to respond positively or negatively toward an object, person, concept, or situation. Thus, there is an assumption that all professional actions and interactions are rooted in certain core values and beliefs.

Seven Core Concepts

In this document, the core values and attitudes of occupational therapy are organized around seven basic concepts--altruism, equality, freedom, justice, dignity, truth, and prudence. How these core values and attitudes are expressed and implemented by occupational therapy practitioners may vary depending upon the environments and situations in which professional activity occurs.

Altruism is the unselfish concern for the welfare of others. This concept is reflected in actions and attitudes of commitment, caring, dedication, responsiveness, and understanding.

Equality requires that all individuals be perceived as having the same fundamental human rights and opportunities. This value is demonstrated by an attitude of fairness and impartiality. We believe that we should respect all individuals, keeping in mind that they may have values, beliefs, or life styles that are different from our own. Equality is practiced in the broad professional arena, but is particularly important in day-to-day interactions with those individuals receiving occupational therapy services.

Freedom allows the individual to exercise choice and to demonstrate independence, initiative, and self-direction. There is a need for all individuals to find a balance between autonomy and societal membership that is reflected in the choice of various patterns of interdependence with the human and nonhuman environment. We believe that individuals are internally and externally motivated toward
action in a continuous process of adaptation throughout the life span. Purposeful activity plays a major role in developing and exercising self-direction, initiative, interdependence, and relatedness to the world. Activities verify the individual's ability to adapt, and they establish a satisfying balance between autonomy and societal membership. As professionals, we affirm the freedom of choice for each individual to pursue goals that have personal and social meaning.

**Justice** places value on the upholding of such moral and legal principles as fairness, equity, truthfulness, and objectivity. This means we aspire to provide occupational therapy services for all individuals who are in need of these services and that we will maintain a goal-directed and objective relationship with all those served. Practitioners must be knowledgeable about and have respect for the legal rights of individuals receiving occupational therapy services. In addition, the occupational therapy practitioner must understand and abide by the local, state, and federal laws governing professional practice.

**Dignity** emphasizes the importance of valuing the inherent worth and uniqueness of each person. This value is demonstrated by an attitude of empathy and respect for self and others. We believe that each individual is a unique combination of biologic endowment, sociocultural heritage, and life experiences. We view human beings holistically, respecting the unique interaction of the mind, body, and physical and social environment. We believe that dignity is nurtured and grows from the sense of competence and self-worth that is integrally linked to the person's ability to perform valued and relevant activities. In occupational therapy we emphasize the importance of dignity by helping the individual build on his or her unique attributes and resources.

**Truth** requires that we be faithful to facts and reality. Truthfulness or veracity is demonstrated by being accountable, honest, forthright, accurate, and authentic in our attitudes and actions. There is an obligation to be truthful with ourselves, those who receive services, colleagues, and society. One way that this is exhibited is through maintaining and upgrading professional competence. This happens, in part, through an unaltering commitment to inquiry and learning, to self-understanding and to the development of an interpersonal competence.

**Prudence** is the ability to govern and discipline oneself through the use of reason. To be prudent is to value judiciousness, discretion, vigilance, moderation, care, and circumspection in the management of one's affairs, to temper extremes, make judgments and respond on the basis
of intelligent reflection and rational thought.

Summary

Beliefs and values are those intrinsic concepts that underlie the core of the profession and the professional interactions of each practitioner. These values describe the profession's philosophy and provide the basis for defining purpose. The emphasis or priority that is given to each value may change as one's professional career evolves and as the unique characteristics of a situation unfold. This evolution of values is developmental in nature. Although we have basic values that cannot be violated, the degree to which certain values will take priority at a given time is influenced by the specifics situation and the environment in which it occurs. In one instance dignity may be a higher priority than truth; in another prudence may be chosen over freedom. As we process information and make decisions, the weight of the values that we hold may change. The practitioner faces dilemmas because of conflicting values and is required to engage in thoughtful deliberation to determine where the priority lies in a given situation.

The challenge for us all is to know our values, be able to make reasoned choices in situations of conflict, and be able to clearly articulate and defend our choices. At the same time, it is important that all members of the profession be committed to a set of common values. This mutual commitment to a set of beliefs and principles that govern our practice can provide a basis for clarifying expectations between the recipient and the provider of services. Shared values empowers the profession and, in addition, builds trust among ourselves and with others.

References


American Occupational Therapy Association. (April 1986). Dictionary definition of occupational therapy. Adopted and approved by the Representative Assembly April 1986 to fulfill Resolution #596-83. (Available from: AOTA, 1383 Piccard Drive, P. O. Box 1725, Rockville, MD 20849-1725.)


**Approved by the Representative Assembly June, 1993**


© 1999 - 2006 American Occupational Therapy Association, Inc. All rights reserved.

[Accessibility](#) | [Disclaimer](#) | [Linking Policy](#) | [Site Map](#) | [Contact Us](#)
## Guidelines to the *Occupational Therapy Code of Ethics*

