AGENDA ITEM B

CALIFORNIA BOARD OF OCCUPATIONAL THERAPY

PROPOSED AMENDED REGULATORY LANGUAGE
Title 16, Division 39, California Code of Regulations

Proposed amendments are shown by strikeout for deleted text and underline for new text.

Add section 4122 to and renumber section 4123 to 4124, Article 4 of Division 39 of Title 16 of the California Code of Regulations to read as follows:

Article 3. License, Certificate, ~~Limited Permit,~~ Inactive Status

4123. ~~Limited Permit~~ Retired Status
(a) A holder of an occupational therapy or occupational therapy assistant license that is current and active, ~~or capable of being renewed pursuant to Business and Professions Code Section 2510 and California Code of Regulations (CCR) Sections 4120 through 4130~~, and whose license is not suspended, revoked, or otherwise restricted by the board or subject to discipline, may apply for a retired license, upon application and payment of a twenty-five dollar ($25) fee.
(b) The application shall be on a form prescribed by the board and contain a certification statement from the licensee whether he or she has been disciplined by another public agency or been convicted or plead nolo contendere to any violation of any state in the Unites States or foreign country.
(c) Submission of a complete application and payment of the retirement fee shall not result in an update to the expiration date of the license.
~~(b)~~ (d) The holder of a retired license shall not engage in any activity for which an active license is required.
~~(c)~~ (e) An occupational therapist holding a retired license shall be permitted to use the title "occupational therapist, retired" or "retired occupational therapist." An occupational therapy assistant holding a retired license shall be permitted to use the title "occupational therapy assistant, retired" or "retired occupational therapy assistant." The designation of retired shall not be abbreviated in any way.
~~(d)~~ (f) The holder of a retired license shall not be required to renew that license.
~~(e)~~ (g) In order for the holder of a retired license issued pursuant to this section to restore his or her license, ~~he or she shall comply with BPC Section 2570.14~~ the following conditions must be met:
(1) The holder's license shall not have expired for a period in excess of five (5) years.
(2) The holder shall submit a renewal application and pay all accrued back renewal fees and a delinquent fee.
(3) The holder shall have completed twenty four (24) PDUs within the two-year period preceeding the date the renewal application is filed.
(h) The holder of a retired license whose license has expired for a period in excess of five (5) years shall not be permitted to renew the license, the holder must submit a new application for licensure and shall comply with BPC Section 2570.14.

(i) The hoder of a retired license that has expired for a period in excess of five (5) years shall be permitted to use the titles specifies in subsection (e). The board shall not purge a retired license record from its licensing data system in order to maintain a public record that the retired license holder is permitted to use the titles specified in subsection (e).

Authority cited: Sections 462, 700, 701, 702, 703, 704, 2570.10, and 2570.11, Business and Professions Code; Reference: Sections 2570.14, 2570.16 and 2570.17, Business and Professions Code.

Article 3.5 Limited Permits

4124. Limited Permits

(a) To qualify for a limited permit, a person must have applied to the National Board for Certification in Occupational Therapy (NBCOT) to take the licensing examination within four (4) months of completing the education and fieldwork requirements for licensure or certification.
(1) Upon receipt from NBCOT, the applicant must forward to the Board a copy of the Authorization to Test (ATT) letter.
(2) A limited permit shall only be valid for three (3) months from the date of issuance by the Board, upon receipt of a failing result, or two (2) weeks following the expiration of the applicants' eligibility to test period, whichever occurs first.
(3) The limited permit holder must immediately notify the Board of the results of the examination.
(4) The limited permit holder must provide to the Board the name, address and telephone number of his or her employer and the name and license number of his or her supervising occupational therapist (OT). Any change of employer or supervising OT must be provided to the Board, in writing, within 10 days of the change.
(b) The limited permit will be cancelled, and the fee forfeited, upon notification to the Board or the limited permit holder by the test administrator that the holder failed to pass the first examination.

AGENDA ITEM C

CALIFORNIA BOARD OF OCCUPATIONAL THERAPY
PROPOSED AMENDED REGULATORY LANGUAGE
Title 16, Division 39, California Code of Regulations

Proposed amendments are shown by strikeout for deleted text and underline for new text.

Article 9. Supervision of Occupational Therapy Assistants, Limited Permit Holders, Students, and Aides

§ 4180. Definitions

In addition to the definitions found in Business and Professions Code sections 2570.2 and 2570.3 the following terms are used and defined herein:
(a) "Client related tasks" means tasks performed as part of occupational therapy services rendered directly to the client.
(b) "Level I student" means an occupational therapy or occupational therapy assistant student participating in activities designed to introduce him or her to fieldwork experiences and develop an understanding of the needs of clients.
(c) "Level II student" means an occupational therapy or occupational therapy assistant student participating in delivering occupational therapy services to clients with the goal of developing competent, entry-level practitioners.
(d) "Level II fieldwork educator" means a licensed occupational therapist or occupational therapy assistant who has a minimum of one year of practice experience following issuance of a license or other authorization to practice issued by another state regulatory board.
(e) "Non-client related tasks" means clerical and secretarial activities; transportation of patients/clients; preparation or maintenance of treatment equipment and work area; taking care of patient/client personal needs during treatments; and assisting in the construction of adaptive equipment and splints.
(f) "Periodic" means at least once every 30 days.
(g) "Clinical supervision," as used in this article, refers to those activities included in the American Occupational Therapy Association's document entitled "Standards of Practice for Occupational Therapy" (Adopted 2010), incorporated herein by reference.

Note: Authority cited: Sections 2570.13 and 2570.20, Business and Professions Code. Reference: Sections 2570.2, 2570.3, 2570.4, 2570.5, 2570.6, and 2570.13, Business and Professions Code.

§ 4184. Delegation of Tasks to Aides.

(a) The primary function of an aide in an occupational therapy setting is to perform routine tasks related to occupational therapy services. Non-client related tasks may be delegated to an aide when the supervising occupational therapy practitioner has determined that the person has been appropriately trained and has supportive documentation for the performance of the services.
(b) Client related tasks that may be delegated to an aide include specifically selected routine aspects of an intervention session. In addition to the requirements of Code section 2570.2, subdivisions (a) and (b), the following factors must be present when an occupational therapist delegates a selected aspect of an intervention to an aide:

(1) The outcome anticipated for the aspects of the intervention session being delegated is predictable.
(2) The situation of the client and the environment is stable and will not require that judgment or adaptations be made by the aide.
(3) The client has demonstrated previous performance ability in executing the task.
(4) The aide has demonstrated competence in the task, routine and process.
(c) The supervising occupational therapist shall not delegate to an aide the following tasks:
(1) Performance of occupational therapy evaluative procedures;
(2) Initiation, planning, adjustment, or modification of treatment procedures.
(3) Acting on behalf of the occupational therapist in any matter related to occupational therapy treatment that requires decision making.
~~(d) All documented client related services shall be reviewed and cosigned by the supervising occupational therapist.~~

Note: Authority cited: Sections 2570.13 and 2570.20, Business and Professions Code. Reference: Sections 2570.2, 2570.4 and 2570.13, Business and Professions Code

§ 4187. Supervision Plan for an Occupational Therapist
An occupational therapy assistant in an administrative role related to the provision of occupational therapy services shall only provide administrative services pursuant to a documented plan for the clinical supervision of any occupational therapy practitioner providing those occupational therapy services. This document shall include provisions for ongoing and formal evaluation of clinical performance, and must be available at time of hire, contract negotiation, and upon request.

