

HANDBOOK FOR
Occupational and Physical Therapy
in Virginia Public Schools



2010

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Acknowledgements

The Virginia Department of Education wishes to thank the individuals who served on the handbook revision committee and the original committee for their commitment to a collaborative spirit throughout the duration of the project. Their perseverance resulted in a product that presents current information and at the same time reflects different points of view. The Department also expresses its appreciation to the committee members' employing agencies for sharing their most valuable resource - people.

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Introduction

The purpose of this handbook is to guide the provision of school-based therapy services in order to support the educational goals of students with disabilities. This revision of the *Handbook for Occupational and Physical Therapy Services in the Public Schools of Virginia* is a resource document to provide information about occupational therapy (OT) and physical therapy (PT) services in Virginia's public schools. As a source of information and suggestions for implementing these services, the handbook is not regulatory. Its intent is to supplement, not to replace, *Regulations Governing Special Education Programs for Children with Disabilities in Virginia* and local school board policy.

The handbook is written for special education administrators, educators and school personnel responsible for occupational and physical therapy services specified in a student's Individual Education Program (IEP) or 504 plan. In addition, it may benefit parents/guardians, teachers, and other professionals. In Virginia, Boards of the Virginia Department of Health Professions regulate occupational and physical therapy. Medical terminology is used in those regulations. In this document, medical terminology has been adapted, where appropriate, to reflect the educational language that is used in the provision of occupational and physical therapy services.

Laws and regulations, both federal and state, mandate that all students have available to them a free and appropriate public education (FAPE) that includes special education and related services. **FAPE** is a statutory term that includes special education and related services to be provided in accordance with an individualized education program (IEP). **Related services** means transportation and such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education. Related services include transportation and such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education and includes speech-language pathology and audiology services; interpreting services; psychological

services; physical and occupational therapy; recreation, including therapeutic recreation; early identification and assessment of disabilities in children; counseling services, including rehabilitation counseling; orientation and mobility services; and medical services for diagnostic or evaluation purposes. Related services also include school health services and school nurse services; social work services in schools; and parent counseling and training. Related services do not include a medical device that is surgically implanted including cochlear implants, the optimization of device functioning (e.g., mapping), maintenance of the device, or the replacement of that device. The list of related services is not exhaustive and may include other developmental, corrective, or supportive services (such as artistic and cultural programs, and art, music and dance therapy), if they are required to assist a child with a disability to benefit from special education (§ 22.1-213 of the *Code of Virginia*; 34 CFR 300.34(a) and (b)).

Local educational agencies (LEAs) are mandated to provide the related services of occupational and/or physical therapy when a student requires them to benefit from special education and/or to access the general education curriculum. The student's school-based therapy needs should directly relate to and support his or her educational program. Occupational and physical therapy services are provided only when a student is unable to benefit from special education and/or to access the general education curriculum without these services. Occupational and/or physical therapy services must be provided when specified in a student's IEP, service plan, or educational plan as defined by the Rehabilitation Act of 1973, Section 504, and its amendments.



Occupational Therapy

Occupational Therapy

Definition of Occupational Therapy

According to the *Code of Virginia* §54.1-2900, the practice of occupational therapy means the evaluation, analysis, assessment, and delivery of education and training in activities of daily living (ADL); the design, fabrication, and application of orthoses (splints); guidance in the selection and use of adaptive equipment; therapeutic activities to enhance functional performance; prevocational evaluation and training; and consultation concerning the adaptation of physical environments for individuals who have disabilities.

According to the *Regulations Governing Special Education Programs for Children with Disabilities in Virginia*, occupational therapy means services provided by a qualified occupational therapist or services provided under the direction or supervision of a qualified occupational therapist and includes (*Regulations Governing the Licensure of Occupational Therapists* (18VAC85-80-10 et seq.); 34 CFR 300.34(c)(6)):

- improving, developing, or restoring functions impaired or lost through illness, injury, or deprivation
- improving ability to perform tasks for independent functioning if functions are impaired or lost
- preventing, through early intervention, initial or further impairment or loss of function

Based on Occupational Therapy Services for Children and Youth Under Individuals with Disabilities Education Act, (2nd Edition, 1999) occupational therapy services are designed to help families, educational personnel, and other caregivers improve the student's participation in school, home, and community settings. Occupational therapy services include:

- Identification, referral, assessment, intervention, and consultation
- Adaptation of the environment, and selection, design, and fabrication of assistive and orthotic devices and other technology to facilitate development and promote the acquisition of functional skills

- Preventing or minimizing the impact of initial or future impairment, delay in development, or loss of functional ability as it relates to educational goals

According to the Occupational Therapy Practice Framework (AOTA, 2002), occupational therapy services support the educational team and help the student to engage successfully in purposeful and meaningful school occupations (Swinth et al., 2003). Outcomes are related to the primary occupation areas of education, activities of daily living (self care), play/leisure, and social participation. As a student matures and is preparing for independent living, the areas of work and instrumental activities of daily living (e.g., home management skills, money management, and safety procedures) may be supported by occupational therapy. Occupational therapy services may address performance skills (motor; process, and communication/interaction), performance patterns (habits, routines, and roles), context (cultural, physical, and social), activity demands, and student factors (body functions and structures).

Qualifications of the Occupational Therapist

Educational Requirements

To practice as an occupational therapist, the individual trained in the United States has the following qualifications:

- Graduation from an occupational therapy program (master's level) accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) or predecessor organizations
- Successful completion of supervised field work experience required by the educational program for occupational therapists that is accredited by ACOTE or predecessor organization
- Passing examination scores from a nationally recognized entry-level examination for occupational therapists
- Fulfillment of state requirements for licensure, certification or registration

An occupational therapist's coursework includes the study of anatomy, neuroscience, human development, and behavior with emphasis on life span occupations, health and prevention. Content related to disease, disability (congenital, developmental, acute and chronic disease processes; psychological), and injury is included. Additionally, studies include occupational therapy theory and practice, activity analysis, occupational therapy evaluation, intervention and implementation, assistive technology, management of occupational therapy services, research, ethics, and supervised fieldwork.

Licensure Requirements

The Board of Medicine of the Virginia Department of Health Professions regulates the practice of occupational therapy and issues licenses. An applicant for licensure to practice as an occupational therapist must submit evidence to the board that he or she has passed the National Board for Certification in Occupational Therapy (NBCOT) national examination (and any other examinations that may be required by NBCOT for initial certification) which is the prescribed examination approved for Virginia licensure. A graduate of an accredited occupational therapy educational program may practice with the designated title of Occupational Therapist, License Applicant (or OTL-Applicant) until he or she has taken and received the results of the licensure examination from the NBCOT or for six months from the date of graduation, whichever occurs sooner. Then the occupational therapist must receive licensure from the Virginia Board of Medicine to practice as a licensed occupational therapist (OTR/L). After passing the certification examination, the graduate may use the designated title (OTR) or any identification or signature in the course of his or her practice (18 VAC 85-80-45). The license for occupational therapists must be renewed every two years by submitting the required biennial continuing competencies of 20 hours of learning activities.

A copy of Regulations for the Licensure of Occupational Therapists (18 VAC 85-80-10 et seq.) may be found at <http://www.dhp.virginia.gov> under "Laws and Regulations" (see left-hand column). Questions should be addressed to:

Department of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463
Phone: (804) 367-4400

Licensed occupational therapists may choose to continue to be registered through NBCOT and use the designation OTR. However, continued NBCOT registration is not required to practice in the state of Virginia once licensure is obtained. Further information regarding registration is available at <http://www.nbcot.org/> or 1-301-990-7979.

Practice Requirements

An occupational therapist provides the specific activities or therapeutic methods to improve or restore optimum functioning for the child, to compensate for dysfunction, or to minimize the student's disability(ies). An occupational therapist's responsibilities may include assessment, program planning, provision of therapy for students and documentation of services delivered and the student's progress. The practice of occupational therapy may include supervisory, administrative, educational or consultative activities or responsibilities for the delivery of such services. The therapist analyzes the tasks and activities of the student's educational program, documents each student's progress, and coordinates delivery of services to support the student's educational needs.

Qualifications of the Occupational Therapy Assistant

The *Code of Virginia*, § 54.1-2956.5 defines "Occupational therapy assistant" as an individual who has met the requirements of the Board of Medicine of the Virginia Department of Health Professions for licensure and who works under the supervision of a licensed occupational therapist to assist in the practice of occupational therapy.

Educational Requirements

The occupational therapy assistant (OTA) provides occupational therapy services to assigned students solely under the direction and supervision of an

occupational therapist. Occupational therapy assistants may support the occupational therapist in student assessment, program planning, education, documentation, and service delivery.

An occupational therapy assistant (OTA) graduates from an approved or accredited occupational therapy assistant program that awards an associate degree or a certificate. An occupational therapy assistant's coursework from an approved or accredited program includes the study of the structure and function of the human body; sensorimotor, psychosocial, and cognitive development; and human behavior. The program includes the studies of conditions commonly referred for occupational therapy, occupational therapy principles and practice skills, occupational therapy process, and supervised fieldwork.

Licensure Requirements

The occupational therapy assistant must obtain initial certification by NBCOT as a certified occupational therapy assistant and subsequently licensed by the Board of Medicine of the Virginia Department of Health Professions. This license must be renewed biennially during the therapist's birth month in each even-numbered year.

The *Code of Virginia*, §54.1-2900 specifies that it shall be unlawful for any person to practice as an occupational therapy assistant as defined in §54.1-2900 or to hold himself or herself out to be or advertise that he or she is an occupational therapy assistant or use the designation "O.T.A." or any variation thereof unless such person holds a current and valid license from the Board to practice as an occupational therapy assistant. However, a person who has graduated from a duly accredited occupational therapy assistant education program may practice with the title "Occupational Therapy Assistant-License Applicant" or "O.T.A.-Applicant" until he or she has taken and received the results of any examination required by the Board or until six months from the date of graduation, whichever occurs sooner.

Practice Requirements

The *Code of Virginia*, § 54.1-2900, defines an

"Occupational therapy assistant" as an individual who has met the requirements of the Board for licensure and who works under the supervision of a licensed occupational therapist to assist in the practice of occupational therapy. Further, OTAs are expected to adhere to the *Occupational Therapy Code of Ethics (2005)* and *Standards of Practice for Occupational Therapy (2005)*. See the code of ethics at <http://www.aota.org/general/otsp.asp>.

The *Regulations Governing the Practice of Occupational Therapists and the Licensure of Occupational Therapy Assistants* (Emergency Regulations Effective 11/1/2008 to 4/26/2010) specify that a licensed occupational therapist shall be responsible for supervision of occupational therapy personnel who work under his or her direction and ultimately responsible and accountable for the student's service delivery. The regulations also indicate that the supervising occupational therapist should meet with occupational therapy personnel to review and evaluate treatment and progress of the individual student at least once every 10th treatment session or every 30 calendar days, whichever occurs first. An occupational therapist must not supervise more than six occupational therapy personnel to include no more than three occupational therapy assistants at any one time. An occupational therapist must be responsible for any action of persons providing occupational therapy under his or her supervision (18 VAC 85-80-110). Tasks assigned to the OTC shall be communicated on a student-specific basis with clear, specific instructions for performance of activities, potential complications, and expected results. The OTA shall document any aspects of the initial evaluation, treatment plan, discharge summary or other notes on student services performed by the assistant. The supervising occupational therapist shall review and countersign the OTA's documentation within 10 days of such information being recorded.

The American Occupational Therapy Association (AOTA) has established guidelines, *Guidelines for Supervision, Roles, and Responsibilities During the Delivery of Occupational Therapy Services* (2004), which are available from AOTA (see Appendix A).



Physical Therapy

Definition of Physical Therapy

According to the *Code of Virginia*, § 54.1-3473, the "practice of physical therapy" means that branch of the healing arts that is concerned with, upon medical referral and direction, the evaluation, testing, treatment, re-education and rehabilitation by physical, mechanical or electronic measures and procedures of individuals who, because of trauma, disease or birth defect, present physical and emotional disorders. The practice of physical therapy also includes the administration, interpretation, documentation, and evaluation of tests and measurements of bodily functions and structures within the scope of practice of the physical therapist. However, the practice of physical therapy does not include the medical diagnosis of disease or injury, the use of Roentgen rays and radium for diagnostic or therapeutic purposes or the use of electricity for shock therapy and surgical purposes including cauterization (2000, c. 688; 2001, c. 858).

The *Regulations Governing Special Education Programs for Children with Disabilities in Virginia*, define physical therapy as services provided by a qualified physical therapist or under the direction or supervision of a qualified physical therapist upon medical referral and direction (*Regulations Governing the Practice of Physical Therapy*, 18VAC112-20; 34 CFR 300.34(c)(9)). The American Physical Therapy Association (APTA) *Guide to Physical Therapist Practice*, 2nd Ed. (APTA, 2001), defines physical therapy as services provided by or under the direction and supervision of a physical therapist and includes:

- Examining individuals with impairments, functional limitations, and disability or other health-related conditions for diagnosis, prognosis, and intervention
- Alleviating impairments and functional limitations by designing, implementing, and modifying therapeutic intervention
- Preventing injury, impairment, functional limitations, and disability, including the promotion and maintenance of fitness, health, and quality of life in all populations
- Engaging in consultation, education, and research

In the educational setting, physical therapy addresses the ability to move parts of the body, to assume and maintain postures, and organize movement into functional gross motor skills. Physical therapists work with students to build strength and endurance for functional mobility (e.g., climbing stairs, opening doors, moving about the school, carrying materials, accessing the playground, participating in field trips).

Qualifications of the Physical Therapist

Educational Requirements

The physical therapist must graduate from an approved program accredited by the Commission on Accreditation in Physical Therapy. Currently, all entry-level programs for physical therapy are at the doctoral degree level. The pre-physical therapy college education program includes courses in psychology, biology, physics, statistics, chemistry, professional writing, and humanities. The professional program covers basic and clinical medical science courses, the theory and practice of physical therapy, assistive technology, and research. The curriculum provides opportunities to apply and integrate theory through extensive clinical education in a variety of practice settings.

Licensure

The physical therapist must pass the physical therapy licensure examination and hold a current Virginia license to practice as issued by the Virginia Board of Physical Therapy. This license must be renewed biennially by December 31 in each even-numbered year and the Board further mandates documented evidence of required biennial continuing competencies of 30 hours of continuing learning activities within the two years immediately preceding renewal. In choosing continuing learning activities or courses, the licensee shall consider the following: (a) the need to promote ethical practice, (b) an appropriate standard of care, (c) patient safety, (d) application of new medical technology, (e) appropriate communication with patients, and (f) knowledge of the changing health care system. School division Human Resources personnel should become familiar with all of the licensure

requirements to ensure uninterrupted licensure of the physical therapist.

Practice Requirements

The physical therapist is responsible for managing all aspects of the physical therapy services of each assigned student. The physical therapist is responsible for ongoing involvement in the delivery of physical therapy services to students that includes regular communication with a physical therapist assistant regarding the student's goals and objectives. Documentation of physical therapy interventions must be recorded by the physical therapist or physical therapist assistant providing the services. The physical therapist must continually assess the student's response to therapy. The physical therapist is responsible for communicating the purpose of therapy services to the student, as appropriate, teachers, parent(s)/guardian, school nurses and health services staff, and other professionals in contact with the student.

Upon approval of the State Board of Physical Therapy, an unlicensed graduate of an accredited physical therapy program may be employed under the direct supervision of a physical therapist. Supervision of unlicensed graduates is defined as "a physical therapist is physically present and immediately available and is fully responsible for the physical therapy task or activities performed by the unlicensed physical therapist." For additional information refer to 18 VAC 112-20-10 & 70. A copy of Regulations Governing the Practice of Physical Therapy (18 VAC 112-20-10 et seq.) may be found at <http://www.dhp.virginia.gov/PhysicalTherapy>. Questions should be addressed to:

Board of Physical Therapy
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

Qualifications of the Physical Therapy Assistant

Educational Requirements

The physical therapist assistant (PTA) provides physical therapy services to assigned students solely under the direction and supervision of the physical therapist. The PTA may support the physical therapist in assessment, program planning, education, documentation, and service delivery. The scope of function of the physical therapist assistant does not include initial evaluation of the students, initiation of new treatments, or alteration of the student's therapy services.

The physical therapist assistant (PTA) must be a graduate of a two-year college-level education program from an approved and accredited physical therapist assistant program. The course of study includes two years of college-level general studies courses with an emphasis on anatomy and courses on specific physical therapy procedures. The curriculum provides opportunities to apply the specialized knowledge and procedures in clinical experiences in a variety of practice settings.

Licensure

Physical therapist assistants must pass the physical therapist assistant licensure examination and hold a current Virginia license to practice as issued by the Virginia Board of Physical Therapy. This license must be renewed every two years, and the Board further mandates data evidence of required biennial continuing competencies of 30 hours of learning activities. A graduate of an accredited physical therapy program may not practice until he or she obtains a license granted by the Virginia Board of Physical Therapy.

