University of Maryland

Department of Hearing & Speech Sciences

CLINIC HANDBOOK
SPEECH-LANGUAGE PATHOLOGY

2019-2020
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University of Maryland
Clinical Education Program in Speech-Language Pathology

Mission
The clinical training component of the Department of Hearing and Speech Sciences provides education which integrates professional practice, scholarship, research, and community service. It operates the Hearing and Speech Clinic on the College Park campus as the primary mechanism to support this mission during students’ first year of training. The clinic provides diagnostic, therapeutic, educational, and consultative services to individuals from the local community who present with a wide variety of communicative disorders. Throughout their participation in the delivery of these comprehensive services, students are supervised and mentored closely by members of the clinical faculty. During the second (final) year of clinical training, students are assigned to externships with experienced speech-language pathologists at schools and hospitals in the Baltimore-Washington area. Upon completion of the program, students are proficient in provision of evidenced-based practice and highly qualified for certification from the American Speech-Language-Hearing Association (ASHA).

The clinical education program is an integral component of the Department of Hearing and Speech Sciences, yet operates with a clear organizational structure of its own.

Clinical Education Program Organizational Chart
Goals of the Clinical Education Program
The clinical education program is designed to facilitate students’ knowledge and skills in four main areas. These goals include:

Application of academic/clinical knowledge and technical skills
- Administer screening and assessment tools to collect, interpret, and summarize information to make appropriate diagnoses, recommendations, and referrals.
- Collect, document, and interpret data to monitor treatment efficacy and client progress.
- Select, handle, and modify session materials/activities which are sensitive to each client’s developmental/chronological age, disorder, and culture.
- Design sessions to promote maximum client performance with regard to proxemics, pace, dynamics, and other environmental supports in individual and group sessions.
- Gather information from various sources (e.g., research articles, coursework, conferences) to formulate long and short term behavioral objectives based on task hierarchies appropriate to the client’s chronological/developmental age, disorder, and culture.
- Use effective teaching strategies (e.g. modeling, guided practice, prompting, delivery of task instructions) to maximize client performance.
- Provide appropriate response reinforcement/feedback and performance summaries based on observation and data.
- Identify and evaluate client behavior to formulate effective plans to address problem behaviors and enhance attention and learning.
- Use culturally appropriate counseling strategies to meet assessment and therapy goals (e.g., interview techniques, client/family education, overcoming barriers to progress, appropriate referrals).
- Design therapy plans, activities, and home assignments to promote generalization and maintenance of client’s communication skills.
- Apply clinical knowledge to promote effective communication skills in the local community through
  - Training and education in normal speech and language development, and recognition of risk factors for communication disorders.
  - Monitoring and screening activities.

Oral and written communication
- Communicate effectively and positively with clients, families, supervisors, colleagues, and professionals.
- Present clinical cases information with clarity and professional demeanor (e.g. maturity, technical vocabulary, adjusts for context and setting).
- Write and edit clinical reports including treatment plans, progress reports, and diagnostic reports with attention to appropriate content, style, and mechanics.

Problem solving/critical thinking
- Adjust treatment parameters (e.g., task and stimulus demands, teaching strategies, pace, interaction style, environmental supports) to maximize client performance.
- Engage in clinical problem solving based on knowledge of communication disorders and client needs, and provides rationales for clinical decisions.
- Engage in thoughtful self-evaluation and develop plans for improving clinical effectiveness.
Professional and personal characteristics

- Demonstrate positive and supportive interactions with clients, families and colleagues.
- Demonstrate “ownership” of all immediate and long-term aspects of case management with an increasing level of independence.
- Communicate consistently with supervisors for effective collaboration regarding case management and personal growth.
- Develop/demonstrate personal characteristics that support successful performance in the clinical training program (e.g., consistently positive attitude toward learning, flexibility, initiative, responsibility).
- Follow clinic procedures and abides by professional standards of conduct (e.g., timely reports/logs, client confidentiality, maintenance of files, completing required paperwork).
- Demonstrate knowledge of current professional issues including ethics, business practices, licensure, specialization, scope of practice, legislation, etc.

Clinical Roles and Responsibilities

Student clinicians function as the primary therapist for each individual in their assigned caseload. Responsibilities typically include the following: programming goals and objectives, preparing for sessions, implementing diagnostic and therapeutic activities, collecting and analyzing data, communicating progress, and writing reports. Case supervisors are responsible for ensuring that all aspects of service delivery are carried out in the most appropriate and effective manner. They work closely with student clinicians to develop, implement, and evaluate the diagnostic and therapeutic services provided to clients, and supervise all aspects of communication with families and other interested parties. **Generally speaking, student clinicians should receive supervisor approval and verify that appropriate releases of information have been signed prior to engaging in any substantive communication with family members or other professionals regarding their clients.** Ultimately, clinical instructors are responsible for all clinical services delivered to specific clients by graduate student clinicians in the department.

Conflict Resolution

Occasionally, a student or clinical instructor may perceive that a problem exists in the supervisory relationship. Within the context of clinical practicum, early problem-solving is crucial for two major reasons:

a) lack of resolution may interfere with student learning and/or affect the quality of client care
b) students need to master the interpersonal and communicative strategies necessary for resolving problematic situations as part of their professional development

If either a student or clinical instructor perceives that a problem exists, the following procedures should be implemented:

1. Discuss the problem together. Simple misunderstandings are often rooted in lack of clear communication and frequently can be cleared up through discussion.
2. If either party feels that discussion has not resolved the situation, the Clinic Director should be contacted immediately. The director will work with both parties to ensure a quick and effective solution to the problem.
3. In the unlikely event that the problem persists, the student may wish to bring the matter to the department chair/ombudsman for discussion.
Clock Hour Documentation

All clinical training is documented in a computerized tracking program. Each clinical hour (50 minutes) of direct contact with clients is identified as fitting within one of nine categories described by ASHA (articulation, fluency, voice, language, dysphagia, cognitive, social, modalities, hearing). ASHA no longer specifies minimum numbers of clock hours in any category. However, the Department of Hearing and Speech Sciences does follow an established rubric in order to ensure that all students graduating from the program have been exposed to the widest possible variety of communication disorders. There are nine major categories which represent the various aspects of the profession:

Articulation
Fluency
Voice
Language
Dysphagia
Cognitive (attention, memory, sequencing, executive function)
Social (challenging behavior, ineffective social skills, lack of communication opportunities)
Modalities (oral, manual, augmentative, alternative)
Hearing

To meet ASHA requirements, each student must acquire a minimum of 375 contact hours (up to 75 of these may be earned through simulated clinical experiences). In addition, a minimum of 25 observation hours must be accumulated by the end of the degree program. Most students graduate from the University of Maryland program with significantly more than this minimum requirement of 400 clock hours (e.g., average of 450-500 hours). Hours from the on-campus clinic as well as outside placements count toward the total accumulation. At least 325 clock hours must be earned at the graduate level of study.

The Department of Hearing and Speech Sciences imposes a further requirement that students must acquire a minimum of at least 5 clock hours in each of the nine categories listed above. These hours can be earned across the categories of observation, evaluation, or treatment for each of the nine specified categories. Please see the sample clock hour form posted on the next page and the HESP 648B practicum course website.

All graduate clinicians record their completion of client contact hours on a regular basis in a binder kept in the student lounge. The clinic assistant enters this data into a spreadsheet tracking program and provides interim summaries on a biweekly basis. Students’ clock hour distributions are used to make caseload assignment decisions in subsequent semesters, so it is the student’s responsibility to submit accurate and timely recording of client contact as a crucial element of the clinical training process.
### SAMPLE GRADUATE STUDENT CLOCK HOUR SUMMARY

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**Total Hours Per Placement** (diagnostic and treatment only)

- **University of Maryland**: 203.5
- **Rolling Terrace Elem.**: 95.5
- **DC VA Medical Center**: 142

**Date Run**: 8/11/2014 12:06

**Signature**: Colleen Worthington, M.S., CCC-SLP
**ASHA #**: 00862730
REPORT OF
UNDERGRADUATE
OBSERVATION HOURS

Name: ___________________________  Semester: _______________________

Name of UMD Clinical Program, Outside Placement or Course Number: ___________________________

**Disorder Categories: A=Articulation/Phonology, L=Language, F=Fluency, V=Voice, AR=Aural Rehabilitation, SW=Swallowing, AU=Audiology

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Total Observation Hours on This Form:
Number of Speech/Language Hours: _______  Number of Audiology Hours: _______
Supervisor’s Signature: ___________________________  Supervisor’s Signature: ___________________________
Supervisor’s ASHA #: ___________________________  Supervisor’s ASHA #: ___________________________
Date: ________________  Date: ________________
The clinical training program is designed to be an integral part of the master’s degree program in speech-language pathology. The department operates an on-campus clinic which provides speech-language pathology services to the campus student body and surrounding community.

Enrollment in clinical practicum requires a fulltime commitment. Students register for practicum during each of the five semesters. A general description of the clinical training program by semester includes the following:

**First semester**
- Register for two credits of HESP 648B and one credit of HESP 648A
- Therapy caseload assignment of 2-3 clients/week generates approximately 6 hrs/week client contact time plus approximately 8-12 hours devoted to planning and paperwork.
- Diagnostic caseload generally entails 3 hrs/week of observation. Primary and secondary clinicians engage in an additional 2-5 hrs/week in planning and report-writing.
- A variety of meetings is held throughout the semester and includes weekly cores, group staffings, and individual supervisory conferences. These meetings generally represent a time commitment of approximately 4 hrs/week.

**Second semester**
- Register for two credits of HESP 648B (you will have received an “Incomplete” for HESP 648A)
- Therapy caseload assignment of 3-4 clients/week generates client contact time of approximately 6 hrs/week. Planning and paperwork time averages 5-8 hrs/week.
- Diagnostic caseload assignment remains unchanged (see description above)
- Meetings and materials room duty remain unchanged (see description above)

**Third semester (6-week summer session)**
- Register for two credits of HESP 648B
- Therapy caseload assignment of 3-4 clients/week generates approximately 8 hrs/week of client contact time. Planning and paperwork time averages 4-5 hrs/week.
- Diagnostic caseload assignment remains unchanged (see description above)
- Meetings and materials room remain unchanged (see description above)

**Fourth semester**
- Register for three credits of HESP 728
- Outside placement assignment averages 3-4 days/week
- Occasional screenings coordinated by core clinic assigned 1-2 days per semester

**Fifth semester**
- Register for three credits of HESP 728
- Outside placement assignment averages 3-4 days/week
- Occasional screenings coordinated by core clinic assigned 1-2 days per semester
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CLINICAL POLICIES AND PROCEDURES

- HIPAA

- Clinic Medical Records

- Session Procedures

- Observation Room

- Safety and Emergency Procedures
The University of Maryland Hearing and Speech Clinic follows all federal regulations contained in the Health Insurance Portability and Accountability Act (HIPAA). This law provides data privacy and security provisions for safeguarding medical information. Accordingly, the clinic has implemented a wide range of policies and procedures to ensure compliance with these regulations.

Information about patients who receive services from our clinic is considered “Protected Health Information” also known as PHI. This includes data such as name, address, date of birth, email address, diagnosis results, therapy objectives, etc. Even the fact that an individual receives a service from our clinic is considered “PHI”. The clinic implements a wide variety of equipment and workflow safeguards to protect patient information. Adherence to the Clinic’s specific HIPAA policies and procedures is mandatory for all student clinicians. This is especially true for ensuring written authorization for sharing information as well as following established procedures for accessing the Clinic’s electronic medical records system.

In an attempt to provide a working/learning environment that is as “user-friendly” as possible while still complying with HIPAA regulations, the Clinic has created a secure drive for all computer applications which contain PHI. This “D:drive” is the site for accessing the medical record system, the clinical session evaluation database, and word-processing folders for working on patient reports. Student clinicians are allowed to access the “D:drive” secure environment only through specific computers physically located within the department – no remote access to any PHI is possible via personal laptop, home computer, etc. All clinical reports/documents must be created and revised using only the designated computer stations located within the department. No exceptions will be made to this policy.

All students will engage in online HIPAA training during orientation and specific policies and procedures regarding HIPAA compliance will be reviewed frequently throughout the course of the first year of clinical practicum training. Additional information on workflow procedures will be presented in subsequent sections of this handbook under relevant topics. Student clinicians are strongly encouraged to ask questions regarding HIPAA whenever they wish.

The Hearing and Speech Clinic complies with all privacy rules outlined in HIPAA. The Clinic feels that it is important for clinic faculty, staff, and graduate clinicians to be knowledgeable about client rights, understand their responsibilities as health care providers, and ensure that client information is handled confidentially at all times (see below for examples). The department has developed an online HIPAA training course for this purpose. All graduate students in the department are required to complete this course and pass a competency test demonstrating knowledge and understanding of

Examples of clinic regulations related to client privacy:

- **Notes taken during chart review:** You may choose to take notes about your patient when you are reviewing a chart. These notes should not contain any Protected Health Information (PHI). Please refer to the HIPAA training module for details about what is considered PHI.
- **Printing of Reports:** Students do not have the computer access necessary to print out client reports and should ask a case supervisor or the clinic office staff to do this when necessary. **Discussion of cases:** Clinicians can discuss cases with one another when necessary to facilitate programming and intervention, but all communication of this nature should take place in private areas of the clinic – not in the hallway or in the student room.
● **Substantive discussions and consultations:** Before engaging in any substantive communication about your client with family members or other professionals, you must seek supervisor approval and verify that all appropriate releases have been signed.

● **Phone messages and email correspondence:** When leaving a phone message or communicating with a client via email, confirm that written authorization form has been submitted by the client. Any discussion of protected health information should be kept to a minimum.
I. CLINIC’S COMMITMENT TO YOUR PRIVACY

The University of Maryland Hearing and Speech Clinic (Clinic) is dedicated to maintaining the privacy of your protected health information (PHI). PHI is individually identifiable health information about you that relates to your past, present or future physical or mental health or other condition, as well as any related health care services. This Notice of Privacy Practices (NOPP) provides you with the following important information: our obligations concerning your PHI; how the Clinic may use and disclose your PHI; and your rights with regard to your PHI. A longer version of this NOPP is available on the Clinic’s website and the Clinic will provide a hard copy upon request.

II. UNIVERSITY STUDENTS

HIPAA requirements for PHI generally exclude student health information, but the confidentiality of such information is protected under the federal Family Education Rights and Privacy Act (FERPA), Maryland state law, and/or University Policy, as applicable. The Clinic recognizes the need for confidentiality and privacy with respect to student health information, and will use, disclose and otherwise treat your health information accordingly, following the requirements of applicable law and University policy (see Section IV below).

III. NON-STUDENTS

A. Clinic’s Obligation. Federal and state laws require that the Clinic maintain the privacy of your PHI. By complying with these laws, the Clinic is required to provide you with this notice regarding its privacy practices, its legal duties, and your rights concerning your PHI. Except for student records and certain records the University creates or receives in its role as an employer, this NOPP applies to all records containing your PHI that are created or retained by the Clinic. A copy of the NOPP is posted in a visible location in the Clinic waiting room at all times, and you may request a copy of the NOPP at any time.

B. How The Clinic Uses And Discloses Your PHI. This paragraph describes, in general terms, the different ways the Clinic may use and disclose your PHI; it does not cover all possible uses and disclosures. The Clinic may use and disclose your PHI:

1. to provide treatment and related health care services to you;
2. to bill and collect payment for the services and items you receive;
3. in connection the Clinic’s health care operations, including administrative, financial, and legal activities;
4. to third-party business associates (e.g., billing services);
5. for health related services, such as recommending treatment alternatives;
6. to individuals involved in your care, unless you object;
7. under limited circumstances, for research purposes in accordance with applicable law and University policy;
8. when required or allowed by law; and
9. with your written authorization. For further information or if you have questions, please consult with the Clinic Directors (see below).

IV. YOUR RIGHTS REGARDING YOUR PHI

A. Non-Students. You have the following rights regarding your PHI, and you may request any of the following:

1. confidential communication of your PHI in the manner of your choosing;
2. restriction on communications with certain individuals otherwise permitted by law to inspect your PHI;
3. inspection of records containing your PHI;
4. copies of your PHI if you believe the information is incorrect or incomplete;
5. a list of disclosures we have made of your PHI; and
6. a copy of this NOPP.

B. University Students. University students have similar rights regarding their health information, including the rights to request confidential communications, restrictions on use or disclosure, inspection and copies, amendments, accounting of disclosures, and copies of this Notice. Those rights may, however, be implemented in different ways under FERPA, Maryland law, and/or University policy, as applicable. If you have questions about your rights regarding your health information, please contact the Clinic Directors (see below).

C. COPIES OF MATERIALS. You have a right to all of your medical records. Written authorization is required; the Clinic’s records release form is available from the Clinic office. The Clinic can fax records or provide them in paper form; for the latter, the Clinic will charge $0.25/page if the records are more than 5 pages.

V. IMPLEMENTATION, QUESTIONS, AND COMPLAINTS

A. Implementation. This NOPP provides a general overview of our privacy practices. This NOPP and our privacy practices are implemented in accordance with applicable University policies and procedures and the requirements of HIPAA and other federal and Maryland laws, as applicable.

B. Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Clinic. All complaints must be submitted in writing. We will not retaliate against you in any way if you file a complaint with us.

VI. CONTACT INFORMATION. If you have any questions regarding this Notice or our health information privacy practices, please contact:

Colleen Worthington, M.S., CCC-SLP
Director of Language Services, Clinic HIPAA Privacy Officer
Nicole Nguyen, Au.D., CCC-A
Director of Audiology Services
nknguyen@umd.edu
(301) 405 – 4221
CLIENT MEDICAL RECORDS

Reviewing Client Files:
Client files are located in our electronic medical records system, Point’n Click (PnC).
1. PnC can be accessed ONLY via the designated workstations in the clinic
2. Once you sign in to PnC select the green arrow labeled UMDHSC PNC production:
3. Client files can be accessed by pressing the “Chart” button on the Application Manager toolbar.

4. Once OpenChart is open, click the radio button that selects “Client,” and enter the last name or medical record number in the yellow search bar.

5. When the client’s file appears, navigate the chart by selecting options on the left toolbar.
   **Medical Summary**- basic information, such as the client’s full name, date of birth, local address, and preferred language.
   **Registration**- additional information about the client, such as preferred level of contact (e.g., phone, email), local address, email address, and telephone number.
   **Notes**- shows previous encounter notes, which include information regarding the client’s billing codes.
   **Diagnoses**- also shows the billing codes used for previous visits and appointments.
   **All Documents**- (first option in the fourth section) to view previous notes, reports, evaluations, case histories, medical documents, emails, as well as scanned reports and evaluations that were created before the installation of PnC.

   All documents have the following information that you might find useful: creation date, document type (e.g., scanned document, encounter note), and summary (e.g., test form, report, case history, hearing screening). Once you click on a document, the item will appear on the right hand side of your screen.

Checking a Client In:

When clients arrive for a therapy or evaluation session, Graduate Clinicians are responsible for checking the client in using PnC. This record of attendance is critical for billing and accounting.
1. After signing into PnC, press the “Scheduling” button on the toolbar, aka ApplicationManager.

2. Once OpenSchedule is open, enter the clinician’s name (Last, First) in the “Provider” toolbar. This will open provider’s daily, weekly, or monthly schedule, which includes the client’s name and session time. If, for some reason, the session isn’t listed on your schedule, you can search under the supervisor’s schedule.

3. Clients who have NOT yet been checked in, will have a yellow bar next to their name. To check a client in, students should right click on the client’s name, and select “Check In” (third from the top of the list). Confirm the information in the pop-up window and select “Ok.” Once complete, the client will have a red bar next to his/her name, indicating he/she is checked in.

**Encounter Notes:**
After each therapy session, students will write an encounter note for documentation of client visits. Encounter notes should be completed within 24hrs of the encounter.

**Writing an Encounter Note:**
1. Select Chart from the Toolbar and click on Encounter Note on the left-hand side of the screen.
2. At the top of the screen under Prior Appointments, scheduled appointments will pop up. Click on the appropriate session. If the session does not appear as a hyperlink, then the client has not been checked in for that session.

1. Fill in the notes section. Most notes should say something like: Client attended regularly scheduled therapy session.
Please also include any information important for scheduling or billing, such as make up or extended sessions.

2. Fill in Diagnosis codes. To find out a client’s Diagnosis code look at past notes from previous clinicians. These can be found by clicking on Notes or Diagnoses on the left-hand side. If you have any questions about the appropriate diagnosis code, discuss this with your supervisor.

3. Fill in the Charge slip form by selecting the session type (ex. Individual SLP Evening Therapy up to 60 min). If your scheduled session begins at 4:30 or after, make sure to bill for evening sessions.

4. When finished, sign as the Graduate Clinician at the end of the page.

5. IMPORTANT: Be sure to close the encounter note (top right corner) once it is complete so that your supervisor can access your note.

Under the tab for Encounter Notes, clinicians can also fill out other important notes about missed appointments, phone/email contact (to document all clinician contact with the client), SLP initial therapy plans, and SLP semester reports, all shown above.

SESSION PROCEDURES

Canceled Sessions:

It is very important to properly record and reschedule canceled appointments for billing purposes. When a client calls/emails to cancel a therapy or evaluation session, the clinician should

1. Inform their supervisor and the front office as soon as possible.
2. Mark the session as canceled in OpenSchedule: Go to Schedule in the ApplicationManager and right click on the appointment. Select either Cancel or No Show. Only use No Show if the client does not show up for an appointment without communicating with you.
3. Document the cancellation: Go to the Encounter Notes tab on the left-hand side. Click on Missed Appointment note under New Non-Appointment Encounters. While filling this out, include the reason for the cancelation.

Make-Up Sessions:

If a session is missed for any reason, every attempt should be made to find a make-up time. Contact the client to find a time to reschedule any missed appointments. There are specific days at the end of the semester that the clinic sets aside for make up sessions. However, if none of these days work for the client, or if there is more than one session to make up, a day that works for both client and clinician can be arranged. If no make-up day can be found, time can also be added in 10 minute increments before or after a regularly scheduled session to account for a missed session. (e.g., Add 10 min after 5 regularly scheduled sessions to make up for a 50 min missed session). This should all be recorded in PnC in the notes section for client visit encounter notes.
When scheduling a make-up sessions or time:

1. Check to make sure there is a room available: In OpenSchedule, click on the Door icon at the top left of the page. Select the date you would like to reschedule for and identify an open room.
2. If you have chosen a time that was not very busy or is the first or last session of the day, check with your supervisor before scheduling the session.
3. Once scheduled, email hespclinik@umd.edu with medical record number of the client, the date, time, supervisor and desired room so that the session can be added to the schedule.
4. Inform your supervisor of the makeup time.

After your session:

Complete the encounter note for the session. Be sure to indicate that all or part of the session was to make up for a missed session and specify the date. Make-up sessions should be applied to cancelled sessions in chronological order (i.e., first make-up is applied to the cancellation which happened first.

Clinical Session Tidbits to Know:

Please get in the habit of turning out the lights as you leave your therapy room.

Do not use push pins or tape to attach anything to the acoustic wall panels or painted doors in the therapy rooms. Picture stimuli should be mounted with magnets on the chalkboard or affixed to an easel, felt board, etc.

“Scavenger hunts” that require stimulus pictures should not be conducted in departmental corridors. No materials should be taped to any surface in the buildings hallways.

Each therapy room contains a cabinet, table, and chairs (two chairs in kiddie rooms and four chairs in adult rooms). On occasion, you may need to rearrange furniture in the therapy rooms to accommodate your client’s needs. Do not place furniture in a manner that causes scratches in the door paint. Please return all furniture to the original configuration immediately after your session.

You may choose to give your personal number to your client so they can call you directly to cancel a session. This may save you a trip to campus, particularly if the client is scheduled toward the beginning or end of the day. Remember, it is still your responsibility to notify both the clinic office and your supervisor. The cancellation procedures should be completed the same day.

Clients are billed for the entire semester at the beginning of treatment and may elect to pay in installments. Student clinicians are not responsible for handling any financial transactions. Clients should contact the clinic office staff to make payments or ask questions about their account. If your evening client wants to make a payment after the clinic office staff have left for the day, please direct them to your supervisor.

Each client is issued one parking permit at the beginning of each semester. They are allowed a second one at no charge. If additional ones are requested, the charge is $10.00 per permit. Clients should use the assigned parking tag only during the days/times when they are coming into the clinic for services

Each student will be assigned a storage bin in which to keep privately-owned therapy materials. These bins should be kept on the shelves in the student room or in the cabinets in the kiddie hallway. Lids on these bins should be used to preserve a neat appearance in the student room and kiddie hallway. Please
register to use the lockers located in the department to hold any materials that don’t fit in your assigned bin. See the secretary in the clinic office for assignment and bring your own lock.  

Please do not store/hoard tests or therapy materials borrowed from the clinic or your supervisor in your bin – they’re for everyone’s use!

When you meet your client in the waiting room, check to make sure that they have signed in at the clinic office. From a safety standpoint, it is important for us to know what clients are being seen in the clinic at any given moment if an emergency situation arises (e.g., fire drill, power outage, etc.).

Guidelines for Student Access to Printing and Copying Services
Limited use of HESP departmental printers and copiers is appropriate for preparing some clinical materials. The materials room holdings are designed to provide clinicians with a wealth of readily available therapy resources. However, there may be some occasions when therapists deem it necessary to create their own session materials or copy an existing set. Please be judicious in your use of departmental printing and copying resources.

Departmental printers and copiers should not be used for personal documents. Please see the list below for guidance on what is considered personal use. If a clinician is unclear about the appropriateness of a specific printing/copying task, please feel free to ask your clinical supervisor. Printers and copiers are available for students’ personal use in the OACS computer lab and in McKeldin Library.

EXAMPLES

OK to print or copy

- individualized materials for client homework/carry-over
- limited amounts of therapy workbook pages or stimulus materials

Not OK to print/copy

- class powerpoint notes
- journal articles
- chapter readings for class
- documents for class projects
- drafts of term papers or candidacy papers
SPEECH-LANGUAGE OBSERVATION POLICY

The observation room is used to view therapy sessions in progress, enabling the clinical instructors to supervise students’ delivery of services to clients. In addition, students in practicum courses are encouraged to observe sessions related to academic courses or clients with goals similar to their own.

We encourage family members to observe therapy sessions. However, there are specific guidelines that must be followed to ensure that the teaching of students in not interrupted, and that therapy and diagnostic evaluations of individual clients are not compromised.

1. In order to respect the privacy of all clients, please only watch your own family member. Only family members and those who are specified on a release form may watch a session.

2. Observations are made through a one-way mirror. Clients in the therapy rooms will not be able to see observers as long as observers do not get too close to the glass or use electronic devices with lighted screens. Please do not adjust the lights in the observation room.

3. Please use headphones when there are others present in the observation room.

4. In order to provide a quiet listening environment for others and to keep noise from traveling into the therapy room, please do not speak above a whisper and keep conversations to a minimum in the observation room.

5. Excessive noise in the hallway travels into the therapy rooms, as well as into classrooms and offices. Accompanying children must be supervised at all times in the hallways and in the waiting room.

6. Food and drink are not permitted in the observation room.

8. Please do not touch the video-recording system components in the observation rooms. Clinical faculty are the only individuals who have been trained to use this system.
Safety and Emergency Procedures

Universal precautions are procedures designed to protect both the student and the client from transmission of communicable diseases. To minimize health risks, always assume that bodily fluids are potentially infected. Each fall, new student clinicians will attend an in-service training session on bloodborne pathogens conducted by the University’s Department of Environmental Safety.

To minimize the risk of communicable diseases, the Department requires that students participating in clinical practicum training be vaccinated against hepatitis B. This vaccine consists of a series of 3 shots administered over a six-month period and should be initiated prior to entering the program.

Routine Hand Washing: This is the best way to reduce transmission of disease. You are expected to wash your hands with soap and water in all of the following situations:

- Before and after each client session
- After sneezing, coughing, or wiping a nose
- After using the toilet
- After handling soiled items such as a diaper or dirty toys
- Before preparing or eating food

Use alcohol-based hand sanitizer is an acceptable alternative to hand washing except after using the toilet, or contact with diapers or bodily fluids.

Use of Disposable Gloves: Gloves should be worn whenever the clinician will come into contact with bodily fluids or place their hands near the client’s face (e.g., oral mechanism exam). Put gloves on immediately prior to touching the client. If you put them on too early and then touch other objects (e.g., clipboard, pencil, own hair, etc), your gloves may become contaminated. Remove gloves by peeling them off from the wrist and turn them inside out as you go.

Cleaning Clinic Materials: Any potentially contaminated surface should be disinfected. Toys/objects that have been mouthed by a child and therapy table tops should be cleaned with a disinfectant wipe immediately after each session. Ear tips used for immitance screenings should be placed in the designated container and will be cleaned on a periodic basis by the clinic assistant.

In case of emergencies, student clinicians should follow established procedures for orderly evacuation of the building. In case of power outage and loss of electrical lighting, each therapy room is equipped with a battery-powered flashlight stored at the top of the blackboard. These flashlights are intended for emergencies only and should not be moved or used for any other purpose.

Upon loss of electrical power or activation of the fire alarm, student clinicians should move their clients quickly and quietly outside the building and gather in front of the South Campus Dining Hall. Therapy room and hallway doors should be closed as each client is evacuated. The clinic office staff will bring the client sign-in sheet to the designated gathering spot in order to allow a member of the clinical faculty to ensure that all students and clients are accounted for. Student clinicians should not re-enter the building until given instructions by a member of the clinical faculty.
SESSION IMPLEMENTATION AND DOCUMENTATION

- Decision Making charts

- Evidence Based Practice

- Disorder Summaries (symptoms, goal areas, common interventions, and resources)

- Clinician Responsibilities

- Daily Logs

- SOAP Notes
EVIDENCE-BASED APPROACH TO TREATMENT

All graduate clinicians are encouraged to incorporate an evidence-based practice (EBP) approach to intervention. EBP is best conceptualized as the integration of three main components: (1) current best scientific evidence; (2) clinician expertise; and (3) client values, beliefs, and preferences including cultural/linguistic factors. Information in the professional literature can be categorized according to levels of scientific design and quality. The table below provides an evidence rating hierarchy that ranges from most to least scientifically robust.

Evidence Rating Hierarchy*

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>IA</td>
<td>Well designed meta-analysis of more than one randomized controlled study</td>
</tr>
<tr>
<td>IB</td>
<td>One well designed randomized controlled study</td>
</tr>
<tr>
<td>IIA</td>
<td>One well designed controlled study without randomization</td>
</tr>
<tr>
<td>IIB</td>
<td>One well designed quasi-experimental study</td>
</tr>
<tr>
<td>III</td>
<td>Well designed non-experimental studies (i.e., correlational and case studies, including multiple baseline designs)</td>
</tr>
<tr>
<td>IV</td>
<td>Expert committee report, consensus conference, clinical experience of respected authorities</td>
</tr>
</tbody>
</table>

* Adapted from ASHA 2008 website

From a practical perspective, clinicians should realize that “gold-standard” evidence (Levels I and II) is frequently unavailable in the research literature for our profession. Clinicians should evaluate existing information from the other levels of the hierarchy to guide their decision-making, to the extent possible. Implementation of an EBP approach may take many forms depending on the disorder and the needs of the client. As students receive caseload assignments during graduate clinical training, they should use these key steps to implement and EBP approach to treatment:

1. Ask an answerable and intelligent clinical question
2. Search for the best available evidence
3. Critically evaluate the evidence
4. Consider individual client characteristics and needs
5. Make a clinical decision with client input
6. Implement treatment plan and document progress/outcome(s)
Accent: a manner of pronunciation of a language
Dialect: variations of language differing in pronunciation, vocabulary, grammar, and prosody

Speech and Language Differences:
- Articulation/pronunciation
- Vocabulary/lexicon
- Syntax and morphology
- Prosody/intonation and stress
- Social language customs
- Knowledge and understanding of figurative language

Potential Clients:
- Speakers of regional American dialects
- Speakers of English as a second language

Goal Areas:
- Articulation
- Grammar
- Stress and intonation
- Co-articulation as it affects the “rhythm” of the language
- Social language, including figurative language and social cues

Focus of Therapy:
- Pronunciation only [similar to articulation therapy]
- Pronunciation and articulation
- Pronunciation, intonation, grammar, and social language

Resources:


Disorder: Aphasia

Clinical Symptoms:
- Agrammatism
- Paraphasias
- Perseverations
- Impaired word finding
- Non-fluent speech
- Impaired auditory comprehension
- Agraphia
- Alexia
- Excessive speech
- Jargon

Associated Conditions: Stroke, Traumatic Brain Injury, Neurosurgery, Agnosia, Cognitive Impairments, verbal apraxia, dysarthria

Goal Areas:
1. Automatic speech
2. Word finding
3. Phrase and sentence production
4. Auditory comprehension
5. Reading comprehension
6. Functional oral or written communication
7. Augmentative/alternative communication

Therapy Approaches
- Psychosocial Approach
- Life Participation Approach to Aphasia
- Functional Communication Approach
- Cognitive Approach
- Group Therapy

Resources:


## Articulation and Phonology Disorders in Children

**Clinical Symptoms:**
- Slow acquisition of speech sounds
- Substitution or omission of speech sounds
- Difficulty identifying/using appropriate phonological rules
- Poor intelligibility of speech

**Associated Conditions:**
- Language impairment
- Hearing loss
- Childhood apraxia of speech
- Cerebral palsy
- Cleft palate
- Intellectual Impairment

**Goals Areas:**
- Increasing repertoire of consonants and vowels
- Increasing accurate production of speech sounds
- Improving mastery of phonological rules
- Improving intelligibility of speech

**Therapy Approaches:**
- Traditional (sensory-perceptual)
- Motokinesthetic
- Paired oppositions (minimal-maximal)
- Phonological processes

**Resources:**
Disorder: Autism Spectrum Disorders

Clinical Symptoms:
- Impairment in social interaction
- Impairment in communication
- Restricted, repetitive patterns of behavior. Narrow interests and activities.

Receptive Language Profile:
- Difficulty processing social meanings and nonsymbolic behavior
- Difficulty with rule extraction and dependence on context cues
- Limited understanding of a variety of semantic categories
- Lack of attention to listener needs and concrete/literal interpretation of language

Expressive Language Profile:
- Limited repertoire of communicative functions and communicative means
- Rote quality of expression and unconventional verbal behavior
- Deficits in oral motor programming

Goal Areas

Preverbal Stage
- Establish reliable system of communication (PCS, sign, verbal)
- Expand conventional means and functions for communication
- Increase joint attention and social reciprocity

Emerging Language Stage
- Expansion of vocabulary and ability to produce intelligible communicative acts (word, sign, picture)
- Ability to combine words, signs, pictures creatively to express relational concepts
- Build literacy skills

Advanced Language Stage
- Increased conversation skills including use of nonverbal behavior to support social interaction
- Use of language as a tool for emotional regulation
- Ability to understand and use higher order language concepts (e.g., figurative language, humor, reading comprehension)
- Ability to understand and explain perspective of others (Theory of Mind)

Therapy approaches (communication training):
- Behavioral approaches
- Developmental/pragmatic approaches

Essential Treatment Strategies and tools:
- Visual teaching and other alternative augmentative communication devices (e.g., pictures, graphic organizers, speech bubbles/clouds)
- Environmental supports with a natural/functional focus
- Consistency, predictability and structure

Resources:


## Disorder: Child Language

### Clinical Symptoms:
- Failure to acquire language
- Delayed language
- Qualitatively different language acquisition
- Acquired language disabilities

### Associated Conditions
- Intellectual Disability
- Hearing Impairment
- Minimal Brain Damage
- Emotional Disturbances
- Learning Disabilities
- Linguistic Differences
- Cerebral Palsy & Other Motor Disorders
- Environmental Deprivation
- Autism Spectrum Disorders

### Goal Areas:
- **Form**—Receptive and/or Expressive Morphology and Syntax
- **Content**—Receptive and/or Expressive Semantics
- **Use**—Receptive and/or Expressive Pragmatics

### Therapy Approaches:
- **Developmental**
  - Cognitive
  - Psycholinguistic
  - Integrative
- **Non-Developmental**
  - Content not from normal acquisition
  - Stress functional skills

### Resources:
## Disorder: Stuttering

### Clinical Symptoms:
- Stuttering-like disfluencies including part-word repetitions, whole-word repetitions, prolongations, and silent blocks.
- Other “normal” disfluencies including interjections, phrase repetitions, multi-syllable word repetitions, and revisions.
- Physical concomitant behaviors including loss of eye contact, facial grimacing, head or limb movements
- Feelings associate with fluency breakdown or inability to effectively communicate including shame, embarrassment, frustration, inferiority, helplessness, and fear of speaking and stuttering
- Escape and avoidance behaviors including those that lead to struggle (tension, concomitant behaviors listed above) and concealment of stuttering symptoms (linguistic coping strategies, attitudinal postures, role playing, etc)

Onset generally in early childhood, most often during the preschool years. The disorder progresses and changes over with increased awareness and desire to hide one’s identity as a person who stutters.

### Goal Areas:
- Increased understanding about the nature of stuttering and the factors that lead to recovery and persistence
- Reduction of struggle and tension in communication
- Reduced fear of speaking/stuttering, as well as feelings of shame associated with stuttering
- Increased speech fluency and/or comfortable, forward-moving speech that includes some easy disfluency
- Reduced situational avoidance and increased comfort in public speaking
- Increase positive attitudes about oneself as a person who stutters and about speech and communication

### Therapy Approaches:
**Direct Therapy**
- Changes in speech pattern: fluency modification; stuttering modification
- Changes in attitudes and emotions: desensitization; cognitive restructuring

**Indirect Therapy (young children)**
- Input and output strategies in the communicative environment

**Operant Approaches**
- Lidcome (young children)

**Adjuncts to Therapy**
- Electronic devices
- Psychopharmacology

### Resources:


The Stuttering Homepage: [http://www.mankato.msus.edu/dept/comdis/kuster/stutter.html](http://www.mankato.msus.edu/dept/comdis/kuster/stutter.html)
**Disorder: Voice**

**Clinical Symptoms:** Clients usually present with a vocal quality that is hoarse and/or breathy or are unable to produce voice at all. Clients may experience pain or discomfort during phonation and may lose their voice frequently. The quality of the voice often affects their communication in social, academic, and professional settings. The etiology of the altered vocal quality may vary. It is important to establish the etiology so that treatment approaches are congruent with the disorder underlying the vocal symptoms.

**Associated Conditions:** Vocal nodules, vocal abuse/misuse, vocal fold paralysis/paresis, dysphonia, vocal hyperfunction/hypofunction, Parkinson’s Disease, surgery, head and neck cancer, neuromotor diseases, craniofacial anomalies, resonance disorders.

**Goal Areas:**
- Vocal volume
- Decreasing hoarseness and breathiness
- Improving breath support
- Use of compensatory strategies (frontal focus and easy onsets)
- Principles of vocal hygiene

**Therapy Approaches:**
1. Vocal function exercises
2. Vocal hygiene and facilitation of lifestyle changes
3. Teaching appropriate compensatory phonation strategies
4. Counseling regarding quality of life
5. Resonant voice therapy
6. Lee Silverman Voice Treatment program

**Resources:**


Clinician Responsibilities

Daily:
- Planning/preparation for therapy sessions
- Daily log (Fall, Spring)
- Home assignments for clients, as appropriate
- Record clock hours
- Record client/clinician cancellations
- Maintain client files (contact notes)
- Therapy session encounter notes in Point and Click

Weekly:
- Communication/meetings with supervisor
- SOAP notes (summer)
- Meeting with co-clinicians, as appropriate
- Attend Central Clinic Core meeting
- Diagnostic Team

Semester:
- Initial Treatment Plan (ITP)
- Progress Report
- Maintenance/carry-over activity for breaks in therapy
- Summer treatment plan (end of Spring semester only)
- Therapy application completed by client/family at end of each semester
- Midterm and final evaluation (grading) meetings with supervisor
- Complete all documentation in Point and Click
DAILY LOGS
Instructions For Completion

Complete a daily log for each therapy session. Logs consist of 6 sections:
1. Behavioral Objectives
2. Rationales
3. Reinforcement
4. Client Performance
5. Self-evaluation of Clinical Skills
6. Problem-Solving, Insights and Planning

Sections 1, 2 and 3 are completed prior to session. The log is then posted within the relevant folder within the secure computer environment (D:drive) so that it may be viewed by the supervisor during the session. After the session, complete sections 4, 5, and 6 and upload to the relevant folder in the secure drive.

1. Behavioral Objectives
All planned objectives for a session should be listed, preferably in the order in which they will occur. There may be more than one objective for a target. List the terminal goal for the session first, and then list the sub-goals leading toward the objective.

Note: In some cases, one activity is used to teach several targets (for example, a play dough activity might target verbal requests as well as joint eye gaze). Conversely, more than one activity may be used to elicit one target (for example, production of /r/ may be practiced with word reading, games, and in answering questions). Speak with your supervisor to agree on a system for listing activities as well as objectives, as appropriate

2. Rationales
Write a rationale for why you chose a particular objective, why the client needs this skill, or why you are focusing on this skill during your session.

3. Reinforcement
Write the type and schedule of reinforcement that you plan to implement during the session.

4. Client Performance
Report the client’s performance on the stated objectives. All data collection should be reported and interpreted here. Any branching that was necessary should be recorded and explained. You can describe the impact of the use of teaching strategies such as prompts, as well. Include subjective comments in reference to factors which you believe have affected client performance.

5. Evaluation of Clinical Skills
Use this section to analyze your own performance. What went well today and why? What did not go well, and why? What changes in your performance would you make? What areas of your performance should be continued? Consider some of the skills listed in the Self-Evaluation of Clinical Skills in your clinic packet.

Look beyond comments provided by your supervisor. What are your own perceptions of your performance during the session? What are your needs for long term change and growth?
6. Problem-Solving, Insights, and Planning

Use this section for solving problems or for generating ideas for continued client improvement. Choose your own topics or consider one or more of the following questions to stimulate your thinking:

Did I observe something that helped me understand my clients learning style or processing strengths and weaknesses?

Was my client performing optimally? If so, what were the factors contributing to the clinical process?

Where will I get from here?

If not, what is impeding optimal performance? What variable can I change?

Were my materials and activities motivating to my client? Did they provide optimum practice of target behaviors? Are they functional and relevant? Do they foster generalization to daily life?

Am I challenging my client enough, yet keeping frustration to a minimum?

Did the clinical environment, session structure, and visual displays aid my client’s learning?

Is my client making steady progress? What are some of the factors that contribute to this?

How am I relating to my client and client’s family? Is there a positive learning environment? Have I made the client and family an active part of the treatment team?

I could improve my sessions if I learned a little more about ________. Explain.
<table>
<thead>
<tr>
<th>Behavioral Objective/Task</th>
<th>Rationale</th>
<th>Reinforcement</th>
<th>Client Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal 1:</td>
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<tr>
<td>Goal 2:</td>
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<tr>
<td>Goal 3:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Goal 4:</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
Evaluation of Clinical Skills:

Problem Solving-Insights-Planning:
**UNIVERSITY OF MARYLAND SPEECH AND HEARING CLINIC**  
**Therapy Session Log**

**Clinician:** M  
**Client:** CE  
**Date:** April 17, 2009  
**Time:** 10:00am-10:50am  
**Category:** Articulation-Reading

<table>
<thead>
<tr>
<th>Behavioral Objective/Task</th>
<th>Rationale</th>
<th>Reinforcement</th>
<th>Client Performance</th>
</tr>
</thead>
</table>
| CE will produce /æ/ "er" (in a variety of vowel contexts) at the word level at a rating of 3 (on a scale of 1 to 3), with 90% accuracy. [special emphasis on plain /æ/ “er”, which has been much less accurate alone than in post-vocalic context at the word level] | To practice correct production at the word level.                       | 1:1 verbal praise and corrective reinforcement | Initial informal assessment found all on target productions of /æ/ /œ/ /œ/ /ɑ/ /ʊ/ /ʊ/ and /ə/. but off target production of /æ/ and /ə/.  
Initial /æ/: 3/4  
Medial /æ/: 15/28  
Final /æ/: 5/8  
Overall: 23/40 (58%) |
| CE will segment and decode written 2-syllable real and nonsense words with consonant clusters and digraphs but only simple vowels (no vowel digraphs) with 90% accuracy. | To increase decoding knowledge.                                           | 1:1 verbal praise and corrective reinforcement | “checklist” correctly segmented and decoded except for /æ/ produced as /l/.  
“checkish” correctly segmented except “ch” which was self-corrected after clinician indicated presence of an error. Correctly decoded. |
| CE will segment and decode written 2-syllable real and nonsense words with consonant clusters and digraphs that include the vowel digraphs <œ> and <æ> with 90% accuracy. | To increase decoding knowledge.                                           | 1:1 verbal praise and corrective reinforcement | 5 real words and 1 nonsense word all correctly segmented. Decoding correct in real words except for vowel errors. Decoding of digraphs 6/6 on possible sounds of digraphs in question (though not always the correct sound target). Sequencing trouble with “kainp”: persistent anticipatory insertion of /l/ right after /k/. |
| CE will segment and decode written 3-syllable words with consonant clusters and digraphs but only simple vowels (no vowel digraphs) with 90% accuracy. | To increase decoding knowledge.                                           | 1:1 verbal praise and corrective reinforcement | [not attempted] |
Evaluation of Clinical Skills

- I was aware that Go Fish is traditionally for carrier phrase level work and that CE was not ready for this level. I wanted to do something different than Memory. I did instruct her to stick to single word production, but she often provided a carrier phrase (which is certainly more natural given the task) which would tend to decrease the speech planning resources she could devote to target production. So, not such a great task.

- Needed to provide her with more decoding support. Phyllis’ instruction to sound out each segment in isolation prior to blending accomplished this.

- Provided her mother with homework sentences for decoding involving the letter combinations we have been working on. (Provided her with a separate solution page with segments separated by / symbols.)

Problem Solving—Insights—Planning

- The problem is determining what the most efficient path is to improve her production. I have noticed that some sound contexts facilitate /ə:/ after a velar and after /a/ and /e/. More specifically, she produces on target /ɔɡ/ and /ɔɡ/ very consistently and /kɔ/ and /ɡɔ/ lead to pretty good /θ/ production (though I wouldn’t say consistent yet). I think I went too far in implicitly concluding that plain / θ/ is the main problem and that the other vowel contexts have been “acquired” (/ɡθ/ clearly is not).

- From this session’s data, she has a higher success rate with initial and final /θ/ than with medial (as could be expected due to coarticulation demands). Given the paucity of real words fitting this shape, our targets will have to be mainly nonsense syllables like /θɛ/ and /θɛ/. I could also try alterations with more successfully productions (as we did at the sound level), such as practice with /θɛm/ to get /θɛm/.

- The original reading goal has two objectives, both based solely on vowel digraphs. The first objective is matching these digraphs to vowel sounds and the second involves decoding real and nonsense words that incorporate the target digraphs. My original intention had been to implement these objectives y gradually introducing more and more digraphs to the mix. I strayed away from these objectives by introducing multiple syllable words after noticing her speaking difficulties with “acrobat” and “ornament”. The idea was that by segmenting and sounding out simple multisyllabic words (i.e., without vowel digraphs), she could practice motor planning on longer words. I now see this direction as somewhat of a distraction. I think we can productively work on /θ/ and vowel digraphs with single syllable words, and save multiple syllables for /θ/ since both CE and AF seem consistently ready to branch up with this latter target.
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>1. Given written stimuli containing target digraphs, E will accurately segment and blend non-words and real words with varying single syllable structures with no more than 1 prompt per word 90% of the time over 2 consecutive sessions.</td>
<td>--Increase automaticity of code knowledge ability to facilitate reading --Focus on 2 previously practiced sounds: “ai” and “ie” --Practice 2 new sounds: “oa” and “oy”</td>
<td>Continuous verbal praise/fixed ration activity reward</td>
<td>Quick review of “ai” and “oa”: 8/8=100% “oy”: 12/12=100%</td>
</tr>
<tr>
<td>2. Given orally presented words and a selection of graphemes to choose from, E will provide the correct spelling of the word with no more than 2 verbal prompts per word with 90% accuracy over 2 consecutive sessions.</td>
<td>To make use of practiced code knowledge to strengthen spelling skills</td>
<td></td>
<td>18/20~90% (see back for details)</td>
</tr>
<tr>
<td>3. Given visual and/or verbal prompts, E will orally read 3–5 sentences consisting of target sounds with no more than 2 errors in 2 consecutive attempts over 2 consecutive sessions.</td>
<td>To reinforce practiced code knowledge and improve reading fluency</td>
<td></td>
<td>1st paragraph: 4 errors</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• 2 mispronunciations</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• 2 substitutions</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2nd paragraph: 3 errors</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• 2 mispronunciations</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• 1 omission (slowly→slow)</td>
</tr>
</tbody>
</table>
Evaluation of Clinical Skills:
Good use of another fun board game that keeps E interested yet not so focused on the game that he doesn’t put effort into actually practicing the target sounds. Reviews of previously practiced sounds continue to be helpful, it’s pretty apparent that the “ai” and “ae” sounds have been maintained so far. E had extra incentive to work hard since his reward for reaching his money goal was to finish therapy at the diner. While filling up our water at the triple-filtered water spout, I had E read the sign describing what kind of water it was and that was fun and functional! E stayed on task and got through the planned readings without much frustration. It was some good clinician/client bonding time!

Problem Solving—Insights—Planning:
Although E was consistently producing the “qa” sound correctly, he still required 1 prompt for 2 words where he inserted as sound (foach→froach) or mispronounced a different sound (roast→roash). These are things he does when he doesn’t pay enough attention to the graphemes, because he knows that the grapheme “s” does not make the /ʃ/ sound. So I have to continuously remind him to pay closer attention to the graphemes. During spelling, he spelled “paint” as “peant”, in which case I can see the confusion (since “qa” can also make that sound) so I’m not always sure what to say or do during these instances since he is using the skill he learned. I just said I can see why he would spell it that way, but English is a silly language and sometimes uses different letter combinations to make the same sound.
<table>
<thead>
<tr>
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<th>Rationale</th>
<th>Reinforcement</th>
<th>Client Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Client will speak without scripts in 90% of opportunities given clinician prompt.</td>
<td>1. To improve intelligibility of speech.</td>
<td>1. Verbal praise; tokens or icons as needed.</td>
<td>1. Client produced jargon-free speech in 20% (2 of 10) of opportunities with maximum clinician prompting (“Just say the real words. Say ____.”).</td>
</tr>
<tr>
<td>2. Client will produce complete sentences in 90% of opportunities given clinician prompt.</td>
<td>2. To improve effectiveness of communication by speaking in complete sentences.</td>
<td>2. Verbal praise; tokens or icons as needed.</td>
<td>2. Client produced complete sentences in 50% (5 out of 10) opportunities with maximum clinician prompting (“Say the whole thing. Say ________.”).</td>
</tr>
<tr>
<td>3. Client will shift eye gaze to conversational partner while speaking and listening in 80% of opportunities given clinician prompt.</td>
<td>3. To improve effectiveness of conversational skills by indicating attention with eye gaze.</td>
<td>3. Verbal praise; tokens or icons as needed.</td>
<td>3. Client shifted eye gaze to the clinician during a structured game in 67% (2 of 3) of opportunities with maximum clinician prompting (“Look at me. Look at my eyes when you talk”). Although client was able to shift eye gaze on some opportunities, eye contact was quickly abandoned while client spoke.</td>
</tr>
<tr>
<td>4. Client will take turns during a structured game format in 90% of opportunities given clinician prompt (“Whose turn is it?”).</td>
<td>4. To establish the foundations of conversational turn taking.</td>
<td>4. Verbal praise; tokens or icons as needed.</td>
<td>4. Client took turns during a structured game activity in 91% of opportunities with moderate clinician prompting (“Whose turn is it?”). Prompting occurred in about half of the turns.</td>
</tr>
</tbody>
</table>
Evaluation of Clinical Skills:

I was at a loss for how to engage S at the beginning of the session. He didn’t respond to the usual enticements at all. I felt patient with him, though, because I know how hard it is for kids like S to have a change in routine. Also, I’m sure it was a lot more enjoyable to be home with Dad than to be in therapy. When he finally did engage with me, it was when I brought the different things over to him. I had remembered that his mom showed him the real objects that were his choices when she was in the session with use one day. She said his teacher at school talks way too much, and I realized I had been yakking away about his choices. After that, I just went on instinct. I had no idea what to do about his insistent scripting. It was as if he wanted me to join him in that little world rather than joining me in the therapy word. I didn’t want to go along with his scripting but I felt conflicted too, because his attempts to have me say it were attempts at connection. But I opted for retreat because I felt like it was the “healthier” choice.

The “shopping for snack” activity was successful. I didn’t think S would talk to a stranger but he did, and was able to ask “May I have some Cheetos please?” or something close to that, with prompting. He had eye contact most of the time too. I think it’s good for him to be challenged a little bit outside his comfort zone, and food may be the way to do it.

Problem Solving—Insights—Planning:

I’m not sure it would have helped, but I could have acknowledged S’s feelings about being at therapy (“You might be feeling angry about coming here today” or “You seem sad to be here”).

I will try bringing objects over to him next time this happens. I wonder what would happen if I just laid down next to him when he shuts down. If it a situation where it was my classroom, I would probably try it. Or if next time I sit on the floor where he can look at me if he wants to, and I start to eat Goldfish crackers one at a time. That might snap him out of it.

I’m still trying to figure out how to extend the snack activity to get new things out of it. He can follow steps for making the “trail mix” pretty independently with visual cues. He doesn’t want any other “recipe” (I tried that). I can continue to have him tell me what to do next (like I do with painting) or have him say what he needs to do next when he makes the snack. I can continue to have him “shop” for the snack. I think it went very well this time because he asked Anne for each item (I was surprised he did it) with a list and prompting. I might see if he’ll shop for snack with one designated person in the student lounge. I could also do something like remove the spoon that he uses to stir the trail mix and ask him what we should do, and give him choices (“We could go get a spoon in the student lounge or you could stir it with this fork”). I’m really seeing how much autistic kids rely on routine and sameness. I think it’s part of the disorder, and changes are best made in tiny increments. I can just imagine how thrown off S was today because of huge changes in his routine.
S.O.A.P Notes

This is the standard format for writing daily or weekly progress notes in medical charts. We have modified our format a little from the typical hospital format. The parts that we have modified are in **BOLD** print.

The idea of a SOAP not in the real world is to be brief, be informative, focus on what the other members of the team (doctors, nurses, OT, PT, dietician, social worker... etc.) need to know, and include whatever information an insurance company would need to see to justify your continued involvement with the patient.

SOAP notes should be turned into your supervisor 24 hours after your session. Every attempt will be made to return them in a timely manner, however, you should keep a copy to help you plan for your next session.

**S: (SUBJECTIVE)** your impressions about the patient’s level of awareness, motivation, mood, willingness to participate. Could also be anything that the patient and/or family may say to you during a session?

**O: (OBJECTIVE):** Your data goes here. Any test scores, percentages for any goals; objectives worked on, any quantitative information clinical observation. NO INTERPRETATION!!!

**A: (ASSESSMENT):** So what? What does all the data mean? This is the interpretation section. **And CRITIQUE** what impact does the objective data have on the patient’s communication. **THIS IS ALSO WHERE YOU CRITIQUE YOURSELF AND THE SESSION.**

**P: (PLAN):** As the result of this session, what is your plan for the next session/week? Any changes to objectives, activities, reinforcement schedules that you want to implement go here.
SAMPLES

Typical Hospital SOAP note:

S: Patient alert for first 10 minutes then became lethargic and complained of pain in abdomen.

O: Patient seen at bedside for meal observation following swallowing study. Diet of pureed foods with honey thick liquids. Patient ate 50% of meal, required moderate cueing follow aspiration precautions. Family present and educated, handout given.

A: Significant improvement in oral stage dysphasia. Patient how able to tolerate mechanical soft diet without difficulty.

P: Consult with physician to upgrade diet to mechanical soft with thin liquids. Continue swallowing precautions. Will see daily for meal observation.

Typical Adult Aphasic Client

S: Patients wife: “He seems to be speaking much more clearly today, and seems to understand me better.

O: 1. Client completed word retrieval activities with 70 % accuracy (7/10)
   Patient needed phonemic cues on 4 items.

2. He followed complex 2 step commands with 60% accuracy (6/10). Visual cueing needed for 2 items, and repetition needed on 4 items.

3. He wrote single words with 70% accuracy with no grammatical or spelling errors. Written homework assignment completed with only 2 errors.

   * Criteria 80% for all objectives

A: Improvement observed in word retrieval activities and writing. Auditory comprehension remains at low level. Commands may be too hard or my presentation too fast. Pace of session was good.

P: Continue with all current objectives. Review auditory commands before next session. If auditory comprehension of commands continues to be low, could consider other types of comprehension activities. Remember to slow down presentation of commands by noting on data sheet.
**Typical Child Artic/ Lang Client**

**S:** Family arrived 15 minutes late for session. Client seemed tired and needed frequent cues to redirect attention.

**O:**
1. Client will produce /k, g/ with 80% accuracy in single CVC words given the clinicians model 10/20 trials correct = 50% accuracy
2. Client will differentially produce indefinite articles “a/am” at the carrier phrase level while describing pictures with 90% accuracy 20/20 trials correct = 100%

**A:** Client continues to demonstrate difficulty with velar consonants even though this is the 5th session to target them. Use of indefinite articles has been mastered at the carrier phrase level. Session pace was slow and may have affected client’s attention. Handled client’s off-task comments effectively.

**P:** Modify Objective #1 listed above by branching down to CV syllable level. Modify objective #2 by moving to spontaneous sentence level. Available time in session will allow for incorporation of new target: to produce personal pronouns (he/she) with 80% accuracy given clinician’s model at carrier phrase level.

**Typical Fluency Client**

**S:** Client reported reduction in overall fear level and tension in neck area during oral presentation in group meetings at work this week. Client is concerned about a telephone conference call scheduled for next Tuesday at work.

**O:**
1. Client will monitor retrial during a two-minute monologue with clinician with 90% accuracy over 2 sessions. 12/30 +40%
2. Client will make 2 phone call per week in a bystander situation at work as reported in 3 homework lag. 6/6/00, 6/8/00 = met this week
3. Client will use pull-outs in 50% of opportunities during a two-minute conversation with the clinician. 4 pull-outs/6 opportunities =66%

**A:** Client continues to demonstrate difficulty distinguishing between core repetition and retrials. **Also, he may be observing retrials but not signaling consistently.** Pull-outs on fixations met target criteria, pull-outs on laryngeal closures did not.

**P:** Use gestural prompt to aid signaling during monitoring, then fade. Add direct modeling for pull-outs on laryngeal closures.
S.O.A.P. Notes—EG

S: EG had a good 3rd week. He was happy, cooperative and willing to participate in all planned therapy activities. He particularly enjoyed building a puzzle and water play with boats.

O:
Goal I. To spontaneously produce pronouns (I, me, my).

Objective B. Given verbal prompts, EG will produce the pronoun “I” in sentences with 90% accuracy over two consecutive sessions.

- “I”
  - 6-15 29/43=67%
  - 6-17 20/32=62%
  - 6-19 19/25=76%

Objective C. EG will spontaneously produce the pronouns “me” and “my” in sentences with 90% accuracy over two consecutive sessions.

- “me”
  - 6-15 12/12=100% [criterion met first time]
  - 6-17 11/11=100% [criterion met second time]

- “my”
  - 6-17 10/10=100% [criterion met first time]
  - 6-19 14/14=100% [criterion met second time]

Goal II. To spontaneously produce four word utterances

Objective D. EG will spontaneously produce 4 word utterances with 90% accuracy over two consecutive sessions.

- 6-15 14/20=70%
- 6-17 15/18=83%
- 6-19 14/19=74%

Goal III. To spontaneously use the articles “a” and “the”.

Objective B. Given visual and verbal prompts, EG will produce the articles “a” and “the” in their obligatory position in a carrier phrase with 90% accuracy over 2 consecutive sessions.

- “the”
  - 6-15 5/11=45%
  - 6-17 9/13=69%
  - 6-19 14/19=74%

- “a”
  - 6-15 [did not address]
  - 6-17 8/11=73%
  - 6-19 9/12=75%

A: EG met some objectives this week, including producing “me” and “my” at the spontaneous level. He continues to use “I” inconsistently; his four word utterances are rather inconsistent as well. He has clearly made progress with the use of articles as compared to last week. I need to make sure I leave enough time for the last activity of each session so that I can elicit a higher number of targets.

P: Continue emphasizing “I” instead of “me,” and giving immediate feedback after an incorrect production. Continue providing proper models for EG to produce 4 word utterances and give him a lot of praise for using long sentences. Work on “a” and “the” within carrier phrases and try to elicit more trials for both “a” and “the”.

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DIAGNOSTIC PROCEDURES

- Before the Diagnostic Session

- During the Diagnostic Session

- After the Diagnostic Session

- Session Assignment Sheet

- Diagnostic Protocol Form

- Preliminary Results Form

- Diagnostic Evaluative Feedback Form

- Hearing and Immitance Screening Procedures
You will be part of a diagnostic team and assigned to a particular day & time. Each week, two members of the team will do an evaluation and the other members of the team will observe. This opportunity to observe diagnostics that are being performed by other members of your team is an important part of your diagnostic clinical training. As an observer, you will be expected to arrive on time, watch carefully, score standardized tests, and may be included in the student/supervisor conference.

**When you are assigned an evaluation:** Two clinicians will be identified for each diagnostic session. Both will receive a notification email at least 10 days prior to the scheduled session and be directed to check their calendars in the medical records system. The slip will identify one student as the primary clinician and the other will assume the role of secondary clinician. The primary clinician will receive a grade and clock hours for the evaluation. The secondary clinician will not receive a grade, but can accrue clock hours as long as all assigned responsibilities are carried out in a satisfactory manner. A basic description of the responsibilities for each role is listed below. *Please be aware that a case supervisor may suggest modifications in how these responsibilities are carried out based on the specific needs of an individual client.*

**PRE-DIAGNOSTIC PREPARATION:** Both students will be responsible for planning the evaluation session. Locate the client chart in PnC and review pertinent case history information and any other available documents. *(Please remember that client charts are confidential medical records).*

Collaborate to decide what clinical questions need to be answered and what information/data should be collected during the session. Form tentative interview questions and identify a list of measures that will enable you to assess the relevant areas of communication (this could include standardized tests, clinician-designed tools, etc). Be prepared to give rationales for your choice of measures/tools.

The primary and secondary clinician should meet together with the case supervisor to discuss the plan for the session. Generally, the supervisor will not agree to a meeting to discuss the case unless both clinicians are in attendance. The secondary clinician should post the Diagnostic Protocol Form in the student room at least 2 school days prior to the session to let the “observer” team members become familiar with the plan. Make enough copies of all test answer forms for the observers (including the supervisor) and put them in their mailboxes so they will be able to follow along during administration of the measures in the session.

The secondary clinician should make sure that the hearing screening equipment (otoscope, audiometer, tympanometer) is functioning properly immediately prior to the start of the diagnostic session and that consumable supplies are available (screening forms, eartips, etc).

The primary clinician should contact the client 1-2 days prior to the session to confirm the appointment (always check for the relevant authorization forms first). Make sure they’ve received the necessary directions/parking information. Inquire about preferred activities/topics/reinforcers, but try not to ask substantial questions about significant background or history. Generally, those questions are better handled in the personal interview. If the client indicates that they will not be keeping the appointment, be sure to ask if they would like to be re-scheduled. Convey this information to the supervisor and other team members. Document this and any other contacts with the client in their electronic chart.
**DURING THE DIAGNOSTIC:** Both primary and secondary clinicians should arrive at least 30 minutes prior to the session in order to set-up. Members of the observation team should arrive at least 15 minutes before the evaluation begins. Post the session protocol in the therapy room window. The secondary clinician generally ensures that any video and/or audio equipment is set up and ready for use.

Primary clinicians should take the lead to introduce themselves and then the secondary clinician as well as the supervisor to the client. Be sure to determine preferred forms of address in advance. Escort the client to the room accompanied by secondary clinician. Review the agenda for the 3 hr. session and then conduct case history interview. If the client is an adult, the secondary clinician generally remains in the room and takes detailed notes that will support the information recorded by the primary. If the client is a young child, the secondary clinician may take the child to another room to record a language sample while the primary clinician conducts the parental interview.

The primary clinician is generally responsible for administration of standardized tests and any other informal measures. This includes presentation of test stimuli, recording client responses, and providing encouraging feedback. The secondary clinician is generally present in the room and will act as the double-scorer of the client’s responses to test items and should make notes regarding clinical observations of the client’s communicative behaviors. These roles may be modified according to the needs of case and should be cleared with the case supervisor in advance.

The secondary clinician may assume responsibility for the parts of the session that consist of hearing screening and oral peripheral examinations. When the testing portion of the session has been completed, the secondary clinician may escort the patient back to the waiting room and suggest that this may be a good time to talk to the clinic secretary about billing.

Both clinicians should meet with the supervisor (and possibly the observer team members) to brainstorm and talk about their impressions of the case before the client leaves the clinic. Discussion may include issues such as: whether a disorder exists, the severity of the impairment, prognosis, and treatment recommendations. This preliminary information should be recorded on the Preliminary Results of Evaluation form. The primary clinician, in conjunction with the supervisor, generally presents the wrap-up info to the client. The secondary clinician may be present in the room or watch from behind the window.

**AFTER THE DIAGNOSTIC:** Documentation that the session occurred should be entered by the primary clinician into PnC, including the correct diagnostic and treatment codes. Once any data has been recorded on a standardized test form (regardless of whether identifying information is included), these are confidential medical records and should be treated as such. If an application for therapy has been filled out by the client, the secondary clinician should ensure that it is submitted to the Clinic office staff. Be sure to fill out the top half of the back of the form.

The primary clinician is responsible for writing the diagnostic report. Before this can happen, the secondary clinician must double-score all tests by reviewing scoring accuracy, recalculating raw scores, percentile ranks, and standard scores. This double-scoring should be recorded on the standardized test forms in a different color ink and include the secondary clinician’s initials and date. This is valuable information that the primary clinician will need to incorporate into the first draft of the diagnostic report. Remember that this analysis will need to be done within the department (either in the student room or an empty therapy room) since none of the actual test forms may leave the building.
WORKFLOW PROCEDURES FOR STANDARDIZED TEST FORM MANAGEMENT

1. Immediately after the dx session, the student places the standardized test forms in the turquoise bin in materials room. They live there temporarily until the double-scoring is completed, score analysis is finished, and data is recorded in the first draft of a report.

2. Once the standardized test forms are no longer needed for score analysis, the student is responsible for returning them promptly to the clinic office for scanning into the patient’s PNC chart (the office has a folder for this). The test forms should not stay in the turquoise bin indefinitely.

3. Clinic office will scan the standardized forms into PNC. Afterward, the forms are either filed in a clinical faculty member’s folder for research purposes, or the forms are designated for shredding.

A draft of the report should be submitted via the secure drive to the case supervisor by the primary clinician within one week. This first draft should represent your best work. Your ability to clearly present data and effectively analyze it in writing represents an important factor in the determination of your grade for diagnostic practicum. Supervisors will not accept submission of a first draft unless the test forms indicate that the double-scoring process has already been completed. The supervisor will notify the primary clinician when written comments/modifications have been uploaded to the secure drive and will generally specify a due date for the revision.

WORKFLOW PROCEDURES FOR REPORT DRAFTS IN SECURE DRIVE

(ITPs, Progress Reports, Dx Reports)

1. Student creates first draft in appropriate D:drive folder (not in PNC). File name should clearly indicate client name.

2. Supervisor uses track-changes to edit report. File name should be re-named to clearly indicate draft # with supervisor initials (to cut down on clutter in the folder - no need to save as a separate document)

3. Student revises report based on supervisor edits:
   1. Margin comments from supervisor should not be deleted
   2. Any specific wording changes the supervisor inserted via track-changes should be accepted by the student.
   3. Revised document should be re-named to clearly indicate “draft #”

4. Repeat these steps as need with clear re-naming of document each time

5. Supervisor should notify student when the report is ready for pasting into PNC.

***No client test forms can leave the building. If a standardized test form has responses recorded on it (regardless of whether identifying information is present), it should not leave the building. Test forms can only be used in the clinic spaces or student room. They may not be taken to the computer lab and information in a file cannot be photocopied. This means that scoring and analysis of test data must be conducted within the department (not at home).***
## DIAGNOSTIC POLICIES AND PROCEDURES

<table>
<thead>
<tr>
<th>PRIMARY CLINICIAN</th>
<th>SECONDARY CLINICIAN</th>
<th>BOTH CLINICIANS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PRE-DIAGNOSTIC PREPARATION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Call client 1-2 days prior to the appointment to confirm</td>
<td>*post the Diagnostic Protocol Form in the student room at least 2 school days prior to the session</td>
<td>*review pertinent case history information</td>
</tr>
<tr>
<td>*document all contact with the client as a miscellaneous note in the client’s electronic chart</td>
<td>*make enough copies of all test answer forms and give to diagnostic team members</td>
<td>*develop the clinical questions and decide on what information/data should be collected during the session</td>
</tr>
<tr>
<td></td>
<td>*check that the hearing screening equipment (otoscope, audiometer, tympanometer) is functioning properly and that consumable supplies are available (screening forms, eartips, etc).</td>
<td>*form tentative interview questions</td>
</tr>
<tr>
<td></td>
<td>*reserve test materials</td>
<td>*generate a list of assessment measures</td>
</tr>
<tr>
<td></td>
<td>*post the Diagnostic Protocol Form in the student room at least 2 school days prior to the session</td>
<td>*have rationales for your choice of measures/tools</td>
</tr>
<tr>
<td></td>
<td>*make enough copies of all test answer forms and give to diagnostic team members</td>
<td>*meet together with the case supervisor to discuss the session plan</td>
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<tr>
<td><strong>DURING THE DIAGNOSTIC</strong></td>
<td></td>
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</tr>
<tr>
<td>*post the session protocol in the therapy room window</td>
<td>*take detailed notes that will support the information recorded by the primary</td>
<td>*arrive at least 20-30 minutes prior to the session in order to set-up</td>
</tr>
<tr>
<td>*conduct case history interview</td>
<td>*with young children, may elicit language sample while the primary clinician conducts the parental interview</td>
<td>*meet with the supervisor (and possibly the observer team members) to brainstorm and talk about their impressions of the case</td>
</tr>
<tr>
<td>*administer standardized tests and any other informal measures</td>
<td>*act as the double-scorder</td>
<td></td>
</tr>
<tr>
<td>*present results and summarize information to the client with the supervisor</td>
<td>*hearing screening and oral peripheral examinations</td>
<td></td>
</tr>
<tr>
<td><strong>AFTER THE DIAGNOSTIC</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*document that the session occurred in the electronic chart</td>
<td>*ensure that the application for therapy has been submitted to the Clinic Director’s mailbox and make sure to fill out the top half of the back of the form</td>
<td></td>
</tr>
<tr>
<td>*write the diagnostic report</td>
<td>*check raw scores and standard scores/percentile ranks. Place initials and date of double-scoring on all test forms.</td>
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</tr>
<tr>
<td>*submit a draft of the report to the case supervisor within one week</td>
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<tr>
<td>*make revisions as appropriate</td>
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This is a preliminary report summarizing the results of the speech-language evaluation. A comprehensive report including test results and implications will be sent to you in approximately three weeks. Please contact us if you have any questions or concerns.

SUMMARY OF SPEECH-LANGUAGE EVALUATION:
Hearing Screening Procedures and Criteria

Audiometric Screening

- Prior to screening, a biological calibration of the equipment must be completed to confirm appropriate function of the equipment and appropriate ambient noise levels for the screening. Perform a self-test of the pure-tones to verify that you (or a partner) can hear the tones at screening levels (20 or 25 dB HL).
- Position the client so they are seated with the screening equipment behind them (so they cannot see the screener).
- Instruct client to raise his/her hand every time the tone is heard, even if it is very soft.
- Place earphones on ears (red on right ear and blue on left ear) and tighten headband to sit on top of the head.
- Present tones at screening levels (see below) for 1000, 2000, and 4000 Hz for each ear. When a response is obtained at the appropriate level, confirm with a second repetition before recording the data. Be careful to watch your timing to avoid patterning so the presentations are not predictable.
- Record your responses on your data sheet
- The screening is “referred” (failed) if any one stimulus presentation is missed at the screening level – all responses must be present for a “pass” result.

ASHA STANDARDS FOR AUDIOMETRIC SCREENING:

<table>
<thead>
<tr>
<th>Frequencies</th>
<th>1000, 2000, 4000 Hz</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presentation level (adults)</td>
<td>20 dB HL</td>
</tr>
<tr>
<td>Presentation level (children &lt;18 y/o)</td>
<td>25 dB HL</td>
</tr>
</tbody>
</table>

Immittance Screening

- Place a clean speculum (small sized diameter for child and large sized diameter for adult) on otoscope and instruct the client that you are going to look in their ears.
- When looking in the ear, take note of the size and shape of ear canal (to select appropriate immittance tip) and whether you can visualize the eardrum. Make a note if you see excessive cerumen, a PE tube, etc.
- Pick an appropriate sized immittance probe tip to obtain a seal in the ear canal. Attach the tip to the probe wand.
- Instruct client that a soft tip will be placed in the ear canal and that they will feel a slight pressure change (like going up in an airplane). The client must sit still for the test.
- Place probe tip in ear and hold it still. Check the indicator light to ensure a seal is maintained:
- Green indicator: blinking (ready to begin) and steady (test successfully started and in progress)
- Yellow indicator: probe is occluded – remove probe, clean, and try again
- Orange: a pressure leak has been detected – remove probe and try again (possibly with a different tip size)
- Repeat on other ear and print tympanograms.

**Immittance Results**
PASS: Normal compliance and pressure – tympanogram will be in the rectangle on the screen

REFER: Reduced compliance and/or negative pressure – tympanogram tracing will not be in the rectangle on the screen

### Normative values for tympanograms:

<table>
<thead>
<tr>
<th></th>
<th>Children</th>
<th>Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance</td>
<td>0.2-0.9 cm³</td>
<td>0.3-1.4 cm³</td>
</tr>
<tr>
<td>Pressure</td>
<td>-150-+100 daPa</td>
<td>-100-+100 daPa</td>
</tr>
<tr>
<td>Ear canal volume</td>
<td>0.4-1.0 ml</td>
<td>0.6-1.5 ml</td>
</tr>
</tbody>
</table>
1. Recommendations:
   ● If the client does not pass either screening, refer for comprehensive audiologic evaluation.
   ● With normal audiometric screening results and a flat tympanogram (compliance < .2cm3), refer for medical evaluation.
   ● With normal audiometric screening results and significant negative pressure (> -150 daPa), re-schedule an immittance screening in 1-2 weeks.
   ● With a failure of the audiometric screening and significant negative pressure, a medical consultation and follow-up audiologic evaluation are recommended.
   ● If the client will not tolerate the use of headphones for the screening, refer for audiologic evaluation with Audiology.
   ● If the audiometric screening is normal but immittance could not be completed (i.e., due to an uncooperative child or excessive wax accumulation in ear canal) attempt to re-screen immittance later, if possible, but no return visit is required.
   ● If the audiometric screening takes longer than 20 minutes, move on to the immittance screening. Attempt hearing screening at a later date or refer patient for evaluation with Audiology.
SAMPLE TYMPANOGRAMS

Type A – Normal tympanogram

Type B – Flat tympanogram (no compliance or pressure)

Type C – Negative tympanogram (negative pressure w/ normal compliance)
For examples of strong writing style and solid critical thinking in diagnostic reports across ages and disorders, please refer to the list of client reports posted in the ELMS website for clinical practicum.
PROFESSIONAL WRITING

As a speech-language pathologist, you will typically write diagnostic reports, therapy plans, case notes, progress reports, and discharge reports. These various report formats allow you to present and interpret test scores, make recommendations, summarize performance and progress in therapy, and provide documentation of various issues related to your client.

Although case notes can be brief and less formal, all other reports and documentation must be written in an appropriate professional and technical style. Remember…your report might be the first contact that another professional has with you. **Your competence and professionalism can and will be judged by how well you communicate in writing.** Poorly written reports can compromise your professional credibility.

**Philosophy**

- Report your findings objectively; conclusions must be supported by the data. Be careful not to state your opinion as if it is fact. You are not expected to be omnipotent. If you cannot fully explain test findings, behaviors, etc., say so in your report. Always acknowledge discrepancies in test results and/or observations and attempt to explain them.
- Assume that your client and/or family members are going to read your report. Take this into consideration when deciding what information to include and how to present it. This is particularly important when summarizing reports from other professionals. Be sure to indicate where you got your information and be careful not to change this information in any way.
- Know your scope of practice and do not overstep these bounds. For example, as a speech-language pathologist, you cannot diagnose ADHD, autism, or learning disabilities.
- Be particularly careful when stating prognoses and making recommendations. Be realistic. Base your prognosis on available all available evidence, and never promise a certain level of success within a specific time period.

**General Rules to Live By**

- Use professional terminology, but provide explanations and examples so that nonprofessionals will understand.
- Avoid needless words.
- State the full name of tests, diagnostic labels, institutions, facilities, etc. the first time you use them in a report. Thereafter, you can use abbreviations or acronyms.
- If you are speculating, make that clear to the reader. Use phrases such as, “It appears that,” “It seemed as though,” “the data suggest that,” and “It is possible that.”
- Avoid misusing words (e.g., affect / effect, among/between, accept/except, principle/principal, ensure/assure).
- Beware of unusual singulars and plurals (e.g., datum/data, criterion/criteria, phenomenon/phenomena, locus/loci, parenthesis/parentheses).
- Use commas, hyphens, colons and semi-colons correctly. Remember….”Punctuation marks are the traffic signals of language. They tell us to slow down, notice this, take a detour, and stop.” (Lynne Truss in *Eats, Shoots, and Leaves*)
- Know your Latin abbreviations and use them correctly (e.g. means “for example” while .i.e. means “that is”)

53
Technical Writing Style
(Adapted from Roth & Worthington, 2016)

- Avoid writing clinical reports in a conversational style (e.g., “He just didn’t get the point” versus “He did not appear to understand the task”).
- Use correct spelling, grammar, and punctuation and write in complete sentences.
- Write in the third person (e.g., “The Token Test was administered” rather than “I administered the Token Test”).
- Avoid use of contracted verb forms (e.g., isn’t, can’t, I’ve).
- Give the full names of tests when first mentioned before sing acronyms and other abbreviations in the remainder of the report.
- Express information in behavioral terms (e.g., “followed two-step command” versus “is able to follow two-step commands”).
- Present information (particularly case history) in chronological sequence.
- Differentiate clearly between information reported by others versus information obtained directly through clinician observation.
- List all data such as test scores or baseline measures before providing any interpretative statements; this approach facilitates interpretation of a client’s overall profile rather than presenting unrelated descriptions of isolated communication skills.
- Include information about a client’s strengths as well as weaknesses in the body of the report.
- Avoid presenting information in the summary section of any report that was not introduced previously in the body of the report.
- Write reports to communicate with colleagues using professional terminology, but include simple explanations and clear examples to make reports meaningful to family members and other non-professionals.
- Use language that is specific and unambiguous (e.g., “He demonstrated language skills characteristic of 4-year-old children” versus “He demonstrated poor language skills”).
- Avoid exaggeration and overstatement (e.g., “completely uncooperative,” “absolutely intelligible,” “never produces /s/,” “extremely motivated”).
Proofreading

• A first draft is your **finished** report
  o The content gives your supervisor a clear window into your critical thinking. Poor proofreading prior to submission of your first draft will negatively affect this perception.
  o Completed tests forms/data sheets should be scanned into the electronic chart with your first draft unless the case supervisor provides specific alternative instructions related to research protocols.
  o All drafts should be written with correct spelling and punctuation.

• Before you submit your first draft and all subsequent drafts…
  o Make sure that you have used the required report format
  o Read the report over… aloud! You are more likely to catch errors that way
  o Check for typos, spelling errors, and grammar errors

• When you get your feedback from the supervisor
  o Read over the comments and ask for clarification when needed
  o As you make each suggested change, check it off in a different color ink to make certain that you have addressed all edits

**ADDITIONAL TIPS FOR PROOFREADING CLINICAL REPORTS**

Student clinicians can use the following set of proofreading questions to edit and monitor the quality of clinical reports.

• Are spelling, grammar, and punctuation correct?
• Are professional terms used accurately?
• Is there redundancy of word usage or sentence type?
• Are any sentences too lengthy, rambling, or unfocused?
• Is all the important client information included in the report?
• Is information presented only in the germane sections of the report? (e.g., recommendation statements should not be included in the background information section)
• Does the report follow a logical sequence from one section to the next (i.e., from background, to data and interpretation, to summary and recommendations)?
• Are raw data interpreted and not merely reported?
• Are all conclusions and assumptions supported by sufficient data?
• Are speculative statements explicitly identified as such?
• Does the report contain seemingly contradictory statements without adequate explanation?
• Is the wording clear or are some statements vague and ambiguous?
• Is content presented with appropriate emphasis (e.g., has any critical information been overlooked)? Has any minor point been overemphasized?)
• Is the report written with ethical/legal considerations in mind?

EQUIPMENT AND MATERIALS ROOM

- Clinic Audio Visual Equipment

- Clinic iPads and Laptops

- Boardmaker Software

- Materials Room
The Hearing and Speech Clinic is equipped with a built-in listening and recording system. Here’s a summary of highlights regarding this equipment:

- At least one camera and one microphone are located in every clinical space (some of the larger spaces have multiple cameras/microphones).
- The cameras record directly to DVD units located in electrical cabinets in the observation rooms.
- Pan-zoom-tilt controllers for the cameras are mounted in the observation rooms next to each window.
- In general, the video recording system is operated by one of the clinic faculty. If you wish to record a session, feel free to ask any supervisor to help you set up the process. At the end of the session, ask a supervisor to finalize the DVD for you.
- For listening purposes, each observation window is equipped with eight headphone jacks. Each jack has its own loudness control.
- Sound from a therapy session can be broadcast through a ceiling speaker located at each window instead of through headphones. The glowing red button on the small white box mounted next to each window is the off/on switch for the overhead speaker.
- Use of the overhead speaker is appropriate when you are the only observer in the room or when there are more than 5-6 observers at a single window.
- With the exception of headphone loudness knobs, clients’ family members and/or other outside observers should not touch any of the audio-video system or change any equipment settings.

WORKFLOW PROCEDURES FOR CD/SD VIDEOS MANAGEMENT
(*these procedures are subject to change*)

1. Supervisor will record session on a numbered CD/SD
2. Supervisor enters date, CD/SD #, name, and student name on log in clinic office
3. Supervisor places CD/SD in storage case located in clinic office
4. Student checks out CD/SD from clinic office - this needs to be documented on log
5. Student views CD or SD only on clinic’s DVD players (video never leaves the building)
6. Video can temporarily live in turquoise box in student room (so it can be accessed during non-office hours as needed)
7. Once analysis of the video is complete, it is the student’s responsibility to return the CD/SD to the clinic office and ensure that this return is documented on the log. The clinic office will insert the video into CD/SD storage case.
8. Once a CD has been logged in as returned by the student, supervisor needs to decide whether to upload it into D:drive for future reference or whether to destroy it. SD cards may be uploaded and/or erased rather than destroyed.

Please remember that all video recordings are part of the client’s confidential medical record and are considered property of the Hearing and Speech Clinic.
The Hearing and Speech clinic has available a laptop and several iPads which student clinicians may check out for use in their sessions. The laptop is intended to be used for voice sessions, but may be used for other purposes. iPads may be a good choice for many different purposes. The following rules apply for use of iPads or clinic computers:

The iPads will be located in a charging station in the materials room. Please note the following procedure for checking out an iPad:

- First, retrieve the charging station key from the clinic office.
- Open the charging station and remove your iPad. After you have taken your iPad, be sure to lock the charging station.
- In the drawer below the charging station, there is a small bin where you need to leave your student ID while the iPad is in your possession.
- Lock the charging station and return the key to the clinic office immediately. Please do not hang onto the key for any length of time.
- When you are finished using the iPad, grab the key from the clinic office to return the device and retrieve your ID. Make sure to connect the iPad to the charger and lock the charging station.
- Return the key to the clinic office.

These iPads and laptops can be used for treatment and diagnostic sessions. They serve a variety of functions. Be sure to coordinate with your supervisor to determine the best way to use the device in your session.

This equipment is intended to be used for clinical purposes only. No personal use is allowed. You may use these devices for your treatment and diagnostic sessions, but not for any other purpose. This includes checking your email, downloading software, or writing reports.

Absolutely no personal data should be stored on laptops or iPads. This includes your personal information and client information. The clinic staff will periodically erase all extraneous data from these devices.

All app requests must be made through the clinic director. Student clinicians are not allowed to download any apps, including free apps. If you need a specific piece of software, be sure to let your supervisor or the clinic director know well in advance of the session for which you intend to use it.
BoardMaker: At-a-Glance

File Menu: Open, save, and print
Edit Menu: undo Copy, paste, delete, and select
View Menu: Screen size, grids, and rulers
Text Menu: Font and alignment
Preferences Menu: Auto resize (to manipulate actual picture not whole cell), board size, ruler/grid/gap, line thickness, and cell corner

How to:
View the whole sheet of cells:
When on the board page, go under View then select “Half size” and you can see the entire sheet of pictures at once.

Create multiple cells that are the same size:
Click on the cell sprayer “Tool along the side bar on the board page (the button has 4 mini cells). Position the pointer inside the cell. Click and drag the pointer down and to the right until you have as many cells as you want. Release the mouse button and the cells will be created automatically.

Place symbols on a grid:
Click on the Symbol finder tool on the board page (the button with the little man). This displays the Symbol Finder Window. Then click the “Draw” button. This will copy the symbol and return the screen to the board page. Position the pointer in the cell and click. This place the picture inside the cell.

Manipulate a picture and text with a cell:
In order to work within a cell, you must turn off Auto Resize in the Preferences menu. This allows you to select the contents of the cell rather than the entire thing.

Delete symbols or text from a cell:
Turn off Auto Resize in Preferences menu. Select the item you wish to delete by clicking on it (shift-click to select multiple items). Press the delete or backspace key to delete what you have selected (either text or picture).

Manually resize symbols:
Select the symbol to resize. It will appear inside a dotted square with a small square in the lower right corner. Click and drag the resize box inward or outward to resize the symbol. Release the mouse button when the symbol is the correct size.

Making text fit within an individual cell:
Select the Text Tool and position the cursor at one end of the word, Click and drag to select the text, then choose a smaller font size from the Text menu.

Change the size of the text (for entire board):
In the Symbol finder window in line 1 next to “English” is the number of the font size.

Change the label of a picture:
First select the Text Tool from the tool side bar (the button with the A). Position the cursor at one end of the word and click and drag to select the text. Now you may enter you new text.
DO NOT change the name of the picture while in the Symbol Finder Window- this will change the name permanently making it very difficult for others to find pictures!

Change corners of cell:
Select the cell to change (if none are selected this command will change the default setting for new cell corners). Go to Preferences Menu on the board page to select the radius of the corners of cells (squared, rounded).
Save your board:
Select “Save” from the File menu. Saying your board requires a file name. Using a descriptive name such as “S-words” can be helpful so others can access your board and use it.

Opening a save board:
Select “Open” from the File menu while in the board window. Select the name of the saved board and double click. It will appear in the board window.

**** When searching for a symbol: be creative and try related or similar words. Also the fewer characters you type, the better the chance of finding a symbol that uses those letters (a search for “books” may fail whereas a search for “book” may not), and do not type extra characters, such as spaces, commas, or periods.
MATERIALS ROOM POLICIES AND PROCEDURES

The department provides a significant amount of materials and equipment to support the clinical training program. This includes a wide range of standardized tests for diagnostic purposes as well as picture cards, games, toys, workbooks, velcro, and construction paper, etc. which can be used in therapy sessions (obviously, this is not an exhaustive list). With approximately 25 clinicians simultaneously engaging in clinical practice, it is important that this supply of materials be adequately monitored and replenished.

All students are required to sign out materials that are borrowed from the clinic’s inventory. Please remember to sign the materials back in when you return them. You may use the sign-in log to reserve specific materials for a particular date. This is especially important for diagnostic tests. Always check the reserve sheet before you take a diagnostic test – it will be very difficult for your colleague to conduct an evaluation without the necessary tests in hand.

If you borrow tests from the materials room and wish to take them home to review them at length, you may do so after 4:00 pm. You are responsible for making sure that the tests are returned the following morning no later than 8:30 am.

Students are permitted to use the phone in the materials room to contact clients (check first to be sure that there is a permission/contact preference form on file). This desktop computer is not a “thin client” and should not be used to access the secure D:drive.

The door to the student room must be shut and locked whenever the room is empty. If you are the last one to leave – shut the door behind you! It is easy to gain re-entry to the room by swiping your student ID card in the reader mechanism located to the right of the hallway door.
FEEDBACK ON CLINICAL PERFORMANCE AND CLINICAL GRADING POLICIES

- Evaluative Feedback

- Grading Procedures

- Clinical Portfolio

- Feedback to Clinical Instructors
Clinical assignments are designed to familiarize students with a wide variety of speech-language impairments across a range of client age levels. The clinical faculty has identified a core set of clinical skills which are fundamental to successful management of all communication disorders. On a regular basis, students are provided with formative and summative feedback regarding their mastery of these essential facets of clinical practice (i.e., technical skills, problem-solving, clinical writing, professional behavior, and personal qualities).

A performance-based course such as clinical practicum is not conducted or graded in the same ways that a typical classroom-based course would be. It’s important for student clinicians to realize that clinical instructors will be giving them evaluative feedback on both technical and professional skills.

The category of technical skills includes behaviors such as writing behavioral objectives, using effective teaching strategies and reinforcers, collecting data, and writing reports. This first major component focuses on short-term behaviors that are generally demonstrated in each session. These tend to be easily observable, are highly dependent on technical knowledge, and are rated using a relatively more objective numerical scale in order to give students formative feedback.

Professional skills are more broadly-based and may include things like initiative, creativity, and ability to handle constructive criticism, self-confidence, and effectiveness as a communicator (see Professional Conduct Standards in Appendix). This second major component to be considered in assessment of student performance includes behaviors less easily measured by numerical ratings which encompass longer-range skills/abilities. These tend to be more conceptual in nature and lend themselves more appropriately to a relatively more subjective type of descriptive/summative feedback.

Clinical instructors go to great lengths to present formative feedback in a helpful, nonthreatening manner. Student clinicians are encouraged to develop strategies for processing this feedback from a positive perspective so that they can receive maximal benefit from clinical mentoring.

The supervisor-supervisee relationship varies over time along a continuum from direct to indirect instruction. Direct instruction along with modeling and close guidance, may be provided early in practicum training to ensure that students feel comfortable engaging in trial-and-error learning (i.e., beginning of the program, start of each semester, initiation of an unfamiliar case, etc). As the clinical education program progresses, case supervisors gradually provide less direct instruction and establish expectations for increasing levels of independence and successful performance from student clinicians.

*This means that as students gain more clinical experience, they should expect fewer numbers of observations and less directive feedback from their supervisors.*

The clinical faculty has established multiple mechanisms for providing feedback to student clinicians:
- Session evaluations are returned with ratings and comments on a periodic basis
- Therapy logs are reviewed and returned with comments on a periodic basis
- Individual supervisory conferences are held on a weekly basis according to supervisee need
- Clinical reports are reviewed and returned with comments on a periodic basis
- Individual grade conferences are held at midterm and final points of each semester
Clinical instructors directly observe a substantial percentage of each client's treatment program and evaluate student clinician performance in several areas (see *Daily Therapy Evaluation Form on HESP 648B practicum course website*). Please note the key which provides a descriptive rating of student performance. These evaluation forms are part of a web-based clinic evaluation system. In this system, supervisors enter ratings and comments for any sessions they have observed. Once the entry is finalized, students can log into the system to view the feedback regarding their clinical performance. In addition, supervisors enter mid-term and final assessments into this numeric system. Students can access only their own evaluations. The number values recorded on these forms will be averaged at the end of the semester. These ratings will be combined and considered in combination with additional evaluative feedback from all relevant clinical faculty members to determine a final semester grade in practicum.

*Please note that these numerical ratings in the web-based system are not the sole factor used to determine a student’s clinic practicum grade. Clinical faculty review each student’s performance in a comprehensive and holistic manner. So, descriptive/subjective feedback from case supervisors regarding conceptual skills/personal qualities in practicum performance has a significant impact on each student’s grade.*

A primary supervisor will be designated to integrate and summarize this information regarding student clinician development and present it during individual grading conferences. *Please see Appendix A for the midterm/final grading rubric used throughout the first year of clinical practicum training.* If a student consistently exhibits significant difficulty meeting expectations in clinical practicum, the *Self-Evaluation Form in Appendix B* will be used to help the student assess clinical performance to date. In addition, the supervisor and/or clinic director will meet with the student and, if appropriate, develop an *Individualized Action Plan* which identifies specific objectives or benchmarks which must be achieved along with mechanisms for facilitating student success. The following is an example of an individualized action plan:
## EXAMPLE Individualized Action Plan

<table>
<thead>
<tr>
<th>Skill Area</th>
<th>Benchmark</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Programming</strong></td>
<td>Independently program 2 clients with rationales supported by baseline information</td>
<td>By end of 3 sessions in summer semester</td>
</tr>
<tr>
<td></td>
<td>able to execute programming through multiple materials/activities that elicit the target behavior [with supervisor review]</td>
<td>Immediate:</td>
</tr>
<tr>
<td></td>
<td>Be able to adjust materials and activities [branch] on a weekly basis [based on performance data] to facilitate client performance</td>
<td>rs in advance of each session, submit written plan to each supervisor:</td>
</tr>
<tr>
<td></td>
<td>ability to independently execute programming through multiple materials/activities that elicit the target behavior</td>
<td>By end of 3 sessions in summer semester</td>
</tr>
<tr>
<td><strong>Supervision</strong></td>
<td>Effectively make use of supervisory resources by:</td>
<td>Immediate</td>
</tr>
<tr>
<td></td>
<td>● Attending weekly meetings</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Bringing written questions to meetings that demonstrate independent problem solving</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Being able to initiate discussion of the case, the session, and own clinical skills and challenges</td>
<td></td>
</tr>
<tr>
<td><strong>Professional Behavior</strong></td>
<td>Take ownership of all aspects of clinical work by:</td>
<td>Immediate</td>
</tr>
<tr>
<td></td>
<td>● Rescheduling missed supervisor meetings</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Attending to late reports</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Rescheduling cancellations / make up sessions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reach closure on all tasks</td>
<td>Ongoing</td>
</tr>
<tr>
<td><strong>Reports</strong></td>
<td>● Utilize proofreading and other strategies to ensure a better first draft</td>
<td>Immediate</td>
</tr>
<tr>
<td></td>
<td>● Make sure edits are complete and that you respond to all supervisory comments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Clarify edits with supervisor if unsure</td>
<td></td>
</tr>
<tr>
<td><strong>Time Management</strong></td>
<td>demonstrate effective time management:</td>
<td>Within one week</td>
</tr>
<tr>
<td></td>
<td>● Limit work to 10 hours per week</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Provide a “sample” week’s schedule of how you’ll handle classes, clinic, work, etc.</td>
<td></td>
</tr>
</tbody>
</table>
Students should note that admission to the academic degree programs does not guarantee access to the clinical training component of the department. Clinical training is required for eventual ASHA Certification, but is not a requirement of any of the degree programs at the University of Maryland.

Departmental permission is required for registration in clinical practicum and is granted only to matriculated students. Students must possess the communicative competencies requisite to satisfactory conduct of usual clinical procedures. Further, as the client population served by this program is predominantly English-speaking, participants in any clinical practicum must be proficient, intelligible speakers of English.

All students enrolled in clinical practicum are expected to abide by the ASHA Code of Ethics, provided to each student upon admission to graduate study. Violations of the Code of Ethics may result in permanent dismissal from practicum placement opportunities, and may additionally subject the student to dismissal from the academic degree program.

**DRESS CODE:** Clinical practicum students are expected to maintain professional dress and demeanor. In general, attire should be consistent with the clinical setting, show respect for the client/family, and not distract from the provision of services or the student clinician’s professional credibility. Supervisors may vary in what they think is appropriate. If you are unsure about any clothing item, just ask. Unprofessional conduct, or any conduct which compromises the quality of care to clinic patients, may result in dismissal from clinical practicum placements (see Appendix C for Professional Conduct Standards).

**Eligibility For Outside Placements Includes The Following:**
- A student may not go on outside placement if he/she is on academic probation (GPA below 3.0).
- A student who earns a grade of C+ or less for any HESP 648b registration during their first year will not be eligible for outside placement until they successfully complete an additional semester of clinical training with a grade of B- or better. If a student earns a grade of C+ or less in a second semester during their first year, eligibility for further clinical practicum training will be determined by the clinical instructors, clinic director, and department chair on a case-by-case basis.
- Students will receive clock hour credit for hours earned in clinic registrations which receive a semester grade of “C” or better; no clock hours will be credited for clinic registrations which receive a grade of less than “C” (e.g., C-, D+). In some cases, supervisors may decline to sign off on clock hours associated with a specific task/event (rather than the clock hours for an entire semester) due to problematic clinical performance within that limited context.
- At their own expense, students may need to obtain vaccinations or health records, undergo criminal background checks, or pass drug screenings in order to be eligible for placement at some sites.
- Students must complete a minimum of 15 hours of academic coursework prior to applying for outside placement.
- Students who receive a grade of “C” or less for an outside placement registration, or whose placements are terminated will be advised by the clinic director and department chair on a case-by-case basis regarding eligibility for continued practicum training. If continued training is
warranted, the student must re-register in a subsequent semester for placement in the department’s central clinic (through HESP 648B) and earn a final grade of B or better before being permitted to re-apply for outside placement. A minimum of two outside placements must be completed successfully.

**Feedback to Clinical Instructors**
Clinical supervisors and student clinicians operate in a dynamic relationship that can be characterized as “mentor-mentee” or “senior-junior colleagues”. New clinicians often have concerns about the solidity of their knowledge base and also about their ability to manage constructive criticism. Clinical supervisors see their role as guiding each student through the program in a nurturing and supportive way. Given the potential array of different learning and communication styles that characterize each of us, honest and direct communication is of paramount importance during clinical training.

**Clinical supervisors are most effective when they master the art of delivering clear, constructive criticism in ways that students find useful. In addition, it is very important that graduate clinicians establish and master techniques for deriving benefit from constructive criticism and effectively communicating their educational needs to their clinical instructors on an ongoing basis.**

Students are encouraged to use their weekly conferences with case supervisors as an opportunity to express their thoughts and concerns. This ensures that necessary changes are implemented in a timely fashion and minimizes the chances of serious miscommunication between supervisor and supervisee. In addition, formal reviews of supervisory performance are conducted at midterm and final points in each semester. Graduate clinicians are encouraged to complete these evaluations in as thoughtful and objective a manner as they would wish the supervisors to use in their evaluations of student clinical performance. This feedback is reviewed by the individual supervisors, the clinic director, and periodically the department chair.
SUPERVISOR EVALUATION

SUPERVISOR ___________________________ DATE __________________

PLEASE RATE YOUR AGREEMENT WITH EACH STATEMENT AND WRITE COMMENTS AT THE BOTTOM OF EACH SECTION.

QUANTITY OF SUPERVISION

1. THE FREQUENCY AND DURATION OF DIRECT OBSERVATION OF MY THERAPY SESSIONS IS WELL-MATCHED WITH MY CLINICAL SKILL LEVEL.

   STRONGLY DISAGREE   DISAGREE   NEUTRAL   AGREE   STRONGLY AGREE

2. I AM SATISFIED WITH THE AMOUNT OF TIME ALLOTTED TO INDIVIDUAL AND/OR GROUP CONFERENCING WITH MY SUPERVISOR.

   STRONGLY DISAGREE   DISAGREE   NEUTRAL   AGREE   STRONGLY AGREE

3. I AM SATISFIED WITH THE RESPONSIVENESS OF MY SUPERVISOR IN RESPONDING TO EMAIL (E.G., WITHIN 24-48 HRS. DURING THE WORK WEEK) AND SCHEDULING APPOINTMENTS.

   STRONGLY DISAGREE   DISAGREE   NEUTRAL   AGREE   STRONGLY AGREE

COMMENTS: ______________________________________________________

____________________________________________________________________

QUALITY OF SUPERVISION

4. MY SUPERVISOR HELPS ME TO MAKE PRODUCTIVE USE OF MY SUPERVISION CONFERENCE TIME.

   STRONGLY DISAGREE   DISAGREE   NEUTRAL   AGREE   STRONGLY AGREE

5. THE SUPERVISION I RECEIVE REFLECTS KNOWLEDGE AND EXPERTISE RELATED TO MY CLIENT’S SPEECH OR LANGUAGE DISORDER.

   STRONGLY DISAGREE   DISAGREE   NEUTRAL   AGREE   STRONGLY AGREE
6. The supervision I receive stimulates my interest in learning about my client’s speech or language disorder.

<table>
<thead>
<tr>
<th>STRONGLY DISAGREE</th>
<th>DISAGREE</th>
<th>NEUTRAL</th>
<th>AGREE</th>
<th>STRONGLY AGREE</th>
</tr>
</thead>
</table>

COMMENTS: ____________________________________________

__________________________________________________________________________________________

SUPPORT AND FEEDBACK

7. My supervisor provides ideas/readings/guidance to help me develop independent therapy planning and problem-solving.

<table>
<thead>
<tr>
<th>STRONGLY DISAGREE</th>
<th>DISAGREE</th>
<th>NEUTRAL</th>
<th>AGREE</th>
<th>STRONGLY AGREE</th>
</tr>
</thead>
</table>

__________________________________________________________________________________________

8. Feedback on daily evaluations, logs and reports is constructive and helpful.

<table>
<thead>
<tr>
<th>STRONGLY DISAGREE</th>
<th>DISAGREE</th>
<th>NEUTRAL</th>
<th>AGREE</th>
<th>STRONGLY AGREE</th>
</tr>
</thead>
</table>

__________________________________________________________________________________________

9. I am assisted in developing a plan to improve my clinical skills.

<table>
<thead>
<tr>
<th>STRONGLY DISAGREE</th>
<th>DISAGREE</th>
<th>NEUTRAL</th>
<th>AGREE</th>
<th>STRONGLY AGREE</th>
</tr>
</thead>
</table>

COMMENTS: ____________________________________________

__________________________________________________________________________________________

SUPERVISION STYLE

10. My learning style and interaction style are considered in the supervision process.

<table>
<thead>
<tr>
<th>STRONGLY DISAGREE</th>
<th>DISAGREE</th>
<th>NEUTRAL</th>
<th>AGREE</th>
<th>STRONGLY AGREE</th>
</tr>
</thead>
</table>

__________________________________________________________________________________________

11. I feel comfortable sharing concerns and discussing my strengths and needs.
12. **My input is welcome in the supervision process.**

<table>
<thead>
<tr>
<th>STRONGLY DISAGREE</th>
<th>DISAGREE</th>
<th>NEUTRAL</th>
<th>AGREE</th>
<th>STRONGLY AGREE</th>
</tr>
</thead>
</table>

**Comments:**

__________________________________________

______________________________________________________________________
APPENDICES

- APPENDIX A: Midterm/Final Clinical Performance Rating Scale

- APPENDIX B: Self-Evaluation Form

- APPENDIX C: Professional Conduct Standards

- APPENDIX D: Graduate Student Consent Forms

- APPENDIX E: Language Sample Analysis

- APPENDIX F: ASHA Code of Ethics

- APPENDIX G: State Licensure and ASHA Certification Information
APPENDIX A

CLINICIAN PROFILE SUMMARY
Midterm/Final

Clinician: 

Semester: 

Client: 

Supervisor: 

♦ Technical Skills - Integrates the following:
Examples from Daily Evals: Ability to collect data; judge responses; provide reinforcement & feedback; formulate goals, objectives, task hierarchies; design and carry out behavior mgt plans; select/create materials/activities; records clinical hours, maintains files.
Examples from Midterm/Final Evals: Schedules meetings/make-ups; utilizes resources; administers tests & analyzes assessment data; actively participates in supervision process.

Excellent Adequate Needs Improvement

♦ Problem-Solving Skills - Integrates the following:
Examples from Daily Evals: Adjusts task (branching, task analysis), environment, teaching strategies to improve client performance; adjusts pace, tone, transitions, communication style; analyzes/adjusts programming, priorities based on data; develops behavior mgt plans.
Examples from Midterm/Final Evals: Expresses rationales for recommendations, discharge, programmatic changes; referrals and additional assessments; proactively identifies needs and implements change based on feedback from supervision process; proactive in learning about the communication disorder.

Excellent Adequate Needs Improvement

♦ Communication Skills - Integrates the following:
Examples from Daily Evals: Accuracy and completeness of logs; self-evaluation and planning from logs; Communication with supervisor (meetings, supervision, email); daily communication with client/families, supervisor, co-clinicians.
From Midterm/Final Evals – Oral communication skills for describing the case, progress made, conferencing with clients/families, interaction with professionals, supervisor; Confidence, poise, maturity in communication; Written reports including content, style, mechanics and editing.

Excellent Adequate Needs Improvement

♦ Professional/Personal Qualities – Integrates the following:
Examples from Daily Evals: Demeanor; teamwork; appearance; timeliness; energy; creativity; flexibility; empathy.
Examples from Midterm/Final Evals: Initiative; responsibility; ownership of case; participation in the supervision process; attitude toward learning.

Excellent Adequate Needs Improvement
APPENDIX B

UNIVERSITY OF MARYLAND
SELF-EVALUATION OF CLINICAL SKILLS

Clinician __________________________ Client __________________________ Date ____________

EVALUATION SCALE:

Skill absent 1
Skill emerging 2
Skill present, but needs refinement, input 3
Skill mastered/Demonstrated independently 4

Rate yourself on the clinical skills listed below.

Consider your case and your level of clinical training. Highlight or mark the areas that appear to have the greatest priority at this time.

When you have completed the self-evaluation, list 2 or 3 areas of relative strength and 2 or 3 areas you would like to improve.

Consider your strengths in order to formulate a plan for self-improvement. Include actions or activities you feel will contribute to your growth as a clinician.

DIAGNOSTIC SKILLS

_____ Selects appropriate formal and informal assessment tools.
_____ Demonstrates familiarity with tests and administration procedures
_____ Obtains and reports reliable and accurate data (from interview, tests, language samples, observations)
_____ Uses effective communication with client and family
_____ Obtains optimum performance from client
_____ Adapts testing procedures as necessary
_____ Accurately scores and interprets assessment results
_____ Makes appropriate recommendations and referrals
_____ Selects pertinent information to share with client/family
_____ Demonstrates effective counseling skills
_____ Integrates pertinent information into written report
_____ Summarizes diagnostic information effectively
_____ Uses professional writing style in written report
_____ Uses acceptable writing mechanics
_____ Proofreads and edits reports independently.

TREATMENT PLANNING/PREPARATION/ONGOING ASSESSMENT

_____ Collects adequate and relevant baseline data prior to treatment
_____ Baseline data is consistent, accurate, and reliable
_____ Raw data representing pre-treatment behavior (transcripts, audiotape, videotape) is collected/maintained
_____ Probes are administered adequately and efficiently
_____ Probes measure adequate sample of behavior
_____ Probes are administered at regular intervals throughout treatment
_____ Lesson plans, data sheets, and materials are organized in advance of session
Relevant research and theory is reviewed when formulating treatment plan and rationales
Engages in ongoing client assessment

Adjusts treatment plan and procedures based on data and clinical observation

Involves client/family in programming decisions when appropriate

SESSION DESIGN/MATERIALS

Adjusts clinical environment/proxemics to facilitate effectiveness
Controls distracting stimuli within the room

DOCUMENTATION/REPORT WRITING

Maintains clinical records (client charts, clinical hours)
Daily logs and treatment plans: Writes measurable behavioral objectives to meet long-term goals
Daily logs: Reports accurate and complete information
Daily logs: Interprets and integrates pertinent information and performance data
Daily logs: Engages in critical and comprehensive self-evaluation
Daily logs: Integrates data, observations, and information from outside resources to problem-solve and/or improve sessions
Reports: Integrates pertinent information into written report (history, baseline data, progress toward meeting objectives, summary of progress)
Reports: Uses professional writing style in written report
Reports: Uses acceptable writing mechanics
Reports: Proofreads and edits reports independently
Completes and submits reports/logs on time

PROFESSIONAL SKILLS

Exhibits a poised, confident demeanor
Upholds ethical standards of the profession (confidentiality, releases)
Follows clinic procedures (cancellations, make-ups, materials room)
Abides by professional standards for conduct and appearance
Engages in effective teamwork with families, colleagues, other professionals
Attends to due dates, appointments therapy start/end times, meetings
Implements suggested modifications from supervisor
Develops and carries out an effective plan of action to improve clinical weaknesses

INTERPERSONAL SKILLS

Consults/observes/helps colleagues to cultivate skills
Demonstrates energy and enthusiasm for clinical work
Strives for creative and innovative approaches to treatment, as appropriate
Exercises good judgment and flexibility in solving problems dealing with emergencies
Offers empathetic understanding, warmth, and respect to client and family
Demonstrates sensitivity to client/family needs and feelings
Deals with client/family frustration and/or resistance as part of the treatment process
Takes on challenges and volunteers for projects to broaden clinical skills
SUMMARY OF SELF-EVALUATION

Relative strengths:

Areas to improve:

Plan of action:
Introduction and Rationale

The Department of Hearing & Speech Sciences has a responsibility to the community to ensure that individuals whom the University of Maryland, College Park, recommends to the State of Maryland for licensure and the American Speech, Language, and Hearing Association for certification are qualified to join the professions of Speech/Language Pathology and Audiology. These professions require strong academic preparation and mastery of clinical and other professional competencies. These professions also require non-academic competencies, such as communication or interpersonal skills, which are as critical to success as those in the academic domain. This document sets forth those essential criteria or “professional conduct standards” that are pertinent to academic and clinical preparation in the Department of Hearing & Speech Sciences (HESP) at the University of Maryland.

Professional Conduct Standards serve several important functions, including, but not limited to: (a) providing information to those considering professional careers in Speech/Language Pathology and Audiology that will help such students in their career decision-making; (b) advising applicants of non-academic criteria considered in admissions decisions made by the University’s professional preparation programs; (c) serving as the basis for feedback provided to students in these programs regarding their progress toward mastery of all program objectives; and (d) serving as the basis for the final assessment of attainment of graduation requirements and recommendation for certification.

All candidates in the UMCP professional preparation programs in HESP are expected to demonstrate that they are prepared to work with clients in a variety of settings. This preparation results from the combination of successful completion of University coursework and clinical practicum experiences and the demonstration of important human characteristics and dispositions that all clinicians should possess. These characteristics and dispositions, the Department of Hearing & Speech Sciences Professional Conduct Standards, are outlined below.

Department of Hearing & Speech Sciences Professional Conduct Standards

The Department of Hearing & Speech Sciences Professional Conduct Standards are grouped into four categories: Communication/Interpersonal Skills, Emotional and Physical Abilities, Cognitive Dispositions, and Personal and Professional Requirements.

Within the professional context to which each candidate aspires, all candidates must:

---

1 The primary sources used in the preparation of this document were the University of Texas at San Antonio and the College of Education at the University of Maryland-College Park.
Demonstrate Appropriate Communication/Interpersonal Skills

- Express themselves effectively in written and oral English in order to communicate concepts, instructions, evaluations, and expectations with faculty, practicum supervisors/administrators, clients, families, peers, and other professionals, given reasonable levels of feedback.
  - Candidates write clearly and legibly and use correct grammar and spelling. They demonstrate sufficient skills in written English to understand content presented in the program and to complete adequately all written assignments, as specified by faculty.
  - Candidates communicate effectively with other students, faculty, staff, and professionals. They express ideas and feelings clearly and demonstrate a willingness and an ability to listen to others.
  - Candidates demonstrate sufficient skills in spoken English to understand content presented in the program, to adequately complete all verbal assignments, and to meet the objectives of clinical practicum experiences (which are designed to teach communication skills to others).

- Utilize communication skills that are responsive to different perspectives represented in diverse classrooms and/or other professional environments
  - Candidates appreciate the value of diversity and look beyond self in interactions with others. They must not impose personal, religious, sexual, and/or cultural values on others.
  - Candidates demonstrate an awareness of appropriate social boundaries between clients and clinicians and show that they are ready and able to observe those boundaries.

- Demonstrate the necessary interpersonal competencies to function effectively with clients, families, practicum supervisors and to function collaboratively as part of a professional team
  - Candidates demonstrate positive social skills in professional and social interactions with faculty, colleagues, clients and families.
  - Candidates demonstrate the ability to express their viewpoints and negotiate difficulties appropriately, without behaving unprofessionally with instructors, peers, or clients.

Demonstrate Acceptable Emotional and Physical Abilities

- Work under time constraints, concentrate in distracting situations, make subjective judgments, and ensure safety in emergencies
  - Candidates demonstrate the ability to work with frequent interruptions, to respond appropriately to unexpected situations; and to cope with extreme variations in workload and stress levels.
  - Candidates possess the ability to make and execute quick, appropriate, and accurate decisions in a stressful environment.
  - Candidates have the capacity to maintain composure and continue to function well in a myriad of situations.
• Demonstrate the physical stamina to engage in fulltime clinical responsibilities and perform extended and additional duties of a professional such as client/family conferences, and other assigned duties
  o Candidates exhibit motor and sensory abilities to attend and participate in class and practicum placements.
  o Candidates are able to tolerate physically demanding workloads and to function effectively under stress.

Demonstrate Appropriate Cognitive Dispositions

• Organize time and materials, prioritize tasks, perform several tasks at once, and adapt to changing situations
  o Candidates have the mental capacity for complex thought as demonstrated in prerequisite course work and in standardized testing.
  o Candidates have sufficient cognitive (mental) capacities to assimilate the technically detailed and complex information presented in formal lectures, small group discussions, and individual teaching, counseling, or administrative settings, and in various practicum settings.
  o Candidates are able to analyze, synthesize, integrate concepts, and problem-solve to formulate clinical judgments.
  o Candidates demonstrate the ability to think analytically about clinical issues. They are thoughtfully reflective about their practice.
  o Candidates demonstrate the ability to multi-task and to adapt to and display flexibility in changing situations.
  o Candidates are able to perform the above skills independently. The use of a trained intermediary is not acceptable in many clinical situations, because a candidate must be able to exercise independent judgment without relying on or having the filter of someone else’s power of observation and selection.

Demonstrate Appropriate Personal and Professional Behaviors

• Arrive on time and be prepared for professional commitments, including classes and practicum experiences
  o Candidates meet deadlines for course assignments and program requirements. A pattern of repeated absences, lateness, and failure to meet deadlines in courses or practicum is not acceptable.

• Seek assistance appropriately and follow supervision in a timely manner, and accept and respond appropriately to constructive review of their work from supervisors/instructors
  o Candidates show that they are ready to reflect on their practice and accept constructive feedback in a professional manner. They demonstrate the ability to act upon reasonable criticism.
  o Candidates are flexible, open to new ideas, and willing and able to modify their beliefs and practices related to their work.

• Demonstrate attitudes of integrity, responsibility, and tolerance
Candidates demonstrate honesty and integrity by being truthful about background, experiences, and qualifications, doing their own work, giving credit for the ideas of others, and providing proper citation of source materials.

Candidates interact courteously, fairly, and professionally with people from diverse racial, cultural, and social backgrounds and of different genders or sexual preferences. Conduct in violation of the University’s Human Relations Code is not acceptable (see http://www.inform.umd.edu/PRES/policies/vi100b.html).

Candidates must not make verbal or physical threats; engage in sexual harassment; become involved in sexual relationships with their clients, clients’ families, supervisors, or faculty; or abuse others in physical, emotional, verbal, or sexual ways.

Candidates demonstrate the ability to understand the perspectives of others in the context of teaching, counseling, administration, etc. and the ability to separate personal and professional issues.

Candidates exhibit acceptance of and are able to make appropriate adjustments for exceptional learners.

Candidates protect the confidentiality of client information unless disclosure serves professional purposes or is required by law.

**Show respect for self and others**

- Candidates exhibit respect for all University of Maryland and practicum personnel, as well as peers, clients and their families and members of their communities.
- Candidates are expected to be free of the influence of illegal drugs and alcoholic beverages in classes and practicum settings. They are expected to abide by the University of Maryland’s Code of Student Conduct (http://www.inform.umd.edu/PRES/policies/v100b.html). The Code prohibits the use of any controlled substance or illegal drug on university premises or at university sponsored activities.
- Candidates demonstrate the ability to deal with current life stressors through the use of appropriate coping mechanisms. They handle stress effectively by using appropriate self-care and by developing supportive relationships with colleagues, peers, and others.
- Candidates use sound judgment. They seek and effectively use help for medical and emotional problems that interfere with scholastic and/or professional performance.

**Project an image of professionalism**

- Candidates demonstrate appropriate personal hygiene habits.
- Candidates dress appropriately for their professional contexts.
- Candidates possess maturity, self-discipline, and good judgment.
- Candidates demonstrate good attendance, integrity, honesty, conscientiousness in work, and teamwork.

**Implementation and Review Procedures**

During the orientation phase of their professional programs, candidates will receive a copy of the Department of Hearing & Speech Sciences Professional Conduct Standards Policy and be asked to sign a Professional Conduct Standards Acknowledgement Form. In addition, candidates in the clinical training programs may be required to submit an updated Professional Conduct Standards Acknowledgement Form in each semester of their graduate training program.
Self-assessments of candidates and supervisor evaluations of students on the Professional Conduct standards may occur during each practicum experience (see Candidate’s Self Assessment and Professional Conduct Standards Evaluation Form). Students will be monitored and given feedback throughout the program. At specified points, students will be notified of inadequacies that may prevent them from progressing through their program. Documentation and consensus regarding the student’s functioning will be sought before any action is taken. Candidates who experience deficiencies in any areas will be encouraged to seek appropriate professional help from University or other sources. If the problem seems to be beyond remediation, continuation in professional programs, graduation or recommendation for certification may be denied.

Assistance For Individuals With Disabilities

Professional Conduct standards may be met with, or without, accommodations. The University complies with the requirements of Section 504 of the Rehabilitation Act and the Americans with Disabilities Act of 1990. Therefore, the Department of Hearing & Speech Sciences will endeavor to make reasonable accommodations with respect to its Professional Conduct standards for an applicant with a disability who is otherwise qualified. “Disability” shall mean, with respect to an individual, (1) a physical or mental impairment that substantially limits one or more of the major life functions of such individual; (2) a record of such an impairment; or (3) being regarded as having such an impairment. The University reserves the right to reject any requests for accommodations that are unreasonable, including those that would involve the use of an intermediary that would require a student to rely on someone else's power of selection and observation, fundamentally alter the nature of the University’s educational program, lower academic standards, cause an undue hardship on the University, or endanger the safety of students or others.

Questions or requests for accommodations pertaining to the Department of Hearing & Speech Sciences Professional Conduct Standards should be directed to the faculty via written notification to the Department Chair. For all other requests for accommodations, students should contact the University’s Disability Support Services and follow established university policy and procedures.

Confidentiality

Unless a student has expressly waived his or her privilege to confidentiality of medical records provided to substantiate either a disability or a recommendation for an accommodation, the Department of Hearing & Speech Sciences faculty to which such information has been communicated shall maintain such information in a manner that preserves its confidentiality. Under no circumstances shall such information become part of a student’s academic records.
Within the professional context to which each candidate aspires, all candidates must:

Communication/Interpersonal Skills

Express themselves effectively in written and oral English in order to communicate concepts, assignments, evaluations, and expectations with members of the professional community such as University faculty, clients, client family members, administrators, and other staff.

Utilize communication skills that are responsive to different perspectives represented in diverse professional environments.

Demonstrate the necessary interpersonal competencies to function effectively with clients and their families, and to function collaboratively as part of a professional team.

Emotional and Physical Abilities

Work under time constraints, concentrate in distracting situations, make subjective judgments, and ensure safety in emergencies.

Demonstrate the physical stamina to engage in a fulltime clinical workload and perform extended and additional duties of a professional such as client/family conferences, and other assigned duties.

Cognitive Dispositions

Organize time and materials, to prioritize tasks, to perform several tasks at once, and to adapt to changing situations.

Personal and Professional Requirements

Arrive on time and prepared for professional commitments, including classes and practicum experiences.

Seek assistance and follow supervision in a timely manner, and accept and respond appropriately to constructive review of their work from supervisors.

Demonstrate attitudes of integrity, responsibility, and tolerance.

Show respect for self and others.

Project an image of professionalism.

I have reviewed the Department of Hearing & Speech Sciences Professional Conduct Standards Policy. I understand that if the criteria listed above are not met satisfactorily, I may be denied participation in the Department’s clinical/academic professional preparation program and/or denied the opportunity to complete the externship component of the curriculum.

________________________________________  ____________
Candidate Signature                              Date

NOTE: The University has a legal obligation to provide appropriate accommodations for students with documented disabilities. If you have a documented disability and are seeking accommodations, you should register with the University’s Office of Disability Support Services and notify your course instructor,
and/or academic advisor of your specific needs, as appropriate. Students should initiate this process as soon as possible (prior to the start of classes and/or practicum).
Within the professional context to which I aspire, I believe I am able to (check all that apply):

Communication/Interpersonal Skills

____ Express myself effectively in written and oral English in order to communicate concepts, assignments, evaluations, and expectations with members of the learning community such as University faculty, clients, client family members, administrators, and other staff.

____ Demonstrate communication skills that are responsive to different perspectives represented in diverse professional environments.

____ Exhibit the necessary interpersonal competencies to function effectively with clients and their families, and to function collaboratively as part of a professional team.

Emotional and Physical Abilities

____ Work under time constraints, concentrate in distracting situations, make subjective judgments, and ensure safety in emergencies.

____ Demonstrate the physical stamina to engage in a fulltime clinical caseload and perform extended and additional duties of a professional such as family conferences, and other assigned duties.

Cognitive Dispositions

____ Organize time and materials, prioritize tasks, perform several tasks at once, and adapt to changing situations.

Personal and Professional Requirements

____ Arrive on time and prepared for professional commitments, including classes and practicum.

____ Seek assistance and follow supervision in a timely manner, and accept and respond appropriately to constructive review of their work from supervisors.

____ Demonstrate attitudes of integrity, responsibility, and tolerance.

____ Show respect for self and others.

____ Project an image of professionalism.

I have reviewed the Department of Hearing & Speech Sciences Professional Conduct Standards Policy. I understand that if the criteria listed above are not met satisfactorily, I may be denied participation in the Department’s clinical/academic professional preparation program and/or denied the opportunity to complete the externship component of the curriculum.

Candidate Signature ___________________________  Date ________________

NOTE: The University has a legal obligation to provide appropriate accommodations for students with documented disabilities. If you have a documented disability and are seeking accommodations, you should register with the University’s Disability Support Services and notify your course instructor, and/or academic advisor, of your specific needs, as appropriate. Students should initiate this process as soon as possible (prior to the start of classes and/or practicum).
DEPARTMENT OF HEARING & SPEECH SCIENCES
PROFESSIONAL CONDUCT STANDARDS EVALUATION FORM

Candidate Name: ____________________________________________
Program Area: ____________________________________________

Rate the candidate on each of the standards listed below:

**KEY:**
- A – Frequently
- B – Sometimes
- C – Rarely Ever
- N/A – Not Applicable/ Insufficient Opportunity to Observe

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<td>Professional Conduct Standards</td>
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<td>Expresses him/herself effectively in written and oral English in order to communicate concepts, assignments, evaluations, and expectations with members of the learning community such as University faculty, clients, their families, administrators, and other staff</td>
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<td>Exhibits the necessary interpersonal competencies to function effectively with clients and their families, and to function collaboratively as part of a professional team</td>
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<td>Arrives on time for professional commitments, including classes and practicum; submits clinical/academic assignments in a timely manner</td>
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<td>Seeks assistance and follows supervision in a timely manner, and accepts and responds appropriately to constructive feedback from supervisors</td>
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Recommendation for program continuance: _____ yes    ____ no    ____ probationary

Additional Comments:

______________________________  ________________________________
Faculty Signature/Date          Student Signature/Date
I. Clinic Procedures/Policies and ASHA Code of Ethics

This is to certify that I have participated in clinic orientation and have reviewed the clinic handbook. I understand and agree to abide by the procedures and policies related to the operations of the University of Maryland Hearing and Speech Clinic, including the ASHA Code of Ethics (appendix D of clinic handbook).

___________________________     __________________________________________
Date                                  Signature

II. Consent for observation and recording

This is to certify that I agree:
(1) That I may be observed during my clinical sessions with the authorization of a Hearing and Speech Sciences faculty member.

___________________________     __________________________________________
Date                                  Signature

(2) That recordings (audio, video, photographic, etc.) of my practicum experience may be permanently stored for review by authorized students and faculty of the Dept. of Hearing and Speech Sciences for the purposes of clinical training for students and professionals, classroom instruction, and research.

___________________________     __________________________________________
Date                                  Signature

IV. Commitment and Responsibility

I understand that once I have initiated therapy with speech clients assigned to me, it is my ethical obligation to complete the clinical practicum (HESP 648). I fully understand that failure to meet this obligation may result in an unfavorable recommendation from this department.

___________________________     __________________________________________
Date                                  Signature

V. Criminal Background Checks/Drug Screenings

I understand that many outside placements may require more extensive documentation of my past medical history as well as criminal background checks or drug screenings at my own expense.

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APPENDIX E

Obtaining & Scoring Language Samples

By
Rachel E. Brown
and
Stacy W. Silverman

(former graduate students)
OBTAINING A LANGUAGE SAMPLE:

*Information taken from Stickler, 1987 and Lund & DUCHAN, 1988*

Advantage: Excellent picture of the child’s language production abilities (when done correctly)

Disadvantage: Time consuming

Nature of the Interaction:

1. Miller suggests a number of language samples with the child interaction with a variety of people including the speech—language clinician, a parent, a sibling, or a peer.
2. A conversation where one partner only asks questions and the other responds is not a natural interaction. As conversational partners, clinicians should make efforts to reduce the number of questions asked and to permit the child to take the lead in the interaction. However, complete absence of questions on the part of the clinician would be impossible to attain and may not result in a representative sampling of the child’s productive abilities.

