

Speech Therapist Required Skills Checklist

(✓ check as appropriate - A = THEORY, NO PRACTICE, B = ONE-TWO YEARS EXPERIENCE C = TWO PLUS YEARS EXPERIENCE)

Name/Client:	Date:
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	A	B	C	Comments
ADULT&GERIATRIC				
Aphasia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Apraxia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Coma Stimulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
CVA - Cerebral Vascular Accident/Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Degenerative Diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dysphagia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Laryngectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stuttering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
TBI - Traumatic Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anoxia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dysarthria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fluency Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing Impaired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sign Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tracheotomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ventilator Dependent/Assisted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Voice Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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ALS - Anterior Lateral Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brain Tumor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cognitive Rehabilitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dysphasia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dyspraxia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscular Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurodevelopmental Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Progressive Neurologic Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
SCI - Spinal Cord Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
PEDIATRIC				
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Apraxia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Articulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asperger's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Autism Spectrum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cleft Palate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Down's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dyspraxia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fluency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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Group Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing Impairments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
IEP Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Learning Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
NICU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stutterling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
TBI-Traumatic Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tracheotomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Visually Impaired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ASSESSMENTS/EVALUATIONS/TREATMENT TECHNIQUES				
Augmentative/Alternative Devices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Communication Board/Devices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Compensatory Techniques	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Computer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Craniosacral Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Feeding Equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Individual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Memory Aide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Modified Barium Swallow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
NDT - Neurodevelopmental Techniques	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
NDT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oral Motor Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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Name/Client:	Date:			
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Patient/Family Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
PECS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Screening - Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Screening - Attention Span	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Screening - Expressive Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Screening - Following Directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Screening - Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Screening - Memory Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Screening - Oral Motor Movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Screening - Receptive Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sensory Stimulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Standardized Testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thermal Stimulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thickening Agents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Video Fluoroscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Videoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
VitalStim Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Voice Restoration Techniques	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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Age Specific Experience (✓ check as appropriate)

A= Newborn (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+)

	A	B	C	D	E	F	G	H	I
Able to communicate and instruct patients	<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 evaluate age-appropriate behavior and skills	<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"/>