Practice Requirements

A physical therapist assistant is permitted to perform all physical therapy functions within his or her capabilities and training as directed by a physical therapist. The scope of such functions excludes initial evaluation of students, initiation of new treatments, and alterations of the therapeutic plan. The physical therapist shall make the initial visit for evaluation of

the student and establishment of a therapy plan. The PTA's first intervention session with a student must be made only after verbal or written communication with the physical therapist regarding the student's status and therapeutic plan. Documentation of the communication and supervised visits must be made in each student's record. The PTA's visits must be made under general supervision (e.g., a physical therapist is available for consultation). The physical therapist shall re-evaluate the therapeutic plan at least once every 30 days or within 12 student visits, whichever comes first (VAC 112-20-100, VAC 112-20-110).

Legally, no one except PTs and PTAs can claim to be a physical therapist or a physical therapist assistant delivering physical therapy services. However, educational staff members may implement therapeutic activities based on the recommendations of the PT or the PTA.

Therapy Aides

Some LEAs utilize therapy aides who do not have the same educational background as occupational therapy assistants or physical therapist assistants. Occupational therapy aides are nonlicensed personnel who support the occupational therapist but may not provide services that are called occupational therapy. Physical therapy aides are nonlicensed personnel who support the physical therapist but may not provide services that are called physical therapy. Refer to Regulations for the Licensure of Occupational Therapists (18 VAC 85-80-10 et seq.) and the Regulations Governing the Practice of Physical Therapy (18 VAC 112-20-10 & 100) for guidance.



Service Delivery

Knowledge and Experience Needed for School-Based Therapists

School administrators should be aware that occupational therapy and/or physical therapy pre-service training does not necessarily address every competency needed by practitioners in educational settings. When an LEA is hiring or contracting for services of an occupational therapist or physical therapist, both parties should discuss expectations for service delivery and how to distinguish educational from medically needed services.

Administrators may wish to promote collaborative and integrated therapy strategies with teachers and school-based therapists. The instructional focus should be on the general curriculum needs of the student. Effective practices include an emphasis on maximizing the amount of time that the student participates in academic instruction. Therapists should be able to provide consultation across all curriculum areas appropriate to the needs of the student. Therapists can find additional information regarding grade-level curriculum at <http://www.doe.virginia.gov/VDOE/Instruction/sol.html> and information about the Enhanced Scope and Sequence at <http://ttaonline.org>.

The following knowledge and abilities are recommended to help ensure appropriate occupational therapy and physical therapy services in educational environments:

- Knowledge of current federal and state regulations and LEA policies and procedures pertaining to special education, Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act, 2008
- Knowledge of educational and medical disabilities of students
- Ability to select and administer appropriate assessment tools and to interpret and report evaluation results correctly
- Ability to evaluate the functional performance of students within school and community environments

- Ability to participate in group decision making and planning of appropriate intervention strategies
- Ability to integrate related services to support the student's educational goals, accommodations and/or modifications
- Knowledge of major theories, intervention strategies and research and the ability to relate that knowledge to the educational implications for students
- Ability to plan, develop, implement, evaluate, and modify activities for student-centered therapeutic intervention within the educational program
- Ability to document progress and intervention results and to relate this information to the student's educational goals
- Ability to communicate effectively (in writing and orally) and work in teams with educational personnel, administrators, parents/guardians, students, and community members
- Ability to interpret the role of therapeutic intervention within the educational program to educational personnel, administrators, parents/guardians, students, and community members

Role of OT and PT Therapists in the Educational Setting

Occupational therapy and/or physical therapists in the educational setting are responsible for five primary roles listed below.

Identification and Planning: The therapist assesses/evaluates students, interprets results, and plans for integrated intervention services in collaboration with the IEP team or 504 Plan committee.

Service Delivery: The therapist develops and implements integrated services based on the goals determined by the IEP team or 504 Plan committee.

Consultation and Collaboration: The therapist provides information and strategies to educational personnel, students, parents/guardians, and community agencies.

Therapy Services Administration and Management: The therapist participates in the LEA's comprehensive planning process for the education of students with disabilities. The therapist is involved with establishing procedures for implementing the therapy program and participates in the administration, management, maintenance and refinement/enhancement of the therapy program. This includes documentation, recordkeeping, and supervision of therapy assistants. If the LEA participates in Medicaid reimbursement, the therapists are expected to follow the established procedures needed to properly document services for reimbursement. The Department of Medical Assistance Services (DMAS) publishes electronic and printable copies of its Provider Manuals and Medicaid Memoranda on the DMAS Web site at www.dmas.virginia.gov. Refer to the "DMAS Content Menu" column on the left-hand side of the DMAS Web page and select Provider Manuals. Then select "list of updates and revisions to provider manuals." This link opens up a page that contains all of the various communications to providers, including Provider Manuals and Medicaid Memoranda. Select "School Division" to review applicable information and requirements.

Professional Growth and Ethics: The therapist adheres to the ethical and legal standards of the profession to develop professionally. He or she adheres to established rules, regulations, and laws and works cooperatively to accomplish the goals of the LEA. It is the responsibility of the therapist to be knowledgeable of and to implement current, effective research-based practices.

Role Delineation of Occupational and Physical Therapists

Both occupational and physical therapists are knowledgeable about biological systems (e.g., nervous, muscular, skeletal, sensory), and movement (e.g., motor development, motor control, motor learning). However, each discipline is distinct in terms of credentials, practice standards and regulations, and functions in the school environment. Further guidance regarding professional practice is provided in the *AOTA Code of Ethics*, 2005 (see Appendix B), <http://www.aota.org> and the *APTA Code of Ethics* (See Appendix D) <http://www.apta.org> and Standards of Conduct.

Occupational and physical therapy personnel are responsible for clarifying service areas and intervention strategies within the educational setting to limit undesirable overlaps or gaps in services. An example of how an LEA may delineate primary areas of responsibility for occupational therapists and physical therapists (See Appendix E). Many of these areas listed in the chart are the regular or special education teacher's responsibility and are addressed by them unless the expertise of the related service providers is required.

School-based OTs and PTs provide services to students and support to staff and families that allow students to be more successful in their educational programs. School-based therapists work closely with educational staff and families to support the students first and foremost in learning. Additionally, therapists play a valuable role in assisting school administrators in divisionwide planning and implementation issues such as building modifications and new construction projects, special transportation, curriculum development, safety and injury prevention, and technology.

The delivery of therapy services should be based on educational and medical research and should adhere to IDEA and No Child Left Behind (NCLB) principles. References from leading experts in school-based therapy services are available in the suggested readings

found in Appendix G. Additionally, the following books serve as guiding standards for therapists working in school systems:

- *Occupational Therapy for Children*, 5th edition (Case-Smith, et al., 2004)
- *Physical Therapy for Children*, 3rd edition (Campbell, et al., 2005)
- *The Consulting Therapist: A Guide of OTs and PTs in Schools* (Hanft & Place, 2008)
- Occupational Therapy in Educational Settings Under the Individuals With Disabilities Education Act, *Occupational Therapy: Skills for the Job of Living* (2003) American Occupational Therapy Association <http://www.medcarerehab.com/patient-family/educational-settings.htm>
- *Providing Physical Therapy Services Under Parts B & C of the Individuals with Disabilities Education Act* (McEwen, 2009)
- *Foundations of Pediatric Practice for the Occupational Therapy Assistant*, Amy Wagenfield and Jennifer Kaldenberg, 2005

These books have received national validation as best practices for therapists in LEAs. References from Michael Giangreco and his co-workers speak to their decades of work establishing creative and best-practice methods for the provision of related services for all students in LEAs. With the fast-paced and ever-changing research in healthcare and education, school-based therapists must accept the responsibility for their continuous learning by monitoring new research concerning the practice of school-based therapy. Therapists are obligated to monitor student progress using evidence-based practices and professional self-assessments. Web sites of interest that report updated research and peer-reviewed journal articles that will guide future practice patterns are listed in Appendix H.

The following are key considerations for the delivery of OT and PT services in the public school setting. These considerations are based on research and guidance from leading experts in the practice of therapy services in school systems:

Services are sufficiently comprehensive to enable the student to access the general curriculum

- Strategies are integrated into the classroom and school environment to support learning of curriculum content
- Interventions support skills that are needed for the student's identified post-secondary goals
- Services are sufficiently comprehensive to address student's needs across the curriculum and focus on strategies to achieve functional independence

Services are provided in the student's daily educational routine by teaching skills across all educational settings

- Therapeutic activities occur throughout the school day and are designed to be implemented by a variety of instructional staff in collaboration with the therapist
- Skills are taught in naturally occurring environments
- Skills are designed for generalization across different school settings (i.e., comfortable seating and positioning options, transfer training, standing programs, wheelchair mobility, strategies for pain control, self-help, peer interaction, strategies for exiting buildings in an emergency and other safety procedures)
- Therapeutic activities continue until the child has mastered goals in all settings identified

Services are provided through a team approach

- Team members share information, strategies, and techniques to assure continuity of services
- Educational strategies and interventions are developed and implemented jointly by the IEP team members including the student when appropriate
- Regular team meetings provide the communication of information and outcomes that guide the plan of activities and

instruction that occurs throughout the day in the classroom, home, and community

Services are provided through the use of a variety of delivery models

- Effective therapy services generally include a combination of models to meet the unique needs of each student
- Service delivery models incorporate a variety of methods such as monitoring, consulting and working directly with students

Effective therapy services may include, but are not limited, to the following

- Training parent(s)/guardians and school staff in activities and accommodations to be implemented throughout the student's day
- Observing and critically analyzing student performance and responses
- Identifying, selecting, and adapting special materials and equipment
- Collaborating and coordinating with teacher and families for needed changes in instruction and in the learning environment
- Consulting with students, parents/guardians and school staff

A student's need for OT and/or PT services may vary over time

- Student therapy needs differ in intensity and in focus throughout the student's school years
- These fluctuations are reflected in IEP, IFSP, or 504 plans and should be fluid and flexible, based on the immediate educational needs at any time during the student's course of study
- Consideration for changes in services and/or service delivery methods may be especially necessary during periods of transition between schools, into community activities, and with significant changes in educational and career transitions.

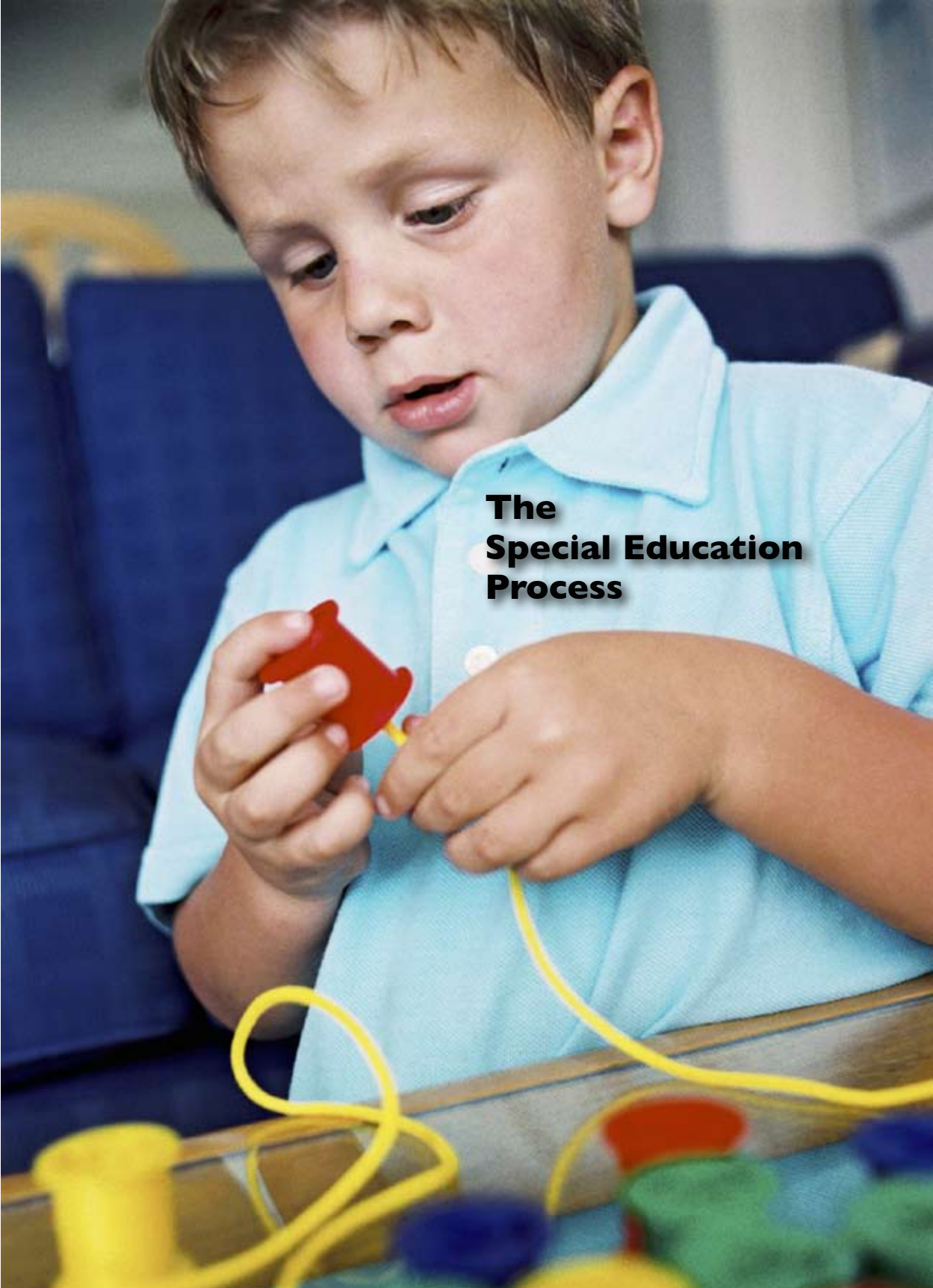
Inclusive Practices for Occupational and Physical Therapists

With the advent and implementation of co-teaching, collaborative teaming and differentiation of instruction to address the needs of students with disabilities, related service providers are spending more time in general education settings to provide direct services for students. Effective inclusive practices focus on maximizing the amount of time students with disabilities receive academic instruction in the general education environment.

The overarching philosophy of inclusive practices is that all students can learn in general education environments and that special education is a service rather than a placement. Occupational and physical therapists implementing inclusive practices work in teams and develop a variety of intervention strategies that all educational staff can use to assist students. Desired outcomes include ongoing academic improvement and success for students, reduction of undesirable overlaps or gaps in services, increased student time on task, the use of positive behavioral supports and maintaining an effective intervention team. Inclusive teams require therapists to provide consultation across all curriculum areas and provide services in a variety of contexts or environments (e.g., classroom, cafeteria, playground, job training site). Some areas the OT and PT therapist may focus on with an inclusive team include the following:

- Standing and walking programs
- Adapting the educational environment or furniture to provide optimal comfortable seating, positioning options and transfer training
- Self-help and alternative and augmentative communication systems
- Wheelchair mobility
- Strategies for exiting buildings in an emergency and other safety procedures
- Adapting instructional materials
- Adaptive equipment and assistive technology
- Strengthening and weight management programs embedded in Adaptive Physical Education

- Assisting and providing information to professionals for wheelchair evaluations and pressure mapping
- Sensorimotor, fine and gross motor development
- Orthotics, as appropriate
- Diet and mealtime plans
- Mobility oriented peer play and social interaction
- Strategies for pain control
- Orientation & mobility and travel training
- Transportation
- Participation in extra-curricular activities
- Interagency collaboration and community services



**The
Special Education
Process**

The Special Education Process

Referral

Anyone who suspects that a student needs occupational and/or physical therapy services may initiate a referral. For example, the referral may be made by a teacher, parent/guardian, physician, or therapist in the community. Refer to LEA policies and procedures for making the referral. A therapy evaluation may be requested by an IEP team or when an initial referral for special education is made. However, because OT and PT are considered a related service by state standards, an LEA may refuse to pursue OT and PT evaluations for children who are not suspected of having a disability. A medical referral (physician's prescription) for occupational or physical therapy may be requested at any time by the therapist or when required by the LEA. Written parent(s)/guardian permission must be obtained, following local procedures. Additionally, because of a student's medical condition, the OT and/or PT may want to obtain specific medical information before providing services. For OT and PT evaluations and interventions, a medical referral is not required by the *Code of Virginia*. Specifically, for PT, the *Code of Virginia*, (§54.1-3482) states that "a licensed physical therapist may provide, without referral or supervision, physical therapy services to special education students who, by virtue of their IEPs, need physical therapy services to fulfill the provisions of the IEPs."

Specific information and guidance about the Certification for Authorization for Direct Access requirements (*Code of Virginia* §54.1-3482 and the *Regulations Governing the Practice of Physical Therapy* 18VAC 112-20-10 et seq.) is beyond the scope of this document. Please refer to the aforementioned *Code of Virginia*, the *Regulations Governing the Practice of Physical Therapy* and the Department of Medical Assistance Services (DMAS) Web site at www.dmas.virginia.gov for the requirements.

