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## Is It Reasonable? Reasonable and Unreasonable Accommodations for Occupational Therapy Students in Clinical Settings

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# Is It Reasonable? Reasonable and Unreasonable Accommodations for Occupational Therapy Students in Clinical Settings

## Abstract

Despite the growing number of graduate students with disabilities, little is known about what accommodations are considered reasonable in various occupational therapy fieldwork settings. This study explores which accommodations fieldwork educators perceive as reasonable or unreasonable for occupational therapy students with disabilities. Snowball sampling methodology was used to distribute a virtual survey, using a descriptive design. One hundred and sixty-two occupational therapists and occupational therapy assistants answered questions relating to demographic information, clinical experience supervising fieldwork students, and their clinical judgement regarding commonly requested accommodations. Using a quantitative approach, the accommodations deemed most reasonable were allowing the use of adaptive equipment (n = 156, reasonable: 96.3%) and permission to excuse oneself from the unit to maintain health (n = 152, reasonable: 93.83%). The accommodations considered the most unreasonable were the use of an intermediary to perform physical tasks (n = 82, unreasonable: 50.62%) and the use of an American Sign Language interpreter (n = 42, unreasonable: 24.93%). Clinicians in rehabilitation most often responded "reasonable" in response to an accommodation (n = 24, reasonable: 80.20%), while those who worked in outpatient pediatrics selected "unreasonable" most often (n = 4, unreasonable: 13.51%). This preliminary data provides stakeholders information about accommodations, creating opportunities to support students with disabilities in their pursuit of becoming clinicians. This will help to better fulfill American Occupational Therapy Association's vision of inclusivity and equitability.

## Comments

The authors declare that they have no competing financial, professional, or personal interest that might have influenced the performance or presentation of the work described in this manuscript.

## Keywords

fieldwork, students with disabilities, accommodations, reasonable, unreasonable

## Cover Page Footnote

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## Credentials Display

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The Americans with Disabilities Amendment Act (ADAA) defines a person with a disability as an individual with a physical and/or mental impairment that limits one or more major life activities. This includes individuals with a record of impairment or who are regarded as having such an impairment (ADAA, 2008). The Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act, and the Individuals with Disabilities Education Act prohibit discrimination against individuals with disabilities in school and work settings. These acts establish the right to reasonable accommodations for students and employees (ADAA, 2008). Overall, these legislations have increased the rights and opportunities of persons with disabilities, enabling them to receive reasonable accommodations in school and the workplace.

The workplace is a common setting that provides accommodations. Reasonable accommodations may include adjustments to a job, work environment, or hiring process to ensure that people with disabilities have an equal opportunity to get a job (U.S. Department of Labor, 2020). Formal accommodations that have been successful include modified work duties, gradual return to work programs, modified hours and scheduling, implementation of breaks throughout the workday, modifying communication styles, and environmental modifications (Gourdeau et al., 2020; Padkapayeva et al., 2017).

The ADA protects not only employees' rights to reasonable accommodations but also students' rights in the classroom. In a school setting, reasonable accommodations include modifications and adjustments to school-related tasks or the environment to create an equal opportunity for students with disabilities (U.S. Department of Education, 2019). An unreasonable accommodation is one that causes an institution undue hardship, such as an unreasonable cost or a structural change (Deckoff-Jones & Duell, 2018). Though most academic accommodations can be provided at no cost, some may impose financial stipulations, such as hiring an ASL interpreter or an intermediary for physical tasks. Academic institutions are legally required by the ADA to cover related costs, as long as those costs do not cause undue hardship (Deckoff-Jones & Duell, 2018).

Research has shown that accommodations are beneficial for students with a variety of disabilities, including visible and invisible disabilities, pursuing higher education. For college students with disabilities, accommodations that mitigate school-related challenges include note-taking assistance, extended time or a distraction-free environment for testing, frequent breaks, preferential seating, excused absences when disability related, and priority registration (Stein, 2013). Further, according to the U.S. Department of Education (2019), enrollment in post-baccalaureate degree programs, which include master's, doctoral, and professional doctoral programs, has increased from 2.2 million to 3.0 million students between 2000 and 2018. By 2029, it is predicted that post-baccalaureate enrollment will increase to 3.1 million students. Further, in 2018, 12% of post-baccalaureate students reported having a disability, another statistic expected to increase in the coming years (U.S. Department of Education, 2019). With the increasing enrollment rates of students with disabilities in institutions of higher education, there is a greater need for understanding which accommodations can be considered reasonable in these settings.

While several studies have investigated successful accommodations in the classroom setting, very few have addressed successful accommodations in the clinical setting (Deckoff-Jones & Duell, 2018; Dupler et al., 2012). For students pursuing a career in health care, clinical components are integral to the curriculum. According to a 2016 study, exposure to the clinical learning environment has a creditable impact on learning outcomes and is beneficial in challenging students to develop their professional skills, including clinical judgment, decision-making, and critical thinking (Papastavrou et al., 2016). The clinical

learning environment also provides students with hands-on clinical practice preparing students for the transition to the workplace (Lee et al., 2018). The clinical environment places unique demands on students that differ from the typical learning environment. Oftentimes, students' difficulties in navigating such unique demands cannot be addressed with standard classroom accommodations. The increased volume of new information, lack of predictability, and variability of supervisors' expectations are a few examples of the demands a student can experience while engaging in the clinical portion of their programs' curriculum (Lee et al., 2018). The current difficulty in determining and providing reasonable accommodations in clinical settings lies in finding the balance between the student's individual learning needs while ensuring academic and professional standards are not compromised (Dupler et al., 2012).

