

Proof of Competency



Adaptive Equipment Review

Name: Bernie Bradshaw Work Location: 809

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

- | | |
|--|--|
| <input checked="" type="checkbox"/> Glasses | <input type="checkbox"/> AFO |
| <input type="checkbox"/> Contacts | <input type="checkbox"/> Splints |
| <input type="checkbox"/> Dentures/ Oral Prosthetics | <input type="checkbox"/> Shower Chair |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Nebulizer |
| <input type="checkbox"/> Cane | <input type="checkbox"/> Reclining Lift Chair |
| <input type="checkbox"/> Hoyer Lift | <input type="checkbox"/> Stander |
| <input type="checkbox"/> C-PAP | <input type="checkbox"/> VNS Device |
| <input type="checkbox"/> Epi-Pen | <input type="checkbox"/> G-Tube |
| <input type="checkbox"/> Glucometer and Lancets | <input type="checkbox"/> Inhaler |
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Adaptive Utensils |
| <input type="checkbox"/> Gait Trainer | <input type="checkbox"/> Oral Braces |
| <input type="checkbox"/> Hearing Aid(s) | <input type="checkbox"/> Gait Belt |
| <input type="checkbox"/> Braces (arm, leg, back) | <input type="checkbox"/> Incontinence Products |
| <input type="checkbox"/> TED Socks (compression stockings) | <input type="checkbox"/> Insulin Pen |
| <input type="checkbox"/> Prosthetics | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Oxygen Tank | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Oxygen Concentrator | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Helmet | |

Signature: Bernie Bradshaw DSP

Date: 10/30/2022