Any parent(s)/guardian refusal to allow either the referral or direction by a physician should be treated as parental refusal of the physical therapy services (Memorandum, September 12, 1996, to the Executive

Director of the Virginia Board of Medicine from the Assistant Attorney General).

PTAs must practice under the supervision of the licensed Physical Therapist and must follow the same requirements for medical referrals as the PT.

A student may be eligible for occupational and/or physical therapy services only when he or she is eligible for special education and requires the service(s) to benefit from the special education services/program.

Evaluation

OT and/or PT evaluations may be selected as appropriate assessment components for a child's initial eligibility or at a later time by the IEP team, as appropriate. The special education eligibility process serves as the foundation for decisions related to the provision of OT and/or PT as a related service. The delivery of occupational and physical therapy services in the educational setting is driven by a student's IEP once it is developed after eligibility determinations. The special education process is defined by the *Regulations Governing Special Education Programs for Children with Disabilities in Virginia*. For complete requirements, refer to these regulations at <http://www.doe.virginia.gov/VDOE/Instruction/Sped/varegs.pdf>

Special education means specially designed instruction, at no cost to the parent(s), to meet the unique needs of a child with a disability, including instruction conducted in a classroom, in the home, in hospitals, in institutions, and in other settings and instruction in physical education. The term includes each of the following if it meets the requirements of the definition of special education:

- Speech-language pathology services or any other related service, if the service is considered special education rather than a related service under state standards
- Career and technical education
- Travel training (§ 22.1-213 of the *Code of Virginia*; 34 CFR 300.39)

OT and PT are considered to be related services by Virginia state standards. Specially designed instruction means adapting, as appropriate to the needs of an eligible child, the content, methodology, or delivery of instruction: (34 CFR 300.39(b)(3)) to address the unique needs of the child that result from the child's disability; and to ensure access of the child to the general curriculum, so that the child can meet the educational standards that apply to all children within the jurisdiction of the LEA.

OT and PT evaluations are requested when school teams require additional information concerning the performance of a student either identified with a disability or referred for consideration of a disability in areas that may be supported by therapy intervention. An OT and/or PT evaluation may be requested at an IEP meeting or through the referral processes previously described. The goals of evaluation are to:

- Identify functional skills and impairments that impact the student's access to the educational program and/or educational environment
- Assist the IEP or 504 Plan team with service determination, goals, objectives, and other suggestions (i.e., equipment, modifications, referrals to other disciplines)

Written parental consent is required prior to initiation of the evaluation. The type of evaluation conducted is determined by the nature of the referral, the student's unique characteristics and the presenting difficulties observed in school. School-based therapists are expected to evaluate the student's performance within the educational environment to determine the student's strengths and weaknesses. The evaluation must be sufficiently comprehensive to identify all of the child's related services needs and conducted by appropriately qualified therapists. Occasionally, sufficient data is available from outside sources which, once reviewed by the team, may be used as the evaluation. If the data is not sufficient or not educationally relevant, additional school evaluations may be warranted. Evaluations typically include the following:

- Review of pertinent medical and neurological information, when available

- Review of educational records including the current IEP or 504 Plan, as appropriate
- Interviews with students, parents or guardians, teachers and paraprofessionals
- Observations in a variety of student contexts or environments (e.g., classroom, cafeteria, playground, job training site)
- Evaluation of activity demands that impact educational performance
- Administration of informal evaluation tools, such as self-care, functional, and behavioral checklists
- Administration of standardized assessments
- Analysis of the evaluation findings as they relate to the educational setting for IEP team consideration

Assessment tools used by occupational and physical therapists in schools should be carefully chosen to evaluate the student's ability to perform in the educational setting. Those tools must provide relevant information to assist in the development of an appropriate educational program. See Appendix C for a listing of assessment tools that may be used in conjunction with structured observations and other assessment strategies.

A written report must be completed at the end of each evaluation. Therapists offer specialized information and recommendations to support an IEP or 504 Plan team decision rather than a unilateral decision. Educators and parents/guardians find it helpful to have OT and PT evaluations and the findings reported in layperson terms. Medical terms should be explained with descriptions of how they apply to the educational setting. If an assessment is not conducted under standard conditions, a description of the extent to which it varied from standard conditions is required to be included in the evaluation report. In the written report, it is beneficial for the therapist to indicate how the student's abilities impact the child's participation in educationally relevant activities. The evidence of a delay or medical condition does not necessarily mandate therapy services.

The evaluation report(s) shall be **available** to the parent(s)/guardian(s) no later than two business days before the meeting to determine eligibility. (34 CFR 300.306(a)(2)). A written copy of the evaluation report(s) shall be **provided** to the parent(s)/guardians prior to or at the meeting where the eligibility group reviews the evaluation report(s) or immediately following the meeting, but no later than 10 days after the meeting. The evaluation report(s) shall be provided to the parent(s)/guardians at no cost. The report should be delivered to other appropriate individuals in a timely manner based on LEA procedures.

Eligibility

If a student is found eligible for special education under IDEA, decisions about the need for related services are made by the IEP team taking into consideration the OT and PT assessment information provided. When a student is suspected of having a disability and initially referred for a comprehensive evaluation, the eligibility committee reviews the assessments and any pertinent information to determine if the child has a disability that requires special education. Once eligibility has been established, the IEP team determines if related services are needed to help the student benefit from his educational program or access the general curriculum. The IEP team makes this determination based on the current data in the child's education record, or by evaluating the child in accordance with applicable requirements.

Individualized Education Program (IEP)

An IEP must be in effect before special education and related services are provided to the student. The IEP is a written plan that describes the unique educational needs of a student with a disability and identifies special education and related services required to meet those needs. The plan is developed, reviewed, and revised during an IEP team meeting. Decisions about the need for and the amount of OT and/or PT services are made by the IEP team.

A physical therapist or occupational therapist is the most appropriate member of the IEP team to include when a child is suspected or known to need occupational therapy or physical therapy, respectively. However, the regulations permit LEAs to use an individual who can interpret the instructional implications of an evaluation's results when that person is unavailable. As educational team members, therapists work closely with teachers, families, and the student, when appropriate, to identify solutions and implement strategies that help students participate in appropriate educational programs.

A statement of the child's present levels of academic achievement and functional performance, including how the child's disability affects the child's involvement and progress in the general curriculum or, for preschool children, as appropriate, how the disability affects the child's participation in appropriate activities is required for the IEP. This statement, referred to as the **Present Level of Educational Performance** is a written passage describing how the disability affects the student's participation and progress in the general curriculum and the educational needs that result from the disability. For early childhood special education students, this section indicates how the disability affects the child's participation in appropriate activities. The Present Level of Educational Performance reports baseline measurements and levels of functional skills in objective and measurable terms. Any data not easily understood needs to be explained. All information should provide a rationale and supporting data for the other components of the IEP.

The IEP must state measurable annual educational goals for the student. Goals must relate to the needs of the student resulting from the disability and help the student be involved and progress in the general education curriculum. The child's need for benchmarks or short-term objectives must be considered by the IEP team. The IEP must sufficiently communicate how OT and PT services will be delivered consistent with these goals. Parental consent is not required before the administration of a test or other evaluation that is used to measure progress on the child's IEP goals or a teacher's or related service provider's observations

of ongoing classroom evaluations. However, the intent to use these kinds of measures should be stated on the IEP and the IEP must state how progress toward the annual goals will be measured. Parental consent is required, in part, before:

- conducting an initial evaluation or re-evaluation, including a functional behavioral assessment if such assessment is not a review of existing data conducted at an IEP meeting
- an initial eligibility determination or any change in categorical identification
- initial provision of special education and related services to a child with a disability
- any revision to the child's IEP services
- any partial or complete termination of special education and related services, except for graduation with a standard or advance studies diploma

Parent(s)/guardians must be informed of progress as often as parent(s)/guardians of children without disabilities are informed. Performance goals should support the student throughout the educational environment with a focus on integration of intervention strategies in the student's daily routine across all areas of the curriculum, transportation and extracurricular activities.

The student's needs, as identified by IEP goals, are the driving force for service determination. The IEP team must decide if the student requires OT and/or PT to benefit from his or her special education program. When looking at the provision of services, it is critical that the services allow the student to progress towards attaining the annual goals, to be involved and progress in the general education curriculum, and to the greatest extent possible, to participate with students without disabilities. The following questions may be helpful additions in service determination (Giangreco, 2001).

1. Will the student progress on the IEP goals and receive appropriate modifications and accommodations with the assistance from staff other than OT and/or PT?

2. Will the student be required to receive his education in a more restrictive environment if OT and/or PT are not provided?

The decision regarding the frequency and amount of therapy service is made by the IEP team. The team should consider how the therapy will effect the student's participation in the general education curriculum and participation with nondisabled peers. If OT and/or PT services are provided, the IEP must specify the following:

- Annual Goals to be supported by OT and/or PT services, as appropriate
- OT and/or PT in the list of services
- Date the services will start and end
- Frequency of services delivered
- Location where services will be delivered

The frequency of services should be specific enough to accurately communicate to all parties how services will be delivered but at the same time permit the needed flexibility for integration of services across a variety of educational settings and the child's school day. For example, working on strategies to stabilize a child's upper trunk for completion of instructional activities may require active involvement in all classes based on the different seating options required for different activities until desired outcomes are achieved.

If the consensus of the IEP team is that school-based services are not needed, the parent(s)/guardian may choose to obtain and pay for services outside of the public school system. This decision may be based on several conditions and may include one or more of the following:

- The student has adequate and appropriate functioning across different educational environments, but the parent(s)/guardian would like further refinement of skills
- The student is benefiting from the special education program, but the parent(s)/guardian would like the student to receive more therapy services
- The student is benefiting from the special education program, but the parent(s)/guardian wishes for the child to have

intensive therapy that is considered “medically necessary” after having surgery or other medical procedures

If the LEA determines that a child is not eligible to receive OT and/or PT services and the parent(s)/guardian disagree with this determination, their options include mediation and/or initiating a due process hearing per requirements in the *Regulations Governing Special Education Programs for Children with Disabilities in Virginia*. If an evaluation was completed as part of the process to determine whether services are required, the parent(s)/guardian also has the option of requesting an Independent Educational Evaluation per the regulatory requirements.

Accountability for and documentation of services provided to students is extremely important. The AOTA and APTA have published guidelines for effective documentation. When providing services, the following strategies for ensuring accountability are beneficial:

- Data collection to document progress on IEP goals and to demonstrate services were provided in accordance with the IEP
- Ongoing assessment of student progress by the therapist
- Regular team progress reports to parent(s)/guardians as often as progress is reported to parent(s)/guardians of students without disabilities
- Therapist’s daily log of contacts with students, parent(s)/guardians, and staff
- Anecdotal/intervention notes

Re-Evaluation

An initial evaluation of a child is the first complete assessment of a child to determine if the child has a disability and the nature and extent of special education and related services required. Once a child has been fully evaluated and eligibility for special education has been determined, any subsequent evaluation of a child constitutes a re-evaluation. The *Regulations Governing Special Education Programs for Children with Disabilities in Virginia* specify that a re-

evaluation shall be conducted as follows:

- If conditions warrant a re-evaluation
- If the student’s parent(s)/guardian or teacher requests a re-evaluation
- At least once every three years unless the parent(s)/guardians and school personnel agree a re-evaluation is not necessary
- If it is determined that the educational and related service needs, including improved academic achievement and functional performance of the child warrant a re-evaluation
- Each student with a disability will not be re-evaluated more than once each year unless the LEA and the parent(s)/guardian agree otherwise

As part of a re-evaluation, the LEA must ensure that a group composed of the same individuals as an IEP team, and other qualified professionals as appropriate, reviews existing evaluation data on the child, including:

- Evaluations and information provided by the parent(s) of the child
- Current classroom-based, local, or state assessments and classroom-based observations
- Observations by teachers and related services providers

On the basis of that review and input from the child’s parent(s), identify what additional data, if any, are needed to determine:

- Whether the child is, or continues to be, a child with a disability
- The present educational needs of the child
- The child’s present level of academic achievement and related developmental needs
- Whether the child needs or continues to need special education and related services
- Whether any additions or modifications to the special education and related services are needed to enable the child to meet the measurable annual goals set out in the IEP of the child and to participate, as appropriate, in the general education curriculum

Due to the variety of ways a re-evaluation may be conducted, it is permissible to review existing evaluation data and a meeting of the required participants may not be necessary. The LEA must administer any tests or evaluations needed in order to meet this requirement. Re-evaluations must be completed within 65 business days of the receipt of referral by the special education administrator or designee. If the re-evaluation is the required three-year evaluation, it must be completed by the third anniversary of the date of the previous eligibility.

If the group determines that no additional data is required to determine that the student continues to have a disability, the LEA must notify the parent(s)/guardians of the determination, the reasons for it and their right to request further testing. This process must be considered the evaluation and no further information is required unless the parent(s)/guardian request additional testing.

Termination of Related Services

The IEP team, which includes the therapist, makes decisions concerning the continued need for OT and/or PT services. The team should again consider the guideline questions in the Service Determination section used during the initial decision to add services. Written parental consent shall be required prior to any partial or complete termination of OT and/or PT services, and the IEP must be amended to reflect this change. If the parent(s)/guardian does not consent to termination, refer to the *Regulations Governing Special Education Programs for Children with Disabilities in Virginia* and the LEA policies and procedures for resolution of such disputes. Refer to the regulatory sections on due process hearings (8VAC20-81-210) and mediation (8VAC20-81-190).

Rehabilitation Act of 1973, Section 504 Process and ADA Amendments, 2008

A student may be considered for occupational and/or physical therapy services under Section 504 of The Rehabilitation Act of 1973, as amended (Section 504). The purpose of Section 504 is to ensure that no student with a disability will be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity that receives or benefits from federal financial assistance. Unlike the Individual with Disabilities Education Act (IDEA), Section 504 does not provide a specific list of categories for disabilities with strict eligibility requirements. Section 504 includes short-and long-term disabilities. The 2008 Americans with Disability amendments define "disability" with respect to an individual, as follows:

- a physical or mental impairment that substantially limits one or more major life activities of such individual
- have a record of such an impairment
- be regarded as having such an impairment

Major life activities as defined in the Section 504 regulations at 34 C.F.R 104.3(j)(2) (ii) include functions such as caring for oneself, performing manual tasks, seeing, hearing, speaking, breathing, learning and working. Congress provided additional examples of general activities that are major life activities, including eating, sleeping, standing, lifting, bending, reading, concentrating, thinking and communicating. Congress further provided a nonexhaustive list of examples of "major bodily functions" that are major life activities, such as the functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

A person meets the requirement of 'being regarded as having such an impairment' if the person establishes that he or she has been subjected to an action prohibited under the Act because of an actual or perceived physical or mental impairment whether or

not the impairment limits or is perceived to limit a major life activity.

Section 504 includes short- and long-term disabilities but does not apply to impairments that are transitory and minor. A transitory impairment is one with an actual or expected duration of six months or less. In 1992, the Office for Civil Rights clarified the definition by explaining that unless a person actually has a disability, the mere fact that there is a "record of" or the person is "regarded as" disabled is insufficient. However, the 2008 ADA amendments further stipulate that:

- The definition of disability shall be construed in favor of broad coverage of individuals under the Act and to the maximum extent permitted by the terms of the Act
- An impairment that substantially limits one major life activity need not limit other major life activities in order to be considered a disability
- An impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active
- The determination of whether an impairment substantially limits a major life activity shall be made without regard to the ameliorative effects of mitigating measures such as medication, medical supplies, equipment, or appliances, low-vision devices (which do not include ordinary eyeglasses or contact lenses), prosthetics including limbs and devices, hearing aids and cochlear implants or other implantable hearing devices, mobility devices, or oxygen therapy equipment and supplies; use of assistive technology; reasonable accommodations or auxiliary aids or services; or learned behavioral or adaptive neurological modifications
- The ameliorative effects of the mitigating measures of ordinary eyeglasses or contact lenses shall be considered in determining whether an impairment substantially limits a major life activity

There may be students who are not eligible for services under the IDEA who may qualify under Section 504 for accommodations, modifications and related services to access the general education curriculum. Similar to IDEA, Section 504 regulations provide that students with disabilities be placed with nondisabled peers to the maximum extent appropriate. It further requires that students be placed in the "regular environment" unless it is established that a satisfactory education cannot be achieved with supplementary aids and services. Similar to IDEA, Section 504 requires the testing of children with disabilities with "periodic" re-evaluation.

Section 504 does not use the word *triennial*. Although less specific than IDEA, Section 504 recognizes a system of procedural safeguards that includes notice, an opportunity for the parents/guardians of the person to examine relevant records, an impartial hearing with opportunity for participation by the person's parent(s) or guardian(s) and representation by counsel, and a review procedure.

