

**SLP Skills Checklist**

Name:  Date:  Experience Since:

	Comfortable With	Done Occasionally	No Experience
<b>I. Adaptive Equipment</b>			
1. Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Augmentative Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Computer-based Treatment/Adaptive Microswitches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>II. Speech/Language/Hearing Disabilities</b>			
1. Cleft Palate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Cognitive Rehab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Coma Stimulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. CVA/Stroke Rehab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Dysphagia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Fluency/Stuttering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Hearing Impaired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Laryngectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Voice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>III. Pediatrics</b>			
1. Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Early Intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Learning Language Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. NDT for Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>IV. Other Skills</b>			
1. Accent Reduction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Aural Rehab/Speech Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Biofeedback - EMG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Cognitive Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Co-Treatment w/Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Co-Treatment w/Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Family Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Group Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Inservice Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Myofunctional Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Prosthetics - Cleft Palate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Rehab Feeding Group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Sign Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Therapeutic Horseback Riding (Hippotherapy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Tracheostomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Ventilator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Videofluoroscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Name:  Date:

	Comfortable With	Done Occasionally	No Experience
18. FEEST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>V. Work Settings</b>			
1. General Acute Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Home Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Nursing Home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Outpatient Clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Pediatric Rehab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Acute Rehab Hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Rehab Unit in a Hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. School System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Signature

\_\_\_\_\_  
Date

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Agency Representative Signature

\_\_\_\_\_  
Date