<table>
<thead>
<tr>
<th>Professional Behaviors</th>
<th>Principles From Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. HONESTY:</strong> <em>Professionals must be honest with themselves, must be honest with all whom they come in contact with, and must know their strengths and limitations.</em></td>
<td></td>
</tr>
<tr>
<td>1.1. In education, research, practice, and leadership roles, individuals must be honest in receiving and disseminating information by providing opportunities for informed consent and for discussion of available options.</td>
<td>Veracity</td>
</tr>
<tr>
<td>1.2. Occupational therapy practitioners must be certain that informed consent has been obtained prior to the initiation of services, including evaluation. If the service recipient cannot give informed consent, the practitioner must be sure that consent has been obtained from the person who is legally responsible for the service recipient.</td>
<td>Autonomy, Veracity</td>
</tr>
<tr>
<td>1.3. Occupational therapy practitioners must be truthful about their individual competencies as well as the competence of those under their supervision. In some cases the therapist may need to refer the client to another professional to assure that the most appropriate services are provided.</td>
<td>Duty, Veracity</td>
</tr>
<tr>
<td>1.4. Referrals to other health care specialists shall be based exclusively on the other provider's competence and ability to provide the needed service.</td>
<td>Beneficence</td>
</tr>
<tr>
<td>1.5. All documentation must accurately reflect the nature and quantity of services provided.</td>
<td>Veracity</td>
</tr>
<tr>
<td>1.6. Occupational therapy practitioners terminate services when they do not meet the needs and goals of the recipient or when services no longer produce a measurable outcome.</td>
<td>Procedural Justice, Beneficence</td>
</tr>
<tr>
<td>1.7. All marketing and advertising must be truthful and carefully presented to avoid misleading the client or the public.</td>
<td>Veracity</td>
</tr>
<tr>
<td>1.8. All occupational therapy personnel shall accurately represent their credentials and roles.</td>
<td>Veracity</td>
</tr>
</tbody>
</table>
1.9. Occupational therapy personnel shall not use funds for unintended purposes or misappropriate funds.  
Duty, Veracity

2. COMMUNICATION: Communication is important in all aspects of occupational therapy. Individuals must be conscientious and truthful in all facets of written, verbal, and electronic communication.

2.1. Occupational therapy personnel do not make deceptive, fraudulent, or misleading statements about the nature of the services they provide or the outcomes that can be expected.  
Veracity

2.2. Professional contracts for occupational therapy services shall explicitly describe the type and duration of services as well as the duties and responsibilities of all involved parties.  
Veracity, Procedural Justice

2.3. Documentation for reimbursement purposes shall be done in accordance with applicable laws, guidelines, and regulations.  
Veracity, Procedural Justice

2.4. Documentation shall accurately reflect the services delivered and the outcomes. It shall be of the kind and quality that satisfies the scrutiny of peer reviews, legal proceedings, payers, regulatory bodies, and accrediting agencies.  
Veracity, Procedural Justice, Duties

2.5. Occupational therapy personnel must be honest in gathering and giving fact-based information regarding job performance and fieldwork performance. Information given shall be timely and truthful, accurate, and respectful of all parties involved.  
Veracity, Fidelity

2.6. Documentation for supervisory purposes shall accurately reflect the factual components of the interactions and the expected outcomes.  
Veracity

2.7. Occupational therapy personnel must give credit and recognition when using the work of others.  
Veracity, Procedural Justice

2.8. Occupational therapy personnel do not fabricate data, falsify information, or plagiarize.  
Veracity, Procedural Justice

2.9. Occupational therapy personnel refrain from using biased or derogatory language in written, verbal, and electronic communication about clients, students, research participants, and colleagues.  
Nonmaleficence, Fidelity
2.10. Occupational therapy personnel who provide information through oral and written means shall emphasize that ethical and appropriate service delivery for clients cannot be done without proper individualized evaluations and plans of care.

<table>
<thead>
<tr>
<th>3. ENSURING THE COMMON GOOD: Occupational therapy personnel are expected to increase awareness of the profession’s social responsibilities to help ensure the common good.</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1. Occupational therapy personnel take steps to make sure that employers are aware of the ethical principles of the profession and occupational therapy personnel’s obligation to adhere to those ethical principles.</td>
</tr>
<tr>
<td>3.2. Occupational therapy personnel shall be diligent stewards of human, financial, and material resources of their employers. They shall refrain from exploiting these resources for personal gain.</td>
</tr>
<tr>
<td>3.3. Occupational therapy personnel should actively work with their employer to prevent discrimination and unfair labor practices. They should also advocate for employees with disabilities to ensure the provision of reasonable accommodations.</td>
</tr>
<tr>
<td>3.4. Occupational therapy personnel should actively participate with their employer in the formulation of policies and procedures. They should do this to ensure that these policies and procedures are legal, in accordance with regulations governing aspects of practice, and consistent with the AOTA Occupational Therapy Code of Ethics.</td>
</tr>
<tr>
<td>3.5. Occupational therapy personnel in educational settings are responsible for promoting ethical conduct by students, faculty, and fieldwork colleagues.</td>
</tr>
<tr>
<td>3.6. Occupational therapy personnel involved in or preparing to be involved in research, including education and policy research, need to obtain all necessary approvals prior to initiating research.</td>
</tr>
</tbody>
</table>

4. COMPETENCE: Occupational therapy personnel are expected to work within their areas of competence and to pursue opportunities to update, increase, and expand their competence.

<p>| 4.1. Occupational therapy personnel developing new areas of competence (skills, techniques, approaches) must engage in appropriate study and training, under appropriate supervision, before incorporating new areas into their practice. | Duty |</p>
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Related Principles</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.2.</td>
<td>When generally recognized standards do not exist in emerging areas of practice, occupational therapy personnel must take responsible steps to ensure their own competence.</td>
<td>Duty</td>
</tr>
<tr>
<td>4.3.</td>
<td>Occupational therapy personnel shall develop an understanding and appreciation for different cultures in order to be able to provide culturally competent service. Culturally competent practitioners are aware of how service delivery can be affected by economic, age, ethnic, racial, geographic, gender, gender identity, religious, and political factors, as well as marital status, sexual orientation, and disability.</td>
<td>Beneficence, Duty</td>
</tr>
<tr>
<td>4.4.</td>
<td>In areas where the ability to communicate with the client is limited (e.g., aphasia, different language, literacy), occupational therapy personnel shall take appropriate steps to facilitate meaningful communication and comprehension.</td>
<td>Autonomy</td>
</tr>
<tr>
<td>4.5.</td>
<td>Occupational therapy personnel must ensure that skilled occupational therapy interventions or techniques are only performed by qualified persons.</td>
<td>Duty, Beneficence, Nonmaleficence</td>
</tr>
<tr>
<td>4.6.</td>
<td>Occupational therapy administrators (academic, research, and clinical) are responsible for ensuring the competence and qualifications of personnel in their employment.</td>
<td>Beneficence, Nonmaleficence</td>
</tr>
</tbody>
</table>

