



Practice Assessment Guide

Name _____

Year _____

Area of Practice: (check all that apply)

<input type="checkbox"/> Critical Care/ER	<input type="checkbox"/> Polysomnography	<input type="checkbox"/> Anesthesia	<input type="checkbox"/> Health Promotion
<input type="checkbox"/> Air Transport	<input type="checkbox"/> General Therapeutics	<input type="checkbox"/> Home Care	<input type="checkbox"/> Education Asthma/COPD
<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Diagnostic	<input type="checkbox"/> Research	<input type="checkbox"/> Education Professional
<input type="checkbox"/> Management	<input type="checkbox"/> Hyperbaric Medicine	<input type="checkbox"/> Other: _____	

Duties and Activities of My Practice

Done Daily	Done Weekly	Done Occasionally	Done Rarely but Required