



JOB DESCRIPTION  
PHYSICAL THERAPIST

Employee Name: \_\_\_\_\_

This agency hereby approves that we shall hire and employ the services of a Physical Therapist, services indicated for functional limitations and deficits in safety, mobility, strength, and range of motion.

The following rules shall apply to the Physical Therapist to be employed by our agency:

1. He/she must be a graduate of an approved school for Physical Therapist.
2. He/she must be currently licensed and registered in this state.
3. He/she must have at least one year of experience in Physical Therapy.

Our agency hereby sets forth the following responsibilities for the Physical Therapist.

- A. He/she shall provide Physical Therapist services as prescribed by a Physician which can be safely provided in the home.
- B. He/she shall assist the Physician in evaluating patients by applying diagnostic and prognostic muscle, nerve, joint and functional abilities test.
- C. He/she shall provide Physical Therapy services.
- D. He/she shall observe and record activities and findings in the clinical record and report to the Physician the patient's reaction to treatment and any changes in the patient's condition, or when there are deviations from the plan of care.
- E. He/she shall instruct the patient and patient's family in the care and use of Physical Therapy devices.
- F. He/she shall instruct other health team personnel including, when appropriate, Home Health Aides and family members in certain phases of Physical Therapy with which they may work with the patient.
- G. He/she shall instruct the patient's family on the patient's total physical therapy program.
- H. Ensure HIPAA guidelines and procedures are maintained.

These responsibilities may be subject to change from time to time to reflect the prevailing state statutes.

\_\_\_\_\_  
Administrator

Date: \_\_\_\_\_

\_\_\_\_\_  
Employee

Date: \_\_\_\_\_

# ORIENTATION CHECKLIST: PROFESSIONAL STAFF

Employee Name: \_\_\_\_\_

## I. GENERAL ORIENTATION

- \_\_\_\_\_ AGENCY ORGANIZATIONAL STRUCTURE
- \_\_\_\_\_ PHILOSOPHY, GOAL & OBJECTIVES, MISSION
- \_\_\_\_\_ TOUR OF FACILITY
  - a) LOCATION OF ADMINISTRATIVE OFFICES
  - b) LOCATION OF EMERGENCY LIGHTS/EXITS
  - c) LOCATION OF FIRE EXTINGUISHERS
  - d) LOCATION OF FIRST AIDE BOX
  - e) EMERGENCY EVACUATION ROUTES
- \_\_\_\_\_ INTRODUCTION TO STAFF/CLIENTS
- \_\_\_\_\_ SCOPE OF SERVICES
- \_\_\_\_\_ EMPLOYMENT POLICIES/JOB DESCRIPTION
- \_\_\_\_\_ COMPLAINTS POLICY/GRIEVANCE FORM
- \_\_\_\_\_ PAYROLL
- \_\_\_\_\_ CORPORATE COMPLIANCE PLAN



## II. CLINICAL ORIENTATION

- \_\_\_\_\_ CLIENT RIGHTS AND RESPONSIBILITIES
- \_\_\_\_\_ ADMISSION/DISCHARGE CRITERIA/THERAPY SERVICES
- \_\_\_\_\_ MEDICAL EMERGENCIES
- \_\_\_\_\_ PSYCHIATRIC EMERGENCIES
- \_\_\_\_\_ DOCUMENTATION REQUIREMENTS/TIME FRAMES
- \_\_\_\_\_ CLINICAL RECORDS

## III. CONFIDENTIALITY/HIPAA GUIDELINES

- \_\_\_\_\_ CLIENT/FAMILY/SIGNIFICANT OTHER
- \_\_\_\_\_ PROGRAM/STAFF
- \_\_\_\_\_ INFORMATION

## IV. SAFETY/RISK MANAGEMENT/INFECTION CONTROL

- \_\_\_\_\_ ACCIDENTAL/INCIDENT REPORTING
- \_\_\_\_\_ OSHA
- \_\_\_\_\_ UNIVERSAL PRECAUTION
- \_\_\_\_\_ BIOHAZARDOUS/INFECTION WASTE
- \_\_\_\_\_ HIV UPDATE
- \_\_\_\_\_ TB UPDATE
- \_\_\_\_\_ EMERGENCY PREPAREDNESS
- \_\_\_\_\_ FIRE DRILL
- \_\_\_\_\_ CARE OF ENVIRONMENT

I HAVE READ AND UNDERSTAND THE POLICIES AND PROCEDURES OF THE AGENCY AND HAVE HAD THE OPPORTUNITY TO HAVE ALL OF MY QUESTIONS/CONCERNS ADDRESSED TO MY COMPLETE SATISFACTION.

I AGREE TO ABIDE AND UPHOLD ALL POLICIES AND PROCEDURE, AND HAVE BEEN ADVISE THAT FAILURE TO DO SO MAY RESULT IN TERMINATION OF EMPLOYMENT.

I ALSO AGREE THAT AS A CONDITION OF EMPLOYMENT THAT I WILL PROVIDE THE AGENCY WITH A FOURTEEN (14) DAY WRITTEN NOTICE OF INTENT TO TERMINATE EMPLOYMENT.

\_\_\_\_\_  
EMPLOYEE SIGNATURE/TITLE

\_\_\_\_\_  
DATE



**PHYSICAL THERAPY COMPETENCY** (page 1)

Name: \_\_\_\_\_

TASKS/BEHAVIORS COMPLETED	DATE PERFORMED OR COMPETENT	INITIALS OF EMPLOYEE OR CONTRACTOR	COMMENTS
Referral process			
ASSESSMENT OF:			
Level of Function			
Physical Assessment			
Rehab. Program			
Home exercise program			
Patient/Family Education			
Therapeutic Exercises			
Transfer Training			
Gait training			
Balance training			
Pulmonary Physical therapy			
Prosthetic training			
Muscle re-education			
Discharge plan discussed with patient on admission/Review of all Literature			
Communication with PCC/Case Manager			
Timely paperwork submission/review of Regulations			

TASKS/BEHAVIORS COMPLETED	DATE PERFORMED OR COMPETENT	INITIALS OF EMPLOYEE OR CONTRACTOR	COMMENTS
Timely notification for patient visits/use of calendar			
All paperwork due by the last day of the 3 <sup>rd</sup> week by 5pm or by 9:00 am the Monday after the last day of the 3 <sup>rd</sup> week to process billing.			
Review of documentation/revisit			
Review of documentation admission			
Notification of patient of discharge 2 wks prior & document			
Evaluation for additional services			
COMMENTS			

MVP Health, Inc.

SIGNATURE OF ORIENTEE \_\_\_\_\_

SIGNATURE OF PRECEPTOR \_\_\_\_\_

