



SPEECH/LANGUAGE PATHOLOGY SKILLS CHECKLIST

First Name	MI	Last Name
E-mail	Last 4 digits SS#	Date

Please indicate how many years of work experience you have in each of the following categories (Example: 6 mo., 1 yr., 3 yrs., 5 yrs., 10+ yrs). If you do not have any work experience in a category, please indicate 0.

General Work Setting Experience:

WORK SETTING	EXPERIENCE LEVEL	WORK SETTING	EXPERIENCE LEVEL
Day Care Center		Hospital – Outpatient	
Pediatric Rehab Hospital		Hospital – Rehab	
Elementary School		Hospital – Psychiatric	
Secondary School		Outpatient Facility	
Headstart Program		Skilled Nursing Facility	
General Acute Care		RUGS	
Home Healthcare		FIM	
Hospital – Inpatient		PPS	
Hospital – Rehabilitation			

Other: _____

Specialty Experience:

Pediatric

EXPERIENCE LEVEL	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: _____

Name: _____

Speech/Language Pathology
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Adult Population

	EXPERIENCE LEVEL		EXPERIENCE LEVEL
Screening – Hearing		Impairments – Voice	
Screening – Speech		Impairments – Fluency	
Impairments – Language		Degenerative Diseases	
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	
Videoflouroscopy			

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- Video stroboscopic	
Documentation		Evaluation - Fiber optic	

Name: _____

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Special Education/School Experience

	EXPERIENCE LEVEL		EXPERIENCE LEVEL
Developmentally Disabled		EI	
Learning Disabled		Early Intervention	
POHI		IEP Development	
EH – (Emotionally Handicapped)		PMH – (Profoundly Mentally Handicapped)	
SMI		ESOL (English Speakers of Other Languages)	
Cerebral Palsy		Stuttering	
Articulation			

Other: _____

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

@WORK Medical Services may utilize this information to make appropriate placements. I also give my permission for @WORK Medical Services to release this survey to potential customers, upon request, during the assignment process.

Signature

Date