**5. CONFIDENTIAL AND PROTECTED INFORMATION:** Information that is confidential must remain confidential. This information cannot be shared verbally, electronically, or in writing without appropriate consent. Information must be shared on a need-to-know basis only with those having primary responsibilities for decision making.

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Related Principles</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1.</td>
<td>All occupational therapy personnel shall respect the confidential nature of information gained in any occupational therapy interaction. The only exceptions are when a practitioner or staff member believes that an individual is in serious, foreseeable, or imminent harm. In this instance, laws and regulations require disclosure to appropriate authorities without consent.</td>
<td>Confidentiality</td>
</tr>
<tr>
<td>5.2.</td>
<td>Occupational therapy personnel shall respect the clients’ and colleagues’ right to privacy.</td>
<td>Confidentiality</td>
</tr>
<tr>
<td>5.3.</td>
<td>Occupational therapy personnel shall maintain the confidentiality of all verbal, written, electronic, augmentative, and non-verbal communications (e.g., HIPAA).</td>
<td>Confidentiality</td>
</tr>
</tbody>
</table>
### 6. CONFLICT OF INTEREST: *Avoidance of real or perceived conflict of interest is imperative to maintaining the integrity of interactions.*

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6.1. Occupational therapy personnel shall be alert to and avoid any action that would interfere with the exercise of impartial professional judgment during the delivery of occupational therapy services.</td>
<td>Nonmaleficence</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6.2. Occupational therapy personnel shall not take advantage of or exploit anyone to further their own personal interests.</td>
<td>Nonmaleficence</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6.3. Gifts and remuneration from individuals, agencies, or companies must be reported in accordance with employer policies as well as state and federal guidelines.</td>
<td>Veracity, Procedural Justice</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6.4. Occupational therapy personnel shall not accept obligations or duties that may compete with or be in conflict with their duties to their employers.</td>
<td>Veracity, Fidelity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6.5. Occupational therapy personnel shall not use their position or the knowledge gained from their position in such a way that knowingly gives rise to real or perceived conflict of interest between themselves and their employers, other association members or bodies, and/or other organizations.</td>
<td>Veracity, Fidelity</td>
<td></td>
</tr>
</tbody>
</table>

### 7. IMPAIRED PRACTITIONER: *Occupational therapy personnel who cannot competently perform their duties after reasonable accommodation are considered to be impaired. The occupational therapy practitioner’s basic duty to students, patients, colleagues, and research subjects is to ensure that no harm is done. It is difficult to report a professional colleague who is impaired. The motive for this action must be to provide for the protection and safety of all, including the person who is impaired.*

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7.1. Occupational therapy personnel shall be aware of their own personal problems and limitations that may interfere with their ability to perform their job competently. They should know when these problems have the potential for causing harm to clients, colleagues, students, research participants, or others.</td>
<td>Nonmaleficence</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7.2. The individual should seek the appropriate professional help and take steps to remedy personal problems and limitations that interfere with job performance.</td>
<td>Nonmaleficence</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7.3. Occupational therapy personnel who believe that a colleague's impairment interferes with safe and effective practice should,</td>
<td>Nonmaleficence</td>
<td></td>
</tr>
</tbody>
</table>
when possible, discuss their questions and concerns with the individual and assist their colleague in seeking appropriate help or treatment.

7.4. When efforts to assist an impaired colleague fail, the occupational therapy practitioner is responsible for reporting the individual to the appropriate authority (e.g., employer, agency, licensing or regulatory board, certification body, professional organization). Nonmaleficence

8. SEXUAL RELATIONSHIPS: Sexual relationships that occur during any professional interaction are forms of misconduct.

8.1. Because of potential coercion or harm to former clients, students, or research participants, occupational therapy practitioners are responsible for ensuring that the individual with whom they enter into a romantic/sexual relationship has not been coerced or exploited in any way. Nonmaleficence

8.2. Sexual relationships with current clients, employees, students, or research participants are not permissible, even if the relationship is consensual. Nonmaleficence

8.3. Occupational therapy personnel must not sexually harass any persons. Nonmaleficence

8.4. Occupational therapy personnel have full responsibility to set clear and appropriate boundaries in their professional interactions. Nonmaleficence

9. PAYMENT FOR SERVICES AND OTHER FINANCIAL ARRANGEMENTS: Occupational therapy personnel shall not guarantee or promise specific outcomes for occupational therapy services. Payment for occupational therapy services shall not be contingent on successful outcomes.