Note: Authority: Sections 2570.13 and 2570.20, Business and Professions Code. Reference: Sections 2570.2, 2570.4 and 2570.13, Business and Professions Code.

22 CA ADC § 72417

22 CCR § 72417

Cal. Admin. Code tit. 22, § 72417

Barclays Official California Code of Regulations Currentness
Title 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies (Refs & Annos)
Chapter 3. Skilled Nursing Facilities
Article 4. Optional Services
➡§ 72417. Occupational Therapy Service Unit -Staff.

(a) The occupational therapy service unit shall be under the direction of an occupational therapist.

(b) An occupational therapy assistant shall work only under the supervision of an occupational therapist.

(c) There shall be occupational therapists and occupational therapy assistants in the number to meet the identified needs of the patients.

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

22 CCR § 72417, 22 CA ADC § 72417
This database is current through 10/14/11 Register 2011, No. 41
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22 CA ADC § 72415

22 CCR § 72415

Cal. Admin. Code tit. 22, § 72415

Barclays Official California Code of Regulations Currentness
Title 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies (Refs & Annos)
Chapter 3. Skilled Nursing Facilities
Article 4. Optional Services
➡§ 72415. Occupational Therapy Service Unit -Policies and Procedures.

(a) Each occupational therapy service unit shall have written policies and procedures for the management of the occupational therapy service.

(b) The policies and procedures shall be established and implemented by the patient care policy committee in consultation with an occupational therapist.

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

22 CCR § 72415, 22 CA ADC § 72415
This database is current through 10/14/11 Register 2011, No. 41
END OF DOCUMENT

22 CA ADC § 72417

22 CCR § 72417

Cal. Admin. Code tit. 22, § 72417

Barclays Official California Code of Regulations Currentness
Title 22. Social Security
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22 CCR § 72417, 22 CA ADC § 72417
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AGENDA ITEM D

§ 4150. Definitions

For the purpose of this article:
(a) "ACOTE" means the Accreditation Council for Occupational Therapy Education.
(b) "Post professional education and training" means education and training obtained subsequent to the qualifying degree program or beyond current ACOTE standards for the qualifying degree program.
(c) "Contact hour" means sixty (60) minutes of coursework or classroom instruction.
(d) "Semester unit" means fifteen (15) contact hours.
(e) "Quarter unit" means ten (10) contact hours.
(f) "Rehabilitation of the hand, wrist, and forearm" as used in Code section 2570.2(l) refers to occupational therapy services performed as a result of surgery or injury to the hand, wrist, or forearm.
(g) "Upper extremity" as used in Code section 2570.3(e) includes education relating to the hand, wrist, or forearm.
(h) "Swallowing" as used in Code section 2570.3 is the passage of food, liquid, or medication through the pharyngeal and esophageal phases of the swallowing process.
(i) "Instrumental evaluation" is the assessment of any aspect of swallowing using imaging studies that include, but are not limited to, endoscopy and videofluoroscopy.
(1) "Endoscopic evaluation of swallowing" or "endoscopy" is the process of observing structures and function of the swallowing mechanism to include the nasopharynx, oropharynx, and hypopharynx.
(2) "Videofluoroscopic swallowing study" or "videofluoroscopy" is the fluoroscopic recording and videotaping of the anatomy and physiology of the oral cavity, pharynx, and upper esophagus using a variety of bolus consistencies to assess swallowing function. This procedure may also be known as videofluorography, modified barium study, oral-pharyngeal motility study and videoradiography.

Note: Authority Cited: Sections 2570.3 and 2570.20, Business and Professions Code. Reference: Sections 2570.2 and 2570.3, Business and Professions Code

