

Job Description / Performance Evaluation

Title: Physical Therapist

Employer Evaluation

Employee Self Evaluation

Job Summary:

A registered professional who provides coordinated care to patients of all age groups. Plans, implements and evaluates patient care plans to restore or maintain patient well being. Plans, organizes and conducts physical therapy treatment program based on the medical referral and their evaluation. Collaborates with interdisciplinary team.

Job Classification: Clinical

Lines of Authority: Reports to Director of Nursing

Job Qualifications:

Education: Bachelor of Science in Physical Therapy from an American Physical Therapy Association approved program.

Licensure: Current State License as a Physical Therapist, current State Drivers License

Experience: Two years experience as a Physical Therapist in an acute care or rehabilitation setting.

Skills: Therapy skills as defined as generally accepted standards of practice. Good interpersonal skills. Proof of Hepatitis profile. Knowledge of durable medical equipment.

Transportation: Reliable transportation and valid and current auto liability insurance

Environmental and Working Conditions:

Works in a health care facility or patients home in various conditions; possible exposure to blood and bodily fluids and infectious diseases; ability to work flexible schedule; ability to travel locally; some exposure to unpleasant weather.

Physical and Mental Effort:

Ability to do heavy lifting, bending, pulling, pushing and standing. Prolonged standing and walking required. Requires working under some stressful conditions to meet deadlines and patient needs and to meet patient/family individualized psycho social needs. Requires hand-eye coordination and manual dexterity.

Essential Functions:

Evaluation

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| Perform initial and ongoing clinical assessments to identify patient needs, determine level of functioning, including assessments at appropriate time points and appropriateness of patient for hospice. | |
| Develop and revise a Plan of Care in consultation with the physician and other IDT members. | |
| Provide therapeutic treatments and evaluation of equipment needs as applicable. | |
| Evaluate outcomes of care with appropriate discharge planning. | |
| Apply concepts of infection control and standard precautions in coordinating/performing patient care activities to prevent contamination and transmission of disease. | |
| Accept clinical assignments that are consistent with education and competence to care for patients. | |
| Supervise PTA as appropriate. | |
| Complete appropriate documentation in a timely manner. | |
| Meet mandatory continuing education requirements of the agency/licensing board and participate in in-service programs. | |
| Use effective interpersonal relations and communication skills to advise and consult with the family and other agency personnel as appropriate. | |
| Promote Agency philosophy and administrative policies. | |
| Demonstrate commitment, professional growth and competency | |

Statement of Understanding: I have read the above job description and essential functions. I understand and agree to carry out these responsibilities as assigned. I understand and acknowledge that nothing contained in this job description may be construed as limiting the employer's right to discipline or terminate my employment at any time for failure to perform satisfactorily.

Employee Signature: _____ **Date:** _____

Employer Signature: _____ **Date:** _____

(For Job Description)

Evaluation Codes: 1-Does not meet job requirements/expectations 2-Occasionally meets job requirement

3-Normally meets job requirements 4-Meets and occasionally exceeds job requirements 5-Regularly exceeds job requirements

Performance Evaluation Addendum

90 Day

Annual

Date On Site Supervisory Visit Completed: _____ (form attached).

Comments/Goals Met or Not Met for this evaluation period: _____

Employer/Employee Mutual Goals set for the next evaluation period: _____

Employee Comments/Response: _____

Employee Signature: _____ **Date:** _____
(For Employer Evaluation / Employee Self Evaluation)

Evaluator/Title: _____ **Date:** _____