Skills/Experience Checklist
HH Speech Language Pathologist

- This form is a self-assessment of your current skills and abilities.
- This form is also used to document skill demonstration.

EMPLOYEE PROFILE			
Last Name	First Name	Middle Initial	Employee Number
Direct Supervisor (Name)	Date Form Initiated	Expiration Date on CPR Card	

The instructions below will guide you in completing this form.
Sections designated with are to be completed by employee.
Sections designated with are to be completed by supervisor or preceptor.

Previous Experience
(Sections Employee Must Complete)

Place an **X** in the appropriate column using the key below:

KEY

A = I am competent to supervise this skill
B = I am competent to perform this skill without supervision
C = I need to review this skill
D = I need additional instruction on this skill
E = I have never performed this skill

Instruction, Review, or Skill Demonstration
(Sections Supervisor or Preceptor Must Complete)

Supervisor: Indicate whether or not instruction is required then document completion in the appropriate columns. If C or D is selected, review the instruction and possibly the skills demonstration is required prior to assignment to applicable patients.

Preceptor: Document completion of skills demonstration or indicate NA as applicable. A date and initials in the Skill Demonstration column indicates competency has been achieved. Do not date or initial until competency is achieved. An additional column is provided for repeat demonstrations.

Complete the signature section at the end of this form.

SLP must demonstrate competencies for items in bold text and marked with an asterisk (*) prior to the first assignment requiring those skill regardless of previous experience.

Previous Experience						Instruction, Review, or Skill Demonstration				
☒ **Required for all SLPs** **Infection Control**	**A**	**B**	**C**	**D**	**E**	**Review of Instruction Needed (Y/N/NA)**	**Review of Instruction Complete Date / Initials**	**Skill Demo Needed (Y/NA)**	**Competency Demonstration Date / Initials**	**For Repeat Skills Demo / Competency Date /Initials**
*** Bag Technique**										
*** Hand Hygiene**										
***Aseptic Technique**										
☒ **Required for all SLPs** **Assessment**	**A**	**B**	**C**	**D**	**E**	**Review of Instruction Needed (Y/N/NA)**	**Review of Instruction Complete Date / Initials**	**Skill Demo Needed (Y/NA)**	**Competency Demonstration Date / Initials**	**For Repeat Skills Demo / Competency Date /Initials**
*** Vital Signs (BP, HR, RR, Temp)**										
Pulse Ox (O_2 Saturation)										
Auditory Comprehension										
Verbal Expression										
Written Expression										
Articulation										
Reading Comprehension										
Pragmatic Language Skills										
Oral Motor Skills										
Dysphagia										

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Previous Experience						Instruction, Review, or Skill Demonstration				
Assessment (continued)	**A**	**B**	**C**	**D**	**E**	**Review of Instruction Needed (Y/N/NA)**	**Review of Instruction Complete Date / Initials**	**Skill Demo Needed (Y/NA)**	**Competency Demonstration Date / Initials**	**For Repeat Skills Demo / Competency Date /Initials**
Voice										
Hearing										
Attention										
Memory										
Reasoning/Insight										
Problem Solving										
Executive Functioning										
Augmentative and Alternative Communication										
Dysarthria										
Apraxia										
Other:										
State Specific:										
Supervisor/Preceptor Comments:										

Previous Experience						Instruction, Review, or Skill Demonstration				
☒ Required for all SLPs Documentation	**A**	**B**	**C**	**D**	**E**	**Review of Instruction Needed (Y/N/NA)**	**Review of Instruction Complete Date / Initials**	**Skill Demo Needed (Y/NA)**	**Competency Demonstration Date / Initials**	**For Repeat Skills Demo / Competency Date /Initials**
***Home Care Consents**										
***Plan of Care Development and Documentation of Physician Orders**										
***Medication Documentation, Including Drug Names, Route, Dosage, Frequency**										
***OASIS Functional Scoring**										
Other:										
State specific:										
Supervisor/Preceptor Comments:										

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Previous Experience						Instruction, Review, or Skill Demonstration				
☒ Required for all SLPs **Intervention**	A	B	C	D	E	Review of Instruction Needed (Y/N/NA)	Review of Instruction Complete Date / Initials	Skill Demo Needed (Y/NA)	Competency Demonstration Date / Initials	For Repeat Skills Demo / Competency Date /Initials
Oral Motor Therapy/Techniques										
Dysphagia Treatment										
Cognitive Retraining and Compensatory Activities										
Environmental Adaptations										
Augmentative Communication										
Esophageal Speech/ Treatment of Laryngectomy										
Aphasia/Language										
Voice										
Dysarthria										
Apraxia										
Other:										
State specific:										

Supervisor/Preceptor Comments:

Initials	Print Name	Signature	Title	Date (m/d/yyyy)