ACCREDITATION STANDARDS FOR A DOCTORAL-DEGREE-LEVEL EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPIST (Effective 1/1/08)		ACCREDITATION STANDARDS FOR A MASTER'S-DEGREE-LEVEL EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPIST (Effective 1/1/08)		ACCREDITATION STANDARDS FOR AN EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPY ASSISTANT (Effective 1/1/08)	
B.5.13.	Explain the use of superficial thermal and mechanical modalities as a preparatory measure to improve occupational performance, including foundational knowledge, underlying principles, indications, contraindications, and precautions. Demonstrate safe and effective application of superficial thermal and mechanical modalities.	B.5.13.	Explain the use of superficial thermal and mechanical modalities as a preparatory measure to improve occupational performance, including foundational knowledge, underlying principles, indications, contraindications, and precautions. Demonstrate safe and effective application of superficial thermal and mechanical modalities.	B.5.13.	Recognize the use of superficial thermal and mechanical modalities as a preparatory measure to improve occupational performance. Based on the intervention plan, demonstrate safe and effective administration of superficial thermal and mechanical modalities to achieve established goals while adhering to contraindications and precautions.
SKILLS, KNOWLEDGE, AND COMPETENCIES FOR ENTRY-LEVEL PRACTICE ARE DERIVED FROM AOTA PRACTICE DOCUMENTS AND NBCOT PRACTICE ANALYSIS STUDIES. SUPERFICIAL THERMAL MODALITIES INCLUDE, BUT ARE NOT LIMITED TO, HYDROTHERAPY/WHIRLPOOL, CRYOTHERAPY (COLD PACKS, ICE), FLUIDOTHERAPY™, HOT PACKS, PARAFFIN, WATER, AND INFRARED. MECHANICAL MODALITIES INCLUDE, BUT ARE NOT LIMITED TO, VASOPNEUMATIC DEVICES AND CONTINUOUS PASSIVE MOTION (CPM). *THE WORD "DEMONSTRATE" DOES NOT REQUIRE THAT A STUDENT ACTUALLY PERFORMS THE TASK TO VERIFY KNOWLEDGE AND UNDERSTANDING. THE PROGRAM MAY SELECT THE TYPES OF LEARNING ACTIVITIES AND ASSESSMENTS THAT WILL INDICATE COMPLIANCE WITH THE STANDARD.* *FOR THOSE INSTITUTIONS IN STATES WHERE REGULATIONS RESTRICT THE USE OF PHYSICAL AGENT MODALITIES, IT IS RECOMMENDED THAT STUDENTS BE EXPOSED TO THE MODALITIES OFFERED IN PRACTICE TO ALLOW STUDENTS KNOWLEDGE AND EXPERIENCE WITH THESE MODALITIES IN PREPARATION FOR THE NBCOT EXAMINATION AND FOR PRACTICE OUTSIDE OF THE STATE IN WHICH THE EDUCATIONAL INSTITUTION RESIDES.*					
B.5.14.	Explain the use of deep thermal and electrotherapeutic modalities as a preparatory measure to improve occupational performance, including indications, contraindications, and precautions.	B.5.14.	Explain the use of deep thermal and electrotherapeutic modalities as a preparatory measure to improve occupational performance, including indications, contraindications, and precautions.		
SKILLS, KNOWLEDGE, AND COMPETENCIES FOR ENTRY-LEVEL PRACTICE ARE DERIVED FROM AOTA PRACTICE DOCUMENTS AND NBCOT PRACTICE ANALISIS STUDIES. DEEP THERMAL MODALITIES INCLUDE, BUT ARE NOT LIMITED TO, THERAPEUTIC ULTRASOUND AND PHONOPHORESIS. ELECTROTHERAPEUTIC MODALITIES INCLUDE, BUT ARE NOT LIMITED TO, BIOFEEDBACK, NEUROMUSCULAR ELECTRICAL STIMULATION, FUNCTIONAL ELECTRICAL STIMULATION, TRANSCUTANEOUS ELECTRICAL NERVE STIMULATIO, ELECTRICAL STIMULATION FOR TISSUE REPAIR, HIGH-VOLTAGE GALVANIC STIMULATION, AND IONTOPHORESIS.					
B.5.15.	Develop and promote the use of appropriate home and community programming to support performance in the client's natural environment and participation in all contexts relevant to the client.	B.5.15.	Develop and promote the use of appropriate home and community programming to support performance in the client's natural environment and participation in all contexts relevant to the client.	B.5.14.	Promote the use of appropriate home and community programming to support performance in the client's natural environment and participation in all contexts relevant to the client.
B.5.16.	Demonstrate the ability to educate the client, caregiver, family, significant others, and communities to facilitate skills in areas of occupation as well as prevention, health maintenance, and safety.	B.5.16.	Demonstrate the ability to educate the client, caregiver, family, and significant others to facilitate skills in areas of occupation as well as prevention, health maintenance, and safety.	B.5.15.	Demonstrate the ability to educate the client, caregiver, family, and significant others to facilitate skills in areas of occupation as well as prevention, health maintenance, and safety.

FULL-TIME EQUIVALENT: a position for a full-time faculty member (as defined by the institution) responsible for contributing to the functioning of the program through a variety of mechanisms, including, but not limited to, teaching, advising, and committee work.

HABITS: "autonomic behavior that is integrated into more complex patterns that enable people to function on a day to day basis..." (Neidstadt & Crepeau, 1998).

HIGHER EDUCATION: includes all degree-granting institutions at levels beyond high school. These institutions are generally divided into community (two year) colleges, colleges, and universities.

> **COMMUNITY COLLEGE**: these institutions offer two year programs, generally in applied areas. Students who complete the prescribed curriculum are awarded an associate's degree. Occupational therapy assistant programs are generally housed in community colleges and students typically receive an Associate of Applied Science (AAS) degree or an Associate of Science (AS) degree.
>
> **COLLEGE**: these institutions offer primarily four year programs leading to baccalaureate degrees. They may offer some master's programs, the first post-graduate degree level. Entry-level master's programs lead to the degree of Master of Science, Master of Arts in Occupational Therapy, or Master of Occupational Therapy depending upon the institution and the curriculum.
>
> **UNIVERSITIES**: these institutions award baccalaureate and master's degrees (and some may have some associate degree programs). In addition, they offer programs at the doctoral level.
>
> **PUBLIC VS. PRIVATE INSTITUTIONS**: public institutions receive a considerable portion of their operating budget from the state or county in which they are located and are subject to control by governmental bodies. Private institutions receive their funding from tuition and fund raising. They are subject to less governmental control.
>
> **VICE PRESIDENT FOR ACADEMIC AFFAIRS**: the chief academic officer of the campus. A member of the President's cabinet; working with the faculty and having responsibility for setting academic directions. Other units, related to the academic area (e.g., library, academic advising, academic computing, registrar) may also report to the VPAA, but this varies from campus to campus. Sometimes the academic area is headed by a person called a Provost; the position is generally similar to that described here.

ACADEMIC DEANS: if the college or university is large, it may be divided into academic divisions or schools (clusters of related departments). Each division is headed by a dean; the deans report to the Vice President for Academic Affairs.

MENTORING: a relationship between two people in which one person (the mentor) is dedicated to the personal and professional growth of the other (the mentee). A mentor has more experience and knowledge than the mentee.

MISSION: the statement which explains the unique nature of the program and how it helps fulfill or advances the mission of the sponsoring institution.

MODALITIES: application of a therapeutic agent, usually a physical agent modality.

> **DEEP THERMAL MODALITIES**: include therapeutic ultrasound and phonophoresis.
>
> **ELECTROTHERAPEUTIC MODALITIES**: include biofeedback, neuromuscular electrical stimulation, functional electrical stimulation, transcutaneous electrical nerve stimulation, electrical stimulations for tissue repair, high-voltage galvanic stimulation, and iontophoresis.
>
> **MECHANICAL MODALITIES**: include vasopneumatic devices and continuous passive motion.
>
> **SUPERFICIAL THERMAL MODALITIES**: include hydrotherapy, whirlpool, cryotherapy, fluidotherapy, hot packs, paraffin, water, and infrared.

AGENDA ITEM E

Business and Professions Code Section 2570.2

(k) "Practice of occupational therapy" means the therapeutic use of purposeful and meaningful goal-directed activities (occupations) which engage the individual's body and mind in meaningful, organized, and self-directed actions that maximize independence, prevent or minimize disability, and maintain health. Occupational therapy services encompass occupational therapy assessment, treatment, education of, and consultation with, *individuals who have been referred for* occupational therapy services subsequent to diagnosis of disease or disorder (or who are receiving occupational therapy services as part of an Individualized Education Plan (IEP) pursuant to the federal Individuals with Disabilities Education Act (IDEA)).

Occupational therapy assessment identifies performance abilities and limitations that are necessary for self-maintenance, learning, work, and other similar meaningful activities. Occupational therapy treatment is focused on developing, improving, or restoring functional daily living skills, compensating for and preventing dysfunction, or minimizing disability. Occupational therapy techniques that are used for treatment involve teaching activities of daily living (excluding speech-language skills); designing or fabricating selective temporary orthotic devices, and applying or training in the use of assistive technology or orthotic and prosthetic devices (excluding gait training). Occupational therapy consultation provides expert advice to enhance function and quality of life. Consultation or treatment may involve modification of tasks or environments to allow an individual to achieve maximum independence. Services are provided individually, in groups, or through social groups.