The clinical learning environment imposes distinct demands on students that differ from the expectations students experience in the classroom. Occupational therapy (OT) students must complete both Level I and Level II clinical experiences, also known as fieldwork (American Council for Occupational Therapy Education [ACOTE], 2018). The expectations of Level II fieldwork are that students learn to deliver and manage evidence-based, purposeful, and meaningful OT to clients with entry-level competence (American Occupational Therapy Association [AOTA], 2012). There are a wide range of skills required for successful completion of fieldwork, including time management, communicating with one's supervisor, professional behavior, ability to integrate constructive criticism, and flexibility (Kemp & Crabtree, 2017). In addition to the aforementioned professional skills, technical skills are also required. Planning, implementing and grading interventions, clinical reasoning, and acquiring information through standardized and non-standardized assessments were found to be the top three technical skills required for Level II fieldwork in a study by Mason et al. (2020).

OT is a dual entry-point career, offering students pursuing a career in OT the option of obtaining either a master's or clinical doctoral degree. However, students enrolled in both master's and doctoral level OT programs must complete fieldwork experiences in a variety of settings (ACOTE, 2018). Specifically, Level II fieldwork experiences must be completed in a minimum of two practice settings (ACOTE, 2018). Each practice setting has unique essential functions that are required to be an entry-level clinician. As such, there could be different accommodations for a student at each site and it is important to investigate what is considered reasonable in various clinical settings. Reasonable accommodations in OT fieldwork have been explored in Canada and Australia. In Canadian OT programs, one of the major themes identified was that the lack of an accessible environment and accommodations throughout the fieldwork settings created a barrier to success for students with disabilities (Jung et al., 2014). Another study from Australia explored practice educators' perspectives on OT students with disabilities. The major theme identified was practice educators needed to balance reasonable accommodations and competency standards and called for established reasonable accommodations for both the student and supervisor (Hirneith & Mackenzie, 2004).

Ozelie and colleagues (2019) explored the use, type, and prevalence of accommodations used with OT students with a disability while on Level II fieldwork and common barriers to accommodation access. According to the survey results, 16.9% of clinicians reported having a disability during Level II fieldwork. Of that percent, 44.4% reported not disclosing their disability during the graduate program even though more than half felt their disability presented challenges during the fieldwork experience. The top challenges individuals with a disability faced during OT Level II fieldwork included mental exhaustion, difficulty communicating with supervisor, and difficulty with written communication (Ozelie et al., 2019).

## Purpose

Despite the rise of graduate students with a visible or invisible disability and the mandated legislation for individuals with disabilities, reasonable accommodations for OT students during fieldwork rotations have not been thoroughly explored. Currently, there is limited research regarding the balance of clinical expectations while meeting the needs of students with disabilities participating in the fieldwork component of OT programs. Therefore, the purpose of this study is to determine, based on practice setting, which accommodations supervising clinicians perceive as reasonable and unreasonable for OT students on Level II fieldwork.

## Method

### Research Design

This study uses a descriptive, non-experimental, exploratory design. This study was granted an exempt status from the affiliated university institutional review board.

### Participants

An electronic survey was distributed to occupational therapists and OT assistants (OTAs) across the United States who graduated from an accredited OT or OTA program. Incomplete survey results were excluded from the analysis. Authors from this study were also excluded from the results. No additional inclusion or exclusion criteria were noted.

### Measures

The principal investigator created the survey using current literature to guide the question content. The survey was structured using skip logic, where each question was dependent on the one prior. Questions 1–5 were demographic questions all the respondents answered. Questions 6–8 asked the respondents about their experience supervising Level II students and providing accommodations. The remainder of the survey asked the respondents to personally evaluate accommodations as reasonable, unreasonable, or neither reasonable or unreasonable in their practice setting.

Definitions of reasonable and unreasonable were provided to the survey respondents. A reasonable accommodation was defined as a change, adaptation, or modification to a policy, program, service, or workplace that allows a qualified person with a disability to participate fully in a program, take advantage of a service, or perform a job. An unreasonable accommodation was defined as one that would introduce undue hardship to an employer's operation, including imposing significant difficulty, excessive cost, removing essential job functions, or placing additional workload on another employee. If the respondents selected unreasonable, they were directed to a skip logic question asking them to select one or more reasons as to why they stated it was unreasonable. The options included were the reasons set forth by ADA that allow the denial of accommodations for causing undue hardship and an "other" option where they could write in additional comments. The types of accommodations included in the survey were derived from a panel of experts and the book *The Guide to Assisting Students with Disabilities: Equal Access in Health Science and Professional Education* (Meeks & Jain, 2015). The survey was developed using the Survey Monkey website ([www.surveymonkey.com](http://www.surveymonkey.com)). It was tested for validity by means of a panel of four experts in survey design, disability rights, and education. The panel included occupational therapists and other professionals. This panel assisted with consultation and finalization of the survey items.