LEAs have the option of adopting IDEA requirements to fulfill Section 504 mandates. In the alternative, LEAs may develop local Section 504 policies and procedures independent of IDEA requirements. In either model, LEAs are required to maintain a copy of its local policies and procedures implementing Section 504. Lastly, each LEA must have a 504 Coordinator:

Section 504 does not require an IEP, but it does require its functional equivalent, which may be termed a 504 Plan. Team members are those knowledgeable about the child, the meaning of evaluation data, and placement options. By regulation, the parents/guardians are not required members; however, best practice supports their involvement. A free, appropriate public education (FAPE) as defined by Section 504 means regular or special education services and related aids and services that are designed to meet the individual education needs of persons with disabilities as adequately as the needs of persons without disabilities are met. LEAs are required to have procedures for implementing Section 504. Failure to comply with Section 504 and its regulations may result in the withholding of all federal funds.

OT and PT therapists have a variety of roles and responsibilities that may include, but are not limited to the following:

- Evaluation
- Participation in developing the student's 504 plan
- Design and construction of adaptive equipment
- Modification of the educational environment
- Consultation
- Provision of direct services

If needed by the student, services, accommodations, and/or modifications must be provided in both academic and nonacademic settings, including extracurricular activities. "Nonacademic services and extracurricular services" may include counseling

services, athletics, transportation, health services, recreational activities, special interest groups or clubs sponsored by the local educational agency, referrals to agencies that provide assistance to individuals with disabilities, and employment of students, including both employment by the local educational agency and assistance in making outside employment available (34 CFR 300.107(b)). OT and PT therapists should refer to their LEA's procedures for guidance.

LEAs may use their set-aside funds for certain services to children with disabilities placed in private schools. Services plans must be developed, reviewed, and revised consistent with the same requirements used for IEPs. In addition, to the extent appropriate, their content must be the same as that required for an IEP (8 VAC 20-81-150 C 7 (d)).



Assistive Technology

Assistive technology (AT) services directly aid a student with a disability in the selection, acquisition, or use of an assistive technology device. State and federal regulations require that assistive technology devices and services be considered during the development of the IEP. Once the IEP team determines what is necessary for the child, LEAs are responsible for purchasing, leasing or otherwise providing for the acquisition of assistive technology devices for children with disabilities. When a student's IEP indicates that AT is necessary, occupational and physical therapists may be integral members of the team providing AT to the student. The therapist, in collaboration with other team members, may assist with providing the following AT services.

Assistive Technology Device

"Assistive technology device" means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of a child with a disability. The term does not include a medical device that is surgically implanted or the replacement of that device (34 CFR 300.5).

Assistive Technology Service

"Assistive technology service" means any service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device. The term includes (34 CFR 300.6):

1. The evaluation of the needs of a child with a disability, including a functional evaluation of the child in the child's customary environment
2. Purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices by children with disabilities

3. Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices
4. Coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs
5. Training or technical assistance for a child with a disability or, if appropriate, that child's family
6. Training or technical assistance for professionals (including individuals providing education or rehabilitation services), employers, or other individuals who provide services to employ or are otherwise substantially involved in the major life functions of that child

Management and Maintenance of AT Devices

The therapist may assist in designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing AT devices.

Coordination

The therapist may assist in coordinating and using other therapies, interventions, or services with AT devices, such as those associated with existing education and rehabilitation plans.

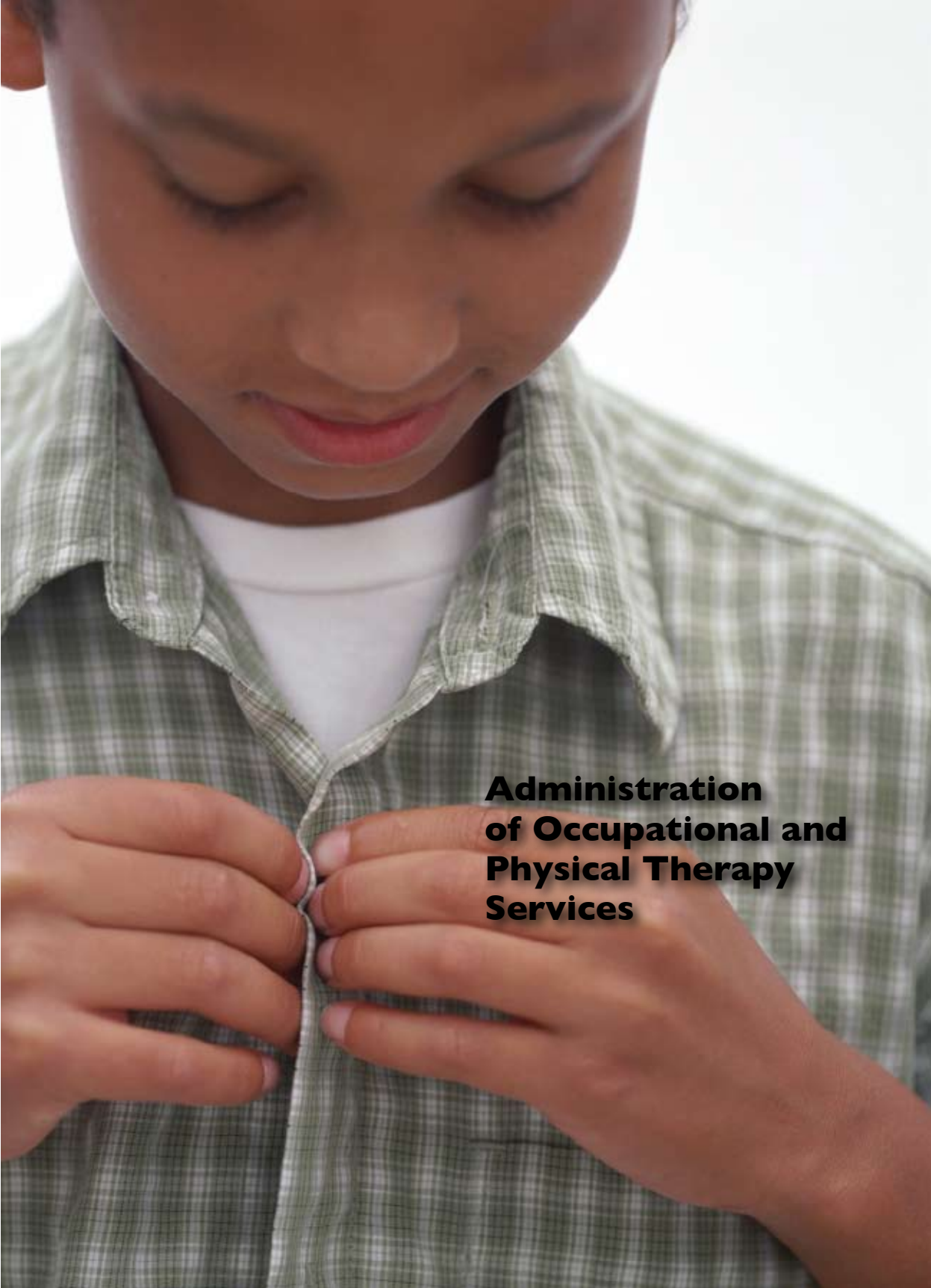
Training

The therapist may train or provide technical assistance on the use and care of an AT device to a student with a disability, the student's family, professionals (including individuals providing education or rehabilitation services), employers, or other individuals who provide services to employ or are otherwise substantially involved in the major life functions of the student.

If a student requires assistive technology to access the general education curriculum or benefit from special education services, the requirement must be documented in the student's IEP. If technology was used during an evaluation, or currently is being used, then the student's performance with the technology should be noted in the present level of educational performance. Use of AT may be the condition under which a student accomplishes an IEP goal. Generic descriptions of AT devices (not brand names) may be listed as accommodations or modifications in the IEP. In the IEP, assistive technology services may be

provided by the OT, PT or other staff, as appropriate.

Therapists must remain current about emerging technology supports for students. Therapists should also be knowledgeable about acceptable AT accommodations across student environments, for learning materials and those that may be used in divisionwide and state testing systems. A comprehensive discussion of assistive technology is provided in the *Assistive Technology: A Framework for Consideration and Assessment*, 2008 resource document posted at www.vaatpp.org under the topic heading "Consideration and Assessment."



**Administration
of Occupational and
Physical Therapy
Services**

Administration of Occupational and Physical Therapy Services

LEAs have a variety of options for securing OT and PT therapy services for schools. The LEA may choose to hire occupational and physical therapists through direct employment either on a full-time or part-time basis. They may choose to establish a contractual agreement through private practitioners, therapy clinics, home health agencies, health departments, or hospitals. LEAs may choose a combination of these options to meet their needs. In the case of an absence or unavailability of a therapist, or a vacancy that cannot be filled, the provision of contracted services may prevent the LEA from needing to provide compensatory therapy services.

As LEAs explore the possibility of acquiring services, they need to examine long-term options as well as short-term strategies. Underpaying or understaffing can result in high therapist turnover and poor continuity of student support. The number of students requiring services and the availability of therapists in the area may influence the options chosen by the LEA.

In cases of direct employment, the therapist is generally a full-time school employee with benefits or a part-time employee with no or limited benefits. LEAs have the option of sharing a therapist with neighboring LEAs. LEAs are responsible for recruitment, verification of credentials, retention, and liability of the therapist. The therapist receives training directly from the LEA, generally with other special education teachers and related service providers. Services are provided in educational environments as indicated in the students' IEPs or 504 plans. The LEA reimburses travel expenses and furnishes tools, materials, and tests for the therapist to perform his or her work. The therapist is an integral part of the school team for cooperative planning with other staff and for observation of students during activities.

When hiring a therapist, the LEA will need to determine the number of hours per day the therapist will work as well as the number of days per week. LEA administrators also need to decide whether the therapist will fill a 10-, 11-, or 12-month position. They need to consider the benefits the

therapist may receive, including continuing education, relocation expenses, insurance, retirement, sick leave, payment of licensure/certification fees, and payment of professional dues. It is common practice for therapists to obtain and provide proof of professional malpractice insurance. In certain situations, therapists' salaries and benefits may need to be significantly different from teacher salaries and benefits to attract therapists to these positions. However, LEA employment is attractive to many therapists because of 10-month employment, summers off, breaks during the school year, and shortened working days.

Contracted services can provide full- and part-time services based on LEA need at a given time. A contractor negotiates payment with the LEA. Frequently, contractors and LEAs bill Medicaid for reimbursement for OT and PT services but it is not permitted for both parties to bill for the same child. Thus, arrangements should be established for the responsible party to assume responsibility for Medicaid billing. The contractor is responsible for his or her own taxes, insurance, and other benefits. Clinics and hospitals that offer contractual services may want the students transported to their sites rather than providing services in the school setting. However, this is not a recommended practice, as it reduces students' access to the instructional program. Contracted service providers are generally responsible for their own travel and usually furnish their own tools, materials, and tests to perform the work. A contracted therapist provides the amount of services as indicated in the student's IEP. A contract for services may limit the number of hours a therapist is able to work, and additional hours would require further negotiations.

Many aspects of a contract for therapy services are negotiable. Contracted therapists should be compelled to follow LEA policies and procedures by specifying it in their written contract. A LEA will identify the students to be served, the amount of time needed as identified on the student's IEP or 504 plan, the therapist's hours, and any therapy assistants that require supervision. Contractual considerations include timelines for completion of evaluations, IEP

meetings, reports, and billing. The contract should specify the fee structure or method of payment. Parties should consider whether there will be a set hourly fee or separate fees for intervention, travel, documentation, and meetings. The contractor must provide documentation of the therapist's qualifications and licensure. The therapist should have orientation and training in school-based therapy services and integrated service delivery methods. The contractor is responsible for ensuring student confidentiality is properly maintained. The contractor should also provide proof of liability and malpractice insurance. Conditions for changing the contract to increase or reduce services provided as well as termination of the contract should be indicated. The right of the LEA to interview and reject an individual therapist should be included. In addition, provisions for equipment, clerical support, and therapy space may need to be included as part of the contract. The agreement should be reviewed by the LEA's attorney and appropriate staff for possible legal issues and hidden costs, prior to final approval.

Interviews

The interview process is helpful in determining if the therapist has the skills necessary to meet the needs of students in the educational setting. Educational, licensure, and registration requirements are discussed in detail in Section I. Therapists and assistants should provide copies of their required credentials as part of the application process. Prospective employers may request oral as well as written references from current and previous employers. Due to the specialized nature of OT and PT services, HR offices are encouraged to include current OT and PT staff or therapy supervisors on interview teams, when such staff are available.

Topics to guide interview questions include the following:

- Ability to work effectively as a member of a multidisciplinary team including collaboration with community-based therapists and other healthcare providers for effective coordination of services
- Knowledge, skills, and training of physical therapy principles, theory, methods and evidence-based practice and their proper application in the education environment
- Knowledge of current legal and regulatory mandates IDEA, *Regulations Governing Special Education Programs for Children with Disabilities in Virginia*, Section 504 of the Rehabilitation Act of 1973, and the ADA Amendments of 2008
- Proficiency in test administration, interpretation of findings and ability to convey information to parents and school team members
- Competency in planning and implementing educationally relevant services including strategies and activities that directly relate to and support the student's academic program and service levels
- Ability to write measurable student goals that directly relate to and support the student's academic program
- Skill in providing a variety of integrated therapy models, including consultation and collaboration with other educators
- Ability to develop physical management plans for daily classroom routines and to train staff in its safe implementation
- Ability to participate in the planning for safe transportation of students with disabilities
- Competency in behavior management skills
- Knowledge of how to improve school accessibility and to plan for environmental modifications, as appropriate
- Ability to document student equipment and adaptive device needs and to assist with acquiring them

- Ability to document student progress and outcomes and to report this information to parents and professionals
- Ability to communicate effectively both orally and in writing with students, parent(s)/guardians, educational personnel, and other professionals
- Organizational skills needed for job duties including documentation of service delivery, scheduling, and time management
- Ability to maintain confidentiality and adhere to professional ethics and legal standards of practice
- Ability to develop and maintain a professional growth plan

Recruitment Resources

Occupational therapy and physical therapy are growing professions with practitioners facing increasing competition for employment in LEAs, rehabilitation services, and sports medicine. LEAs will need to be proactive, creative, and vigilant in recruiting and retaining therapists. The use of multiple recruitment resources and documentation of all recruitment efforts are essential. In addition to the resources listed below, advertising in therapy newsletters and publications as well as in local and regional newspapers is recommended.

A list of OT and OTA programs is available from:

American Occupational Therapy Association (AOTA)
 4001 Springfield Road
 Glen Allen, VA 23060
 (804) 346-4840
<http://www.members.aol.com/VOTA>

A list of the PT and PTA programs is available from:

American Physical Therapy Association (APTA)
 1111 North Fairfax Street
 Alexandria, VA 22314-1488
 (703) 684-2782, 1-800-999-2782
 Fax 703-684-7343
http://www.apta.org/Career_center

Job Fairs, Career Awareness and Student Therapist Fieldwork

Job fairs are held at a variety of locations to recruit OT and PT therapists. Many private and public sectors, including LEAs, colleges, and universities sponsor and/or participate in job fairs. See Appendix F for addresses for Virginia colleges and universities with therapy programs. Most college and university programs have career centers that assist interested candidates with online postings that provide an overview of training programs, pre-enrollment requirements, suggested timetables for program completion, and suggested extracurricular activities. School-based OTs, COTAs, PTs, and PTAs should be encouraged and provided release time to participate in career days to recruit middle and high school students into the profession. LEAs are also encouraged to support all forms of student practicum, fieldwork and affiliation opportunities for OT, COTA, PT, and PTA students with the therapists employed by the LEA.

Professional Organizations

The Virginia Occupational Therapy Association (VOTA) and the Virginia Physical Therapy Association (VPTA) sponsor periodic meetings and annual conferences. LEAs can rent exhibit space at conferences and job fairs. Contact information for these organizations is listed below:

Virginia Occupational Therapy Association (VOTA)
 4001 Springfield Road
 Glen Allen, VA 23060
 (804) 346-4840
<http://www.members.aol.com/VOTA>

Virginia Physical Therapy Association (VPTA)
 1111 North Fairfax Street
 Alexandria, VA 22314
 (800) 999-2782 x3235
<http://www.vpta.org>

Online Publication Advertisements

Advance for OT Practitioners
<http://www.advanceforot.com>

PT Bulletin Online
<http://www.apta.org/bulletin>

Teacher-Teacher.com
<http://www.teachers-teachers.com>

Virginia Department of Education
<http://www.doe.virginia.gov/teaching>

Council for Exceptional Children (CEC)
<http://www.cec.sped.org>

OT Practice Magazine
<http://www.aota.org>

Tuition Assistance

Many health care facilities utilize written agreements with therapy students to employ a student for one or two years following graduation in exchange for tuition and related expenses. LEAs may want to consider this arrangement. If so, the contract should be reviewed by the LEA's attorney. Graduating students sometimes exercise the buy-out option of these contracts by repayment of the amount of the loan.

Retention Strategies

Historically, therapists have found working in school systems rewarding but sometimes frustrating because of feelings of isolation away from their health care professional environments and peers. School salaries can fall below those of the private sector in some areas creating a disincentive for LEA recruitment.