9.1. Occupational therapy personnel shall only collect fees legally. Fees shall be fair and reasonable and commensurate with services delivered. Procedural Justice

9.2. Occupational therapy personnel do not ordinarily participate in bartering for services because of potential exploitation and conflict of interest. However, such an arrangement may be appropriate if it is not clinically contraindicated, if the relationship is not exploitative, and if bartering is a culturally appropriate custom. Beneficence

9.3. Occupational therapy practitioners can render pro bono (“for the
Guidelines to the Occupational Therapy Code of Ethics

<table>
<thead>
<tr>
<th>Procedural Justice</th>
<th>Beneficence</th>
<th>Duty</th>
<th>Fidelity</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.4. Occupational therapy personnel may engage in volunteer activities to improve access to occupational therapy or by providing individual service and expertise to charitable organizations.</td>
<td>9.5. Occupational therapy personnel who participate in a business arrangement as owner, stockholder, partner, or employee have an obligation to maintain the ethical principles and standards of the profession. They also shall refrain from working for or doing business with organizations that engage in illegal or unethical business practices (e.g., fraudulent billing).</td>
<td>10. RESOLVING ETHICAL ISSUES: Occupational therapy personnel should utilize any and all resources available to them to identify and resolve conflicts and/or ethical dilemmas.</td>
<td>10.1. Occupational therapy personnel are obligated to be familiar with the Code and its application to their respective work environments. Occupational therapy practitioners are expected to share the Code with their employer and other employees and colleagues. Lack of familiarity with and knowledge of the Code is not an excuse or a defense against a charge of ethical misconduct.</td>
</tr>
</tbody>
</table>
10.6. Occupational therapy personnel shall cooperate with ethics committee proceedings and comply with resulting requirements. Failure to cooperate is, in itself, an ethical violation.  Procedural Justice

10.7. Occupational therapy personnel shall only file formal ethics complaints aimed at protecting the public or promoting professional conduct rather than harming or discrediting a colleague.  Fidelity

Authors
Ethics Commission (EC)

S. Maggie Reitz, PhD, OTR/L, FAOTA, Chairperson
Darryl John Austin, MS, OT/L
Lea C. Brandt, OTD, OTR/L
Betsy DeBrakeleer, COTA/L, AP, ROH
Linda Gabriel Franck, PtD, OTR/L
Donna F. Homenko, RDH, Ph.D
Lorie J. McQuade, M.Ed, C.R.C.
Deborah Yarett Slater, MS, OT/L, FAOTA, Staff Liaison

Note: Commission on Standards and Ethics (SEC) changed to Ethics Commission (EC) in September 2005 per AOTA Bylaws. This document was developed by the EC in 2005 and replaces the 1998 document of the same name.

Previously published and copyrighted in 1998 by the American Occupational Therapy Association in the American Journal of Occupational Therapy, 52, 881-884.

To be published and copyrighted in 2006 by the American Occupational Therapy Association in the American Journal of Occupational Therapy, 60 (November/December).
The preservation of the highest standards of integrity and ethical principles is vital to the responsible discharge of obligations by speech-language pathologists, audiologists, and speech, language, and hearing scientists. This Code of Ethics sets forth the fundamental principles and rules considered essential to this purpose.

Every individual who is (a) a member of the American Speech-Language-Hearing Association, whether certified or not, (b) a nonmember holding the Certificate of Clinical Competence from the Association, (c) an applicant for membership or certification, or (d) a Clinical Fellow seeking to fulfill standards for certification shall abide by this Code of Ethics.

Any violation of the spirit and purpose of this Code shall be considered unethical. Failure to specify any particular responsibility or practice in this Code of Ethics shall not be construed as denial of the existence of such responsibilities or practices.

The fundamentals of ethical conduct are described by Principles of Ethics and by Rules of Ethics as they relate to the responsibility to persons served, the public, speech-language pathologists, audiologists, and speech, language, and hearing scientists, and to the conduct of research and scholarly activities.

Principles of Ethics, aspirational and inspirational in nature, form the underlying moral basis for the Code of Ethics. Individuals shall observe these principles as affirmative obligations under all conditions of professional activity.

Rules of Ethics are specific statements of minimally acceptable professional conduct or of prohibitions and are applicable to all individuals.

<table>
<thead>
<tr>
<th>Principle of Ethics I</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals shall honor their responsibility to hold paramount the welfare of persons they serve professionally or who are participants in research and scholarly activities, and they shall treat animals involved in research in a humane manner.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rules of Ethics</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Individuals shall provide all services competently.</td>
</tr>
<tr>
<td>B. Individuals shall use every resource, including referral when appropriate, to ensure that high-quality service is provided.</td>
</tr>
<tr>
<td>C. Individuals shall not discriminate in the delivery of professional services or the conduct of research and scholarly activities on the basis of race or ethnicity, gender, gender identity/gender expression, age, religion, national origin, sexual orientation, or disability.</td>
</tr>
<tr>
<td>D. Individuals shall not misrepresent the credentials of assistants, technicians, support personnel, students, Clinical Fellows, or any others under their supervision, and they shall inform those they serve professionally of the name and professional credentials of persons providing services.</td>
</tr>
<tr>
<td>E. Individuals who hold the Certificate of Clinical Competence shall not delegate tasks that require the unique skills, knowledge, and judgment that are within the scope of their profession to assistants, technicians, support personnel, or any nonprofessionals over whom they have supervisory responsibility.</td>
</tr>
</tbody>
</table>
F. Individuals who hold the Certificate of Clinical Competence may delegate tasks related to provision of clinical services to assistants, technicians, support personnel, or any other persons only if those services are appropriately supervised, realizing that the responsibility for client welfare remains with the certified individual.

G. Individuals who hold the Certificate of Clinical Competence may delegate tasks related to provision of clinical services that require the unique skills, knowledge, and judgment that are within the scope of practice of their profession to students only if those services are appropriately supervised. The responsibility for client welfare remains with the certified individual.

H. Individuals shall fully inform the persons they serve of the nature and possible effects of services rendered and products dispensed, and they shall inform participants in research about the possible effects of their participation in research conducted.

I. Individuals shall evaluate the effectiveness of services rendered and of products dispensed, and they shall provide services or dispense products only when benefit can reasonably be expected.

J. Individuals shall not guarantee the results of any treatment or procedure, directly or by implication; however, they may make a reasonable statement of prognosis.