### Procedure

The final survey was electronically distributed using a snowball sampling procedure via SurveyMonkey® (1999). Snowball sampling has been found to increase the pool of participants by

respondents identifying potential participants known to current participants (Etikan et al., 2016). Email distribution lists maintained by the affiliated institution's Department of Occupational Therapy, regional clinical site contacts, and academic listservs were used for initial distribution of the survey in spring of 2020. A recruitment email that included the purpose of the study and assurance of confidentiality was sent to potential participants. Those that received the recruitment email were invited to complete the survey and distribute it to OT colleagues. The email was sent out again to participants 3 weeks after the initial email to obtain saturation, and statistics were used to summarize data from closed-ended questions. The survey was open for 5 weeks.

### Results

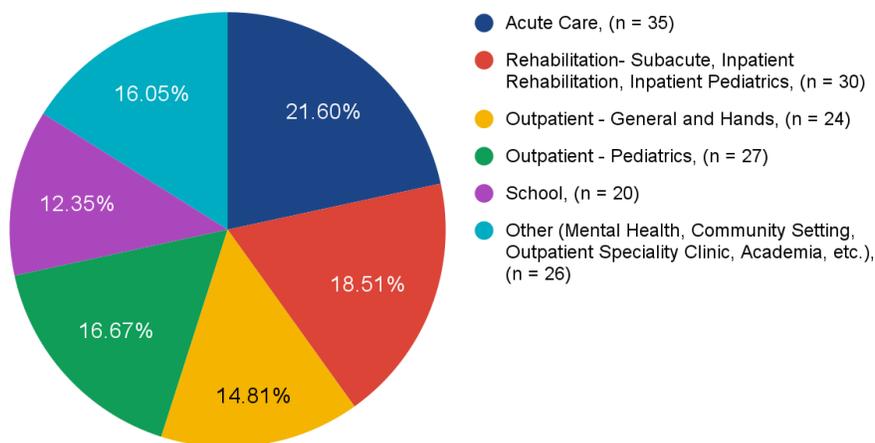
One hundred and eighty-five respondents from across the United States completed the survey. Surveys were filtered based on total completeness, resulting in a total of 162 respondents. A total of 156 survey respondents identified as occupational therapists (96.3%, n=156). The remainder of the survey respondents identified as OTAs (1.23%, n = 2) and others (2.47%, n = 4). A majority of those who completed the survey practice as staff occupational therapists (75.93%, n = 123). The remainder of the survey respondents fulfill duties as clinical coordinators, in administration, or other related roles (6.17%, n = 10; 7.41%, n = 12; 10.79%, n = 17), in addition to holding OT or OTA licensure. The region represented the most was the Midwest (74.69%, n = 121). However, all regions of the U.S. were represented: Western (9.88%, n = 16), Northeastern (5.56%, n = 9), Southwestern (3.09%, n = 5), Southeastern (4.32%, n = 7), Non Contiguous U.S. (1.85%, n = 3), and one therapist from outside of the US (0.62%, n = 1).

Survey respondents had varying degrees of understanding and experience with fieldwork students and reasonable accommodations. Out of all survey respondents, 75.3% (n = 122) reported supervising a Level II fieldwork student (acute care: 85.71, n = 30; rehabilitation: 66.67%, n = 20; outpatient- general and hands: 75%, n = 18; outpatient-pediatrics: 74.07%, n = 20; school: 55%, n = 11; other: 88.46%, n = 23). In addition, respondents, 24.07% (n = 39) reported having a fieldwork student who reported having a visible and/or invisible disability. In addition, 87.04% (n = 141) reported having a prior understanding of the definition of reasonable and unreasonable accommodation (acute care: 91.43%, n = 32; rehabilitation: 90%, n = 27; outpatient-general and hands: 75%, n = 18; outpatient-pediatrics: 85.19%, n = 23; school: 90%, n = 18; other: 88.46%, n = 23). Figure 1 represents the distribution of practice settings of the respondents. Due to the small sample size some practice settings were combined (see Figure 1).

Across all six practice settings, accommodations considered *most reasonable* consisted of allowing the use of adaptive equipment (e.g., back braces, adaptive gait belt, etc.) (reasonable: 96.30%, n = 156; unreasonable: 0.62%, n = 1) and permission to excuse oneself from the unit to maintain health as needed (e.g., glucose check, medications) (reasonable: 93.83%, n = 152; unreasonable: 1.85%, n = 3) (see Appendix for Table 1). The practice settings found to be the most likely to consider an accommodation reasonable for fieldwork students was the rehabilitation group which consisted of therapists from subacute rehabilitation, inpatient rehabilitation, and inpatient pediatrics (see Appendix). Conversely, across all eight practice settings, accommodations that were considered the *most unreasonable* consisted of an intermediary to perform physical tasks (e.g., transfers) (unreasonable: 50.62%, n = 82; reasonable: 29.01%, n = 47) and use of American Sign Language (ASL) interpreters (unreasonable: 24.93%, n = 42; reasonable: 51.23%, n = 83) (see Appendix). The top reason physical intermediary was considered unreasonable was it removes essential job function (90.24%, n = 74). The top reason an ASL interpreter was considered unreasonable was it imposes excessive cost (66.67%, n = 28) (see Table 2). The practice

setting found to be the most likely to consider an accommodation unreasonable for fieldwork students was outpatient pediatrics (see Appendix).

