CLINICAL COMPETENCY EVALUATION FORM

The purpose of completing the Clinical Performance Evaluation form by the supervisor(s) is to determine the knowledge and clinical skills of the applicant and to evaluate his/her overall performance as an eligibility requirement for VRT certification.

Objectives of Performance Rating:

1. To determine knowledge and clinical skills in the area of Vision Rehabilitation Therapy.

2. Objectively evaluate the applicant’s overall performance as an eligibility requirement for professional certification in Vision Rehabilitation Therapy.

Applicant’s Name: ____________________________________________________________

Name of Agency: _____________________________________________________________

Dates of Clinical Practice under CVRT Supervision (minimum of 350 hours required):

From: ___________________________ To: ______________________________

If the clinical practice is part-time, please indicate the number of hours per week.

Hours per week: _______

If the VRT applicant has completed the required clinical practice of 350 hours at more than one agency, please list the additional agencies (names of agencies, addresses, phone numbers, and dates of clinical practice)

Directions: For each knowledge area and skill listed please indicated if the applicant has performed at a professional rating of Acceptable or Not Acceptable. It is important that you impartially and objectively assess performance to ensure high quality delivery of service those who are visually impaired.

Section A

Rating Did the applicant:

1. Demonstrate appropriate interpersonal relationships
2 Demonstrate a working knowledge of the environmental influences upon client's behavior?

3 Demonstrate a working knowledge of teaching and learning principles?

4 Demonstrate a working knowledge of the concepts of blind rehabilitation?

5 Demonstrate a working knowledge of the dynamics of blindness?

6 Demonstrate a working knowledge of the function and physiology of the eye?

7 Demonstrate a working knowledge of physical and mentally disabling conditions?

8 Demonstrate a professional attitude and ethical behavior?

9 Demonstrate the ability to assess and evaluate learners needs and abilities in home, work and community environments?

10 Demonstrate the ability to select, design, and implement a sequential instructional plan?

11 Demonstrate knowledge of community, state and national resources?

12 Demonstrate the ability to write reports which synthesize written information as applicable to the learners' progress in reaching the goals and objectives of the rehabilitation teaching plans.

Section B
Did the applicant demonstrate the ability to instruct individuals who are blind or visually impaired in the following areas:

a. **Personal Management:**
   1) grooming skills
   2) care of clothing
   3) socialization skills
   4) adaptive eating technique
   5) personal record keeping
   6) financial management
   7) indoor orientation and movement
   8) health care and medical management

b. **Communication:**
   1) recording skills and use of talking book equipment
   2) keyboard/typing instruction
   3) handwriting instruction and use of writing devices
   4) integration and utilization of low vision devices
   5) utilization of assistive technology
   6) adapted calculators and/or abacus
   7) labeling and organization methods
   8) adaptive telephone devices, services and techniques
   9) utilization of time management, time devices, calendars and concepts
   10) alternative communication systems for individuals who are deaf-blind such as manual alphabet and print on Palm

c. **Braille and Alternative Tactual Systems:**
   1) Braille readiness activities
   2) contracted Braille reading
   3) contracted Braille writing with both Braille writer and slate and stylus

d. **Home Management:**
   1) nutrition and meal planning
   2) food preparation and shopping
   3) clothing management
   4) household organizing and maintenance
   5) safety techniques
If the applicant rates Not Acceptable in any of the areas under Section A and/or Section B, please explain:
______________________________________________________________________________
______________________________________________________________________________

If the applicant demonstrates superior strengths or qualities, please explain:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

I verify that the applicant has successfully completed a _____ hour internship (Applicants must complete a 350 hour internship).

I further verify that the applicant has completed _______ hours of direct service with consumers and/or family members (Category 2 Applicants must have completed a minimum of 260 hours of direct services with consumers and/or family members)

I would _____ would not _____ recommend the applicant for ACVREP certification.

**Statement of Integrity:** “I do hereby acknowledge that all the information submitted on this form is true and correct to the best of my knowledge and was completed in accordance with the Vision Rehabilitation Therapy Code of Ethics (see Appendix F). I understand that falsified information on this form is grounds for the denial of certification eligibility for the applicant.”

__________________________________________  _______________________
Signature of CVRT Supervisor                 Date

__________________________________________  _______________________
Name (please print)                               Title

Please return this completed Clinical Performance Evaluation form to the applicant so it can be included in his/her eligibility application packet.

If the internship was off-site, please answer the following questions:

1. How many hours of direct supervision were actually provided? _____
2. Do you have any suggestions for improving communication, etc. to ensure a successful internship for both parties? _____ Yes _____ No

If yes, please list your suggestions: