



**AUDIOLOGIST
COMPETENCY VERIFICATION**

Name: _____

Please complete the following information, if applicable:

License #: _____ License expiration date: _____
 Certification #: _____ Certification expiration date: _____

COMPETENCY CHECKLIST

Reviewer: Please indicate whether the above-named practitioner demonstrates competence in each skill by initialing under the “Yes,” “No,” or “N/A” column.

<u>Basic Skills:</u>	<u>Date:</u>	<u>Yes</u>	<u>No</u>	<u>N/A</u>
Speech and language screening	_____	_____	_____	_____
Speech and language cognitive evaluation	_____	_____	_____	_____
Dysphagia evaluation and treatment	_____	_____	_____	_____
Assist with modified barium swallow assessment	_____	_____	_____	_____
Augmentative communication assessment	_____	_____	_____	_____
Hearing screening	_____	_____	_____	_____
Passey-Muir valve evaluation and treatment	_____	_____	_____	_____

<u>Basic Skills:</u>	<u>Date:</u>	<u>Yes</u>	<u>No</u>	<u>N/A</u>
Individual and group speech, language cognitive therapy	_____	_____	_____	_____
Aural habilitation and aural rehabilitation therapy	_____	_____	_____	_____
Puretone air, bone and speech testing	_____	_____	_____	_____
Auditory brainstem response	_____	_____	_____	_____
Tympanometry	_____	_____	_____	_____
Hearing aid evaluation	_____	_____	_____	_____

Additional comments: _____

Reviewer signature: _____

Reviewer name (printed): _____ Title _____

Date: _____