**Figure 1**  
*Practice Settings of Respondents*



**Table 2**  
*Respondents’ Reasons for Selecting “Unreasonable” for Each Accommodation*

Accommodation (percentage that selected “unreasonable”)	Causes significant difficulty	Imposes excessive cost	Removes essential job functions	Places additional workload onto another employee	Other
Flexible scheduling (e.g., shortened shifts, part-time scheduling, etc.) (9.88%, n = 16)	25.00%	6.25%	68.75%	81.25%	18.75%
Extended time for documentation (6.17%, n = 10)	0.00%	40.00%	40.00%	70.00%	60.00%
Changes to the work environment (including physical modifications in regards to equipment and ergonomics) (8.64%, n = 14)	35.71%	57.14%	64.29%	64.29%	21.43%
Allow the use of adaptive equipment (e.g., back braces, adapted gait belt, etc.) (0.62%, n = 1)	0.00%	0.00%	100.00%	100.00%	0.00%
Provision of assistive technology (e.g., voice recognition software, scribe software, etc.) (9.26%, n = 15)	26.67%	80.00%	0.00%	13.33%	40.00%
Use of American Sign Language (ASL) interpreter (25.93%, n = 42)	54.76%	66.67%	28.57%	30.95%	40.48%
Sensory breaks (e.g., stepping away from the unit to sit, rest eyes, wear ear buds to reduce noise distractions, etc.) (4.94%, n = 8)	25.00%	0.00%	62.50%	75.00%	37.50%
Permission to excuse oneself from unit to maintain health as needed; student ensures client safety before leaving (e.g., glucose check, taking medication, etc.) (1.85%, n = 3)	33.33%	0.00%	66.67%	33.33%	33.33%
Extended meeting time with clinical instructor to review fieldwork cases/fieldwork experience (7.41%, n = 12)	41.67%	25.00%	16.67%	66.67%	66.67%
Reduced distractions in the workplace environment (e.g., quiet place to document, private space for treatment, etc.) (14.20%, n = 23)	56.52%	8.70%	21.74%	30.43%	65.22%
Adjusted lighting (17.28%, n = 28)	39.39%	39.29%	14.29%	3.57%	57.14%
Written instructions in addition to verbal cues (9.88%, n = 16)	31.25%	12.50%	6.25%	75.00%	50.00%
Release from shift for health-related appointments (i.e., student and clinical instructor to determine how/when to remediate missed practicum time at alternate time) (1.85%, n = 3)	33.33%	0.00%	0.00%	66.67%	66.67%

Accommodation (percentage that selected “unreasonable”)	Causes significant difficulty	Imposes excessive cost	Removes essential job functions	Places additional workload onto another employee	Other
Temporary accommodation (e.g., broken bone, illness, scheduled surgery, etc.) (9.26%, n = 15)	40.00%	13.33%	60.00%	26.67%	46.67%
Intermediary to perform physical tasks (e.g., transfers) (50.62%, n = 82)	36.59%	12.20%	90.24%	69.51%	15.85%
Access to a refrigerator on the student’s current placement unit (necessary for certain medications) (1.23%, n = 2)	0.00%	33.33%	0.00%	0.00%	66.67%
Additional time to practice technical skills prior to use of skills with client (e.g., additional or simulated opportunities for practice with splint making, transfers, use of adaptive equipment, etc.) (3.09%, n = 5)	20.00%	20.00%	20.00%	80.00%	60.00%

### Discussion

This study sought to explore what OT clinicians perceived as reasonable accommodations in their practice setting for OT students with disabilities on fieldwork. The use of accommodations on fieldwork is important, as this portion of the OT curriculum presents unique demands in comparison to the didactic component (Lee et al., 2018). Through these study results, preliminary conversations regarding the use of accommodations in a clinical setting for OT students can be initiated between all stakeholders, including fieldwork supervisors, OT faculty, and OT students.

Across all eight practice settings, the two accommodations for fieldwork students considered most reasonable were allowing the use of adaptive equipment (e.g., back braces, adaptive gait belt, etc.) (reasonable: 96.30%, n = 156) and permission to excuse oneself from the unit to maintain health as needed (e.g., glucose check, medications) (reasonable: 93.83%, n = 152). OT clinicians are familiar with and often recommend adaptive equipment as they often educate and train clients on the usage and purpose of these various devices (Arsh et al., 2020; Boland et al., 2018; Lampe et al., 2019). In addition, occupational therapists provide interventions to individuals in need of medication management (Schwartz et al., 2017). Therefore, OT clinicians are cognizant and informed on the various benefits and importance of adaptive equipment and medication management to increase an individual’s participation and function in daily occupations. Because occupational therapists frequently are exposed to these needs for their clients, the survey respondents may justify the use of adaptive equipment and permission to excuse oneself from the unit to maintain health as reasonable accommodations for OT students on fieldwork. In addition, these accommodations are unlikely to present with undue hardship, financial cost, or structural changes to the clinical site.

In analyzing the eight practice settings, the survey respondents working in rehabilitation most often responded “reasonable” in response to the presented accommodations. An average of 80.20% (n = 24) of the survey respondents from rehabilitation selected “reasonable” in response to each of the presented accommodations. This finding can be attributed to several personal or setting-based factors. One personal factor that may affect responses is experience supervising OT students. Per survey results, 67% (n = 20) of the respondents who worked in subacute, inpatient rehabilitation, and inpatient pediatric settings had supervised a Level II fieldwork student previously. In addition, 90% (n = 27) of therapists in these settings had a prior understanding of the definition of a reasonable accommodation. This experience and awareness of reasonable accommodations could lead more therapists, practicing in rehabilitation settings, to deem accommodations as reasonable.