Setting:

Miller suggests using more than one setting during the language sample. I.e., home, school, residential facility, or the clinic. Differences may arise in the language of the child because of the setting. The resulting differences will add to the description of the child’s communication abilities

Materials:

Different materials may result in differences in language frequency and complexity. The differences, however, do not seem to be predictable for children. Therefore it is wise to provide a variety of developmentally appropriate materials and to encourage the child to interact with as many materials as possible. Differences again will contribute to the overall picture of the child’s communication abilities.

SAMPLE SIZE:

1. First—obtain a specific number of utterances from the child. Various authors have suggested number of utterances ranging from 50-200 for the sample to be representative.
2. A 30 minute session (with a child at the 24-month old level or older) will most likely result in a sample of 100-200 utterances.
3. The more utterances, the better. However, 100 utterances gathered under various conditions typically results in a respectably diverse sample.

Method of Recording:

1. The optimum method of recording is video—tape recording, because it permits the clinician to interact freely with the child or to watch undistracted as others interact with the child. Transcription from video—tape recordings is considered to be the most reliable method and permits detailed delineation of changes in nonverbal context.
2. The second method of recording is audio—tape recording. Again the clinician is free to interact with the child, but making notes about the child’s activities during the taping is important for providing the nonverbal context for transcription. One advantage of audiotape is that they are readily available in the clinical setting and are battery operated so they can be taken anywhere the sample is being collected.

3. The third method of recording is on-line transcription. This is particularly useful in recording the child’s productions on outings away from the clinical setting. Miller suggests time sampling that is transcribing for a couple of minutes and then resting before continuing with the transcribing. The alternative, writing down everything the child says, can be cumbersome and exhausting.

**Guidelines for interaction:**

1. Begin with parallel play and parallel talk. With a young child at the one-word stage, imitate his verbalizations and use many animal sounds and vehicle noises. With a child older than two years, talk about what you are doing as you play and use role playing dialogue (e.g., “I’m gonna make my guy drive. Here’s the tractor for him. ‘Wow, what a big tractor. I’m gonna go fast’”)

2. Move into Interactive conversation. With a young child, use some routine questions (e.g., “what’s a doggie say?”) and elicit finger plays such as patty cake. With an older child, invite him to participate in play. Continue with role playing dialogue, unless establishing rules for play. Encourage this child to participate in plans for play, including what toy people/animals will be doing.

3. Continue with the child’s topic. If he is role playing, stay in the role. If he shifts out of role, follow his lead. Respond to questions, acknowledge comments, solicit more information about a topic.

4. Attempt to restrict your use of questions to approximately one question every four speaking turns. Use of questions may reduce the length of the child’s utterance. Instead, try using a phrase such as “tell me about this…”

5. Give the child options that are presented as alternative questions (i.e., “should we play with XXX or XXX?”). This make the child feel in control.

6. Use utterances that are slightly longer than the child’s utterances. Keep the number of utterances per speaking turn to approximately the same number as the child.

7. Learn to be comfortable with pauses in the conversation give the child opportunity to talk!

8. Have a variety of materials to keep the child’s motivation high, but do not move abruptly from one activity to the other. Offer the child the option of changing activities and follow his interests. A diverse combination of materials might include role playing toys like cars, trucks, and people,
farm sets, and kitchen sets as well as manipulative materials like clay, paints, paper, pens, markers, and items for making a snack.

9. Do not be afraid to be silly and have fun! Many shy children can be brought into the interacting by asking silly, obvious question (i.e., “those are great shoes. Can I wear them?”) Or by making silly comments (i.e., “there’s a mouse in your pocket!”). Enjoy the child and he will enjoy he interaction.

Transcribing Language Samples:

1. Adult and child utterances can be transcribed in English except when utterances are unintelligible or the child’s approximation deviates substantially from expectations.
2. It is important to make context notes during the interaction so that the situational context may be specified in the transcript.

Numbering Language Transcripts:

1. The final step in preparing a language transcript is numbering the child’s utterances. Each fully intelligible child utterance to be analyzed should be assigned an utterance number.
2. If an utterance is repeated with no intervening activity or utterance by the other speaker, the utterance is considered a repetition and does not receive an utterance number.
3. Totally or partially unintelligible utterances should not be assigned an utterance number.
4. Incomplete utterances resulting from self—interruption/overlapping sprks, are not assigned utterance #s.
5. Utterance boundaries are determined by a rise or fall in pitch, followed by a pause in speech. The end of a sentence indicates the utterance boundary, whether or not a pause in speech is detected. Compound and complex sentences are always counted as one utterance.

Example (Taken from Lund & Duchan, 1988, p. 209)

Sample as Transcribed

Well in school I always go to a a / kind of a / silly kind of school / (laugh) / well what we do is / with big pieces of papers / an we what we do is make make writing things like that with a H and O and all those kinds of homeworks // we make math homeworks on little little pieces of squares

Segmented Sample

1. (Well in school) I always go to (a a) kind of a silly kind of school.
2. (Well) what we do is with big pieces of papers (an we).
3. (Well) what we do is make (make) writing things like that with a H and O and all those kinds of homeworks.
4. We make math homeworks on little little pieces of squares.
Not all children will be eager to talk to the clinician during the language sample. Here are some hints for getting reluctant children to talk:

1. Keep the focus off your attempt to get the child to talk. With children who are very hesitant to say anything, offer contexts that demand little verbalizations for participation, such as drawing pictures or playing a game. This allows the child to become a participant with you in a nontthreatening way. During the event you should comment on what you are doing and allow for, but not directly request, the child's verbal participation.

2. Do not talk too much and do not be afraid to allow silent pauses during the conversation. Do not fill up every empty space with a question. This encourages the child to let you take the lead.

3. Select materials appropriate to the child’s interest level. For example, children operation at the preschool level tend to more interested in toys than in books or games. Older tend to like unusual objects or things that can be manipulated.

4. Toys with detachable or moving parts and broken toys generally stimulate interest. If possible, you might have the child or caretaker bring in one or two of the child’s favorite toys. Children often have more to say about familiar things than about new ones.

5. Most children are naturally curious. If the know you have something concealed from them, they usually want to find out more about it, having a big bag (or pillow case) from which you withdraw objects may prompt conversation about what else it contains. Likewise, noise sources they cannot see or mechanisms that make toys move stimulate curiosity.

6. If the child will initiate conversation about your materials, let him or her take the lead, and you ask questions or comments briefly on what the child is saying.

7. If the child does not initiate, make comments yourself about the materials and ask open-ended leading questions, such as “That looks broken. What do you suppose happened to it?” or “Can you figure out what’s going on here?” if these prompts do not elicit verbalization, try more specific questions which require minimum output, such as “Do you…?” “Where…?” “What is…?” and then build up to more open ended questions, such as “Tell me…” or “What about?”

8. If statements or questions trigger no reaction, demonstrate what you expect of the child. For example, take toy yourself and play with it, tell about what you are doing, and personalize your account using an imaginary situation. Engage the child in the play as soon as possible and begin to prompt indirectly.

9. If the child is reluctant to talk about pictures or tell stories, go first and set the stage. A series of sequence pictures provides more storey structure than a single picture and therefore is generally easier for a beginning story. You can have the child tell the same story after you or create a new story using different pictures or characters. Unless you are analyzing for storytelling structures,
do not ask the child to tell a familiar story, since it might be memorized and unlike more natural output.

10. Include another person in the elicitation or collection procedure. This might be another clinician or aide who can model the responses you expect from the child or it might be the child’s parent, sibling, or friend who can be included in the activities. Having a third party involved tends to take the focus off the child and makes talking more comfortable.

Table: Brown’s 14 Morphemes

Brown’s Rules for Counting Morphemes

**To compute the mean length of utterance:**

1. Count the number of morphemes on each utterance using the rules below

2. Compute the total number of morphemes in the sample and divide by the number of utterances.

<table>
<thead>
<tr>
<th>MORPHEME</th>
<th>EXAMPLE</th>
<th>AGE OF MASTERY (MONTHS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present progressive –ing (no auxiliary verb)</td>
<td>Mommy driving</td>
<td>19=28</td>
</tr>
<tr>
<td>IN</td>
<td>Ball in cup</td>
<td>27-30</td>
</tr>
<tr>
<td>On</td>
<td>Doggie on Sofa</td>
<td>27-30</td>
</tr>
<tr>
<td>Regular Plural –S</td>
<td>Kitties eat my ice cream Forms: /s/, /z/, and /lz/</td>
<td>24-33</td>
</tr>
<tr>
<td></td>
<td>Cats /kt/, Dogs /d/gz/ Classes /kl slz/</td>
<td></td>
</tr>
<tr>
<td>Irregular Past</td>
<td>Came, Fell, broke, went</td>
<td>25-46</td>
</tr>
<tr>
<td>Possessive ‘s</td>
<td>Mommy’s balloon broke. Forms: /s/, /z/, and /lz/ as in regular plural</td>
<td>26-40</td>
</tr>
<tr>
<td>Un-contractible Copula (Verb to be as main verb)</td>
<td>He is, (i.e. Response to “Who’s sick?”)</td>
<td>27-39</td>
</tr>
<tr>
<td>Articles</td>
<td>I see a kitty. I throw the ball to daddy</td>
<td>28-46</td>
</tr>
<tr>
<td>---------------</td>
<td>------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Regular past –ed</td>
<td>Mommy pulled the wagon. Forms: /d/, /t/, /ld/ Pulled /p ld/ Walked /w kt/ Glided /glaldid/</td>
<td>26-48</td>
</tr>
<tr>
<td>Regular third person</td>
<td>Kathy hits. Forms: /s/, /z/ &amp; /lz/ as in regular plural</td>
<td>26-48</td>
</tr>
<tr>
<td>Irregular third person</td>
<td>Does, has</td>
<td>28-48</td>
</tr>
<tr>
<td>Un-contractible auxiliary</td>
<td>He is. (response to “Who’s wearing your hat?”)</td>
<td>29-48</td>
</tr>
<tr>
<td>Contractible Copula</td>
<td>Man’s big. Man is big.</td>
<td>29-49</td>
</tr>
<tr>
<td>Contractible auxiliary</td>
<td>Daddy’s drinking juice. Daddy is drinking juice.</td>
<td>30-50</td>
</tr>
</tbody>
</table>

### RULE

**COUNT AS ONE MORPHEME:**
- Reoccurrences of a word for emphasis
- Compound words (two or more free morphemes), Proper Names, Ritualized reduplications, Irregular past tense verbs, Diminutives, Auxiliary Verbs

**COUNT AS TWO MORPHEMES:**
- Possessive Nouns, Plural Nouns, Third person singular present tense verbs, Regular past tense verbs, Present Progressive Verbs

**DO NOT COUNT**
- Dys-fluencies, except for most complete filler

<table>
<thead>
<tr>
<th>STAGE</th>
<th>MLU</th>
<th>APPROXIMATE AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>1.0-2.0</td>
<td>12-26 Months</td>
</tr>
<tr>
<td>II</td>
<td>2.0-2.5</td>
<td>27-30 Months</td>
</tr>
<tr>
<td>III</td>
<td>2.5-3.0</td>
<td>31-34 Months</td>
</tr>
<tr>
<td>IV</td>
<td>3.0-3.75</td>
<td>35-40 Months</td>
</tr>
<tr>
<td>V</td>
<td>3.75-4.5</td>
<td>41-46 Months</td>
</tr>
<tr>
<td>V+</td>
<td>4.5+</td>
<td>47+</td>
</tr>
</tbody>
</table>

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>93</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1. Scan the language sample for instances where the child uses a word or phrase differently than an adult would. Record those instances, providing the context in which they occur. Include all correct and incorrect productions of the item. Note the overextension or under extension of words or phrases.

2. Examine the sample for indefinite words, phrases, and gestures (e.g. “things” and “stuff”). If the sample seems to have disproportionately high number of these, suspect lexical deficits. Determine the lexical type under which most of these occur (e.g. action verbs, nouns, etc.)

3. Look for the overall absence of word classes in the sample.
Grammatical Classifications of First 50 Words Produced:

<table>
<thead>
<tr>
<th>Grammatical Function</th>
<th>Percentage of Vocabulary</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Benedict (1979)</td>
<td>Nelson (1973)</td>
</tr>
<tr>
<td>Nominals General Specific</td>
<td>50</td>
<td>51</td>
</tr>
<tr>
<td>Action Words</td>
<td>19</td>
<td>14</td>
</tr>
<tr>
<td>Modifiers</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Personal-Social</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Functional</td>
<td>10</td>
<td>9</td>
</tr>
</tbody>
</table>

Sequence of Language Skills for children, ages 5-9

The following charts will be helpful for clinicians who are not sure what is considered “normal” for ages 5-9. Additionally, these charts will be useful for speech language clinicians when developing objectives.

### Five- to Six- Year-Olds

**Listening Skills**
- Child can identify environmental sounds
- Child can respond to a musical pattern.
- Child can give rhyming words when given a model word and the beginning sound of the next word.
- Child can identify the following consonant sounds in any position in words: w, k, y, p.

**Following and Giving Instructions**
- Child can follow on direction using a position in space.
- Child can manipulate objects by following two verbal directions.
- Child can verbalize and perform oral direction.
- Child can orally give 1-step directions to peers.

**Narrative Abilities**
- Child can tell a personal experience in a complete sentence containing 3-5 words with one beginning.
- Child can express emotions as shown in a picture.
- Child can explain why she has certain feelings. Given a series of 3 pictures, child can make up her own story of at least 3 (3-5 word) simple sentences.
- After hearing a sequence of 3 series of 4 sounds, child can reproduce 3 of the 4 sequences in the same order.
- After hearing 4 series of 5 numbers, child can reproduce 3 of the 4 sequences in the same order.

**Vocabulary**
- Child can name parts of the body.
- Child can identify objects that are alike.
- Child can describe simple objects.
- Child can give a cause of an action or an event.
### Syntax

Child can use sentences 4-5 words in length.

<table>
<thead>
<tr>
<th>Six- to Seven-Year-Olds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Listening Skills</strong></td>
</tr>
<tr>
<td>Child can respond to intonation by differentiating another’s questions from statements.</td>
</tr>
<tr>
<td>Child can differentiate between commands, questions, and exclamations, by the examiner’s intonation.</td>
</tr>
<tr>
<td>When given the following words, child can rhyme one word with each in 4 out of 5 trials: cat, met, red, hit, tree, say.</td>
</tr>
<tr>
<td>After hearing a story, child can recall events at beginning and end.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Following and Giving Instructions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Child can follow 3 or 4 directions meteorically.</td>
</tr>
<tr>
<td>Child can verbalize and follow 2-step oral directions 4 out 5 times.</td>
</tr>
<tr>
<td>Child can give 2-step directions to her peers.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Narrative Abilities</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Child can imitate or dramatically express a character of choice in a given story with intonation and inflection (role play or puppetry)</td>
</tr>
<tr>
<td>Given a picture, the child can tell a story of 3 or more sentences, inventing an ending</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Vocabulary</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Child can describe objects in terms of their position in space.</td>
</tr>
<tr>
<td>Child can classify objects according to a specific criterion.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Syntax</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Child uses compound sentences.</td>
</tr>
<tr>
<td>Child uses possessive pronouns, singular and plural. Child uses regular and irregular simple verbs in past tense.</td>
</tr>
<tr>
<td>Child uses common regular plurals correctly.</td>
</tr>
<tr>
<td>Child ask questions using “wh” question words.</td>
</tr>
</tbody>
</table>
Seven- to Eight-Year-Olds

**Listening Skills**

- Child can complete a sentence with a rhyme.
- Child can identify the following consonant sounds in all positions in words: the, ch, sh.
- Child can identify the positions of the following sounds: l, k, w, th, ch, sh, r, s in nonsense words.

**Following and Giving Instructions**

- Child can manipulate objects by following 3-4 verbal directions.
- Child can verbalize and perform 3-4 step oral directions correctly, 4 out of 5 times.
- Child can give orally 3-step directions to his peers.

**Narrative Abilities**

- Child can describe emotions using synonyms, words, phrases or sentences.
- Child can tell a creative story of 3-5 sentences.
- Child can create and dramatize her own story.
- Child can express anticipated need and wants for a task to be completed that day.
- Child can tell an experience in sequence with a beginning and an end.
- Child can tell an experience with a beginning, a middle, and an ending, telling in sequential order what happened first, second, third.
- Child can describe an event with voice intonations and inflections.

**Vocabulary**

- Child can categorize in a group of similar objects all those that are like in some specific way.
- Child can produce at least three descriptive words on a chosen topic.
- Child can tell what he thinks will happen as the result of an action or an incident.

**Syntax**

- Child can produce sentences showing cause and effect.
- Child can use plural pro nouns correctly.
- Child can use interrogative pronouns correctly.
- Child can use simple verbs in future tense correctly.
- Child can use common irregular plurals correctly.
- Child can ask questions using when, why and how with a clarifier- e.g., How many? How big?
Eight- to Nine- Year- Olds

<table>
<thead>
<tr>
<th>Listening Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child gives evidence of understanding of rhythm and intonations by participating in a group recitation of rote materials.</td>
</tr>
<tr>
<td>Child can rhyme nonsense words. After hearing a story, child can recall events happening in the beginning, middle and end.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Following and Giving Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child can follow and give 4-step directions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Narrative Abilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child can assess and express needs or wants for an anticipated project to be completed in a week.</td>
</tr>
<tr>
<td>Child can assess and express needs for a teacher-suggested project.</td>
</tr>
<tr>
<td>Child can tell an experience with the elements of (who, what), (where, when, how) and (why).</td>
</tr>
<tr>
<td>Child can describe emotions, using phrases or sentences with intonation and inflection.</td>
</tr>
<tr>
<td>Child can tell a well-organized original story.</td>
</tr>
<tr>
<td>Child can participate in and/pr contribute to the creation and dramatization of a group story or group activity.</td>
</tr>
<tr>
<td>Child can participate in the adaptation of a familiar story into script form for dramatization.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vocabulary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child can name orally the function of familiar objects.</td>
</tr>
<tr>
<td>Child can name orally pictures of activities or situations.</td>
</tr>
<tr>
<td>Child can associate objects with common qualities.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Syntax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child can use reflexive pronouns.</td>
</tr>
<tr>
<td>Child can use present perfect tense correctly.</td>
</tr>
<tr>
<td>Child can use simple regular and irregular plurals correctly.</td>
</tr>
<tr>
<td>Child can use s, es, or ies ending correctly.</td>
</tr>
<tr>
<td>Child can ask why, what if, how come, how about, whose, which.</td>
</tr>
<tr>
<td>Child can change a statement into a question.</td>
</tr>
</tbody>
</table>
Eliciting Questions from Children

This is a suggested procedure for eliciting questions from a child who does not ask them spontaneously. This method works best when 3 people are involved. The child asks as a messenger, carrying information from one person to another. It is also more realistic if the two people who are exchanging messages through the child are not within view of one another. A problem with the question formulation might be revealed if the child uses the request as a model for forming his or her own questions: e.g. Adult: Ask her how she got to this school. Child: How you to this school?

