Name:____ Date: ________________

STAMBUSH STAFFING

Speech-Language Pathologist Skills Checklist

Experience Level

A – No experience
B – Intermittent experience
C – One year consistent experience
D – Two year consistent experience
E – Able to teach and supervise
F – Last time you performed this function (e.g. last month, last year, daily, weekly, daily as needed, N/A)

Work Setting

	A	B	C	D	E	F
Rehabilitation Hospital						
General Acute Care						
Children's Hospital						
School System						
Home Health Care						
Hand Clinic						
Outpatient Clinic						
Sports Medicine						
Work Hardening						
Nursing Home						
Skilled Nursing Facility						
Comprehensive Outpatient Rehab Facility (CORF)						
Psychiatric Hospital						

Adult

	A	B	C	D	E	F
CVA Rehabilitation						
Coma Stimulation						
TBI						
Degenerative Diseases						
Mental Retardation						
Mild						
Moderate						
Severe						
Profound						
Anoxia						
Laryngectomy						
Tracheotomy						
Ventilator Dependent/Assisted						
Fluency						

Name:____ Date: __________________

Voice						
Screenings						
Hearing Impairments						
Sign Language						

Pediatrics

	A	B	C	D	E	F
CVA						
Coma Stimulation						
TBI						
Degenerative Diseases						
Mental Retardation						
Mild						
Moderate						
Severe						
Profound						
Anoxia						
Laryngectomy						
Tracheotomy						
Ventilator Dependent/Assisted						
Fluency						
Voice						
Screenings						
Hearing Impairments						
Sign Language						

Dysphasia

	A	B	C	D	E	F
Bedside Swallow Evaluation						
Modified Barium Swallow Study						
Thermal Stimulation						
Thickening Agents						
Compensatory Techniques						
Laryngectomy						
Trache						
Ventilator Dependent/Assisted						

Adaptive Equipment

	A	B	C	D	E	F
Communication Board						
Augmentative/Alt. Comm. Device						
Memory Aide						
Feeding Equipment						

Name:____ Date: ___________________

Other

	A	B	C	D	E	F
Medicare Documentation						
Home Health Documentation						
Family Education						
In-service Training						
Transfer Training						
Video Stroboscopic Voice Evaluation						
Fiber Optic Voice Evaluation						
Aural Rehabilitation						
Functional Maintenance						
Video Fluoroscopy						
Multiple Sclerosis						
Muscular Distrophy						

Name:____ Date: ___________________

Other

	A	B	C	D	E	F
Work Capacity Evaluation						
Functional Capacity Evaluation						
Feldenkrais						
Cardiac Rehabilitation						
Chest Physiotherapy						