One contextual factor that may be attributed to the responses of rehabilitation settings is the nature of the medical model and rehabilitation frame of reference that is common in these settings. The respondents working in these settings are frequently using these models and frames of reference that have the theoretical basis that the client must focus on the remaining abilities, despite any disabilities, to attain their highest level of occupational performance (Gillen, 2014). This includes concepts of adaptation, compensation, and environmental modifications that are part of providing accommodations for students with disabilities, thus potentially making these respondents more agreeable to accommodations for students with disabilities.

While most accommodations were deemed reasonable, the accommodation that was considered the most unreasonable was an intermediary to perform physical tasks (e.g., transfers). Only 29.01% (n = 47) of the respondents reported that they considered it a reasonable accommodation and over half (50.62%, n = 82) reported that they considered it unreasonable in their practice setting. The two most common reasons for reporting that an intermediary to perform physical tasks was considered unreasonable were (a) that it removes essential job functions (90.24%, n = 74) and (b) it places additional workload onto another employee (69.51%, n = 57). The setting that found this accommodation to be most unreasonable was acute care (unreasonable: 71.43%, n = 25), and outpatient found it to be the most reasonable (reasonable: 41.67%, n = 10), potentially because of the differences in essential job functions between sites. Specifically, the work demand of outpatient settings may be more conducive to students that require a physical intermediary to perform physical tasks. According to Brewer et al. (2016), outpatient therapists typically work with clients who can ambulate independently or with the use of an assistive device. This diminishes the need to complete physically demanding manual transfers, which may reduce the need or frequency for this accommodation in this practice setting. In addition, the nature of the work provided by outpatient clinicians requires an average of 4 hr of sitting and 4–5 hr of standing per day (Brewer et al., 2016). This balance of sedentary and active physical work demands allows for the student to take rest breaks when needed and preserve energy throughout the day, if that is a necessity for managing their disability and application of this accommodation.

In review of additional comments that explained why this accommodation would be unreasonable in their particular setting, most comments expanded on how this accommodation removes the essential job functions, stating that, “a requirement of the job is to accommodate 50 lbs. lifting. If the student is not able to accommodate this, then they should not be allowed in this setting.” Many comments included remarks about staff safety/availability and that this accommodation would not be allowed for a practicing OT clinician in their setting and, therefore, should not be allowed for students. According to most of the survey respondents, because of the unique demands of their setting, this accommodation would cause undue hardship and is, therefore, unreasonable.

Some of the respondents stated that they might consider allowing the use of a physical intermediary under very specific circumstances. The concern over the additional workload for another employee may be negated if a student was able to provide their own intermediary, which alludes to concerns over the accommodation imposing excessive costs. This was the only accommodation to be considered reasonable by less than half of respondents (reasonable: 29.01%, n = 47), indicating that many practice settings would find an intermediary to complete job tasks difficult to accommodate. It is important to note that providing a physical intermediary to completed tasks may also include activities such as pediatric handling skills, complete range of motion assessments, splinting, etc. As the respondents were only given the example of transfers in the survey this may have impacted their response to this question. As OT is a diverse

profession that works in many settings and completes many physical skills, it is important to consider all the physical skills that one might need to complete and how this accommodation could be implemented.

The other most unreasonable accommodation was the use of an American Sign Language (ASL) interpreter, with only 51.23% ( $n = 83$ ) of the respondents stating that it is a reasonable accommodation. The two most common reasons for stating that the use of an ASL interpreter was unreasonable were: imposes excessive cost (66.67%,  $n = 28$ ) and causes significant difficulty (54.76%,  $n = 23$ ). While an ASL interpreter will impose a cost, it is important for clinical sites to understand that accommodations and their associated costs are the school's responsibility under Section 504 of the Rehabilitation Act of 1973 (Madaus & Shaw, 2004). Other concerns regarding the use of an ASL interpreter included the perception that it would take an interpreter away from clients at the site. There were comments that the use of an ASL interpreter may also violate a client's HIPAA rights, which is inaccurate as interpreters for providers fall under the business associate category of HIPAA (Alborn & McKinney, 2014). These misunderstandings demonstrate a lack of knowledge surrounding the use of an ASL interpreter as an accommodation for students and illustrate the need for additional education and awareness on reasonable accommodations and associated laws.

In addition, the other main concern voiced was that the use of an ASL interpreter causes too much of a challenge in working with certain populations and, therefore, is not conducive to building rapport. The respondents included examples of populations where an ASL interpreter causes significant challenges including stroke/traumatic brain injury clients with cognitive or communication difficulties, children on the autism spectrum, non-English speakers already using translation services, clients with severe mental health needs, and clients with visual impairments. One of the identified challenges of an ASL interpreter was that it may negatively impact the therapeutic relationship between the client and therapist, one of the distinct values of the OT profession. For example, the setting that found this accommodation the most unreasonable was outpatient pediatrics (unreasonable: 29.63%,  $n = 8$ ). In this setting, a therapeutic relationship needs to be established between the therapist and the caregiver, in addition to the one between the therapist and the client (D'Arrigo et. al., 2020). Clients in outpatient pediatrics may also have communication and cognitive difficulties, further complicating rapport building. Whereas, the mental health and community settings found it the most reasonable (reasonable: 65.38%,  $n = 17$ ), potentially because of differences in essential job functions and client needs. The barriers to the use of an ASL interpreter illustrated in the comments are very dependent on setting and the population with which the survey respondent worked. Overall, while this was found to be the second most unreasonable accommodation, most of the respondents still found it reasonable (51.23%,  $n = 83$ ) even with some misunderstanding of costs and HIPAA implications and identified potential challenges.