STANDARDS OF PRACTICE FOR OCCUPATIONAL THERAPY

This document defines minimum standards for the practice of occupational therapy. The practice of occupational therapy means the therapeutic use of everyday life activities (occupations) with individuals, groups, organizations, and populations for the purpose of participation in roles and situations in the home, school, workplace, community, or other settings. Occupational therapy services are provided for the purpose of promoting health and wellness and to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. Occupational therapy addresses physical, cognitive, psychosocial, sensory, communication, and other areas of performance in various contexts and environments in everyday life activities that affect health, well-being, and quality of life (American Occupational Therapy Association [AOTA], 2004). The overarching goal of occupational therapy is "to support [people's] health and participation in life through engagement in occupations" (AOTAa, 2008, p. 626).

The *Standards of Practice for Occupational Therapy* are requirements for occupational therapists and occupational therapy assistants for the delivery of occupational therapy services. *The Reference Manual of Official Documents of the American Occupational Therapy Association, Inc.* (current version as of press time, AOTA, 2009b) contains documents that clarify and support occupational therapy practice, as do various issues of the *American Journal of Occupational Therapy.* These documents are reviewed and updated on an ongoing basis for their applicability.

Education, Examination, and Licensure Requirements

All occupational therapists and occupational therapy assistants must practice under federal and state law.

To practice as an occupational therapist, the individual trained in the United States

- Has graduated from an occupational therapy program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE®) or predecessor organizations;
- Has successfully completed a period of supervised fieldwork experience required by the recognized educational institution where the applicant met the academic requirements of an educational program for occupational therapists that is accredited by ACOTE® or predecessor organizations;
- Has passed a nationally recognized entry-level examination for occupational therapists; and
- Fulfills state requirements for licensure, certification, or registration.

To practice as an occupational therapy assistant, the individual trained in the United States

- Has graduated from an occupational therapy assistant program accredited by ACOTE® or predecessor organizations;

- Has successfully completed a period of supervised fieldwork experience required by the recognized educational institution where the applicant met the academic requirements of an educational program for occupational therapy assistants that is accredited by ACOTE® or predecessor organizations;
- Has passed a nationally recognized entry-level examination for occupational therapy assistants; and
- Fulfills state requirements for licensure, certification, or registration.

Definitions

The following definitions are used in this document:

- ***Activity (Activities):*** A class of human behaviors that are goal directed.
- ***Assessment:*** Specific tools or instruments that are used during the evaluation process.
- ***Client:*** The entity that receives occupational therapy services. Clients may include (1) individuals and other persons relevant to the individual's life, such as family, caregivers, teachers, employers, and others who also may help or be served indirectly; (2) organizations such as business, industry, or agencies; and (3) populations within a community (Moyers & Dale, 2007).
- ***Evaluation:*** The process of obtaining and interpreting data necessary for intervention. This includes planning for and documenting the evaluation process and results.
- ***Intervention:*** The process and skilled actions taken by occupational therapy practitioners in collaboration with the client to facilitate engagement in occupation related to health and participation. The intervention process includes the plan, implementation, and review.
- ***Occupation:*** "Goal-directed pursuits that typically extend over time, have meaning to their performance, and involve multiple tasks" (Christiansen, Baum, & Bass-Haugen, 2005, p. 548); "all the things that people want, need, or have to do, whether of a physical, mental, social, sexual, political, spiritual, or any other nature, including sleep and rest activities." (Wilcock & Townsend, 2009, p. 193); "activities of everyday life named, organized, and given meaning by individuals and a culture" (Law, Polatajko, Baptiste, & Townsend, 1997, p. 32).
- ***Outcomes:*** What occupational therapy actually achieves for the client. Changes desired by the client that can focus on any area of the client's occupational performance.
- ***Re-evaluation:*** The process of critical analysis of client response to intervention. This analysis enables the therapist to make any necessary changes to intervention plan in collaboration with the client.
- ***Screening:*** Obtaining and reviewing data relevant to a potential client to determine the need for further evaluation and intervention.

- ***Transitions:*** Transitions are "actions coordinated to prepare for or facilitate a change, such as from one functional level to another, from one life [change] to another, from one program to another, or from one environment to another"(AOTA, 1998, p. 866).

Standard I. Professional Standing and Responsibility

1. An occupational therapy practitioner (occupational therapist or occupational therapy assistant) delivers occupational therapy services that reflect the philosophical base of occupational therapy and are consistent with the established principles and concepts of theory and practice.
2. An occupational therapy practitioner is knowledgeable about and delivers occupational therapy services in accordance with AOTA standards, policies, and guidelines and state, federal, and other regulatory and payer requirements relevant to practice and service delivery.
3. An occupational therapy practitioner maintains current licensure, registration, or certification as required by law or regulation.
4. An occupational therapy practitioner abides by the *Occupational Therapy Code of Ethics* (AOTA, 2005a).
5. An occupational therapy practitioner abides by the *Standards for Continuing Competence* (AOTA, 2005b) by establishing, maintaining, and updating professional performance, knowledge, and skills.
6. An occupational therapist is responsible for all aspects of occupational therapy service delivery and is accountable for the safety and effectiveness of the occupational therapy service delivery process (AOTA, 2009a).
7. An occupational therapy assistant is responsible for providing safe and effective occupational therapy services under the supervision of and in partnership with the occupational therapist and in accordance with laws or regulations and AOTA documents (AOTA, 2009a).
8. An occupational therapy practitioner maintains current knowledge of legislative, political, social, cultural, societal, and reimbursement issues that affect clients and the practice of occupational therapy.
9. An occupational therapy practitioner is knowledgeable about evidence-based research and applies it ethically and appropriately to provide occupational therapy services consistent with best practice approaches.
10. An occupational therapy practitioner respects the client's sociocultural background and provides client-centered and family-centered occupational therapy services.

Standard II. Screening, Evaluation, and Re-evaluation

1. An occupational therapist is responsible for all aspects of the screening, evaluation, and re-evaluation process.

2. An occupational therapist accepts and responds to referrals in compliance with state or federal laws, other regulatory and payer requirements, and AOTA documents.

3. An occupational therapist, in collaboration with the client, evaluates the client's ability to participate in daily life by considering the client's history, goals, capacities, and needs; the activities and occupations the client wants and needs to perform; and the environments and context in which these activities and occupations occur.

4. An occupational therapist initiates and directs the screening, evaluation, and re-evaluation process and analyzes and interprets the data in accordance with federal and state law, other regulatory and payer requirements, and AOTA documents.

