Holsman Healthcare LLC
Healthcare Staffing and Consulting Services
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Speech Therapy Skills Checklist

Print Name: ____________________

Please check the column that best describes your experience level with each skill.

Key:
1 - Very Experienced/Performs well (no assistance required)
2 - Some experience (some assistance required)
3 - No experience

PATIENT GROUPS	1	2	3
Geriatric	___	___	___
Adult	___	___	___
Adolescent	___	___	___
Pediatric	___	___	___

WORK SETTINGS	1	2	3
General Acute Care	___	___	___
Rehabilitation Hospital	___	___	___
Early Intervention	___	___	___
Children's Hospital	___	___	___
School System	___	___	___
Home Health Care	___	___	___
Skilled Nursing Facility	___	___	___
Outpatient	___	___	___
MR/DD	___	___	___

DIAGNOSTIC	1	2	3
CVA/Stroke	___	___	___
Dysphagia	___	___	___
Aphasia	___	___	___
Apraxia	___	___	___
Laryngectomy	___	___	___
Stuttering	___	___	___
Hearing Impaired	___	___	___
Dysarthria	___	___	___
Head Injury	___	___	___
Voice Disorders	___	___	___
Fluency Disorders	___	___	___

PEDIATRICS	1	2	3
Early Intervention	___	___	___
NDT for Speech	___	___	___
Fluency	___	___	___
Autism	___	___	___
Feeding Disorders	___	___	___
Hearing Impaired	___	___	___
Mental Retardation	___	___	___
Cerebral Palsy	___	___	___
Learning Disabled	___	___	___
Cleft Palate	___	___	___

TREATMENT/PROCEDURES	1	2	3
Individual	___	___	___
Group	___	___	___
Augmentative Devices	___	___	___
Computer	___	___	___
Sensory Stimulation	___	___	___
Modified Barium Swallow	___	___	___
Video Fluoroscopy	___	___	___
Family/Patient Education	___	___	___
Voice Restoration Techniques	___	___	___

List any additional skills, training or certifications.

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Signature: ______________________________

Date: ______________________