The survey respondents practicing in outpatient pediatrics selected unreasonable the most often in response to presented accommodations. Per question, an average of 13.51% ( $n = 4$ ) of clinicians working in outpatient pediatrics selected "unreasonable" in response to the presented accommodation. Survey respondents working in outpatient pediatrics may have reservations about providing accommodations to students as it may be perceived to compromise the workflow that is required to provide effective therapy to children in an active and dynamic environment and the critical rapport building needed with parents and children. This was supported by comments from the respondents that selected accommodations as unreasonable that the accommodations would result in removing essential job functions and interference with the established environment and workflow in outpatient pediatrics.

Kemp and Crabtree (2018) found that outpatient pediatric settings have higher student ability demands than school settings. In addition, this study supported findings by Campbell et al. (2015) that found that pediatric practice settings labeled empathy, creativity and ability to be personable as essential professional behaviors. These additional student demands for pediatric fieldwork may impact clinician's perception of what is reasonable in this setting.

Furthermore, 88.89% (n = 24) of the respondents in the pediatric settings have never supervised a Level II fieldwork student with a disability. This lack of experience may contribute to respondents' perceptions of accommodations. Based on these findings, it is suggested that clinical sites carefully examine the essential job functions at their site and provide a list of these functions to present and prospective fieldwork students. According to the U.S Equal Employment Opportunity Commission, essential functions are the basic job tasks that an employee must be able to perform with or without the provision of a reasonable accommodation. It is advisable to provide this information to students and academic fieldwork coordinators, allowing them to determine how the student's requested accommodation may impact essential job functions at the site. This will allow the student and academic fieldwork coordinator to evaluate fieldwork placements that are in alignment with the student's preferences, needs and abilities while adhering to the essential functions of the site. It is also critical to note that the decision about what is considered reasonable and unreasonable is often not solely that of the direct fieldwork educator but also that of administrators, human resource professionals, legal representatives and others. Results from this study represent only the perspectives of the fieldwork educators.

Understanding more about what are considered reasonable accommodations at various clinical sites will result in more opportunities to support students with disabilities in becoming clinicians. Intentionally making the OT profession more accessible, inclusive, and equitable is part of the AOTA's *Vision 2025* (2017). With the results of this study, it will be possible to better support students with disabilities in attending school, becoming practitioners, and ultimately fulfill the AOTA's vision and goals.

### **Limitations**

The COVID-19 pandemic resulted in a decreased response rate of the survey as well as an overall, limited sample size. In addition, snowball sampling was used, and this sampling may not be representative of the broader population and respondents may share similar feelings, thoughts, and biases because of the method of recruitment. Last, the survey respondents were limited to OT clinicians and OTAs. These professionals are not always the ones to decide if accommodations are deemed reasonable in the workplace. Accommodations may need to be formally and legally agreed on by other policy-makers and human resource employees.

### **Conclusion**

With the increase of students with disabilities in graduate-level OT programs, research is needed to explore clinical accommodations in order to best support students with disabilities (Ozelie et al., 2019). This study found that OT clinicians generally view accommodations for OT students on fieldwork as reasonable. Overall, survey respondents deemed most accommodations as reasonable barring the use of an intermediary to perform physical tasks. This preliminary data provides a better understanding of clinical sites perceptions of what is a reasonable accommodation. This information can be used as a starting point to facilitate discussions amongst clinicians, academic fieldwork coordinators, and students as they determine sites that will fit their needs while promoting inclusivity and equal access.

This study also highlights a lack of understanding surrounding reasonable accommodations that illustrated the need for continued education on accommodations. This study is a call to action to further explore the use of accommodations at clinical sites and what is considered reasonable. As occupational therapists, we advocate for the inclusivity of our clients through accommodations. Therefore, the same standard needs to be upheld for students entering the profession.