School administrators are encouraged to adopt one or more of the following strategies to support retention of therapists:

- Offer incentives to attract therapists, such as relocation provisions and/or sign on bonuses
- Establish career ladders for professional and salary advancements by providing salary scales that recognize educational degree levels and years of experience in all therapy settings, both full- and part-time
- Accept continuing education units (CEU) and other contact hours in lieu of, or in addition to, graduate credits for salary placement and or advancement
- Create leadership opportunities within the organizational structure that recognizes added competencies and professional responsibilities
- Encourage and financially support advanced degrees, board certified specialties, and job specific certifications
- Support continuing education to enhance therapists' skills and knowledge through release time and other incentives
- Provide an experienced mentor for each new therapist. If no other therapists are working in the LEA, contact neighboring LEAs, university programs or private providers about possible mentors. The APTA and the AOTA have national mentor assignments that are easily accessible
- Encourage interactions, training, and networking among therapists within the LEA and among various LEAs
- Participate in training of future school-based therapists by providing fieldwork and affiliations for OT and PT students
- Maintain positive morale through shared decision making, manageable caseloads, and administrative recognition of achievements
- Promote a pride of "organizational belonging" with an expectation of and recognition for job-specific professional growth and advanced competencies

Due to the role of therapists in the school setting, administrators must be cognizant of the need to provide office space, clerical and technical support, supplies, equipment, a staff mailbox and a mechanism for securing needed materials and equipment. Since therapists often serve in an itinerant position serving several schools, administrators should ensure that therapists are updated regarding changes in school policies and procedures and are included in school and faculty social events.

Orientation of OT and PT Therapists to the LEA

Like all new school employees, therapists need proper orientation to the LEA. They may need training to understand the specifics of school-based therapy and expectations for integrated service delivery models for inclusive settings. They will need information regarding local special education policies, procedures and forms in order to provide appropriate services. New therapists should be introduced to special education administrative and clerical staff, appropriate human resource personnel, building level principals (administrators), special and regular education teachers, paraprofessionals, related service personnel, and other staff, as appropriate. New therapists benefit from being paired with an experienced school-based therapist, if available. Therapists need support in meeting established community services partners and learning the various service delivery configurations. Therapists also need qualified and knowledgeable staff to supervise and complete their personnel evaluations.

Virginia Department of Education Documents

These documents can be found at

<http://www.doe.virginia.gov/VDOE/sess>

- *Handbook for Occupational and Physical Therapy Services in the Public Schools of Virginia*
- *Regulations Governing Special Education Programs for Children with Disabilities in Virginia*
- *The Family Educational Rights and Privacy Act (FERPA)*

- *A Parent's Guide to Special Education*
- *Virginia Standards of Learning and Aligned Standards of Learning*
- *First Aid Guide for School Emergencies*
- *MRSA Fact Sheet*
- *Dispute Resolution Options* (mediation, due process, complaints)
- *Child Abuse and Neglect Recognition and Intervention Training Curriculum Guideline*

School Division Documents

- Personnel handbook
- Special education policy/procedure manual(s)
- IEP manual
- Special education forms
- Student Code of Conduct
- Emergency Medical Procedures Including Pandemic Flu
- 504 procedures manual
- LEA phone and e-mail directory
- School calendar and maps

It is recommended that each LEA develop an occupational and physical therapy procedures manual, which may include the following elements:

- Policies related to the provision of OT and PT services
- Organizational chart and direct line of supervision
- Job descriptions
- Description of service delivery approaches
- Referral process for OT and PT
- Confidentiality requirements
- Evaluation and assessment procedures
- Emergency medical procedures for students including Pandemic Flu
- Complete set of forms and a description of how to complete the forms
- Documentation guidelines
- Maintenance of Student Records
- Procedures to requisition materials and equipment
- Procedures to inventory and maintain equipment
- Supervision of COTAs, PTAs, therapy aides, and student affiliates

- Procedures to request travel reimbursement
- Procedures to request leave (professional and personal)
- Conflict-of-interest policy
- Appropriate central office contacts such as the Human Resource Office, etc.
- Performance evaluation process

Other sections of this document speak to the overall administration of OT and PT therapy services. Please see the APTA Standards of Practice for Physical Therapy (HOD-06-03-09-10), Appendix C, Administration of the Physical Therapy Service, p. 42 and Administrative Supervision and Performance Evaluation, p. 48 and Appendix K.

Supervision and Performance Evaluation

Physical and occupational therapists should be supervised and evaluated in the same manner as all other professional employees. Supervisors of occupational and physical therapists are responsible for the evaluation of the professional behavior and job performance of the therapists providing services to students in the LEA. The supervisor should be knowledgeable about the provision of therapy services in the educational setting. This person can be a therapist or a school administrator. A LEA representative should have input into the evaluation of therapists hired through a private contractual agreement.

Therapists should receive routine, written evaluations of their effectiveness in meeting the standards of performance expected of them. Therapy practices should be evaluated to determine the quality and the effectiveness of the interventions and their appropriateness for the various disability groups that receive therapy services. Data that may be gathered to conduct the evaluation includes the therapist's demonstration of appropriate skills in the following areas:

- Compliance with the special education and 504 processes

- Knowledge of the general education curriculum as it relates to therapy
- Knowledge and expertise with integrated service delivery methods
- Selection, administration, and scoring of assessment tools
- Analysis of data and determination of relevance to educational performance
- Expertise in therapy techniques and strategies
- Management of student behavior and performance
- Consultation and collaboration with families and school staff
- Written and oral communication skills
- Therapist self-assessment
- Professional ethics and personal responsibilities, especially confidentiality
- Professional growth and development

The process for evaluation of a therapist's performance should be clear, discussed prior to employment, and reviewed as necessary. Mutual acknowledgement of the evaluation outcome is dated and signed. Should the therapist's performance not meet expected standards, LEA procedures regarding corrective actions or dismissal should be followed. Sample performance appraisal criteria forms are included in Appendix J. One form might be used for both the OT and the PT.

As related services, the provision of school-based occupational and physical therapy supports the educational goals of students with disabilities. When occupational and/or physical therapy is specified in a student's IEP, 504 Plan or Services Plan, these services should provide the student access to and participation in the general education curriculum. Refer to Appendices G and H for a list of suggested readings and Web sites that may further assist with the provision of occupational and physical therapy services in the public schools of Virginia.

Documentation of Services Delivered

Documentation is a necessary requirement for therapy services that are given to students by school-based therapists. All therapy services should be

documented, dated, and authenticated by the therapist or therapy assistant who performs the services.

Documentation should include:

- Dates and amount of service
- Reasons why therapist or student were not available for services on a scheduled date
- Contacts with parents/guardians, staff, and other professionals
- Data that measures progress for goals
- IEP progress reports
- Anecdotal/intervention notes as needed

Every page of student documentation should be properly labeled with the student's name and the date for accuracy and identification. All student information, including therapist documentation, is subject to parental (or guardian) and legal review. Student confidentiality is highly regulated by state and federal laws. Therapists must have written parent(s)/guardian consent prior to releasing any student information, written or verbal, to any outside agency. Discussion with other school staff should be on a need-to-know basis only. Therapists must be knowledgeable of confidentiality requirements and access-to-information rights.

If the LEA participates in Medicaid or other public and private insurance programs, additional types of documentation are usually required (see the DMAS Web page at www.dmas.virginia.gov).

Student Education Records

The student's scholastic record or education record is the record collected orally, in writing, or by electronic methods that is directly related to a student and maintained by a LEA. The content and the management of information in the scholastic or education record are determined by federal, state, and local regulations and guidelines.

Documentation specific to OT/PT found in a student's scholastic or education record includes the following:

- Request for evaluation
- Parent(s)/guardian notice and consent for OT and/or PT evaluation
- Parent(s)/guardian permission for release of

information to or from professionals outside of the LEA

- Physician referrals, as appropriate
- Written OT and/or PT evaluations and reports (initial, reviews/updates, re-evaluations)
- IEP, IEP (or Service Plan) progress reports, 504 Plan
- Intervention or service provision notations
- Written parent/guardian permission for termination of therapy services

Additional documentation that is sometimes found in a student's scholastic or education record or is sometimes maintained in the therapist's working file includes the following:

- Narrative notes of assessment, intervention, progress, and communications
- Data on IEP (or Service Plan) goal progress
- Testing protocols
- Student work samples
- Daily log or attendance record

All components of the student's scholastic record or education record as well as the therapist's working file are subject to legal and parent/guardian review and may be subpoenaed for due process and/or court cases. This includes evaluation data as well as intervention data.

Liability

It is essential to protect the practice of school-based therapy by appropriate levels of insurance coverage. Prior to the first day of work, administrators and therapists should work together to identify the extent of the LEA's insurance coverage for general liability (personal and professional) and malpractice liability. Therapists are responsible for knowing the limits of their professional and personal liability relative to their school-based therapy duties and performances in order to protect themselves personally and to prevent undue risks to students and the school system. Personally transporting students is usually prohibited by LEA policy. Many therapists working in LEAs may purchase additional professional liability insurance

that is easily obtained through the APTA, AOTA, CEC, or other professional organizations. Therapists may want to seek professional advice in determining their insurance needs.

Professional Development

The Virginia Board of Medicine and the Virginia Board of Physical Therapy mandate continuing education for OTs, PTs, and PTAs in order to maintain licensure. Section I of this handbook lists specific requirements. Therapists should identify and discuss their own educational needs with their supervisor and pursue continuing education programs to meet those needs. It is imperative that therapists maintain current knowledge of and skills for pediatric therapy practices in addition to educational methods and theories. Therapists must also be knowledgeable of current federal, state, and local initiatives and mandates that impact the delivery of occupational and physical therapy services. Administrators can support professional development in the following ways:

- Paid professional leave
- Reimbursement for continuing education and reference texts/materials
- Sponsorship of workshops, courses, and regional pediatric interest groups
- In-service training on pertinent topics
- Partnering with other LEAs in the region for training

Scheduling

Therapists must allow for flexibility in scheduling to provide a variety of service delivery methods for meeting each student's needs. It is imperative that therapy services do not prevent students from accessing their academic instruction. It is not within the scope of this document to prescribe caseload numbers. However, therapists and administrators should work together to ensure that all students' IEP time requirements are met within the therapist's workday, with allowances for the following:

- Therapy scheduled to address student needs in a variety of settings (e.g., art, lunch, community-based instruction, physical education, work)

- Evaluation and assessment of students
- Supervision of assistants and paraprofessionals
- Consultation with school personnel, parent(s)/guardians, physicians, and community agencies
- Travel time and efficient travel patterns for the itinerant therapist
- Attendance at meetings (e.g., eligibility, IEP, staff meetings, in-services, committees)
- Administrative time (e.g., documentation, planning, communication and program development)
- Fabrication, ordering, and maintenance of equipment
- Setup and cleanup time for group or individual sessions

Therapists are responsible for notifying teachers regarding their schedule. This should include changes to accommodate student needs, therapist absences, and meetings.

Regulations governing special education and Section 504 require that students' IEPs and 504 plans be fully implemented. Services are not to be interrupted because of staff absences, vacancies or lack of resources. Therapists should be knowledgeable about local policies and procedures whenever there is an interruption in services due to the student's unavailability or if there is a question of the therapists' or assistants' availability.

Work Space

Therapy services are most often provided in the student's environment (e.g., classroom, physical education class, cafeteria, playground, community). Therapy should be related to the activity occurring at the time and not be a distraction to the student's participation or to other students. A separate room for the delivery of therapy services is generally not appropriate, as it causes the student to miss time from the instructional program and does not permit intervention to be delivered with the real task demands. At times, however, a student may need to

be seen in a small group or individually in an area that provides privacy and limited distraction. Appropriate space for assessment may be arranged as needed.

Office space for the therapist is required in order to address documentation of therapy services, report writing, and communication with parent(s)/guardians, staff, and the medical community. The office should include adequate lighting and ventilation, a desk and chair, locked file cabinet, and storage space for supplies and equipment. Therapists need access to a computer with an internet connection, fax, copier and a telephone with privacy. A staff mailbox, school e-mail address, and voicemail will enhance communication between therapists, administrators, staff, and parent(s)/guardians.

Materials and Equipment

Materials and equipment to support the provision of therapy services are necessary, and their purchase and storage need to be addressed by administrators and therapists. The therapist or other staff within the LEA may fabricate some materials requiring additional workspace and special purchasing considerations. Materials and equipment should support the goals and accommodations as stated in the student's IEP.

Materials and equipment most often used include the following:

- Positioning equipment (e.g., wedges, bolsters, standers, adapted seating, exercise mats)
- Self-help devices (e.g., spoons, zipper pulls, reachers)
- Mobility equipment (e.g., walkers, wheelchairs, scooters)
- Supplies for adapting materials and equipment (e.g., strapping, Velcro, foam, splinting supplies)
- Technology devices (e.g., switches, computers, word processors)
- Tools (e.g., wrenches, air pumps, electric knives, and electric skillets)
- Adaptive classroom tools (e.g., pencil grips, slant boards, self-opening scissors)
- Evaluation tools (e.g., goniometers, dynamometers, cameras)
- Assessments (e.g., test kits, protocols, manuals)

See Appendix J for a list of equipment vendors.

The therapist will also require office supplies, manuals, and computer software. Universal precaution supplies including gloves, paper towels, and disinfectants should be provided as needed.



Appendix A

AOTA, Guide for Supervision of Occupational Therapy Personnel in the Delivery of Occupational Therapy Services

The intent of this document is to clarify the supervisory relationships and responsibilities among the occupational therapist (OT), occupational therapy assistant (OTA), and other personnel involved in the delivery of occupational therapy services. This document does not address responsibilities for supervision of students. Supervision is a process in which two or more people participate in a joint effort to promote, establish, maintain, and/or elevate a level of performance and service. Supervision is a mutual undertaking between the supervisor and the supervisee that fosters growth and development; ensures appropriate use of training and potential; encourages creativity and innovation; and provides guidance, education, support, encouragement, and respect while working toward a goal. As described here, supervision helps promote quality occupational therapy and fosters development of the persons involved.

The American Occupational Therapy Association (AOTA) maintains that overall clinical supervision specific to the application of occupational therapy principles must be overseen by an OT. When an OT is not available to clinically supervise another OT, the OT should seek networking and mentoring opportunities with more advanced therapists to develop further knowledge and skill in the unique application of occupational therapy. OTs may also receive a portion of clinical supervision from those outside of the profession who have knowledge and skill in a discrete aspect of practice that is related to occupational therapy. For example, a hand surgeon may be very helpful in increasing a practitioner's outcomes with respect to tendon glide. However, the surgeon would not be the appropriate clinical supervisor to relate increased tendon glide to the client's desired occupational outcome. In addition, it is recognized that occupational therapy practitioners may be administratively supervised by others, such as principals, facility administrators, or physicians.

Types of Supervision for Occupational Therapy Personnel

Supervision occurs along a continuum that includes close, routine, general, and minimal for the occupational therapy practitioner (AOTA, 1993a, p. 1088). Typically, entry-level OTs and OTAs require close supervision. Intermediate-level practitioners will require routine supervision, and advanced-level practitioners will require general supervision. For the occupational therapy aide who is providing client-related tasks, supervision is at the continuous level. When an aide is performing nonclient-related tasks, the supervision required is determined by the supervisor (AOTA, 1999). Definitions of these levels of supervision are as follows.

Levels of Supervision Defined

Occupational Therapy Practitioners¹

Close supervision requires daily, direct contact at the site of work. Routine supervision requires direct contact at least every two weeks at the site of work, with interim supervision occurring by other methods, such as telephone or written communication. General supervision requires at least monthly direct contact, with supervision available as needed by other methods. Minimal supervision is provided only on a need basis, and may be less than monthly (AOTA, 1993a, p. 1088).

Aide²

Continuous supervision means that the occupational therapy supervisor is in sight of the aide who is

¹*Occupational Therapy Practitioner: an individual initially certified to practice as an occupational therapist or occupational therapy assistant or licensed or regulated by a state, district, commonwealth, or territory of the United States to practice as an occupational therapist or occupational therapy assistant and who has not had that certification, license, or regulation revoked due to disciplinary action (AOTA, 1998).*

²*Depending on the setting in which service is provided, "aides" may be referred to by various names. Examples include, but are not limited to, rehabilitation aides, restorative aides, extenders, paraprofessionals, and rehab technician's service recipients, and the service setting requirements. The ultimate criteria used in selecting the level of supervision is related to the ability of the OTA to safely and effectively provide those interventions that are delegated by the OT. When new aspects of practice are delegated to the assistant, service competency³ must be established between the supervising OT and the OTA.*

performing delegated client-related tasks (AOTA, 1993a, p. 1090).

Occupational Therapist

OTs have the ultimate responsibility for service delivery. When services are also delivered by an OTA, it is the responsibility of the OT to be directly involved with the recipient of services during the initial assessment. Further, if an OTA is to be involved in the implementation of a treatment plan, the OTA should be included in the development of the intervention plan. The OT has the ongoing responsibility to determine how direct contact by the OT needs to be continued with the recipient of service.

