Adaptive Equipment Competency

Name: Kym Weeks **Work Location:** Jefferson

I certify that I have read, reviewed, and understand the following adaptive equipment policies and procedures.

☑Glasses	☐AFO
☐Contacts	☐Splints
☐ Dentures/ Oral Prosthetics	☑Shower Chair
☑Walker	☐Nebulizer*
☐Cane	☑Reclining Lift Chair
☑Hoyer Lift*	☐Stander*
☐ C-PAP	☐VNS Device*
☐Epi-Pen*	☐ G-Tube*
☐Glucometer and Lancets*	☐Inhaler*
☑Wheelchair	☑Adaptive Utensils
☐Gait Trainer*	☐Oral Braces
☐Hearing Aid(s)	☑Gait Belt
☑Braces (arm, leg, back)	☑Incontinence Products
☐TED Socks (compression stockings)	☐Insulin Pen*
☐Continuous Glucose Monitoring Device*	☐Insulin Pump*
☐Prosthetics	☐Other: _____
☐Oxygen Tank	☐Other: _____
☐Oxygen Concentrator	☐Other: _____
☐Helmet	☐Other: _____

*indicates must be trained by RN

Signature: Kymberly Weeks **Date:** 9/6/22