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## Appendix

Table 1

*Reasonableness of Accommodations According to Respondents by Practice Setting*

Accommodation	Setting	Reasonable	Neither	Unreasonable
<b>Flexible scheduling (e.g., shortened shifts, part-time scheduling, etc.)</b>	Acute Care	85.71%	5.71%	8.57%
	Rehabilitation - Subacute, Inpatient Rehabilitation, Inpatient Pediatrics	80.00%	10.00%	10.00%
	Outpatient - General and Hands	75.00%	16.67%	8.33%
	Outpatient - Pediatrics	74.07%	11.11%	14.81%
	School	90.00%	10.00%	0.00%
	Other (Mental Health, Community Setting, etc.)	69.23%	15.38%	15.38%
	<i>All settings (combined)</i>	<i>79.01%</i>	<i>11.11%</i>	<i>9.88%</i>
<b>Extended time for documentation</b>	Acute Care	80.00%	17.14%	2.86%
	Rehabilitation - Subacute, Inpatient Rehabilitation, Inpatient Pediatrics	90.00%	0.00%	10.00%
	Outpatient - General and Hands	87.50%	4.17%	8.33%
	Outpatient - Pediatrics	85.19%	3.70%	11.11%
	School	90.00%	10.00%	0.00%
	Other (Mental Health, Community Setting, etc.)	92.31%	3.85%	3.85%
	<i>All settings (combined)</i>	<i>87.04%</i>	<i>6.79%</i>	<i>6.17%</i>
<b>Changes to the work environment (including physical modifications in regard to equipment and ergonomics)</b>	Acute Care	65.71%	17.14%	17.14%
	Rehabilitation - Subacute, Inpatient Rehabilitation, Inpatient Pediatrics	80.00%	13.33%	6.67%
	Outpatient - General and Hands	75.00%	25.00%	0.00%
	Outpatient - Pediatrics	66.67%	22.22%	11.11%
	School	75.00%	25.00%	0.00%
	Other (Mental Health, Community Setting, etc.)	84.62%	3.85%	11.54%
	<i>All settings (combined)</i>	<i>74.07%</i>	<i>17.28%</i>	<i>8.64%</i>
<b>Allow the use of adaptive equipment (e.g., back braces, adapted gait belt, etc.)</b>	Acute Care	97.14%	2.86%	0.00%
	Rehabilitation - Subacute, Inpatient Rehabilitation, Inpatient Pediatrics	96.67%	3.33%	0.00%
	Outpatient - General and Hands	95.83%	4.17%	0.00%
	Outpatient - Pediatrics	96.30%	3.70%	0.00%
	School	90.00%	5.00%	5.00%
	Other (Mental Health, Community Setting, etc.)	100.00%	0.00%	0.00%
	<i>All settings (combined)</i>	<i>96.30%</i>	<i>3.09%</i>	<i>0.62%</i>
<b>Provision of assistive technology (e.g., voice recognition software, scribe software, etc.)</b>	Acute Care	65.71%	22.86%	11.43%
	Rehabilitation - Subacute, Inpatient Rehabilitation, Inpatient Pediatrics	83.33%	10.00%	6.67%
	Outpatient - General and Hands	75.00%	16.67%	8.33%
	Outpatient - Pediatrics	59.26%	22.22%	18.52%
	School	90.00%	10.00%	0.00%
	Other (Mental Health, Community Setting, etc.)	84.62%	7.70%	7.70%
	<i>All settings (combined)</i>	<i>75.31%</i>	<i>15.43%</i>	<i>9.26%</i>

IS IT REASONABLE?

<b>Use of American Sign Language (ASL) interpreter</b>	Acute Care	45.71%	25.71%	28.57%
	Rehabilitation - Subacute, Inpatient Rehabilitation, Inpatient Pediatrics	53.33%	10.00%	36.67%
	Outpatient - General and Hands	50.00%	37.50%	12.50%
	Outpatient - Pediatrics	44.44%	25.93%	29.63%
	School	50.00%	30.00%	20.00%
	Other (Mental Health, Community Setting, etc.)	65.38%	11.54%	23.08%
	<i>All settings (combined)</i>	<i>51.23%</i>	<i>22.84%</i>	<i>25.93%</i>
<b>Sensory breaks (e.g., stepping away from the unit to sit, rest eyes, wear ear buds to reduce noise distractions, etc.)</b>	Acute Care	85.71%	11.43%	2.86%
	Rehabilitation - Subacute, Inpatient Rehabilitation, Inpatient Pediatrics	86.67%	6.67%	6.67%
	Outpatient - General and Hands	75.00%	20.83%	4.17%
	Outpatient - Pediatrics	81.48%	7.41%	11.11%
	School	95.00%	5.00%	0.00%
	Other (Mental Health, Community Setting, etc.)	73.08%	23.08%	3.85%
	<i>All settings (combined)</i>	<i>82.72%</i>	<i>12.35%</i>	<i>4.94%</i>
<b>Permission to excuse oneself from unit to maintain health as needed; student ensures client safety before leaving (e.g., glucose check, taking medication, etc.)</b>	Acute Care	91.43%	8.57%	0.00%
	Rehabilitation - Subacute, Inpatient Rehabilitation, Inpatient Pediatrics	96.67%	0.00%	3.33%
	Outpatient - General and Hands	100.00%	0.00%	0.00%
	Outpatient - Pediatrics	92.59%	3.70%	3.70%
	School	85.00%	10.00%	5.00%
	Other (Mental Health, Community Setting, etc.)	96.15%	3.85%	0.00%
	<i>All settings (combined)</i>	<i>93.83%</i>	<i>4.32%</i>	<i>1.85%</i>
<b>Extended meeting time with clinical instructor to review fieldwork cases/fieldwork experience</b>	Acute Care	82.86%	17.14%	0.00%
	Rehabilitation - Subacute, Inpatient Rehabilitation, Inpatient Pediatrics	86.67%	3.33%	10.00%
	Outpatient - General and Hands	75.00%	16.67%	8.33%
	Outpatient - Pediatrics	77.78%	7.41%	14.81%
	School	90.00%	10.00%	0.00%
	Other (Mental Health, Community Setting, etc.)	76.92%	11.54%	11.54%
	<i>All settings (combined)</i>	<i>81.48%</i>	<i>11.11%</i>	<i>7.41%</i>
<b>Reduced distractions in the workplace environment (e.g., quiet place to document, private space for treatment, etc.)</b>	Acute Care	54.29%	28.57%	17.14%
	Rehabilitation - Subacute, Inpatient Rehabilitation, Inpatient Pediatrics	70.00%	20.00%	10.00%
	Outpatient - General and Hands	62.50%	25.00%	12.50%
	Outpatient - Pediatrics	44.44%	18.52%	37.04%
	School	50.00%	50.00%	0.00%
	Other (Mental Health, Community Setting, etc.)	73.08%	23.08%	3.85%
	<i>All settings (combined)</i>	<i>59.26%</i>	<i>26.54%</i>	<i>14.20%</i>