By virtue of their education and training, OTs, after initial certification, are able to deliver services independently. AOTA, nevertheless, recommends that OTs receive close supervision at entry level and routine or general supervision at intermediate level (AOTA, 1993a, p. 1089).

Supervision from another, more advanced therapist helps to ensure and reinforce best practice application of core occupational therapy principles. Therapists who do not have access to formal supervision from another OT are encouraged to seek mentoring from other practitioners as a way to continue their professional growth and develop best practice approaches.

Occupational Therapy Assistant

When providing occupational therapy services, OTAs require close supervision at entry level, routine supervision at intermediate level, and general supervision at advanced level (AOTA, 1993a, p. 1090).

Note: Supervision by an OT is not required when the OTA is functioning in a role outside of OT service delivery (e.g., activity director, adult day-care coordinator). The level of supervision required for an OTA is determined by the supervising OT and is based on an assessment of the OTA's skills, the demands of the job, the needs of the service recipients, and the service setting requirements. The ultimate criteria used in selecting the level of

supervision is related to the ability of the OTA to safely and effectively provide those interventions that are delegated by the OT. When new aspects of practice are delegated to the assistant, service competency 3 must be established between the supervising OT and the OTA.

Aides (AOTA, 1999)

The occupational therapy aide receives different types of supervision based on the type of tasks being supervised.

Nonclient-related tasks include clerical and maintenance activities and preparation of work area or equipment. The aide receives a level of supervision determined by the supervisor. Depending on the nature of the task assigned, this supervision generally ranges from routine to minimal. Client-related tasks that may be delegated to an aide include specifically selected routine aspects of an intervention session. The following factors must be present when an occupational therapy practitioner delegates a selected aspect of an intervention to an aide:

- The outcome of the aspects being delegated is predictable
- The situation of the client and the environment is stable and will not require judgment or adaptations to be made by the aide
- The client has demonstrated some previous performance ability in executing the task
- The task routine and process have been clearly established
- For best practice, aides should receive continuous supervision when they are carrying out delegated client-related tasks. Continuous supervision includes the task and the use of equipment, if appropriate. The aide must have been instructed specifically on how to carry out the delegated task with the specific client.

During the supervision of occupational therapy practice, it is the supervisor who is responsible for setting, encouraging, and evaluating the standard of work performed by the supervisee. In selecting the

level of supervision required, factors such as type of practitioner, clinical experience, level of expertise, and roles and responsibilities need to be considered. Reassessment of supervisory needs and changes in amount of supervision may occur with changes in job demands (e.g., client population, duties, procedures), practice settings (e.g., move from nursing home to public school setting), and roles assumed (e.g., taking on the role of supervisor).

The level of supervision for all personnel is determined by the supervising OT. The level of supervision should be the one most suitable to the situation after considering the multiple factors that impact supervision. Levels of supervision should be determined after the establishment of service competency and should be re-evaluated regularly for effectiveness. In all cases, it is the occupational therapy practitioner's ethical responsibility to ensure that the amount, degree, and pattern of supervision are consistent with the service competency demonstrated. As changes in the practice situation occur, the intensity of the required supervision may also change to reflect new demands.

³Service competency is the process of teaching, training, and evaluating in which the occupational therapist determines that the occupational therapy assistant performs tasks in the same way that the occupational therapist would and achieves the same outcomes. If a high degree of competence cannot be assured in this process, the occupational therapist must question the appropriateness of delegating the task.

These supervision guidelines are to assist occupational therapy practitioners in the appropriate and effective provision of occupational therapy services (see Table 1). The guidelines themselves cannot be interpreted to constitute a standard of supervision in any particular locality; rather, they indicate recommended best practice patterns and levels of supervision. All personnel are expected to meet applicable state and federal regulatory mandates, adhere to relevant

Association policies regarding supervision standards, and participate in ongoing professional development activities to maintain continuing competency.

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Adopted by the Representative Assembly 1999M7.
Note: This document replaces the 1994 document, *Guide for Supervision of Occupational Therapy Personnel* (*American Journal of Occupational Therapy*, 49, 1027–1028), which was rescinded by the 1999 Representative Assembly.

Table I
Guide for Supervision of Occupational Therapy Personnel

OT Personnel	Supervision	Supervises
Entry-level OT* (working on initial skill development or entering new practice) (AOTA, 1993a, p. 1088)	Not required. Close supervision by an intermediate-level or an advanced-level OT recommended.	Aides, technicians, all levels of OTAs, volunteers, Level I fieldwork students
Intermediate-level OT* (working on increased skill development and mastery of basic role functions, and demonstrates ability to respond to situations based on previous experience) (AOTA, 1993a, p. 1088)	Not required. Routine or general supervision by an advanced-level OT recommended.	Aides, technicians, all levels of OTAs, volunteers, Level I and II fieldwork students, entry-level OTs
Advanced-level OT* (refining specialized skills with the ability to understand complex issues affecting role functions) (AOTA, 1993a, p. 1088)	Not required. Minimal supervision by an advanced-level OT is recommended.	Aides, technicians, all levels of OTAs, volunteers, Level I and II fieldwork students, entry-level and intermediate-level OTs
Entry-level OTA* (working on initial skill development or entering new practice) (AOTA, 1993a, p. 1088)	Close supervision by all levels of OTs, or an intermediate or an advanced-level OTA who is under the supervision of an OT	Aides, technicians, volunteers
Intermediate-level OTA* (working on increased skill development and mastery of basic role functions, and demonstrates ability to respond to situations based on previous experience) (AOTA, 1993a, p. 1088)	Routine supervision by all levels of OTs, or an advanced-level OTA who is under the supervision of an OT	Aides, technicians, entry-level OTAs, volunteers, Level I OT fieldwork students, Level I and II OTA fieldwork students.
Advanced-level OTA** (refining specialized skills with the ability to understand complex issues affecting role functions) (AOTA, 1993a, p. 1088)	General supervision by all levels of OTs, or an advanced-level OTA who is under the supervision of an OT	Aides, technicians, entry-level and intermediate-level OTAs, volunteers, Level I OT fieldwork students, Level I and II OTA fieldwork students
Personnel other than occupational therapy practitioners assisting in occupational therapy service (aides, paraprofessionals, technicians, volunteers)*** (AOTA, 1993a, p. 1088)	For nonclient-related tasks, supervision is determined by the supervising practitioner. For client-related tasks, continuous supervision is provided by all levels of practitioners.	No supervisory capacity.

* Refer to the *Occupational Therapy Roles* document for descriptions of entry-level, intermediate-level, and advanced-level OTs and OTAs (AOTA, 1993a).

**Although specific state regulations may dictate the parameters of certified occupational therapy assistant practice, the American Occupational Therapy Association supports the autonomous practice of the advanced certified occupational therapy assistant practitioner in the independent living setting (AOTA, 1993b, p. 1079). (Note. Removed from active files and placed in archives April 1999.)

***Students are not addressed in this category. The student role as a supervisor is addressed in the *Essentials and Guidelines for an Accredited Educational Program for the Occupational Therapist* (AOTA, 1991a) and *Essentials and Guidelines for an Accredited Educational Program for the Occupational Therapy Assistant* (AOTA, 1991b).

Appendix B

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
2. Educate the general public and members regarding established principles to which occupational therapy personnel are accountable
3. Socialize occupational therapy personnel new to the practice to expected standards of conduct
4. Assist occupational therapy personnel in recognition and resolution of ethical dilemmas

The AOTA *Occupational Therapy Code of Ethics* (2005) defines the set principles that apply to occupational therapy personnel at all levels:

Principle I. 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.
- 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:

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.
- 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

Compensatory - Making reparation for wrongs that have been done

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

Distributive justice - The act of distributing goods and burdens among members of society

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

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

Procedural justice - Assuring that processes are organized in a fair manner and policies or laws are followed

Veracity - A duty to tell the truth; avoid deception

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American Occupational Therapy Association. (2004). Association policies. *American Journal of Occupational Therapy*, *58*, 694–695.

Beauchamp, T. L., & Childress, J. F. (2001). *Principles of biomedical ethics* (5th ed.). New York: Oxford University Press.

Definition of Occupational Therapy Practice for the AOTA Model Practice Act (2004). Retrieved April 9, 2005, from <http://www.aota.org/members/area4/docs/defotpractice.pdf>

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FAOTA Adopted by the Representative Assembly
2005C202

Note. This document replaces the 2000 document, Occupational Therapy Code of Ethics (2000) (*American Journal of Occupational Therapy*, *54*, 614–616). Prepared 4/7/2000, revised draft—January 2005, second revision 4/2005 by SEC.

Appendix C

Standards of Practice for Physical Therapy (HOD-06-03-09-10)

Reprinted with permission of the American Physical Therapy Association

Preamble

The physical therapy profession's commitment to society is to promote optimal health and function in individuals by pursuing excellence in practice. The American Physical Therapy Association attests to this commitment by adopting and promoting the following Standards of Practice for Physical Therapy. These Standards are the profession's statement of conditions and performances that are essential for provision of high quality professional service to society, and provide a foundation for assessment of physical therapist practice.

I. Ethical/Legal Considerations

A. Ethical Considerations

The physical therapist practices according to the Code of Ethics of the American Physical Therapy Association.

The physical therapist assistant complies with the Standards of Ethical Conduct for the Physical Therapist Assistant of the American Physical Therapy Association.

B. Legal Considerations

The physical therapist complies with all the legal requirements of jurisdictions regulating the practice of physical therapy. The physical therapist assistant complies with all the legal requirements of jurisdictions regulating the work of the assistant.

II. Administration of the Physical Therapy Service

A. Statement of Mission, Purposes, and Goals

The physical therapy service has a statement of mission, purposes, and goals that reflects the needs and interests of the patients/clients served, the physical therapy personnel affiliated with the service, and the community.

B. Organizational Plan

The physical therapy service has a written organizational plan.

C. Policies and Procedures

The physical therapy service has written policies and procedures that reflect the operation, mission, purposes, and goals of the service, and are consistent with the Association's standards, policies, positions, guidelines, and Code of Ethics.

D. Administration

A physical therapist is responsible for the direction of the physical therapy service.

E. Fiscal Management

The director of the physical therapy service, in consultation with physical therapy staff and appropriate administrative personnel participates in planning for, and allocation of, resources. Fiscal planning and management of the service is based on sound accounting principles.

F. Improvement of Quality of Care and Performance

The physical therapy service has a written plan for continuous improvement of quality of care and performance of services.

G. Staffing

The physical therapy personnel affiliated with the physical therapy service have demonstrated competence and are sufficient to achieve the mission, purposes, and goals of the service.

H. Staff Development

The physical therapy service has a written plan that provides for appropriate and ongoing staff development.

I. Physical Setting

The physical setting is designed to provide a safe and accessible environment that

facilitates fulfillment of the mission, purposes, and goals of the physical therapy service. The equipment is safe and sufficient to achieve the purposes and goals of physical therapy.

J. Collaboration

The physical therapy service collaborates with all disciplines as appropriate.

III. Patient/Client Management

A. Patient/Client Collaboration

Within the patient/client management process, the physical therapist and the patient/client establish and maintain an ongoing collaborative process of decision-making that exists throughout the provision of services.

B. Initial Examination/Evaluation/Diagnosis/Prognosis

The physical therapist performs an initial examination and evaluation to establish diagnosis and prognosis prior to intervention.

C. Plan of Care

The physical therapist establishes a plan of care and manages the needs of the patient/client based on the examination, evaluation, diagnosis, prognosis, goals, and outcomes of the planned interventions for identified impairments, functional limitations, and disabilities.

The physical therapist involves the patient/client and appropriate others in the planning, implementation, and assessment of the plan of care.

The physical therapist, in consultation with appropriate disciplines, plans for discharge of the patient/client taking into consideration achievement of anticipated goals and expected outcomes, and provides for appropriate follow-up or referral.

D. Intervention

The physical therapist provides, or directs and supervises, the physical therapy intervention consistent with the results of the examination, evaluation, diagnosis, prognosis, and plan of care.

E. Re-examination

The physical therapist reexamines the patient/client as necessary during an episode of care to evaluate progress or change in patient/client status and modifies the plan of care accordingly or discontinues physical therapy services.

F. Discharge/Discontinuation of Intervention

The physical therapist discharges the patient/client from physical therapy services when the anticipated goals or expected outcomes for the patient/client have been achieved.

The physical therapist discontinues intervention when the patient/client is unable to continue to progress toward goals or when the physical therapist determines that the patient/client will no longer benefit from physical therapy.

G. Communication/Coordination/Documentation

The physical therapist communicates, coordinates and documents all aspects of patient/client management including the results of the initial examination and evaluation, diagnosis, prognosis, plan of care, interventions, response to interventions, changes in patient/client status relative to the interventions, reexamination, and discharge/discontinuation of intervention and other patient/client management activities.

IV. Education

The physical therapist is responsible for individual professional development. The physical therapist assistant is responsible for individual career development. The physical therapist, and the physical therapist assistant under the direction and supervision of the physical therapist, participate in the education of students.

The physical therapist educates and provides consultation to consumers and the general public regarding the purposes and benefits of physical therapy.

The physical therapist educates and provides consultation to consumers and the general public regarding the roles of the physical therapist and the physical therapist assistant.

V. Research

The physical therapist applies research findings to practice and encourages, participates in, and promotes activities that establish the outcomes of patient/client management provided by the physical therapist.

VI. Community Responsibility

The physical therapist demonstrates community responsibility by participating in community and community agency activities, educating the public, formulating public policy, or providing pro bono physical therapy services.

Appendix D

Physical Therapy Code of Ethics

CODE OF ETHICS HOD S06-00-12-23

(Program 17) [Amended HOD 06-91-05-05; HOD 06-87-11-17; HOD 06-81-06-18; HOD 06-78-06-08; HOD 06-78-06-07; HOD 06-77-18-30; HOD 06-77-17-27; Initial HOD 06-73-13-24] [Standard]

Preamble

This *Code of Ethics* of the American Physical Therapy Association sets forth principles for the ethical practice of physical therapy. All physical therapists are responsible for maintaining and promoting ethical practice. To this end, the physical therapist shall act in the best interest of the patient/client. This *Code of Ethics* shall be binding on all physical therapists.

Principle 1

A physical therapist shall respect the rights and dignity of all individuals and shall provide compassionate care.

Principle 2

A physical therapist shall act in a trustworthy manner towards patients/clients, and in all other aspects of physical therapy practice.

Principle 3

A physical therapist shall comply with laws and regulations governing physical therapy and shall strive to effect changes that benefit patients/clients.

Principle 4

A physical therapist shall exercise sound professional judgment.

Principle 5

A physical therapist shall achieve and maintain professional competence.

Principle 6

A physical therapist shall maintain and promote high standards for physical therapy practice, education, and research.

Principle 7

A physical therapist shall seek only such remuneration as is deserved and reasonable for physical therapy services.

Principle 8

A physical therapist shall provide and make available accurate and relevant information to patients/clients about their care and to the public about physical therapy services.

Principle 9

A physical therapist shall protect the public and the profession from unethical, incompetent, and illegal acts.

Principle 10

A physical therapist shall endeavor to address the health needs of society.

Principle 11

A physical therapist shall respect the rights, knowledge, and skills of colleagues and other health care professionals. (See also Ethics and Judicial Committee document [Guide for Professional Conduct](#)) (Program 17 – Judicial/Legal Issues, ext.3253)

Appendix E

Role Delineation

Areas of Emphasis	Physical Therapy	Overlap	Occupational Therapy
Motor Foundation Skills for Educational Needs			
Range of Motion	x		
Strength	x		
Endurance	x		
Posture	x		
Muscle Co-Contraction		x	
Support of Motor-Skill Development			
Gross Motor Skill Acquisition	x		
Fine Motor Skill Acquisition			x
Motor Planning		x	
Bilateral Coordination		x	
Visual Motor Integration (eye/hand)			x
Sitting Posture/Classroom Seating		x	
Wheelchair Positioning		x	
Adaptive Equipment/Standers	x		
Sensory Processing			
Sensory Input (<i>including movement & spatial awareness</i>)			x
Visual Perceptual Skill Development			x
Functional Mobility			
Equilibrium and Balance	x		
Gait Evaluation and Training: Use of Mobility Aids	x		
Assistance with Wheelchair Evaluations and Training	x		
Transfer Skills	x		
School-Related Community Access	x		
School-Related Self-Care Skills			
Mobility and Transfers for Self-Care/Hygiene			x
Oral-Motor Skill Acquisition			x
Self-Care Needs (<i>dressng, mealtime management, personal hygiene</i>)			x
Environmental Adaptations/Adaptive Equipment			
Modifications & Monitoring of Splints, Orthotics		x	
Technology Equipment Use/Augmentative Communication			x
School Playground Equipment Use	x		
Building/Community Access	x		
Career and Transition Readiness			
Task-Specific Strength/Range of Motion/Endurance		x	
Task-Oriented Sitting Balance & Tolerance		x	
Manual Dexterity			x
Adaptive Equipment & Compensatory Strategies			x

Appendix F

Assessment Tools

The following list contains norm-referenced, criterion-referenced, and judgment-based assessment tools commonly used by school-based therapists. Test information, such as normative data, reliability, and validity, should be scrutinized carefully prior to administration. This information can be found in several reference manuals. *Buros Mental Measurement Yearbook* is published annually and can be found at most major university libraries. An online search site, <http://www.unl.edu/buros>, provides basic information and a reference to the exact publication in the *Buros Mental Measurement Yearbook*. Additional information regarding assessments can be found in books, such as *Compendium of Neuropsychological Tests* by Spreen and Strauss. Additionally, therapists should check with individual LEAs for specific usage and/or guidelines prior to administering these tests.