5. An occupational therapy assistant contributes to the screening, evaluation, and re-evaluation process by implementing delegated assessments and by providing verbal and written reports of observations and client capacities to the occupational therapist in accordance with federal and state laws, other regulatory and payer requirements, and AOTA documents.

6. An occupational therapy practitioner uses current assessments and assessment procedures and follows defined protocols of standardized assessments during the screening, evaluation, and re-evaluation process.

7. An occupational therapist completes and documents occupational therapy evaluation results. An occupational therapy assistant contributes to the documentation of evaluation results. An occupational therapy practitioner abides by the time frames, formats, and standards established by practice settings, federal and state law, other regulatory and payer requirements, external accreditation programs, and AOTA documents.

8. An occupational therapy practitioner communicates screening, evaluation, and re-evaluation results within the boundaries of client confidentiality and privacy regulations to the appropriate person, group, organization, or population.

9. An occupational therapist recommends additional consultations or refers clients to appropriate resources when the needs of the client can best be served by the expertise of other professionals or services.

10. An occupational therapy practitioner educates current and potential referral sources about the scope of occupational therapy services and the process of initiating occupational therapy services.

Standard III. Intervention

1. An occupational therapist has overall responsibility for the development, documentation, and implementation of the occupational therapy intervention based on the evaluation, client goals, best available evidence, and professional and clinical reasoning.

2. An occupational therapist ensures that the intervention plan is documented within the time frames, formats, and standards established by the practice settings, agencies, external accreditation programs, state and federal law, and other regulatory and payer requirements.

3. An occupational therapy practitioner collaborates with the client to develop and implement the intervention plan, on the basis of the client's needs and priorities, safety issues, and relative benefits and risks of the interventions.

4. An occupational therapy practitioner coordinates the development and implementation of the occupational therapy intervention with the intervention provided by other professionals, when appropriate.

5. An occupational therapy practitioner uses professional and clinical reasoning to select the most appropriate types of interventions, including therapeutic use of self, therapeutic use of occupations and activities, consultation, education, and advocacy.

6. An occupational therapy assistant selects, implements, and makes modifications to therapeutic interventions that are consistent with the occupational therapy assistant's demonstrated competency and delegated responsibilities, the intervention plan, and requirements of the practice setting.

7. An occupational therapist modifies the intervention plan throughout the intervention process and documents changes in the client's needs, goals, and performance.

8. An occupational therapy assistant contributes to the modification of the intervention plan by exchanging information with and providing documentation to the occupational therapist about the client's responses to and communications throughout the intervention.

9. An occupational therapy practitioner documents the occupational therapy services provided within the time frames, formats, and standards established by the practice settings, agencies, external accreditation programs, federal and state laws, other regulatory and payer requirements, and AOTA documents.

Standard IV. Outcomes

1. An occupational therapist is responsible for selecting, measuring, documenting, and interpreting expected or achieved outcomes that are related to the client's ability to engage in occupations.

2. An occupational therapist is responsible for documenting changes in the client's performance and capacities and for transitioning the client to other types or intensity of service or discontinuing services when the client has achieved identified goals, reached maximum benefit, or does not desire to continue services.

3. An occupational therapist prepares and implements a transition or discontinuation plan based on the client's needs, goals, performance, and appropriate follow-up resources.

4. An occupational therapy assistant contributes to the transition or discontinuation plan by providing information and documentation to the supervising occupational therapist related to the client's needs, goals, performance, and appropriate follow-up resources.

5. An occupational therapy practitioner facilitates the transition or discharge process in collaboration with the client, family members, significant others, other professionals (e.g., medical, educational, or social services), and community resources, when appropriate.

6. An occupational therapist is responsible for evaluating the safety and effectiveness of the occupational therapy processes and interventions within the practice setting.

7. An occupational therapy assistant contributes to evaluating the safety and effectiveness of the occupational therapy processes and interventions within the practice setting.

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Note. These standards are intended as recommended guidelines to assist occupational therapy practitioners in the provision of occupational therapy services. These standards serve as a minimum standard for occupational therapy practice and are applicable to all individual populations and the programs in which these individuals are served.

SCOPE OF PRACTICE

Statement of Purpose
The purpose of this document is to define the scope of practice in occupational therapy in order to

1. delineate the domain of occupational therapy practice that directs the focus and actions of services provided by occupational therapists and occupational therapy assistants;
2. delineate the dynamic process of occupational therapy evaluation and intervention services to achieve outcomes that support the participation of clients in their everyday life activities (occupations);
3. describe the education and certification requirements to practice as an occupational therapist and occupational therapy assistant; and
4. inform consumers, health care providers, educators, the community, funding agencies, payers, referral sources, and policymakers regarding the scope of occupational therapy.

Introduction
The occupational therapy scope of practice is based on the American Occupational Therapy Association (AOTA) document *Occupational Therapy Practice Framework: Domain and Process* (AOTA, 2002) and on the *Philosophical Base of Occupational Therapy*, which states that "the understanding and use of occupations shall be at the central core of occupational therapy practice, education, and research" (AOTA, 2003a, Policy 1.11). Occupational therapy is a dynamic and evolving profession that is responsive to consumer needs and to emerging knowledge and research.

This scope of practice document is designed to support and be used in conjunction with the *Definition of Occupational Therapy Practice for the Model Practice Act* (AOTA, 2004a). While this scope of practice document helps support state laws and regulations that govern the practice of occupational therapy, it does not supercede those existing laws and other regulatory requirements. Occupational therapists and occupational therapy assistants are required to abide by statutes and regulations when providing occupational therapy services. State laws and other regulatory requirements typically include statements about educational requirements to practice occupational therapy, procedures to practice occupational therapy legally within the defined area of jurisdiction, the definition and scope of occupational therapy practice, and supervision requirements.

AOTA (1994) states that a referral is not "required for the provision of occupational therapy services" (p. 1034); however, a referral may be indicated by some state laws and other regulatory requirements. The AOTA 1994 document *Statement of Occupational Therapy Referral* states that "occupational therapists respond to requests for services, whatever their sources. They may accept and enter cases at their own professional discretion and based on their own level of competency" (p. 1034). Occupational therapy assistants provide services under the supervision of an occupational therapist. State laws and other regulatory requirements should be viewed as minimum criteria to practice occupational therapy. Ethical guidelines that ensure safe and effective delivery of occupational therapy services to clients always influence occupational therapy practice (AOTA, 2000).

Definition of Occupational Therapy

AOTA's *Definition of Occupational Therapy for the Model Practice Act* defines occupational therapy as

> 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 services are provided for the purpose of promoting health and wellness and to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. 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" (AOTA, 2004a).

Scope of Practice—The Domain and Process

The scope of practice includes the domain and process of occupational therapy services. These concepts are intertwined with the domain defining the focus of occupational therapy (see Figure 1) and the process defining the delivery of occupational therapy (see Figure 2). The domain of occupational therapy is the everyday life activities (occupations) that people find meaningful and purposeful. Within this domain, occupational therapy services enable clients to engage (participate) in their everyday life activities in their desired roles, context, and life situations. Clients may be individuals, groups, communities, or populations. The occupations in which clients engage occur throughout the life span and include

- activities of daily living (self-care activities);
- education (activities to participate as a learner in a learning environment);
- instrumental activities of daily living (multistep activities to care for self and others, such as household management, financial management, and childcare);
- leisure (nonobligatory, discretionary, and intrinsically rewarding activities);
- play (spontaneous and organized activities that promote pleasure, amusement, and diversion);
- social participation (activities expected of individuals or individuals interacting with others); and
- work (employment-related and volunteer activities)

DOMAIN OF OCCUPATIONAL THERAPY

Engagement in Occupation to Support Participation in Context or Contexts

Performance in Areas of Occupation

Activities of Daily Living (ADL)*
Instrumental Activities of Daily Living (IADL)
Education
Work
Play
Leisure
Social Participation

Performance Skills	**Performance Patterns**
Motor Skills	Habits
Process Skills	Routines
Communication/Interaction Skills	Roles

Context	**Activity Demands**	**Client Factors**
Cultural	Objects Used and Their Properties	Body Functions[1]
Physical	Space Demands	Body Structures[2]
Social	Social Demands	
Personal	Sequencing and Timing	
Spiritual	Required Actions	
Temporal	Required Body Functions	
Virtual	Required Body Structures	

*Also referred to as basic activities of daily living (BADL) and personal activities of daily living (PADL).

(AOTA, 2002, p. 611)
[1]Body Functions (e.g., neuromuscular, sensory, visual, perceptual, cognitive, mental)
[2]Body Structures (e.g., cardiovascular, digestive, integumentary systems)

Figure 1

Within this domain of practice, occupational therapists and occupational therapy assistants consider the repertoire of occupations in which the client engages, the performance skills and patterns the client uses, the contexts influencing engagement, the features and demands of the activity, and the client's body functions and structures. Occupational therapists and occupational therapy assistants use their knowledge and skills to help clients "attain and resume daily life activities that support function and health" throughout the lifespan (AOTA, 2002, p. 610). Participation in activities and occupations that are meaningful to the client involves emotional, psychosocial, cognitive, and physical aspects of performance. This participation provides a means to enhance health, well-being, and life satisfaction.

The domain of occupational therapy practice complements the World Health Organization's (WHO) conceptualization of participation and health articulated in the *International Classification of Functioning, Disability and Health* (*ICF*) (WHO, 2001). Occupational therapy incorporates the basic constructs of ICF, including environment, participation, activities, and body structures and functions, when addressing the complexity and richness of occupations and occupational engagement.

The process of occupational therapy relates to service delivery (see Figure 2) and includes evaluating, intervening, and targeting outcomes. Occupation remains central to the occupational therapy process. It is client-centered, involving collaboration with the client throughout each aspect of service delivery. During the evaluation, the therapist develops an occupational profile, analyzes the client's ability to carry out everyday life activities, and determines the client's occupational needs, problems, and priorities for intervention. Evaluation and intervention may address one or more of the domains (see Figure 1) that influence occupational performance. Intervention includes planning and implementing occupational therapy services and involves therapeutic use of self, activities, and occupations, as well as consultation and education. The occupational therapist and occupational therapy assistant utilize occupation-based theories, frames of reference, evidence, and clinical reasoning to guide the intervention (AOTA, 2002).

The outcome of occupational therapy intervention is directed toward "engagement [of the client] in occupations that support participation in [daily life situations] (AOTA, 2002, p. 618). Outcomes of the intervention determine future actions with the client. Outcomes include the client's occupational performance, role competence and adaptation, health and wellness, quality of life and satisfaction, and prevention initiatives (AOTA, 2002, p. 619).

