**CLINICAL COMPETENCY EVALUATION FORM**

**Applicant Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Agency/School**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information and signatures are required for each portion of the internship if it has not been completed at a single location. Use as many pages as needed to provide the information and signatures that are required on page 5 for each location and portion of the internship.**

Dates of Entire Program of O&M Clinical Practice:

**From \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Each of the following minimal competencies must be met during a minimum of 350 hours of discipline-specific supervised practice (e.g., internship(s) or student teaching in conjunction with the university program), under the Onsite supervision of a COMS or if prior approval has been obtained and Off-Site supervision of a COMS, as part of the ACVREP certification requirements. This evaluation form must be submitted with the application for certification. (It is strongly recommended that applicants for certification demonstrate clinical competence with various populations of individuals with blindness and low vision, including children, adults, and individuals with multiple disabilities.) Applicant must complete a minimum of 250 Instructional hours as part of this internship and no more than 50 of these hours may come from the category of lesson/material preparation and/or route scouting combined.

**Clinical or field placement hours may be accrued through a combination of coursework designated as practicum (pre-internship) and/or internship**.

**Instructional hours include time spent in the following endeavors:**

* Assessment of students in any of the domain areas identified in the Orientation and Mobility Scope of Practice
* Direct teaching of students in any of the domain areas identified in the Orientation and Mobility Scope of Practice
* Active participation in IEP, IWRP, assessment, or other formal meetings where the instructor is actively engaged in presenting information that will affect instruction provided to the student
* Providing direct consultation and training to parents, caregivers, teachers, and other related professionals
* Lesson/material preparation and/or route scouting

**Non-Instructional hours include, but are not limited to, time spent in the following endeavors:**

* Observation of lessons conducted by other COMS
* Report writing
* Attendance at conferences
* Travel to and from contact with a student
* Travel to conferences
* General staff meetings
* Supervision meetings
* Public education

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| # | **Description of Clinical Competency** | **Date Met (MM/DD/YYYY)** | **Supervising COMS****(Printed Name)** | **Supervising COMS (Signature)** |
|   | **Communication and Professional Relationships** |   |   |  |
| 1 | Candidate is able to establish and maintain effective communication and professional relationships with students, families, colleagues, and supervisors, including individuals from culturally and linguistically diverse backgrounds. |   |   |  |
|   | **O&M Assessment** |   |   |  |
| 2 | Candidate is able to plan and conduct individualized comprehensive O&M assessments, synthesize the findings in a professionally written report, and communicate results with students, families, and members of the individualized intervention/education/rehabilitation team, as appropriate. |   |   |  |
|   | **Instructional Planning** |   |   |  |
| 3 | Candidate is able to plan for individualized O&M instruction through the: |   |   |  |
| 3a | Review and interpretation of relevant records and reports. |   |   |  |
| 3b | Selection and preview of potential training areas (e.g., home, school, work or community). |   |   |  |
| 3c | Design and/or procurement of instructional materials and appropriate devices (with appropriate medical consultation regarding optical devices). |   |   |  |
| 3d | Provision of accurate information regarding options for mobility systems (e.g., long cane, dog guide, electronic travel devices) to the student and his/her family so that s/he can make informed choices regarding the most appropriate option for a given time. |   |   |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| # | **Description of Clinical Competency** | **Date Met (MM/DD/YYYY)** | **Supervising COMS****(Printed Name)** | **Supervising COMS (Signature)** |
| 3e  | Collaboration with the student, his/her family, and colleagues to developappropriate goals and behavioral objectives, and development and sequencing of individual lessons based on the student’s abilities, needs, and goals. |   |   |  |
|   | **Instruction** |  |  |  |
| 4 | Candidate is able to effectively teach and reinforce the following elements of O&M instruction across a range of environments (such as indoor, residential, and light business): |  |  |  |
| 4a | Concepts related to independent movement and orientation (such as body, laterality, directionality, spatial, environmental, and time-distance). |  |  |  |
| 4b | Mobility techniques, including, but not limited to, basic skills, cane skills, adapted mobility devices, route travel, street crossings, and the use of public and other transportation systems. |  |  |  |
| 4c | Orientation skills, including, but not limited to, use of cognitive processes; landmarks; cardinal directions; room, store, and community familiarization; address system; independent information gathering; route planning; and maps. |  |  |  |
| 4d | Use of low vision in maintaining safe and independent movement and orientation (such as the use of non-optical devices, use of optical devices in conjunction with eye care professionals, use of visual skills, and incorporating vision use with cane or other mobility systems). |  |  |  |
| 4e | Use of remaining senses (other than vision) in maintaining safe and independent movement and orientation (such as the use of auditory skills, reflected sound, tactile recognition, proprioceptive and kinesthetic awareness). |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| # |  **Description of Clinical Competency** | **Date Met (MM/DD/YYYY)** | **Supervising COMS****(Printed Name)** | **Supervising COMS (Signature)** |
|   | **Monitoring and Safety** |  |  |  |
| 5 | Candidate is able to effectively monitor orientation and mobility skills, recognize potentially dangerous situations, and intervene as appropriate to ensure student safety. |  |  |  |
|   | **Facilitating Independence** |  |  |  |
| 6 | Candidate is able to facilitate student independence and problem solving ability across a variety of travel situations, in familiar and unfamiliar environments. |  |  |  |
|   | **Professionalism** |  |  |  |
| 7 | Candidate demonstrates professional conduct consistent with the Code of Ethics for Orientation & Mobility Specialists, finds and accesses appropriate resources, keeps on-time scheduling, and follows and maintains appropriate record keeping and reporting procedures. |  |  |  |