K. Individuals shall not provide clinical services solely by correspondence.

L. Individuals may practice by telecommunication (e.g., telehealth/e-health), where not prohibited by law.

M. Individuals shall adequately maintain and appropriately secure records of professional services rendered, research and scholarly activities conducted, and products dispensed, and they shall allow access to these records only when authorized or when required by law.

N. Individuals shall not reveal, without authorization, any professional or personal information about identified persons served professionally or identified participants involved in research and scholarly activities unless doing so is necessary to protect the welfare of the person or of the community or is otherwise required by law.

O. Individuals shall not charge for services not rendered, nor shall they misrepresent services rendered, products dispensed, or research and scholarly activities conducted.

P. Individuals shall enroll and include persons as participants in research or teaching demonstrations only if their participation is voluntary, without coercion, and with their informed consent.

Q. Individuals whose professional services are adversely affected by substance abuse or other health-related conditions shall seek professional assistance and, where appropriate, withdraw from the affected areas of practice.

R. Individuals shall not discontinue service to those they are serving without providing reasonable notice.

Principle of Ethics II

Individuals shall honor their responsibility to achieve and maintain the highest level of professional competence and performance.
### Rules of Ethics

A. Individuals shall engage in the provision of clinical services only when they hold the appropriate Certificate of Clinical Competence or when they are in the certification process and are supervised by an individual who holds the appropriate Certificate of Clinical Competence.

B. Individuals shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their level of education, training, and experience.

C. Individuals shall engage in lifelong learning to maintain and enhance professional competence and performance.

D. Individuals shall not require or permit their professional staff to provide services or conduct research activities that exceed the staff member's competence, level of education, training, and experience.

E. Individuals shall ensure that all equipment used to provide services or to conduct research and scholarly activities is in proper working order and is properly calibrated.

### Principle of Ethics III

Individuals shall honor their responsibility to the public by promoting public understanding of the professions, by supporting the development of services designed to fulfill the unmet needs of the public, and by providing accurate information in all communications involving any aspect of the professions, including the dissemination of research findings and scholarly activities, and the promotion, marketing, and advertising of products and services.

### Rules of Ethics

A. Individuals shall not misrepresent their credentials, competence, education, training, experience, or scholarly or research contributions.

B. Individuals shall not participate in professional activities that constitute a conflict of interest.

C. Individuals shall refer those served professionally solely on the basis of the interest of those being referred and not on any personal interest, financial or otherwise.

D. Individuals shall not misrepresent research, diagnostic information, services rendered, results of services rendered, products dispensed, or the effects of products dispensed.

E. Individuals shall not defraud or engage in any scheme to defraud in connection with obtaining payment, reimbursement, or grants for services rendered, research conducted, or products dispensed.

F. Individuals' statements to the public shall provide accurate information about the nature and management of communication disorders, about the professions, about professional services, about products for sale, and about research and scholarly activities.

G. Individuals' statements to the public when advertising, announcing, and marketing their professional services; reporting research results; and promoting products shall adhere to professional standards and shall not contain misrepresentations.

### Principle of Ethics IV

Individuals shall honor their responsibilities to the professions and their relationships with colleagues, students, and members of other professions and disciplines.
Rules of Ethics

A. Individuals shall uphold the dignity and autonomy of the professions, maintain harmonious interprofessional and intraprofessional relationships, and accept the professions' self-imposed standards.

B. Individuals shall prohibit anyone under their supervision from engaging in any practice that violates the Code of Ethics.

C. Individuals shall not engage in dishonesty, fraud, deceit, or misrepresentation.

D. Individuals shall not engage in any form of unlawful harassment, including sexual harassment or power abuse.

E. Individuals shall not engage in any other form of conduct that adversely reflects on the professions or on the individual’s fitness to serve persons professionally.

F. Individuals shall not engage in sexual activities with clients, students, or research participants over whom they exercise professional authority or power.

G. Individuals shall assign credit only to those who have contributed to a publication, presentation, or product. Credit shall be assigned in proportion to the contribution and only with the contributor's consent.

H. Individuals shall reference the source when using other persons’ ideas, research, presentations, or products in written, oral, or any other media presentation or summary.

I. Individuals' statements to colleagues about professional services, research results, and products shall adhere to prevailing professional standards and shall contain no misrepresentations.

J. Individuals shall not provide professional services without exercising independent professional judgment, regardless of referral source or prescription.

K. Individuals shall not discriminate in their relationships with colleagues, students, and members of other professions and disciplines on the basis of race or ethnicity, gender, gender identity/gender expression, age, religion, national origin, sexual orientation, or disability.

L. Individuals shall not file or encourage others to file complaints that disregard or ignore facts that would disprove the allegation, nor should the Code of Ethics be used for personal reprisal, as a means of addressing personal animosity, or as a vehicle for retaliation.

M. Individuals who have reason to believe that the Code of Ethics has been violated shall inform the Board of Ethics.

N. Individuals shall comply fully with the policies of the Board of Ethics in its consideration and adjudication of complaints of violations of the Code of Ethics.
Scope of Practice in Speech-Language Pathology

Ad Hoc Committee on the Scope of Practice in Speech-Language Pathology


Index terms: scope of practice
doi:10.1044/policy.SP2007-00283
About This Document

This scope of practice document is an official policy of the American Speech-Language-Hearing Association (ASHA) defining the breadth of practice within the profession of speech-language pathology. This document was developed by the ASHA Ad Hoc Committee on the Scope of Practice in Speech-Language Pathology. Committee members were Kenn Apel (chair), Theresa E. Bartolotta, Adam A. Brickell, Lynne E. Hewitt, Ann W. Kummer, Luis F. Riquelme, Jennifer B. Watson, Carole Zangari, Brian B. Shulman (vice president for professional practices in speech-language pathology), Lemmietta McNeilly (ex officio), and Diane R. Paul (consultant). This document was approved by the ASHA Legislative Council on September 4, 2007 (LC 09-07).