COLLABORATIVE PROCESS MODEL

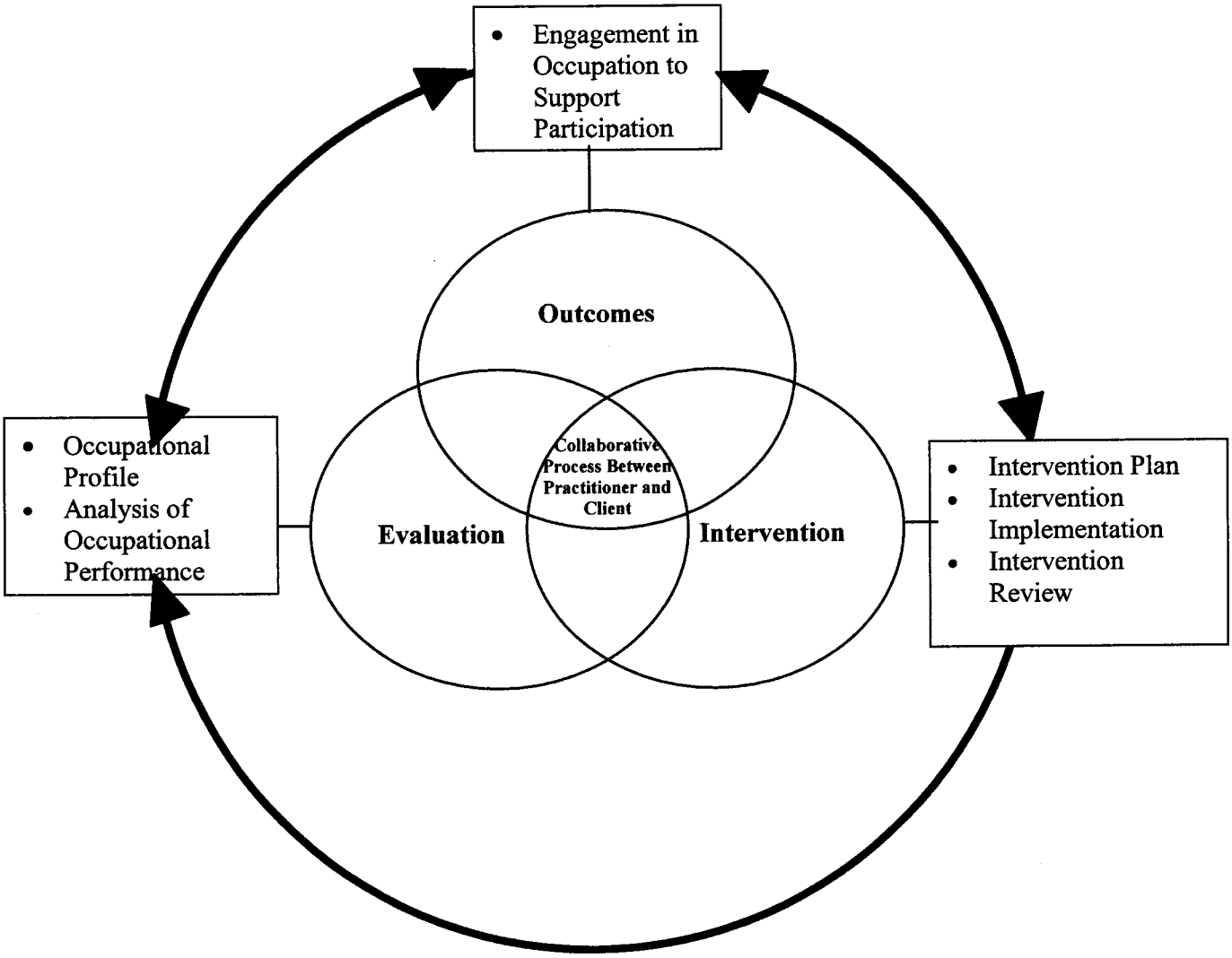

Figure 2: Illustration of the framework emphasizing client–practitioner interactive relationship and interactive nature of the service delivery process (AOTA 2002, 614).

Occupational Therapy Practice

Occupational therapists and occupational therapy assistants are experts at analyzing the performance skills and patterns necessary for people to engage in their everyday activities in the context in which those activities and occupations occur. The occupational therapist assumes responsibility for the delivery of all occupational therapy services and for the safety and effectiveness of occupational therapy services provided. The occupational therapy assistant delivers occupational therapy services under the supervision of and in partnership with the occupational therapist (AOTA, 2004b).

The practice of occupational therapy includes

A. Strategies selected to direct the process of interventions, such as
   1. Establishment, remediation, or restoration of a skill or ability that has not yet developed or is impaired.
   2. Compensation, modification, or adaptation of activity or environment to enhance performance.
   3. Maintenance and enhancement of capabilities without which performance in everyday life activities would decline.
   4. Health promotion and wellness to enable or enhance performance in everyday life activities.
   5. Prevention of barriers to performance, including disability prevention.

B. Evaluation of factors affecting activities of daily living (ADL), instrumental activities of daily living (IADL), education, work, play, leisure, and social participation, including
   1. Client factors, including body functions (e.g., neuromuscular, sensory, visual, perceptual, cognitive) and body structures (e.g., cardiovascular, digestive, integumentary, genitourinary systems).
   2. Habits, routines, roles, and behavior patterns.
   3. Cultural, physical, environmental, social, and spiritual contexts and activity demands that affect performance.
   4. Performance skills, including motor, process, and communication/interaction skills.

C. Interventions and procedures to promote or enhance safety and performance in activities of daily living (ADL), instrumental activities of daily living (IADL), education, work, play, leisure, and social participation, including
   1. Therapeutic use of occupations, exercises, and activities.
   2. Training in self-care, self-management, home management, and community/work reintegration.
   3. Development, remediation, or compensation of physical, cognitive, neuromuscular, sensory functions, and behavioral skills.
   4. Therapeutic use of self, including one's personality, insights, perceptions, and judgments, as part of the therapeutic process.
   5. Education and training of individuals, including family members, caregivers, and others.
   6. Care coordination, case management, and transition services.
   7. Consultative services to groups, programs, organizations, or communities.
   8. Modification of environments (home, work, school, or community) and adaptation of processes, including the application of ergonomic principles.

9. Assessment, design, fabrication, application, fitting, and training in assistive technology, adaptive devices, and orthotic devices, and training in the use of prosthetic devices.
10. Assessment, recommendation, and training in techniques to enhance functional mobility, including wheelchair management.
11. Driver rehabilitation and community mobility.
12. Management of feeding, eating, and swallowing to enable eating and feeding performance.
13. Application of physical agent modalities, and use of a range of specific therapeutic procedures (e.g., wound care management; techniques to enhance sensory, perceptual, and cognitive processing; manual therapy techniques) to enhance performance skills.

(AOTA, 2004a)

Site of Intervention

Along the continuum of service, occupational therapy services may be provided to clients throughout the life span in a variety of settings. The settings may include, but are not limited to, the following:

- Institutional settings (inpatient) (e.g., acute rehabilitation, psychiatric hospital, community and specialty focused hospitals, nursing facilities, prisons)
- Outpatient settings (e.g., hospitals, clinics, medical and therapy offices)
- Home and community settings (e.g., home care, group homes, assisted living, schools, early intervention centers, day-care centers, industry and business, hospice, sheltered workshops, wellness and fitness centers, community mental health facilities)
- Research facilities

Education and Certification Requirements

To practice as an occupational therapist, the individual

- must have graduated from an occupational therapy program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE®) or predecessor organizations[1], and
- must have successfully completed a period of supervised fieldwork experience required by the recognized educational institution where the applicant met the academic requirements of an educational program for occupational therapists that is accredited by ACOTE® or predecessor organization (AOTA, 2003b, Policy 5.3).
- must have successfully passed the national certification examination for occupational therapists and/or met state requirements for licensure/registration.

To practice as an occupational therapy assistant, the individual

- must have graduated from an associate- or certificate-level occupational therapy assistant program accredited by ACOTE® or predecessor organizations, and

[1] Foreign educated graduates of occupational therapy programs approved by the World Federation of Occupational therapy (WFOT) may also be eligible for certification/licensure as an occupational therapist provided additional requirements are met.

- must have successfully completed a period of supervised fieldwork experience required by the recognized educational institution where the applicant met the academic requirements of an educational program for occupational therapy assistants that is accredited by ACOTE® or predecessor organizations (AOTA, 2003b, Policy 5.3).
- must have successfully passed the national certification examination for occupational therapy assistants and/or met state requirements for licensure/registration.

AOTA supports licensure of qualified occupational therapists and occupational therapy assistants (AOTA, 2003b, Policy 5.3). State and other legislative or regulatory agencies may impose additional requirements to practice as an occupational therapist and occupational therapy assistants in their area of jurisdiction.

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STANDARDS OF PRACTICE FOR OCCUPATIONAL THERAPY

Preface

This document defines minimum standards for the practice of occupational therapy. The *Standards of Practice for Occupational Therapy* are requirements for occupational therapists and occupational therapy assistants for the delivery of occupational therapy services. *The Reference Manual of Official Documents* contains documents that clarify and support occupational therapy practice (American Occupational Therapy Association [AOTA, 2004]). These documents are reviewed and updated on an ongoing basis for their applicability.

Education, Examination, and Licensure Requirements

All occupational therapists and occupational therapy assistants must practice under federal and state law.