**Please complete the information on the following page for each for each internship placement, attaching additional record sheets as necessary.**

**Record of On-Site Supervisor(s) or Off-Site COMS Supervisor(s) (if Onsite Supervisor is not a COMS)**

**If the internship was not completed in one location, the information on this page must be completed for each internship site.**

Name of Supervising COMS:

Name of Onsite Supervisor OMS if applicable

Name and Address of Practice/Facility:

Dates Applicant Has Accrued Clinical Hours Under Your Supervision: **From \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Statement of Integrity: We do hereby acknowledge that all the information submitted on this form is true and correct to the best of our knowledge and was completed in accordance with the Orientation and Mobility Specialist Code of Ethics. We understand that falsified information on this form is grounds for the denial of certification eligibility for the applicant.

I, the undersigned, verify that the applicant has met the competencies which I have signed and dated in the above evaluation under my supervision. ***I also verify that the applicant has completed a \_\_\_\_\_\_\_ hour O&M internship under my supervision.***

Signature of Supervising COMS Supervisor:

Date:

Signature of On-Site Supervisor (if applicable):

Date:

**Comments:**

If signing as the final Supervisor that culminates the applicant’s complete Clinical Competency including Competency Areas from Evaluation Form as well as the 350 hours of discipline-specific supervised practice, please complete the following question as well.

I would \_\_\_\_\_ / would not \_\_\_\_\_ recommend the applicant for ACVREP certification.

**University Verification of Internship Completion**

Name of Supervising University/Education Internship Coordinator:

Name of University/Professional Preparation Program:

Dates Applicant Has Accrued Clinical Hours Under Your Supervision: **From To**

Statement of Integrity: We do hereby acknowledge that all the information submitted on this form is true and correct to the best of our knowledge and was completed in accordance with the Orientation and Mobility Specialist Code of Ethics. We understand that falsified information on this form is grounds for the denial of certification eligibility for the applicant.

I, the undersigned, verify that the applicant has met the competencies which all supervising COMS have signed and dated in the above evaluation under my supervision. ***I verify that the applicant has completed a \_\_­\_\_\_\_\_ hour O&M internship under my supervision including \_\_\_\_\_\_\_\_\_\_\_\_hours of direct instruction. I also verify that the non-instructional hours were designed to best enhance student learning.***

I would \_\_\_\_\_ / would not \_\_\_\_\_ recommend the applicant for ACVREP certification.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Supervising University/Education Internship Coordinator:

Date:

**Comments:**