

Speech Language Pathologist Skills Checklist



Your Partner in Staffing™

This profile is for use by Speech Language Pathologists with more than one year of experience in their discipline and specialty. It will not be a determining factor for the program. Return this checklist to us by fax at 317-780-3745.

www.healthcaredirectstaffing.com

 First name:

 Last name:

____ - ____ - ____
 Social Security number:

Please mark your level of experience

 A

Theory, no practice

 B

Intermittent experience

 C

One - two years experience

 D

Two plus years experience

A. Clinical Skills

- | | A | B | C | D |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Familiarity with standardized tests | | | | |
| a. ALPS (Aphasia language performance scale) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Boston | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. CADL (Communication ability for daily living) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Detroit | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Minnesota (Schuell) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. PICA (Porch index of communication ability) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Token | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Western Aphasia Battery (WAB) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

2. Informal testing - description of:

3. Screening

- | | | | | |
|---------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Ability to follow directions | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Attention span | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Expressive/receptive skills | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Familiarize self with chart | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Hearing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Memory skills | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Oral motor movement | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Talking to staff | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

B. Therapy Skills/Quantity Experience

- | | | | | |
|-----------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Aphasia | | | | |
| a. CVA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Head trauma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Low level functioning patients | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Oral motor disorders | | | | |
| a. Apraxia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Dysarthria | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

C. Neurological Disorders

- | | A | B | C | D |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Adaptive feeding | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. ALS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Alzheimer's (Dementia) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Augmentative communications | | | | |
| a. Communication boards, etc. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Electronic devices | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Aural rehabilitation | | | | |
| a. Hearing aids | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Hearing loss | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Dysarthria | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Dysphagia | | | | |
| a. Trachs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Ventilator dependent patients | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Videofluoroscopy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Fluency | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Parkinson's disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Therapy techniques | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Voice - laryngectomy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. How do you feel about proceeding with therapy if you can only rely on bedside evaluation? | | | | |

D. Pediatrics

- | | | | | |
|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Articulation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Autism | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Cleft palate | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Early intervention | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Feeding disorders | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Fluency | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Hearing impaired | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Traumatic brain injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

_____ / _____ / _____
First name:

_____ / _____ / _____
Last name:

Please check the boxes below for each age group for which you have expertise in providing age-appropriate nursing care.

AGE SPECIFIC PRACTICE CRITERIA

A. Newborn/Neonate (birth - 30 days)	D. Preschooler (3 - 5 years)	G. Young adults (18 - 39 years)
B. Infant (30 days - 1 year)	E. School age children (5 - 12 years)	H. Middle adults (39 - 64 years)
C. Toddler (1 - 3 years)	F. Adolescents (12 - 18 years)	I. Older adults (64+)

EXPERIENCE WITH AGE GROUPS:

	A	B	C	D	E	F	G	H	I
Able to adapt care to incorporate normal growth and development.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to adapt method and terminology of patient instructions to their age, comprehension and maturity level.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can ensure a safe environment reflecting specific needs of various age groups.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

My experience is primarily in: (Please indicate number of years.)

Practice area _____ Year(s) _____

Certification: (mo/day/year)

BCLS Exp Date: _____ / _____ / _____ CPR: Exp Date: _____ / _____ / _____

ACLS: Exp Date: _____ / _____ / _____

Other (type) _____ Exp Date: _____ / _____ / _____

Computerized charting system: _____ Date: _____ / _____ / _____

I attest that the information I have given is true and accurate to the best of my knowledge and that I am the individual completing this form. I hereby authorize the Company to release this Speech Language Pathology Skills Checklist to their Client facilities in relation to consideration of employment as a Traveler with those facilities.

Signature

_____ / _____ / _____
Date