To practice as an occupational therapist, the individual trained in the United States

- has graduated from an occupational therapy program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE®) or predecessor organizations;
- has successfully completed a period of supervised fieldwork experience required by the recognized educational institution where the applicant met the academic requirements of an educational program for occupational therapists that is accredited by ACOTE® or predecessor organizations;
- has passed a nationally recognized entry-level examination for occupational therapists; and
- fulfills state requirements for licensure, certification, or registration.

To practice as an occupational therapy assistant, the individual trained in the United States

- has graduated from an associate- or certificate-level occupational therapy assistant program accredited by ACOTE® or predecessor organizations;
- has successfully completed a period of supervised fieldwork experience required by the recognized educational institution where the applicant met the academic requirements of an educational program for occupational therapy assistants that is accredited by ACOTE® or predecessor organizations;
- has passed a nationally recognized entry-level examination for occupational therapy assistants; and
- fulfills state requirements for licensure, certification, or registration.

Definitions

Assessment. Specific tools or instruments that are used during the evaluation process.

Client. A person, group, program, organization, or community for whom the occupational therapy practitioner is providing services.

Evaluation. The process of obtaining and interpreting data necessary for intervention. This includes planning for and documenting the evaluation process and results.

Screening. Obtaining and reviewing data relevant to a potential client to determine the need for further

evaluation and intervention.

Standard I: Professional Standing and Responsibility

1. An occupational therapy practitioner (occupational therapist or occupational therapy assistant) delivers occupational therapy services that reflect the philosophical base of occupational therapy and are consistent with the established principles and concepts of theory and practice.

2. An occupational therapy practitioner is knowledgeable about and delivers occupational therapy services in accordance with AOTA standards, policies, and guidelines, and state and federal requirements relevant to practice and service delivery.

3. An occupational therapy practitioner maintains current licensure, registration, or certification as required by law or regulation.

4. An occupational therapy practitioner abides by the AOTA *Occupational Therapy Code of Ethics* (AOTA, 2000).

5. An occupational therapy practitioner abides by the AOTA *Standards for Continuing Competence* (AOTA, 1999) by establishing, maintaining, and updating professional performance, knowledge, and skills.

6. An occupational therapist is responsible for all aspects of occupational therapy service delivery and is accountable for the safety and effectiveness of the occupational therapy service delivery process.

7. An occupational therapy assistant is responsible for providing safe and effective occupational therapy services under the supervision of and in partnership with the occupational therapist and in accordance with laws or regulations and AOTA documents.

8. An occupational therapy practitioner maintains current knowledge of legislative, political, social, cultural, and reimbursement issues that affect clients and the practice of occupational therapy.

9. An occupational therapy practitioner is knowledgeable about evidence-based research and applies it ethically and appropriately to the occupational therapy process.

Standard II: Screening, Evaluation, and Re-evaluation

1. An occupational therapist accepts and responds to referrals in compliance with state laws or other regulatory requirements.

2. An occupational therapist, in collaboration with the client, evaluates the client's ability to participate in daily life activities by considering the client's capacities, the activities, and the environments in which these activities occur.

3. An occupational therapist initiates and directs the screening, evaluation, and re-evaluation process and analyzes and interprets the data in accordance with law, regulatory requirements, and AOTA documents.

4. An occupational therapy assistant contributes to the screening, evaluation, and re-evaluation process by implementing delegated assessments and by providing verbal and written reports of observations and client capacities to the occupational therapist in accordance with law, regulatory requirements, and AOTA documents.

5. An occupational therapy practitioner follows defined protocols when standardized assessments are used.

6. An occupational therapist completes and documents occupational therapy evaluation results. An occupational therapy assistant contributes to the documentation of evaluation results. An occupational therapy practitioner abides by the time frames, formats, and standards established by practice settings, government agencies, external accreditation programs, payers, and AOTA documents.

7. An occupational therapy practitioner communicates screening, evaluation, and re-evaluation results within the boundaries of client confidentiality to the appropriate person, group, or organization.

8. An occupational therapist recommends additional consultations or refers clients to appropriate resources when the needs of the client can best be served by the expertise of other professionals or services.

9. An occupational therapy practitioner educates current and potential referral sources about the scope of occupational therapy services and the process of initiating occupational therapy services.

Standard III: Intervention

1. An occupational therapist has overall responsibility for the development, documentation, and implementation of the occupational therapy intervention based on the evaluation, client goals, current best evidence, and clinical reasoning.

2. An occupational therapist ensures that the intervention plan is documented within the time frames, formats, and standards established by the practice settings, agencies, external accreditation programs, and payers.

3. An occupational therapy assistant selects, implements, and makes modifications to therapeutic activities and interventions that are consistent with the occupational therapy assistant's demonstrated competency and delegated responsibilities, the intervention plan, and requirements of the practice setting.

4. An occupational therapy practitioner reviews the intervention plan with the client and appropriate others regarding the rationale, safety issues, and relative benefits and risks of the planned interventions.

5. An occupational therapist modifies the intervention plan throughout the intervention process and documents changes in the client's needs, goals, and performance.

6. An occupational therapy assistant contributes to the modification of the intervention plan by exchanging information with and providing documentation to the occupational therapist about the client's responses to and communications throughout the intervention.

7. An occupational therapy practitioner documents the occupational therapy services provided within the time frames, formats, and standards established by the practice settings, agencies, external accreditation programs, payers, and AOTA documents.

Standard IV: Outcomes

1. An occupational therapist is responsible for selecting, measuring, documenting, and interpreting expected or achieved outcomes that are related to the client's ability to engage in occupations.

2. An occupational therapist is responsible for documenting changes in the client's performance and capacities and for discontinuing services when the client has achieved identified goals, reached maximum benefit, or does not desire to continue services.

3. An occupational therapist prepares and implements a discontinuation plan or transition plan based on the client's needs, goals, performance, and appropriate follow-up resources.

4. An occupational therapy assistant contributes to the discontinuation or transition plan by providing information and documentation to the supervising occupational therapist related to the client's needs, goals, performance, and appropriate follow-up resources.

5. An occupational therapy practitioner facilitates the transition process in collaboration with the client, family members, significant others, team, and community resources and individuals, when appropriate.

6. An occupational therapist is responsible for evaluating the safety and effectiveness of the occupational therapy processes and interventions within the practice setting.

7. An occupational therapy assistant contributes to evaluating the safety and effectiveness of the occupational therapy processes and interventions within the practice setting.

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Adopted by the Representative Assembly 2005C218

NOTE: This document replaces the 1998 *Standards of Practice for Occupational Therapy*. These standards are intended as recommended guidelines to assist occupational therapy practitioners in the provision of occupational therapy services. These standards serve as a minimum standard for occupational therapy practice and are applicable to all individual populations and the programs in which these individuals are served.

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