<b>Adjusted lighting</b>	Acute Care	40.00%	37.14%	22.86%
	Rehabilitation - Subacute, Inpatient Rehabilitation, Inpatient Pediatrics	63.33%	20.00%	16.67%
	Outpatient - General and Hands	45.83%	37.50%	16.67%
	Outpatient - Pediatrics	48.15%	29.63%	22.22%
	School	45.00%	50.00%	5.00%
	Other (Mental Health, Community Setting, etc.)	73.10%	11.54%	15.38%
	<i>All settings (combined)</i>	<i>52.47%</i>	<i>30.25%</i>	<i>17.28%</i>
<b>Written instructions in addition to verbal cues</b>	Acute Care	74.29%	20.00%	5.71%
	Rehabilitation - Subacute, Inpatient Rehabilitation, Inpatient Pediatrics	86.67%	10.00%	3.33%
	Outpatient - General and Hands	83.33%	8.33%	8.33%
	Outpatient - Pediatrics	66.67%	18.52%	14.81%
	School	80.00%	10.00%	10.00%
	Other (Mental Health, Community Setting, etc.)	76.92%	3.85%	19.23%
	<i>All settings (combined)</i>	<i>77.78%</i>	<i>12.35%</i>	<i>9.88%</i>
<b>Release from shift for health-related appointments (i.e., student and clinical instructor to determine how/when to remediate missed practicum time at alternate time)</b>	Acute Care	91.43%	5.71%	2.86%
	Rehabilitation - Subacute, Inpatient Rehabilitation, Inpatient Pediatrics	100.00%	0.00%	0.00%
	Outpatient - General and Hands	95.83%	4.17%	0.00%
	Outpatient - Pediatrics	92.59%	3.70%	3.70%
	School	75.00%	25.00%	0.00%
	Other (Mental Health, Community Setting, etc.)	76.92%	19.23%	3.85%
	<i>All settings (combined)</i>	<i>89.51%</i>	<i>8.64%</i>	<i>1.85%</i>
<b>Temporary accommodation (e.g., broken bone, illness, scheduled surgery, etc.)</b>	Acute Care	60.00%	22.86%	17.14%
	Rehabilitation - Subacute, Inpatient Rehabilitation, Inpatient Pediatrics	73.33%	13.33%	13.33%
	Outpatient - General and Hands	91.67%	8.33%	0.00%
	Outpatient - Pediatrics	88.89%	7.41%	3.70%
	School	70.00%	25.00%	5.00%
	Other (Mental Health, Community Setting, etc.)	88.46%	0.00%	11.54%
	<i>All settings (combined)</i>	<i>77.78%</i>	<i>12.96%</i>	<i>9.26%</i>
<b>Intermediary to perform physical tasks (e.g., transfers)</b>	Acute Care	8.57%	20.00%	71.43%
	Rehabilitation - Subacute, Inpatient Rehabilitation, Inpatient Pediatrics	26.67%	6.67%	66.67%
	Outpatient – General and Hands	41.67%	20.83%	37.50%
	Outpatient – Pediatrics	33.33%	37.04%	29.63%
	School	40.00%	25.00%	35.00%
	Other (Mental Health, Community Setting, etc.)	34.62%	15.38%	50.00%
	<i>All settings (combined)</i>	<i>29.01%</i>	<i>20.37%</i>	<i>50.62%</i>

IS IT REASONABLE?

<b>Access to a refrigerator on the student's current placement unit (necessary for certain medications)</b>	Acute Care	85.71%	11.43%	2.86%
	Rehabilitation – Subacute, Inpatient Rehabilitation, Inpatient Pediatrics	96.67%	0.00%	3.33%
	Outpatient – General and Hands	100.00%	0.00%	0.00%
	Outpatient – Pediatrics	96.30%	3.70%	0.00%
	School	90.00%	10.00%	0.00%
	Other (Mental Health, Community Setting, etc.)	92.31%	7.70%	0.00%
	<i>All settings (combined)</i>	<i>93.21%</i>	<i>5.56%</i>	<i>1.23%</i>
<b>Additional time to practice technical skills prior to use of skills with client (e.g., additional or simulated opportunities for practice with splint making, transfers, use of adaptive equipment, etc.)</b>	Acute Care	94.29%	2.86%	2.86%
	Rehabilitation - Subacute, Inpatient Rehabilitation, Inpatient Pediatrics	93.33%	3.33%	3.33%
	Outpatient - General and Hands	83.33%	16.67%	0.00%
	Outpatient - Pediatrics	88.89%	7.41%	3.70%
	School	80.00%	20.00%	0.00%
	Other (Mental Health, Community Setting, etc.)	73.08%	19.23%	7.70%
	<i>All settings (combined)</i>	<i>86.42%</i>	<i>10.49%</i>	<i>3.09%</i>