



Speech/Language Pathology Skills Checklist

Name: _____ Date: _____

Please list any special certifications you have (Example: Hand Certification, NDT, NBCOT, etc.):

Please indicate how many years of work experience you have in each of the following categories, (Example: 6 months, 1 year, 3 years, 5 years, 10 years) If you have no experience in a category indicate a '0'.

General Work Setting Experience

Work Setting	Experience	Work Setting	Experience
Day Care Center		Hospital – Outpatient	
Pediatric Rehab Hospital		Hospital – Rehab	
Elementary School		Hospital – Psychiatric	
Headstart Program		Outpatient Facility	
General Acute Care		Skilled Nursing Facility	
Home Healthcare		PPS	
Hospital - Inpatient		RUGS	
Sports Medicine		FIMS	

Other:

Specialty Experience Pediatric:

	Experience Level		Experience Level
Traumatic Brain Injury		Impairments – Fluency	
Screenings – Hearing		Sign Language	
Screenings – Speech		Group Treatments	
Impairments – Hearing		Tracheotomy	
Impairments – Language		Ventilator Assisted / Dependent	
Impairments – Voice			

Other:

Adult Population:

	Experience Level		Experience Level
Screening – Hearing		Impairments – Voice	
Screening – Speech		Impairments – Fluency	
Impairments – Language		Degenerative Disease	
Impairments – Hearing		Traumatic Brain Injury	
Cardiovascular Attack		Anoxia	
Aphasia		Muscular Dystrophy	
Multiple Sclerosis		Alzheimer’s	

Other:

Dysphagia Experience:

	Experience Level		Experience Level
Ventilator Assisted / Dependent		Bedside Swallow Evaluation	
Laryngectomy		Modified Barium Swallow	
Tracheotomy		Thermal Stimulation	
Thickening Agents		Compensatory Techniques	
Videofluoroscopy			

Other:

Equipment, Documentation and Evaluation:

	Experience Level		Experience Level
Feeding Equipment		Documentation – Medicare	
Augmentative Communication Devices		Documentation – Medicaid	
Memory Aide		Documentation – OBRA	
Communication Board		Evaluation Videostroboscopic	
Documentation – MDS		Evaluation – Fiberoptic	

Other:

Special Education/School Experience:

	Experience Level		Experience Level
Developmentally Disabled		Early Intervention	
Learning Disabled		IEP Development	
POHI		Emotionally Handicapped	
Profoundly Mentally Handicapped		Speech Language Impaired	
Cerebral Palsy		Stuttering	
Articulation			

Other:

I verify that this statement of my work experience is accurate to the best of my knowledge.

Shamrock Medical Staffing, Inc. may utilize this information to make appropriate placements for me. I also give permission for Shamrock Medical Staffing, Inc. to release this survey to potential customers, upon request, during the assignment process.

Signature

Print Name

_____/_____/_____
Date