Sensory Profile Assessment Products

The Sensory Profile family of products include the *Sensory Profile*, *Infant/Toddler Sensory Profile*, *Adolescent/Adult Sensory Profile* and the new *Sensory Profile School Companion*. Developed by Dr. Dunn, a Fellow of AOTA and a member of the American Occupational Therapy Foundation's Academy of Research. These products assess sensory processing and problem solving strategies to assist in targeting effective instruction in a standardized format. Therapists can then assess the possible contributions of sensory processing to the student's daily performance patterns and obtain information about everyday sensory experiences and their impact on behavior.

The Psychological Corporation
19500 Bulverde Road
San Antonio, Texas 78259
1-800-872-1726
<http://www.psychcorp.com>

Assessment, Evaluation, and Programming System for Infants and Children – Second Edition (Ages birth-6)

These materials allow professionals to identify educational targets tailored for each child's needs, formulate developmentally, track a child's progress over time and includes families in the process. It

gathers assessment data in the areas of fine motor; gross motor; adaptive, cognitive, and social/communication.

Brookes Publishing Co.
P.O. Box 10624
Baltimore, MD 21285-0624
1-800-638-3775
<http://www.brookespublishing.com>

Battelle Developmental Inventory, Second Edition (BDI-2) (Ages birth-7-11 years)

The Battelle is used for screening, diagnosis, evaluation, and program development. It is also available in Spanish. Test domains include personal-social, adaptive, motor, communication, and cognitive. It can be administered to children with known disabilities by using modifications listed in the administration manual.

Nelson Education
1120 Birchmount Road
Scarborough, ON

MIK 5G4 Canada
1-800-268-2222
<http://www.nelson.com>

Riverside Publishing
425 Spring Lake Drive
Itasca, IL 60143-2079
1-800-323-9540
<http://www.riverpub.com>

Carolina Curriculum for Preschoolers with Special Needs – Third Edition (Ages 2-5)

This curriculum-based assessment tool is used to evaluate preschoolers with disabilities in the developmental areas of personal-social, cognition, cognition-communication, fine motor and gross motor.

Brookes Publishing Co.
P.O. Box 10624
Baltimore, MD 21285-0624
1-800-638-3775
<http://www.brookespublishing.com>

COMPS Clinical Observations of Motor and Postural Skills, Second Edition (Ages 5-15)

A screening tool based on 6 of the Clinical Observations developed by A.J. Ayres. Slow movements, rapid forearm rotation, finger nose touching, prone extension posture, asymmetrical tonic neck reflex & supine flexure posture.

Therapro Inc.
225 Arlington Street
Framingham, MA 01702-8723
1-508-872-9494 or 1-800-257-5376
www.theraproducts.com

Developmental Assessment of Young Children (DAYC) (Ages 0-5 years)

This quick screening assesses the areas of cognition, communication, social-emotional development, physical development, and adaptive behavior. Subtests can be individually administered, separately or as a comprehensive battery, in approximately 10-20 minutes. The test format allows you to collect information about a child's abilities through observation, caregiver interview, and direct assessment.

Western Psychological Services
12031 Wilshire Blvd
Los Angeles CA 90025-1251
1-800-648-8857
<http://www.wpspublish.com>

Developmental Test of Visual Perception (DTVP-2) (Ages 4 to 10 years, 11 months)

This assessment measures both visual perception and visual motor integration skills. It has eight subtests (eye-hand coordination, figure ground, visual closure, copying, spatial relations, form constancy, visual motor speed and form constancy).

PRO-ED, Inc.
8700 Shoal Creek Boulevard
Austin, Texas 78757-6897
1-800-897-3202
<http://www.proedinc.com>

Western Psychological Services
12031 Wilshire Blvd.
Los Angeles, CA 90025-1251
1-800-648-8857

<http://www.wpspublish.com>

Developmental Test of Visual Perception - Adolescent/Adult (Ages 11.0 - 74.11 years)

This battery of six subtests is designed to measure different but interrelated visual-perceptual and visual-motor abilities. The DTVP-A is especially useful in the evaluation of the neuropsychological integrity of TBI and stroke patients where right-hemisphere function may be at issue.

PRO-ED, Inc.
8700 Shoal Creek Boulevard
Austin, Texas 78757-6897
1-800-897-3202

<http://www.proedinc.com>

Western Psychological Services
12031 Wilshire Blvd.
Los Angeles, CA 90025-1251
1-800-648-8857

<http://www.wpspublish.com>

The Beery-Buktenica Developmental Test of Visual-Motor Integration-Fifth Edition (Beery VMI-5) (Ages 2.0 - 18.11 years)

This standardized test is designed to screen for visual-motor deficits that can lead to learning, neuropsychological, and behavior problems. The Beery VMI helps assess the extent to which individuals can integrate their visual and motor abilities.

PRO-ED, Inc.
8700 Shoal Creek Boulevard
Austin, Texas 78757-6897
1-800-897-3202

<http://www.proedinc.com>

Western Psychological Services
12031 Wilshire Blvd.
Los Angeles, CA 90025-1251
1-800-648-8857

<http://www.wpspublish.com>

Evaluation Tool of Children's Handwriting (Grades 1-6)

This criterion-referenced tool is designed to evaluate manuscript and cursive handwriting skills of children in Grades 1 through 6. Its focus is to assess a student's legibility and speed of handwriting tasks similar to those required of students in the classroom.

Therapro Inc.
225 Arlington Street
Framingham, MA 01702-8723
1-508-872-9494 or 1-800-257-5376
www.theraproducts.com

First Step: Screening Test for Evaluating Preschoolers (Ages 2.9 to 6.2 years)

This screening tool in a game format is used to assess cognition, communication, and motor domains. It also includes a social-emotional scale and an adaptive behavior rating scale.

The Psychological Corporation
19500 Bulverde Road
San Antonio, Texas 78259
1-800-872-1726
<http://www.psychcorp.com>

Gross Motor Function Measure (Ages 0-5 years)

Physical therapists frequently use the 66-item Gross Motor Function Measure (GMFM-66) with the Gross Motor Function Classification System (GMFCS) to examine gross motor function in children with cerebral palsy (CP).

[Amazon.com](http://www.amazon.com)

Hawaii Early Learning Profile (Ages 0-3)

This curriculum-based test assesses areas of cognitive, gross and fine motor, social and self-help, through direct observation and/or caregiver report.

Hawaii Early Learning Profile for Preschoolers (Ages 3-6)

This curriculum-based assessment is for children who are "at risk" for developmental delays. It covers 622 developmental skills in the areas of cognitive, language, social/emotional, self-help, fine and gross motor.

VORT Corporation
P.O. Box 60132-tx
Palo Alto, CA 94306
1-650-322-8282
<http://www.vort.com>

Minnesota Handwriting Assessment (First-second grade)

This assessment analyzes handwriting skills used in standard manuscript and D'Nealian styles of print. It identifies how students are performing in relationship to their peers. Scores are based on rate and five quality categories: legibility, form, alignment, size, and spacing.

The Psychological Corporation
19500 Bulverde Road
San Antonio, Texas 78259
1-800-872-1726
<http://www.psychcorp.com>

Motor Free Visual Perception Test - Third Edition (Ages 4 - 85 years)

This test is designed to assess visual perception without reliance on motor skills. Five categories of visual perception are measured: spatial relationship, visual closure, visual discrimination, visual memory, and figure ground.

PRO-ED, Inc.
8700 Shoal Creek Boulevard
Austin, Texas 78757-6897
1-800-897-3202
<http://www.proedinc.com>

Western Psychological Services
12031 Wilshire Blvd.
Los Angeles, CA 90025-1251
1-800-648-8857
<http://www.wpspublish.com>

Movement Assessment Battery for Children – Second Edition (Ages 3.0 – 16.11 years)

This screening checklist examines manual dexterity, static and dynamic balance, ball handling skills, and visual motor skills and the extent to which a child's attitudes and feelings about motor tasks are situation

specific or more generalized. Therapists can also obtain parents' or teachers' views on a child's movement in everyday settings.

The Psychological Corporation
19500 Bulverde Road
San Antonio, Texas 78259
1-800-872-1726
<http://www.psychcorp.com>

Peabody Developmental Motor Scales – Second Edition (Ages Birth - 5 years)

This early childhood motor development test measures motor skills in the areas of reflexes, stationary, locomotion, object manipulation, grasping, and visual-motor integration.

PRO-ED, Inc.
8700 Shoal Creek Boulevard
Austin, Texas 78757-6897
1- 800-897-3202
<http://www.proedinc.com>

The Psychological Corporation
19500 Bulverde Road
San Antonio, Texas 78259
1-800-872-1726
<http://www.psychcorp.com>

Pediatric Evaluation of Disability Inventory – Second Edition (Ages 6 months - 7 years)

It is a descriptive measure of a child's current functional performance that can be used to track changes over time. The assessment measures both capability and performance of functional activities in three content domains: self-care, mobility, and social function. It can also be used to evaluate older children whose functional abilities are lower than those of seven-year-olds without disabilities. The new computerized format (PEDI-MCAT), provides individual reports that summarize a child's functional status in the domains of self-care and mobility function and compares the child's scores to norms from 6 months to 14 years of age.

The Psychological Corporation
19500 Bulverde Road
San Antonio, Texas 78259
1-800-872-1726
<http://www.psychcorp.com>

Preschool Visual Motor Integration Assessment (Ages 3.5 – 5.5 years)

Specific skills assessed include perception of position in space, awareness of spatial relationships, color and shape discrimination, matching two attributes simultaneously, and the ability to reproduce what is seen and interpreted.

Therapro, Inc.
225 Arlington Streets
Framingham, MA 01702-8723
800-257-5376
<http://www.theraproducts.com>

School Function Assessment (Grades K - 6)

This assessment for students with disabilities identifies their strengths and needs in nonacademic functional tasks, including communication, self-care, playground skills, and social awareness/interaction. Three scales are included for evaluating students—Participation, Task Supports, and Activity Performance.

The Psychological Corporation
19500 Bulverde Road
San Antonio, Texas 78259
1-800-872-1726
<http://www.psychcorp.com>

DeGangi-Berk Test of Sensory Integration (TSI) (Ages 3 – 5 years)

Permits early detection of sensory processing deficits that could lead to later learning difficulties.

Western Psychological Services
12031 Wilshire Blvd
Los Angeles, CA 90025-1251
1-800-648-8857
<http://www.wpspublish.com>

Sensory Processing Measure (SPM)

Grounded in sensory integration theory, the SPM provides norm-referenced standard scores across three forms.

- Home Form – completed by the child's parent or home-based care provider
- Main Classroom Form – completed by the child's primary classroom teacher
- School Environments Form – completed by school personnel

Each requiring just 15 to 20 minutes, the Home and Main Classroom Forms yield eight parallel standard scores: Social Participation, Vision, Hearing, Touch, Body Awareness (proprioception), Balance and Motion (vestibular function), Planning and Ideas (praxis), and Total Sensory Systems. Provided on an unlimited-use CD, the school environments form lets you look at the child's functioning in six school environments outside of the main classroom: Art Class, Music Class, Physical Education Class, Recess/Playground, Cafeteria, and School Bus.

Western Psychological Services
12031 Wilshire Blvd
Los Angeles, CA 90025-1251
1-800-648-8857

<http://www.wpspublish.com>

Bruininks-Oseretsky Test of Motor Proficiency, Second Edition (BOT-2) (Ages 4 – 21)

The BOT-2 covers a broad array of fine and gross motor skills with the following eight subtests: Fine Motor Precision, Fine Motor Integration, Manual Dexterity, Bilateral Coordination, Balance, Running Speed and Agility, Upper-Limb Coordination, and Strength. Composite scores in four motor areas (Fine Manual Control, Manual Coordination, Body Coordination and Strength and Agility) and one comprehensive measure of overall motor proficiency.

The Psychological Corporation
19500 Bulverde Road
San Antonio, Texas 78259
1-800-872-1726

<http://www.psychcorp.com>

Appendix G

Suggested Readings

- American Occupational Therapy Association (2002). Occupational therapy practice framework: Domain and process. *American Journal of Occupational Therapy*, *56*, 609-639.
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Appendix H

Web Sites

American Academy of Cerebral Palsy and
Developmental Medicine
<http://www.aacpdm.org>

American Occupational Therapy Association
<http://www.aota.org>

American Physical Therapy Association
<http://www.apta.org>

APTA Pediatric Physical Therapy Journal
<http://www.pediatricphysicaltherapy.com>

APTA Pediatric Section
<http://www.pediatricapta.org>

Assistive Technology Training Online
<http://www.atto@buffalo.edu>

Center for Applied Special Technology
<http://www.cast.org>

Computer Technology in Special Education and
Rehabilitation
<http://www.closingthegap.com>

Council for Exceptional Children
<http://www.cec.sped.org>

Department of Health Professionals Virginia
<http://www.dhp.state.va.us>

Disability Information
<http://www.disabilityinfo.gov>

EDLAW Center
<http://www.edlaw.net>

Educational Resources Information Clearinghouse
http://www.ed.gov/prog_info/ERIC

Family Center on Technology and Disabilities
<http://www.fctd.info>

Federal Resource Center for Children with Disabilities
<http://www.dssc.org/frc>

IDEA Practices
<http://www.ideapractices.org>

International Center for Disability Information
<http://www.icdi.wvu.edu>

Job Accommodations Network
<http://janweb.icdi.wvu.edu>

National Center for the Dissemination of Disability
Research
<http://www.ncddr.org>

National Center on Educational Outcomes
<http://www.education.umn.edu/nceo>

National Center on Physical Activity and Disability
<http://www.uic.edu/orgs/ncpad>

National Center on Secondary Education and
Transition (NCSET)
<http://www.ncset.org>

National Collaborative Workforce and Disability
–Youth
<http://www.ncwd-youth.info>

National Information Center for Children and Youth
with Disabilities
<http://www.nichcy.org>

National Library of Medicine
<http://www.nlm.nih.gov>

National Library of Medicine's Medline and Pre-
Medline Databases
<http://www.medportal.com>

National Organization for Rare Disorders
<http://www.rarediseases.org>

National Rehab Network
<http://www.medgroup.com>

OT Systematic Evaluation of Evidence
<http://www.Otseeker.com>

Partnerships in Assistive Technology
<http://www.pat.org>

Pediatric Orthopedics and Pediatric Sports Medicine
for Parents/guardians
<http://www.orthoseek.com>

Pediatric Physical Therapy Journal
<http://www.pedpt.com>

Rehabilitation Engineering and Assistive Technology
Society of North America (RESNA)
<http://www.resna.org>

Special Education NEWS
<http://www.specialednews.com>

The Arc
<http://www.thearc.org>

The Physiotherapy Evidence Database
<http://www.pedro.fhs.usyd.edu.au>

United Cerebral Palsy Association
<http://www.ucp.org>

Virginia Department of Education
<http://www.doe.virginia.gov>

Virginia's Regional Training and Technical Assistance
Centers
<http://www.doe.virginia.gov/VDOE/sped/ta.shtml>

Wheelchair Net
<http://www.wheelchairnet.org>

Appendix I

Virginia College and University Therapy Programs

Occupational Therapy Programs

Shenandoah University
Occupational Therapy Program
333 West Cork Street, 5th Floor
Winchester, VA 22601
(540) 665-5559
<http://www.su.edu/ot>

Virginia Commonwealth University
1000 E. Marshall Street
P.O. Box 980008
Richmond, VA 23298-0008
(804) 828-2219
<http://www.saph.vcu.edu/occu>

James Madison University
Occupational Therapy Program
Department of Health Sciences
College of Integrated Science and Technology,
MSC 4301
Harrisonburg, VA 22807-0001
(540) 568-2399
<http://www.jmu.edu>

College of Health Sciences
Occupational Therapy Program
Community Hospital of Roanoke Valley
920 S. Jefferson Street
Roanoke, VA 24016
(540) 985-8594
<http://www.chs.edu>

Radford University
Department of Occupational Therapy
P.O. Box 6985
Radford, VA 24142
(540) 831-2693
<http://ot.asp.radford.edu>

Physical Therapy Programs

Hampton University
Physical Therapy Program
Hampton, VA 23668
(757) 727-5328, (800) 624-3328
<http://www.hamptonu.edu>

Marymount University
Physical Therapy Program
2807 N. Glebe Road
Arlington, VA 22207
(703) 284-1500, (800) 548-7638
<http://www.marymount.edu>