Introduction

The Scope of Practice in Speech-Language Pathology includes a statement of purpose, a framework for research and clinical practice, qualifications of the speech-language pathologist, professional roles and activities, and practice settings. The speech-language pathologist is the professional who engages in clinical services, prevention, advocacy, education, administration, and research in the areas of communication and swallowing across the life span from infancy through geriatrics. Given the diversity of the client population, ASHA policy requires that these activities are conducted in a manner that takes into consideration the impact of culture and linguistic exposure/acquisition and uses the best available evidence for practice to ensure optimal outcomes for persons with communication and/or swallowing disorders or differences.

As part of the review process for updating the Scope of Practice in Speech-Language Pathology, the committee made changes to the previous scope of practice document that reflected recent advances in knowledge, understanding, and research in the discipline. These changes included acknowledging roles and responsibilities that were not mentioned in previous iterations of the Scope of Practice (e.g., funding issues, marketing of services, focus on emergency responsiveness, communication wellness). The revised document also was framed squarely on two guiding principles: evidence-based practice and cultural and linguistic diversity.

Statement of Purpose

The purpose of this document is to define the Scope of Practice in Speech-Language Pathology to

1. delineate areas of professional practice for speech-language pathologists;
2. inform others (e.g., health care providers, educators, other professionals, consumers, payers, regulators, members of the general public) about professional services offered by speech-language pathologists as qualified providers;
3. support speech-language pathologists in the provision of high-quality, evidence-based services to individuals with concerns about communication or swallowing;
4. support speech-language pathologists in the conduct of research;
5. provide guidance for educational preparation and professional development of speech-language pathologists.
This document describes the breadth of professional practice offered within the profession of speech-language pathology. Levels of education, experience, skill, and proficiency with respect to the roles and activities identified within this scope of practice document vary among individual providers. A speech-language pathologist typically does not practice in all areas of the field. As the ASHA Code of Ethics specifies, individuals may practice only in areas in which they are competent (i.e., individuals' scope of competency), based on their education, training, and experience.

In addition to this scope of practice document, other ASHA documents provide more specific guidance for practice areas. Figure 1 illustrates the relationship between the ASHA Code of Ethics, the *Scope of Practice*, and specific practice documents. As shown, the ASHA Code of Ethics sets forth the fundamental principles and rules considered essential to the preservation of the highest standards of integrity and ethical conduct in the practice of speech-language pathology.

Speech-language pathology is a dynamic and continuously developing profession. As such, listing specific areas within this *Scope of Practice* does not exclude emerging areas of practice. Further, speech-language pathologists may provide additional professional services (e.g., interdisciplinary work in a health care setting, collaborative service delivery in schools, transdisciplinary practice in early intervention settings) that are necessary for the well-being of the individual(s) they
are serving but are not addressed in this Scope of Practice. In such instances, it is both ethically and legally incumbent upon professionals to determine whether they have the knowledge and skills necessary to perform such services.

This scope of practice document does not supersede existing state licensure laws or affect the interpretation or implementation of such laws. It may serve, however, as a model for the development or modification of licensure laws.

The overall objective of speech-language pathology services is to optimize individuals' ability to communicate and swallow, thereby improving quality of life. As the population profile of the United States continues to become increasingly diverse (U.S. Census Bureau, 2005), speech-language pathologists have a responsibility to be knowledgeable about the impact of these changes on clinical services and research needs. Speech-language pathologists are committed to the provision of culturally and linguistically appropriate services and to the consideration of diversity in scientific investigations of human communication and swallowing. For example, one aspect of providing culturally and linguistically appropriate services is to determine whether communication difficulties experienced by English language learners are the result of a communication disorder in the native language or a consequence of learning a new language.

Additionally, an important characteristic of the practice of speech-language pathology is that, to the extent possible, clinical decisions are based on best available evidence. ASHA has defined evidence-based practice in speech-language pathology as an approach in which current, high-quality research evidence is integrated with practitioner expertise and the individual's preferences and values into the process of clinical decision making (ASHA, 2005). A high-quality basic, applied, and efficacy research base in communication sciences and disorders and related fields of study is essential to providing evidence-based clinical practice and quality clinical services. The research base can be enhanced by increased interaction and communication with researchers across the United States and from other countries. As our global society is becoming more connected, integrated, and interdependent, speech-language pathologists have access to an abundant array of resources, information technology, and diverse perspectives and influence (e.g., Lombardo, 1997). Increased national and international interchange of professional knowledge, information, and education in communication sciences and disorders can be a means to strengthen research collaboration and improve clinical services.

The World Health Organization (WHO) has developed a multipurpose health classification system known as the International Classification of Functioning, Disability and Health (ICF; WHO, 2001). The purpose of this classification system is to provide a standard language and framework for the description of functioning and health. The ICF framework is useful in describing the breadth of the role of
the speech-language pathologist in the prevention, assessment, and habilitation/rehabilitation, enhancement, and scientific investigation of communication and swallowing. It consists of two components:

- **Health Conditions**
  - **Body Functions and Structures**: These involve the anatomy and physiology of the human body. Relevant examples in speech-language pathology include craniofacial anomaly, vocal fold paralysis, cerebral palsy, stuttering, and language impairment.
  - **Activity and Participation**: Activity refers to the execution of a task or action. Participation is the involvement in a life situation. Relevant examples in speech-language pathology include difficulties with swallowing safely for independent feeding, participating actively in class, understanding a medical prescription, and accessing the general education curriculum.

