



DME COMPETENCY & INTAKE FORM

CAREGIVER NAME:

DATE:

CAREGIVER EXPERIENCE CHECKLIST:

(Please reply with "" for items you are proficient with, or "T" if you need a demonstration)

- | | |
|--|--|
| <input type="checkbox"/> Gait Belts | <input type="checkbox"/> Multi-Purpose Lifts |
| <input type="checkbox"/> Transfer / Pivot Discs | <input type="checkbox"/> Air-Assisted Lateral Transfer |
| <input type="checkbox"/> Swivel Cushions | <input type="checkbox"/> Transfer Benches |
| <input type="checkbox"/> Stand-Assist Bars | <input type="checkbox"/> Friction-Reducing Sheets |
| <input type="checkbox"/> Sara Steady | <input type="checkbox"/> Hospital Bed Controls |
| <input type="checkbox"/> Electric Sit-to-Stand | <input type="checkbox"/> Rolling Commode/Shower Chairs |
| <input type="checkbox"/> Transfer / Slide Boards | DME ADDITIONS (If present) |
| <input type="checkbox"/> BeasyTrans | <input type="checkbox"/> Trapeze Bar |
| <input type="checkbox"/> Hoyer Lift (Manual) | <input type="checkbox"/> Bed Rails/Couch Canes |
| <input type="checkbox"/> Hoyer Lift (Electric) | <input type="checkbox"/> Vertical Platform Lift |
| <input type="checkbox"/> Ceiling Lifts | |

PROFESSIONAL ACKNOWLEDGMENT:

(Circle one option below)

A) I am confident and competent to operate the equipment listed above independently.

B) I require further hands-on training for this specific brand/model before starting.

C) I am declining this assignment after observing the equipment and requirements.

CAREGIVER SIGNATURE/REPLY: _____

**Any questions regarding these instructions please contact
Washington Home Care, LLC at 203.577.8979**