Old Dominion University
School of Physical Therapy
3118 Health Sciences Bldg
Norfolk, VA 23529
(757-683-3000
<http://www.odu.edu>

Shenandoah University
Physical Therapy Program
333 West Cork Street, 5th Floor
Winchester, VA 22601
(540) 665-5559
<http://www.su.edu/pt>

Virginia Commonwealth University
Department of Physical Therapy
1000 E. Marshall Street
P.O. Box 980008
Richmond, VA 23298-0008
(804) 828-2219
<http://www.vcu.edu/pt>

Occupational Therapy Assistant Programs

Tidewater Community College
Occupational Therapy Assistant Program
1700 College Crescent
Virginia Beach, VA 23456-1918
(757) 822-7273
<http://www.tcc.vccs.edu/vabeach/hstdiv/ota/index.htm>

College of Health Sciences
Occupational Therapy Assistant Program
Community Hospital of Roanoke Valley
920 South Jefferson Street
Roanoke, VA 24016-4443
(540) 985-8594
<http://www.chs.edu>

Southwest Virginia Community College
Occupational Therapy Assistant Program
P.O. Box SVCC
Richlands, VA 24641-1101
(276) 964-7643 or (276) 935-7748
<http://www.sw.vccs.edu>

Physical Therapy Assistant Programs

College of Health Sciences
Physical Therapy Assistant Program
Community Hospital of Roanoke Valley
920 S. Jefferson Street
Roanoke, VA 24016
(540) 985-8594
<http://www.chs.edu>

Tidewater Community College
Physical Therapy Assistant Program
1700 College Crescent
Virginia Beach, VA 23456-1918
(757) 822-7273
<http://www.tcc.vccs.edu/vabeach/hstdiv/ota/index.htm>

Northern Virginia Community College
Physical Therapy Assistant Program
4001 Wakefield Chapel Road
Annandale, VA 22003-3723
(703) 323-3000
<http://www.nv.cc.va.us>

Wytheville Community College
Physical Therapy Assistant Program
1000 E. Main Street
Wytheville, VA 24382
(800) 468-1195
<http://www.wcc.vccs.edu>

Appendix J

Equipment Vendors

Intervention Products

AliMed, Inc.
297 High Street
Dedham, MA 02026
(800) 225-2610
<http://www.alimed.com>

Abilitations/Sportime/Chimetime
One Sportime Way
Atlanta, GA 30340
(800) 850-8602
<http://www.abilitations.com>

Achievement Products
P.O. Box 9033
Canton, OH 44711
(800) 373-4699
<http://www.achievementproducts.com>

Benik Corporation
11871 Silverdale Way, NW #107
Silverdale, WA 98383
(800) 442-8910
<http://www.benik.com>

Best Priced Products, Inc.
P.O. Box 1174
White Plains, NY 10602
(800) 824-2939
<http://www.best-priced-products.com>

Consumer Care Products
1446 Pilgrim Road
Plymouth, WI 53073
(920) 893-4614
<http://www.comsumercareinc.com>

Danmar Products, Inc.
221 Jackson Industrial Drive
Ann Arbor, MI 48103
(800) 783-1998
<http://www.danmarproducts.com>

Equipment Shop
P.O. Box 33
Bedford, MA 01730
(800) 525-7681
<http://www.equipmentshop.com>

Flaghouse
601 Flaghouse Drive
Hasbrouck, NJ 7604-3116
(800) 793-7900
<http://www.flaghouse.com>

GE Miller, Inc.
45 Saw Mill River Road
Yonkers, NY 10701
(800) 431-2924
<http://www.gemiller.com>

Handwriting Without Tears
Mrs. Jan Olsen, OTR
8001 MacArthur Boulevard
Cabin John, MD 20818
(301) 263-2700
<http://www.hwtears.com>

Kaye Products, Inc.
535 Dimmocks Mill Road
Hillsborough, NC 27278
(919) 732-6444
<http://www.kayeproducts.com>

K&L Resources
P.O. Box 2612
Springfield, VA 22152
(703) 455-15031

OT Ideas, Inc.
124 Morris Turnpike
Randolph, NJ 07869
(877) 768-4332
<http://www.otideas.com>

Pocket Full of Therapy
 P.O. Box 174
 Morganville, NJ 07751
 (732) 441-0404
<http://www.pfot.com>

Pro-Ed
 8700 Shoal Creek Boulevard
 Austin, TX 78758-6897
 (800) 897-3202
<http://www.proedinc.com>

Rifton Equipment
 P.O. Box 901, Rt. 213
 Rifton, NY 12471-0901
 (800) 777-4244
<http://www.rifton.com>

Southpaw Enterprises, Inc.
 P.O. Box 1047
 Dayton, OH 45401
 (800) 228-1698
<http://www.southpawenterprises.com>

Sammons Preston, Inc.
 Ability One Corporation
 4 Sammons Court
 Bollingbrook, IL 60440
 (800) 323-5547
<http://www.sammonspreston.com>

Sunrise Medical
 2355 Crenshaw Boulevard, Suite 150
 Torrance, CA 90501
 (800) 388-4083
<http://www.sunrisemedical.com>

TherAdapt Products, Inc.
 17 W. 163 Oak Lane
 Bensenville, IL 60106
 (800) 261-4919
<http://www.theradapt.com>

Therapro
 225 Arlington Street
 Framingham, MA 01701-8723
 (800) 257-5376
<http://www.theraproducts.com>

Therapy Shoppe, Inc.
 P.O. Box 8875
 Grand Rapids, MI 49515
 (616) 863-5978
<http://www.therapyshoppe.com>

Therapy Skill Builders
 19500 Belverde Road
 San Antonio, TX 78204-2498
 (800) 211-8378
<http://www.psychcorp.com>

Troll Learn and Play
 100 Corporate Drive
 Mahwah, NJ 07430
 (800) 541-1097
<http://www.troll.com>

The Writer Learning Systems
 P.O. Box 186
 Paso Robles, CA 933447-186
 (800) 797-7121
<http://www.writerlearning.com>

Braces and Orthotics Materials

Benik Corporation
 11871 Silverdale Way, NW #107
 Silverdale, WA 98383
 (800) 442-8910
<http://www.benik.com>

North Coast Medical
 18305 Suter Boulevard
 Morgan Hill, CA 95037-2845
 (800) 821-9319
<http://www.ncmedical.com>

Rolyan Ability One
 Division of Sammons Preston
 4 Sammons Court
 Bollingbrook, IL 60440
 (800) 323-5547
<http://www.sammonspreston.com>

Sammons Preston, Inc.
 4 Sammons Court
 Bollingbrook, IL 60440
 (800) 323-5547
<http://www.sammonspreston.com>

Tri-Wall Containers Company
 2626 Country Road 71
 Butler, IN 46721
 (260) 868-2151
<http://www.triwall.com>

Seating Systems

Amigo Mobility
 6693 Dixie Highway
 Bridgeport, MI 48722
 (800) 692-6446
<http://www.myamigo.com>

Best Priced Products, Inc.
 P. O. Box 1174
 White Plains, NY 10602
 (800) 824-2939
<http://www.best-priced-products.com>

Everest and Jennings
 2935 Northeast Parkway
 Atlanta, GA 30360
 (800) 788-3633
<http://www.everestjennings.com>

Gunnell, Inc.
 1165 Portland Avenue
 Millington, MI 48746
 (800) 551-0055
<http://www.gunnell-inc.com>

Invacare Corp.
 39400 Taylor Street
 Northridgeville, OH 44039
 (800) 333-6900
<http://www.invacare.com>

Kaye Products, Inc.
 535 Dimmocks Mill Road
 Hillsborough, NC 27278
 (919) 732-6444
<http://www.kayeproducts.com>

Kid-Kart, Inc. sold by Sunrise Medical
 2355 Crenshaw Boulevard, Suite 150
 Torrance, CA 90501
 (800) 388-4083
<http://www.sunrisemedical.com>

Mulholland Positioning Systems
 839 Albion Avenue
 Burley, ID 83318
 800-543-4769
<http://www.mulhollandinc.com>

Ortho-Kinetics, Inc.
 3275 Intertech Drive Suite 500
 Brookfield WI, 53045
 800-824-1068
<http://www.ez-international.com>

Otto Bock Orthopedic Industry, Inc.
 Two Carlson Parkway, Suite 100
 Minneapolis, MN 55447-4467
 (800) 328-4058
<http://www.ottobockus.com>

Quickie Wheelchairs
 513 W. Thomas Road
 Phoenix, AZ 85013
 (800) 236-4215
<http://www.quickiewheelchairs.com>

Roho, Inc.
 100 Florida Avenue
 Belleville, IL 62222
 (618) 277-9150
<http://www.crownthera.com>

Snug Seat, Inc.
P.O. Box 1739
Matthews, NC 28106
(800) 336-7684
<http://www.snugseat.com>

Sammons Preston, Inc.
4 Sammons Court
Bollingbrook, IL 60440
(800) 323-5547
<http://www.sammonspreston.com>

Independent Living Products

Adaptability
75 Mill Street
Colchester, CT 06415
(800) 937-3482
<http://www.adaptability.com>

Dining with Dignity
101 Deerwood Drive
Williamsburg, VA 23185
(757) 565-2452
<http://www.diningwithdignity.com>

Dragon Fly Toys: Aides for Daily Living
291 Yale Avenue
Winnepeg, MB, Canada R3M 0L4
(866) 559-1086
<http://www.dragonflytoys.com>

eSpecial Needs
11724 Lackland Industrial Drive
St. Louis, MO 63146
(877) 664-4565
<http://www.especialneeds.com>

Extensions for Independence
555 Saturn Blvd. #B-368
San Diego, CA 92154
(619) 618-2154
<http://www.mouthstick.net>

RD Equipment Incorporated
230 Percival Drive
West Barnstable, MA 02668
(508) 362-7498
<http://www.rdequipment.com>

Clothing Products

Adaptations by Adrian
P.O. Box 65
San Marcos, CA 92079-0065
(800) 831-2577
<http://www.adrianscloset.com>

Abel Apparel
2121 Hillside Avenue
New Hyde Park, NY 11040
1-888-688-ABLE or 1-516-873-6552
<http://www.ableapparel.com>

Professional Fit Clothing
1-800-422-2348
<http://www.professionalfit.com>

Special Clothes
P.O. Box 330
Harwich, MA 02645
<http://www.special-clothes.com>

Exercise Devices and Equipment

Access to Recreation, Inc.
8 Sandra Court
Newbury Park, CA 91320
1-800-634-4351
<http://www.accesstr.com>

Flexiciser International Corporation
800 Grand Ave., Suite B2
Carlsbad, CA 92008-1805
(888) 353-9462
<http://www.flexiciser.com>

Therapeutic Alliances Inc.
333 North Broad Street
Fairborn, OH 45324
1-937- 879-0734
<http://www.musclepower.com>

Uppertone
535 Floyd Smith Drive
El Cajun, CA 92020
1-619-593-7381
<http://www.quadriplegia.com/>

Toy Products

AblePlay
<http://www.ableplay.org>

Angeles Toys, Inc.
9 Capper Drive
Dailey Industrial Park
Pacific, MO 63069
<http://www.angelesstore.com>

Enabling Devices
Toys for Special Children
385 Wargurton Avenue
Hastings on Hudson, NY 10706
(800) 832-8697 x20
<http://enablingdevices.com>

Nintendo of America
P.O. Box 957
Redmond, WA 98073
(800) 255-3700
<http://www.nintendo.com>

Toys for Special Children
85 Warburton Avenue
Hastings-on-Hudson, NY 10706
(800) 832-8697
<http://www.enablingdevices.com>

Triaid, Inc.
P.O. Box 1364
Cumberland, MD 21501-1364
(301) 759-3525
<http://www.triaid.com>

Communication/Technology

Ablenet, Inc.
1081 Tenth Avenue, S. E.
Minneapolis, MN 55414
(800) 322-0956
<http://www.ablenetinc.com>

AlphaSmart, Inc.
973 University Avenue
Los Gatos, CA 95032
(800) 274-0680
<http://www.alphasmart.com>

Apple Computer, Inc.
Attn: Inside Sales
2420 Ridgepoint Drive
M/S 198 ED
Austin, TX 78754-5205
(800) 800-2775
<http://www.apple.com>

Canon USA, Inc.
1 Canon Plaza, Bldg. C
Lake Success, NY 11042
(800) 652-2666
<http://www.usa.canon.com>

Communication Aids for Children & Adults
c/o Crestwood Company
6625 N. Sidney Place, Dept. 21F
Milwaukee, WI 53209-3259
(414) 352-5678
<http://www.communicationaids.com>

Don Johnston, Inc.
26799 West Commerce Drive
Volo, IL 60073
(800) 999-4660
<http://www.donjohnston.com>

Dynavox Systems LLC
2100 Wharton Street, Suite 400
Pittsburgh, PA 15203
(800) 344-1778
<http://www.dynavoxsys.com>

Enabling Devices
Division of Toys for Special Children
385 Warburton Avenue
Hastings-on-Hudson, NY 10706
<http://enablingdevices.com>

Edmark
399 Boylston Street
Boston, MA 02116
(617) 778-7600
<http://www.riverdeep.net>

Envision Technology
4905 Del Ray Avenue, Suite 220
Bethesda, MD 20814
(301) 652-1761
<http://envisiontechnology.org>

Enabling Devices
Division of Toys for Special Children
385 Warburton Avenue
Hastings-on-Hudson, NY 10706
<http://www.enablingdevices.com>

Envision Technology
4905 Del Ray Avenue, Suite 220
Bethesda, MD 20814
(301) 652-1761
<http://www.envisiontechnology.org>

IBM Corporation
Accessibility Center
11400 Burnet Road
Austin, TX 78758
(800) 426-4832
<http://www.3.ibm.com/able>

Intellitools, Inc.
1720 Corporate Circle
Petaluma, CA 94954
(707) 773-2000
<http://www.intellitools.com>

Key Technologies, Inc.
P.O. Box 1997
Morganton, NC 28680-1997
(828) 433-5302
<http://www.gokeytech.com>

Laetare Solutions
2409 Belair Drive
Bowie, MD 20715
(888) 466-7294
<http://www.mdtap.org>

LC Technologies
9455 Silver King Court
Fairfax, VA 22031
(703) 385-7133
<http://www.eyegaze.com>

Prentke Romich
1022 Heyl Road
Wooster, OH 44691
(800) 262-1984
<http://www.prentrom.com>

Appendix K

Sample Performance Appraisal Criteria Forms

Physical and Occupational Therapists Performance Evaluation

Name _____ Location: _____ Date: _____

Check 1, 2, 3, 4, 5 or NA For Each Category

1-Unsatisfactory 2-Below Average 3-Average 4-Above Average 5-Superior NA-Not Applicable

I. Student Assessment

	1	2	3	4	5	NA
1. Assists in identifying students needing evaluations and/or services.						
2. Performs formal observations and/or evaluation procedures which provide information as to the strengths and weaknesses of the student.						
3. Determines educational implications of assessment data and results.						
4. Presents written/oral reports to school personnel and parents/guardians.						
5. Performs evaluations within specified time frame.						
6. Assists in the consideration of Assistive Technology needs for the student.						

II. Service Delivery

1. Works collaboratively with school staff, parents/guardians and personnel in community agencies to determine IEP annual goals, frequency and scheduling of therapy services.						
2. Implements strategies that allow the student to access the general education curriculum.						
3. Evaluates and documents student progress regularly.						
4. Modifies services as the student progresses or regresses.						
5. Provides services that relate to the student's daily educational routine.						
6. Services are provided through a series of delivery models (direct, consultation and monitoring).						

III. Consultation

1. Suggests modifications to the physical environment of the student's educational setting to provide access to the general education curriculum.						
2. Provides effective consultation to teachers and parents/guardians concerning the student's areas of strengths and areas that need improvement.						
3. Assists the education team to ensure that therapeutic activities occur throughout the school day and are generalized to multiple environments.						
4. Provides information concerning available community resources.						
5. Assists in the adaptation and modification of instructional materials and equipment.						
6. Provides effective consultation to administrators to make them aware of service delivery plans and update progress periodically.						
7. Collaborates with administrators when special problems arise.						
8. Assists in examining issues such as building modifications, new construction, special transportation, safety and injury prevention, and technology infrastructure.						

Check 1, 2, 3, 4, 5 or NA For Each Category
 1-Unsatisfactory 2-Below Average 3-Average 4-Above Average 5-Superior NA-Not Applicable

IV. Professional Issues

	1	2	3	4	5	NA
1. Maintains good rapport with school personnel.						
2. Appearance falls within guidelines acceptable to individual school settings.						
3. Demonstrates a positive attitude toward work.						
4. Behaves and communicates in a professional manner.						
5. Follows guidelines for appropriate paperwork.						
6. Provides appropriate supervision for paraprofessional (PT/OT).						

V. Professional Growth

	1	2	3	4	5	NA
1. Listens to new ideas, viewpoints and procedures and can accept and adjust to change.						
2. Continues to pursue professional development.						
3. Implements advances in specialists' fields.						
4. Presents and/or attends in-service presentations.						

COMMENTS:



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