- **Contextual Factors**
  - **Environmental Factors**: These make up the physical, social, and attitudinal environments in which people live and conduct their lives. Relevant examples in speech-language pathology include the role of the communication partner in augmentative and alternative communication, the influence of classroom acoustics on communication, and the impact of institutional dining environments on individuals' ability to safely maintain nutrition and hydration.
  - **Personal Factors**: These are the internal influences on an individual's functioning and disability and are not part of the health condition. These factors may include, but are not limited to, age, gender, ethnicity, educational level, social background, and profession. Relevant examples in speech-language pathology might include a person's background or culture that influences his or her reaction to a communication or swallowing disorder.

The framework in speech-language pathology encompasses these health conditions and contextual factors. The health condition component of the ICF can be expressed on a continuum of functioning. On one end of the continuum is intact functioning. At the opposite end of the continuum is completely compromised functioning. The contextual factors interact with each other and with the health conditions and may serve as facilitators or barriers to functioning. Speech-language pathologists may influence contextual factors through education and advocacy efforts at local, state, and national levels. Relevant examples in speech-language pathology include a user of an augmentative communication device needing classroom support services for academic success, or the effects of premorbid literacy level on rehabilitation in an adult post brain injury. Speech-language pathologists work to improve quality of life by reducing impairments of body functions and structures, activity limitations, participation restrictions, and barriers created by contextual factors.

**Qualifications**

Speech-language pathologists, as defined by ASHA, hold the ASHA Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP), which requires a master's, doctoral, or other recognized postbaccalaureate degree. ASHA-certified speech-language pathologists complete a supervised postgraduate professional experience and pass a national examination as described in the ASHA certification standards. Demonstration of continued professional development is
mandated for the maintenance of the CCC-SLP. Where applicable, speech-language pathologists hold other required credentials (e.g., state licensure, teaching certification).

This document defines the scope of practice for the field of speech-language pathology. Each practitioner must evaluate his or her own experiences with preservice education, clinical practice, mentorship and supervision, and continuing professional development. As a whole, these experiences define the scope of competence for each individual. Speech-language pathologists may engage in only those aspects of the profession that are within their scope of competence.

As primary care providers for communication and swallowing disorders, speech-language pathologists are autonomous professionals; that is, their services are not prescribed or supervised by another professional. However, individuals frequently benefit from services that include speech-language pathologist collaborations with other professionals.

Speech-language pathologists serve individuals, families, and groups from diverse linguistic and cultural backgrounds. Services are provided based on applying the best available research evidence, using expert clinical judgments, and considering clients’ individual preferences and values. Speech-language pathologists address typical and atypical communication and swallowing in the following areas:

- speech sound production
  - articulation
  - apraxia of speech
  - dysarthria
  - ataxia
  - dyskinesia
- resonance
  - hypernasality
  - hyponasality
  - cul-de-sac resonance
  - mixed resonance
- voice
  - phonation quality
  - pitch
  - loudness
  - respiration
- fluency
  - stuttering
  - cluttering
- language (comprehension and expression)
  - phonology
  - morphology
  - syntax
  - semantics
  - pragmatics (language use, social aspects of communication)
  - literacy (reading, writing, spelling)
  - prelinguistic communication (e.g., joint attention, intentionality, communicative signaling)
  - paralinguistic communication

Professional Roles and Activities
• cognition
  ◦ attention
  ◦ memory
  ◦ sequencing
  ◦ problem solving
  ◦ executive functioning
• feeding and swallowing
  ◦ oral, pharyngeal, laryngeal, esophageal
  ◦ orofacial myology (including tongue thrust)
  ◦ oral-motor functions

Potential etiologies of communication and swallowing disorders include
• neonatal problems (e.g., prematurity, low birth weight, substance exposure);
• developmental disabilities (e.g., specific language impairment, autism spectrum disorder, dyslexia, learning disabilities, attention deficit disorder);
• auditory problems (e.g., hearing loss or deafness);
• oral anomalies (e.g., cleft lip/palate, dental malocclusion, macroglossia, oral-motor dysfunction);
• respiratory compromise (e.g., bronchopulmonary dysplasia, chronic obstructive pulmonary disease);
• pharyngeal anomalies (e.g., upper airway obstruction, velopharyngeal insufficiency/incompetence);
• laryngeal anomalies (e.g., vocal fold pathology, tracheal stenosis, tracheostomy);
• neurological disease/dysfunction (e.g., traumatic brain injury, cerebral palsy, cerebral vascular accident, dementia, Parkinson’s disease, amyotrophic lateral sclerosis);
• psychiatric disorder (e.g., psychosis, schizophrenia);
• genetic disorders (e.g., Down syndrome, fragile X syndrome, Rett syndrome, velocardiofacial syndrome).

The professional roles and activities in speech-language pathology include clinical/educational services (diagnosis, assessment, planning, and treatment), prevention and advocacy, and education, administration, and research.

**Clinical Services**

Speech-language pathologists provide clinical services that include the following:
• prevention and pre-referral
• screening
• assessment/evaluation
• consultation
• diagnosis
• treatment, intervention, management
• counseling
• collaboration
• documentation
• referral

Examples of these clinical services include
1. using data to guide clinical decision making and determine the effectiveness of services;
2. making service delivery decisions (e.g., admission/eligibility, frequency, duration, location, discharge/dismissal) across the lifespan;
3. determining appropriate context(s) for service delivery (e.g., home, school, telepractice, community);
4. documenting provision of services in accordance with accepted procedures appropriate for the practice setting;
5. collaborating with other professionals (e.g., identifying neonates and infants at risk for hearing loss, participating in palliative care teams, planning lessons with educators, serving on student assistance teams);
6. screening individuals for hearing loss or middle ear pathology using conventional pure-tone air conduction methods (including otoscopic inspection), otoacoustic emissions screening, and/or screening tympanometry;
7. providing intervention and support services for children and adults diagnosed with speech and language disorders;
8. providing intervention and support services for children and adults diagnosed with auditory processing disorders;
9. using instrumentation (e.g., videofluoroscopy, electromyography, nasendoscopy, stroboscopy, endoscopy, nasometry, computer technology) to observe, collect data, and measure parameters of communication and swallowing or other upper aerodigestive functions;
10. counseling individuals, families, coworkers, educators, and other persons in the community regarding acceptance, adaptation, and decision making about communication and swallowing;
11. facilitating the process of obtaining funding for equipment and services related to difficulties with communication and swallowing;
12. serving as case managers, service delivery coordinators, and members of collaborative teams (e.g., individualized family service plan and individualized education program teams, transition planning teams);
13. providing referrals and information to other professionals, agencies, and/or consumer organizations;
14. developing, selecting, and prescribing multimodal augmentative and alternative communication systems, including unaided strategies (e.g., manual signs, gestures) and aided strategies (e.g., speech-generating devices, manual communication boards, picture schedules);
15. providing services to individuals with hearing loss and their families/caregivers (e.g., auditory training for children with cochlear implants and hearing aids; speechreading; speech and language intervention secondary to hearing loss; visual inspection and listening checks of amplification devices for the purpose of troubleshooting, including verification of appropriate battery voltage);
16. addressing behaviors (e.g., perseverative or disruptive actions) and environments (e.g., classroom seating, positioning for swallowing safety or attention, communication opportunities) that affect communication and swallowing;
17. selecting, fitting, and establishing effective use of prosthetic/adaptive devices for communication and swallowing (e.g., tracheoesophageal prostheses, speaking valves, electrolarynges; this service does not include the selection or fitting of sensory devices used by individuals with hearing loss or other auditory perceptual deficits, which falls within the scope of practice of audiologists; ASHA, 2004);
18. providing services to modify or enhance communication performance (e.g., accent modification, transgender voice, care and improvement of the professional voice, personal/professional communication effectiveness).

Speech-language pathologists engage in prevention and advocacy activities related to human communication and swallowing. Example activities include
1. improving communication wellness by promoting healthy lifestyle practices that can help prevent communication and swallowing disorders (e.g., cessation of smoking, wearing helmets when bike riding);
2. presenting primary prevention information to individuals and groups known to be at risk for communication disorders and other appropriate groups;
3. providing early identification and early intervention services for communication disorders;
4. advocating for individuals and families through community awareness, health literacy, education, and training programs to promote and facilitate access to full participation in communication, including the elimination of societal, cultural, and linguistic barriers;
5. advising regulatory and legislative agencies on emergency responsiveness to individuals who have communication and swallowing disorders or difficulties;
6. promoting and marketing professional services;
7. advocating at the local, state, and national levels for improved administrativel and governmental policies affecting access to services for communication and swallowing;
8. advocating at the local, state, and national levels for funding for research;
9. recruiting potential speech-language pathologists into the profession;
10. participating actively in professional organizations to contribute to best practices in the profession.

Speech-language pathologists also serve as educators, administrators, and researchers. Example activities for these roles include
1. educating the public regarding communication and swallowing;
2. educating and providing in-service training to families, caregivers, and other professionals;
3. educating, supervising, and mentoring current and future speech-language pathologists;
4. educating, supervising, and managing speech-language pathology assistants and other support personnel;
5. fostering public awareness of communication and swallowing disorders and their treatment;
6. serving as expert witnesses;
7. administering and managing clinical and academic programs;
8. developing policies, operational procedures, and professional standards;
9. conducting basic and applied/translational research related to communication sciences and disorders, and swallowing.

Speech-language pathologists provide services in a wide variety of settings, which may include but are not exclusive to
1. public and private schools;
2. early intervention settings, preschools, and day care centers;
3. health care settings (e.g., hospitals, medical rehabilitation facilities, long-term care facilities, home health agencies, clinics, neonatal intensive care units, behavioral/mental health facilities);
4. private practice settings;
5. universities and university clinics;
6. individuals' homes and community residences;
7. supported and competitive employment settings;
8. community, state, and federal agencies and institutions;
9. correctional institutions;
10. research facilities;
11. corporate and industrial settings.

References

Resources
**ASHA Cardinal Documents**

**General Service Delivery Issues**
**Admission/Discharge Criteria**

**Autonomy**

**Culturally and Linguistically Appropriate Services**

**Definitions and Terminology**


**Evidence-Based Practice**


**Private Practice**


**Professional Service Programs**


**Speech-Language Pathology Assistants**


**Supervision**


Clinical Services and Populations

Apraxia of Speech

Auditory Processing

Augmentative and Alternative Communication (AAC)

Aural Rehabilitation

Autism Spectrum Disorders
Cognitive Aspects of Communication

Deaf and Hard of Hearing

Dementia

Early Intervention
Fluency

Hearing Screening

Language and Literacy

Mental Retardation/Developmental Disabilities

Orofacial Myofunctional Disorders

**Prevention**

**Severe Disabilities**

**Social Aspects of Communication**

**Swallowing**


**Voice and Resonance**


**Health Care Services**

**Business Practices in Health Care Settings**


**Multiskilling**

**Neonatal Intensive Care Unit**

**Sedation and Anesthetics**

**Telepractice**

**School Services**
**Collaboration**

**Evaluation**
Facilities

Inclusive Practices

Roles and Responsibilities for School-Based Practitioners

“Under the Direction of” Rule

Workload