<table>
<thead>
<tr>
<th>MESSAGE CARRIED BY THE CHILD</th>
<th>QUESTION FORM ELICITED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ask her where she lives.</td>
<td>Where + Do</td>
</tr>
<tr>
<td>2. Ask her when her birthday is.</td>
<td>When</td>
</tr>
<tr>
<td>3. Ask her how she got to this school</td>
<td>How + Did</td>
</tr>
<tr>
<td>4. Ask her to tell you what this is for.</td>
<td>What + For</td>
</tr>
<tr>
<td>5. Ask her who she eats with.</td>
<td>Who + Do</td>
</tr>
<tr>
<td>6. Ask her what time it is.</td>
<td>What</td>
</tr>
<tr>
<td>7. Ask her which one she wants – this one or that one</td>
<td>Which</td>
</tr>
<tr>
<td>8. Ask her how many shoes she has on</td>
<td>How many</td>
</tr>
<tr>
<td>9. Ask her when she is going home.</td>
<td>When</td>
</tr>
<tr>
<td>10. Ask her if she will eat out tonight.</td>
<td>Will</td>
</tr>
<tr>
<td>11. Ask her what color her hair is.</td>
<td>What</td>
</tr>
<tr>
<td>12. Ask her if she wants this.</td>
<td>Do</td>
</tr>
<tr>
<td>13. Ask her if she likes what she is doing.</td>
<td>Do (complex)</td>
</tr>
<tr>
<td>14. Ask her how she catches a ball.</td>
<td>How + Do</td>
</tr>
<tr>
<td>15. Ask her when you can go to lunch</td>
<td>When + Can</td>
</tr>
<tr>
<td>16. Ask her why she isn’t home now.</td>
<td>Why + Aren’t</td>
</tr>
<tr>
<td>17. Ask her if she can jump.</td>
<td>Can</td>
</tr>
<tr>
<td>18. Ask her if she will help you snap your fingers</td>
<td>Will (Complex)</td>
</tr>
<tr>
<td>19. Ask her why this won’t work.</td>
<td>Why+ Won’t</td>
</tr>
<tr>
<td>20. Ask her why this is dirty.</td>
<td>Why</td>
</tr>
<tr>
<td>Your Question to the Child</td>
<td>Meaning Elicited</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>When</td>
<td>Time</td>
</tr>
<tr>
<td>Where</td>
<td>Space</td>
</tr>
<tr>
<td>Why</td>
<td>Cause- effect</td>
</tr>
<tr>
<td>Who</td>
<td>People</td>
</tr>
<tr>
<td>Whose</td>
<td>Possessive</td>
</tr>
<tr>
<td>Is, are, was, were, am</td>
<td>Identity, quality description</td>
</tr>
<tr>
<td>How</td>
<td>Number</td>
</tr>
<tr>
<td>How many- few</td>
<td>Quantity</td>
</tr>
<tr>
<td>Much – little</td>
<td>Tune</td>
</tr>
<tr>
<td>Often – Soon</td>
<td>Distance</td>
</tr>
<tr>
<td>Far- Near</td>
<td>Linear Measure</td>
</tr>
<tr>
<td>Long</td>
<td>Weight</td>
</tr>
<tr>
<td>Heavy- light</td>
<td>Size</td>
</tr>
<tr>
<td>Big small</td>
<td>Probability, Cause- effect</td>
</tr>
<tr>
<td>Would</td>
<td>Selection, Multiple Choice</td>
</tr>
<tr>
<td>Which</td>
<td>Inference, Cause- Effect</td>
</tr>
<tr>
<td>Do, Does</td>
<td>Classification</td>
</tr>
<tr>
<td>What If</td>
<td>Identity</td>
</tr>
<tr>
<td>What Kind, color, shape, size, day</td>
<td>Action</td>
</tr>
<tr>
<td>What + do + verb + with</td>
<td>Function</td>
</tr>
<tr>
<td>May</td>
<td>Request and future</td>
</tr>
<tr>
<td>Will you</td>
<td>Possibility</td>
</tr>
<tr>
<td>Can</td>
<td>Judgment</td>
</tr>
<tr>
<td>Should</td>
<td>Event description</td>
</tr>
</tbody>
</table>
### Early Pragmatic Functions

<table>
<thead>
<tr>
<th>Functions</th>
<th>Examples</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instrumental</td>
<td>I want. I need.</td>
<td>Child attempts to satisfy needs or desires.</td>
</tr>
<tr>
<td>Regulative</td>
<td>Do as I tell you.</td>
<td>Child attempts to control the behavior of others</td>
</tr>
<tr>
<td>Interactional</td>
<td>You and Me.</td>
<td>Child establishes and defines social relationships and attempts to participate in social intercourse.</td>
</tr>
<tr>
<td>Personal</td>
<td>Here I come</td>
<td>Child expresses individually or gives personal opinions or feelings.</td>
</tr>
<tr>
<td>Imaginative</td>
<td>Let’s pretend.</td>
<td>Child expresses fantasies or creates imaginary word</td>
</tr>
<tr>
<td>Heuristic</td>
<td>Tell me why.</td>
<td>Child seeks information</td>
</tr>
<tr>
<td>Informative</td>
<td>I’ve got something to tell you</td>
<td>Child provides information.</td>
</tr>
<tr>
<td>Primitive Speech Acts</td>
<td>Child’s utterance</td>
<td>Child’s Non-Linguistic Behavior</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Requesting (Answer)</td>
<td>Want</td>
<td>Addresses adult; may make gesture regarding object</td>
</tr>
<tr>
<td>Calling</td>
<td>Word (With marked Prosodic contour)</td>
<td>Addresses adult by uttering adults name loudly; awaits response</td>
</tr>
<tr>
<td>Greeting</td>
<td>Word</td>
<td>Attends to adult or object</td>
</tr>
<tr>
<td>Protesting</td>
<td>Word or Marked prosodic pattern</td>
<td>Attends to adult; addresses adult; resists or denies adult’s action</td>
</tr>
<tr>
<td>Practicing</td>
<td>Word or Prosodic pattern</td>
<td>Attends to no specific object or event; does not address adult; does not await response</td>
</tr>
<tr>
<td>Labeling</td>
<td>Word</td>
<td>Attends to object or event; does not address adult; does not await response</td>
</tr>
<tr>
<td>Repeating</td>
<td>Word or Prosodic Pattern</td>
<td>Attends to adult utterance before his utterance; may not address adult; does not await response</td>
</tr>
<tr>
<td>Answering</td>
<td>Word</td>
<td>Attends to adult utterance before his utterance; addresses adult</td>
</tr>
<tr>
<td>Requesting (Action)</td>
<td>Word or Marked prosodic Pattern</td>
<td>Attends to objects or event; addresses adult; awaits response; most often performs signaling gesture</td>
</tr>
</tbody>
</table>
Preamble

The American Speech-Language-Hearing Association (ASHA; hereafter, also known as “The Association”) has been committed to a framework of common principles and standards of practice since ASHA’s inception in 1925. This commitment was formalized in 1952 as the Association’s first Code of Ethics. This Code has been modified and adapted as society and the professions have changed. The Code of Ethics reflects what we value as professionals and establishes expectations for our scientific and clinical practice based on principles of duty, accountability, fairness, and responsibility. The ASHA Code of Ethics is intended to ensure the welfare of the consumer and to protect the reputation and integrity of the professions.

The ASHA Code of Ethics is a framework and focused guide for professionals in support of day-to-day decision making related to professional conduct. The Code is partly obligatory and disciplinary and partly aspirational and descriptive in that it defines the professional’s role. The Code educates professionals in the discipline, as well as students, other professionals, and the public, regarding ethical principles and standards that direct professional conduct.

The preservation of the highest standards of integrity and ethical principles is vital to the responsible discharge of obligations by audiologists, speech-language pathologists, and speech, language, and hearing scientists who serve as clinicians, educators, mentors, researchers, supervisors, and administrators. This Code of Ethics sets forth the fundamental principles and rules considered essential to this purpose and is applicable to the following individuals:

- a member of the American Speech-Language-Hearing Association holding the Certificate of Clinical Competence (CCC)
- a member of the Association not holding the Certificate of Clinical Competence (CCC)
- a nonmember of the Association holding the Certificate of Clinical Competence (CCC)
- an applicant for certification, or for membership and certification

By holding ASHA certification or membership, or through application for such, all individuals are automatically subject to the jurisdiction of the Board of Ethics for ethics complaint adjudication. Individuals who provide clinical services and who also desire membership in the Association must hold the CCC.

The fundamentals of ethical conduct are described by Principles of Ethics and by Rules of Ethics. The four Principles of Ethics form the underlying philosophical basis for the Code of Ethics and are reflected in the following areas: (I) responsibility to persons served professionally and to research participants, both human and animal; (II) responsibility for one’s professional competence; (III) responsibility to the public; and (IV) responsibility for professional relationships. Individuals shall honor and abide by these Principles as affirmative obligations under all
conditions of applicable professional activity. Rules of Ethics are specific statements of minimally acceptable as well as unacceptable professional conduct.

The Code is designed to provide guidance to members, applicants, and certified individuals as they make professional decisions. Because the Code is not intended to address specific situations and is not inclusive of all possible ethical dilemmas, professionals are expected to follow the written provisions and to uphold the spirit and purpose of the Code. Adherence to the Code of Ethics and its enforcement results in respect for the professions and positive outcomes for individuals who benefit from the work of audiologists, speech-language pathologists, and speech, language, and hearing scientists.

**Terminology**

**ASHA Standards and Ethics**

The mailing address for self-reporting in writing is American Speech-Language-Hearing Association, Standards and Ethics, 2200 Research Blvd., #313, Rockville, MD 20850.

**advertising**

Any form of communication with the public about services, therapies, products, or publications.

**conflict of interest**

An opposition between the private interests and the official or professional responsibilities of a person in a position of trust, power, and/or authority.

**crime**

Any felony; or any misdemeanor involving dishonesty, physical harm to the person or property of another, or a threat of physical harm to the person or property of another. For more details, see the "Disclosure Information" section of applications for ASHA certification found on [www.asha.org/certification/AudCertification/](http://www.asha.org/certification/AudCertification/) and [www.asha.org/certification/SLPCertification/](http://www.asha.org/certification/SLPCertification/).

**diminished decision-making ability**

Any condition that renders a person unable to form the specific intent necessary to determine a reasonable course of action.

**fraud**

Any act, expression, omission, or concealment—the intent of which is either actual or constructive—calculated to deceive others to their disadvantage.

**impaired practitioner**

An individual whose professional practice is adversely affected by addiction, substance abuse, or health-related and/or mental health-related conditions.

**individuals**

Members and/or certificate holders, including applicants for certification.

**informed consent**

May be verbal, unless written consent is required; constitutes consent by persons served, research participants engaged, or parents and/or guardians of persons served to a proposed course of action after the communication of adequate information regarding expected outcomes and potential risks.

**jurisdiction**
The "personal jurisdiction" and authority of the ASHA Board of Ethics over an individual holding ASHA certification and/or membership, regardless of the individual's geographic location.

**know, known, or knowingly**
Having or reflecting knowledge.

**may vs. shall**
*May* denotes an allowance for discretion; *shall* denotes no discretion.

**misrepresentation**
Any statement by words or other conduct that, under the circumstances, amounts to an assertion that is false or erroneous (i.e., not in accordance with the facts); any statement made with conscious ignorance or a reckless disregard for the truth.

**negligence**
Breaching of a duty owed to another, which occurs because of a failure to conform to a requirement, and this failure has caused harm to another individual, which led to damages to this person(s); failure to exercise the care toward others that a reasonable or prudent person would take in the circumstances, or taking actions that such a reasonable person would not.

**nolo contendere**
No contest.

**plagiarism**
False representation of another person's idea, research, presentation, result, or product as one's own through irresponsible citation, attribution, or paraphrasing; ethical misconduct does not include honest error or differences of opinion.

**publicly sanctioned**
A formal disciplinary action of public record, excluding actions due to insufficient continuing education, checks returned for insufficient funds, or late payment of fees not resulting in unlicensed practice.

**reasonable or reasonably**
Supported or justified by fact or circumstance and being in accordance with reason, fairness, duty, or prudence.

**self-report**
A professional obligation of self-disclosure that requires (a) notifying ASHA Standards and Ethics and (b) mailing a hard copy of a certified document to ASHA Standards and Ethics (see term above). All self-reports are subject to a separate ASHA Certification review process, which, depending on the seriousness of the self-reported information, takes additional processing time.

**shall vs. may**
*Shall* denotes no discretion; *may* denotes an allowance for discretion.

**support personnel**
Those providing support to audiologists, speech-language pathologists, or speech, language, and hearing scientists (e.g., technician, paraprofessional, aide, or assistant in audiology, speech-language pathology, or communication sciences and disorders). For more information, read the Issues in Ethics Statements on Audiology Assistants and/or Speech-Language Pathology Assistants.
telepractice, teletherapy
Application of telecommunications technology to the delivery of audiology and speech-language pathology professional services at a distance by linking clinician to client/patient or clinician to clinician for assessment, intervention, and/or consultation. The quality of the service should be equivalent to in-person service. For more information, see the telepractice section on the ASHA Practice Portal.

written
Encompasses both electronic and hard-copy writings or communications.

Principle of Ethics I
Individuals shall honor their responsibility to hold paramount the welfare of persons they serve professionally or who are participants in research and scholarly activities, and they shall treat animals involved in research in a humane manner.

Rules of Ethics

A. Individuals shall provide all clinical services and scientific activities competently.

B. Individuals shall use every resource, including referral and/or interprofessional collaboration when appropriate, to ensure that quality service is provided.

C. Individuals shall not discriminate in the delivery of professional services or in the conduct of research and scholarly activities on the basis of race, ethnicity, sex, gender identity/gender expression, sexual orientation, age, religion, national origin, disability, culture, language, or dialect.

D. Individuals shall not misrepresent the credentials of aides, assistants, technicians, support personnel, students, research interns, Clinical Fellows, or any others under their supervision, and they shall inform those they serve professionally of the name, role, and professional credentials of persons providing services.

E. Individuals who hold the Certificate of Clinical Competence may delegate tasks related to the provision of clinical services to aides, assistants, technicians, support personnel, or any other persons only if those persons are adequately prepared and are appropriately supervised. The responsibility for the welfare of those being served remains with the certified individual.

F. Individuals who hold the Certificate of Clinical Competence shall not delegate tasks that require the unique skills, knowledge, judgment, or credentials that are within the scope of their profession to aides, assistants, technicians, support personnel, or any nonprofessionals over whom they have supervisory responsibility.

G. Individuals who hold the Certificate of Clinical Competence may delegate to students tasks related to the provision of clinical services that require the unique skills, knowledge, and judgment that are within the scope of practice of their profession only if those students are adequately prepared and are appropriately supervised. The responsibility for the welfare of those being served remains with the certified individual.

H. Individuals shall obtain informed consent from the persons they serve about the nature and possible risks and effects of services provided, technology employed, and products dispensed. This obligation also includes informing persons served about possible effects
of not engaging in treatment or not following clinical recommendations. If diminished decision-making ability of persons served is suspected, individuals should seek appropriate authorization for services, such as authorization from a spouse, other family member, or legally authorized/appointed representative.

I. Individuals shall enroll and include persons as participants in research or teaching demonstrations only if participation is voluntary, without coercion, and with informed consent.

J. Individuals shall accurately represent the intended purpose of a service, product, or research endeavor and shall abide by established guidelines for clinical practice and the responsible conduct of research.

K. Individuals who hold the Certificate of Clinical Competence shall evaluate the effectiveness of services provided, technology employed, and products dispensed, and they shall provide services or dispense products only when benefit can reasonably be expected.

L. Individuals may make a reasonable statement of prognosis, but they shall not guarantee—directly or by implication—the results of any treatment or procedure.

M. Individuals who hold the Certificate of Clinical Competence shall use independent and evidence-based clinical judgment, keeping paramount the best interests of those being served.

N. Individuals who hold the Certificate of Clinical Competence shall not provide clinical services solely by correspondence, but may provide services via telepractice consistent with professional standards and state and federal regulations.

O. Individuals shall protect the confidentiality and security of records of professional services provided, research and scholarly activities conducted, and products dispensed. Access to these records shall be allowed only when doing so is necessary to protect the welfare of the person or of the community, is legally authorized, or is otherwise required by law.

P. Individuals shall protect the confidentiality of any professional or personal information about persons served professionally or participants involved in research and scholarly activities and may disclose confidential information only when doing so is necessary to protect the welfare of the person or of the community, is legally authorized, or is otherwise required by law.

Q. Individuals shall maintain timely records and accurately record and bill for services provided and products dispensed and shall not misrepresent services provided, products dispensed, or research and scholarly activities conducted.

R. Individuals whose professional practice is adversely affected by substance abuse, addiction, or other health-related conditions are impaired practitioners and shall seek professional assistance and, where appropriate, withdraw from the affected areas of practice.

S. Individuals who have knowledge that a colleague is unable to provide professional services with reasonable skill and safety shall report this information to the appropriate authority, internally if a mechanism exists and, otherwise, externally.

T. Individuals shall provide reasonable notice and information about alternatives for obtaining care in the event that they can no longer provide professional services.
Principle of Ethics II

Individuals shall honor their responsibility to achieve and maintain the highest level of professional competence and performance.

Rules of Ethics

A. Individuals who hold the Certificate of Clinical Competence shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their certification status, education, training, and experience.

B. Members who do not hold the Certificate of Clinical Competence may not engage in the provision of clinical services; however, individuals who are in the certification application process may engage in the provision of clinical services consistent with current local and state laws and regulations and with ASHA certification requirements.

C. Individuals who engage in research shall comply with all institutional, state, and federal regulations that address any aspects of research, including those that involve human participants and animals.

D. Individuals shall enhance and refine their professional competence and expertise through engagement in lifelong learning applicable to their professional activities and skills.

E. Individuals in administrative or supervisory roles shall not require or permit their professional staff to provide services or conduct research activities that exceed the staff member's certification status, competence, education, training, and experience.

F. Individuals in administrative or supervisory roles shall not require or permit their professional staff to provide services or conduct clinical activities that compromise the staff member's independent and objective professional judgment.

G. Individuals shall make use of technology and instrumentation consistent with accepted professional guidelines in their areas of practice. When such technology is not available, an appropriate referral may be made.

H. Individuals shall ensure that all technology and instrumentation used to provide services or to conduct research and scholarly activities are in proper working order and are properly calibrated.

Principle of Ethics III
Individuals shall honor their responsibility to the public when advocating for the unmet communication and swallowing needs of the public and shall provide accurate information involving any aspect of the professions.

**Rules of Ethics**

A. Individuals shall not misrepresent their credentials, competence, education, training, experience, and scholarly contributions.

B. Individuals shall avoid engaging in conflicts of interest whereby personal, financial, or other considerations have the potential to influence or compromise professional judgment and objectivity.

C. Individuals shall not misrepresent research and scholarly activities, diagnostic information, services provided, results of services provided, products dispensed, or the effects of products dispensed.

D. Individuals shall not defraud through intent, ignorance, or negligence or engage in any scheme to defraud in connection with obtaining payment, reimbursement, or grants and contracts for services provided, research conducted, or products dispensed.

E. Individuals' statements to the public shall provide accurate and complete information about the nature and management of communication disorders, about the professions, about professional services, about products for sale, and about research and scholarly activities.

F. Individuals' statements to the public shall adhere to prevailing professional norms and shall not contain misrepresentations when advertising, announcing, and promoting their professional services and products and when reporting research results.

G. Individuals shall not knowingly make false financial or nonfinancial statements and shall complete all materials honestly and without omission.

**Principle of Ethics IV**

Individuals shall uphold the dignity and autonomy of the professions, maintain collaborative and harmonious interprofessional and intraprofessional relationships, and accept the professions' self-imposed standards.

**Rules of Ethics**

A. Individuals shall work collaboratively, when appropriate, with members of one's own profession and/or members of other professions to deliver the highest quality of care.

B. Individuals shall exercise independent professional judgment in recommending and providing professional services when an administrative mandate, referral source, or prescription prevents keeping the welfare of persons served paramount.

C. Individuals' statements to colleagues about professional services, research results, and products shall adhere to prevailing professional standards and shall contain no misrepresentations.

D. Individuals shall not engage in any form of conduct that adversely reflects on the professions or on the individual's fitness to serve persons professionally.
E. Individuals shall not engage in dishonesty, negligence, fraud, deceit, or misrepresentation.

F. Applicants for certification or membership, and individuals making disclosures, shall not knowingly make false statements and shall complete all application and disclosure materials honestly and without omission.

G. Individuals shall not engage in any form of harassment, power abuse, or sexual harassment.

H. Individuals shall not engage in sexual activities with individuals (other than a spouse or other individual with whom a prior consensual relationship exists) over whom they exercise professional authority or power, including persons receiving services, assistants, students, or research participants.

I. Individuals shall not knowingly allow anyone under their supervision to engage in any practice that violates the Code of Ethics.

J. Individuals shall assign credit only to those who have contributed to a publication, presentation, process, or product. Credit shall be assigned in proportion to the contribution and only with the contributor’s consent.

K. Individuals shall reference the source when using other persons’ ideas, research, presentations, results, or products in written, oral, or any other media presentation or summary. To do otherwise constitutes plagiarism.

L. Individuals shall not discriminate in their relationships with colleagues, assistants, students, support personnel, and members of other professions and disciplines on the basis of race, ethnicity, sex, gender identity/gender expression, sexual orientation, age, religion, national origin, disability, culture, language, dialect, or socioeconomic status.

M. Individuals with evidence that the Code of Ethics may have been violated have the responsibility to work collaboratively to resolve the situation where possible or to inform the Board of Ethics through its established procedures.

N. Individuals shall report members of other professions who they know have violated standards of care to the appropriate professional licensing authority or board, other professional regulatory body, or professional association when such violation compromises the welfare of persons served and/or research participants.

O. Individuals shall not file or encourage others to file complaints that disregard or ignore facts that would disprove the allegation; the Code of Ethics shall not be used for personal reprisal, as a means of addressing personal animosity, or as a vehicle for retaliation.

P. Individuals making and responding to complaints shall comply fully with the policies of the Board of Ethics in its consideration, adjudication, and resolution of complaints of alleged violations of the Code of Ethics.

Q. Individuals involved in ethics complaints shall not knowingly make false statements of fact or withhold relevant facts necessary to fairly adjudicate the complaints.

R. Individuals shall comply with local, state, and federal laws and regulations applicable to professional practice, research ethics, and the responsible conduct of research.

S. Individuals who have been convicted; been found guilty; or entered a plea of guilty or nolo contendere to (1) any misdemeanor involving dishonesty, physical harm—or the threat of physical harm—to the person or property of another, or (2) any felony, shall self-report by notifying ASHA Standards and Ethics (see Terminology for mailing address) in writing
within 30 days of the conviction, plea, or finding of guilt. Individuals shall also provide a certified copy of the conviction, plea, nolo contendere record, or docket entry to ASHA Standards and Ethics within 30 days of self-reporting.

T. Individuals who have been publicly sanctioned or denied a license or a professional credential by any professional association, professional licensing authority or board, or other professional regulatory body shall self-report by notifying ASHA Standards and Ethics (see Terminology for mailing address) in writing within 30 days of the final action or disposition. Individuals shall also provide a certified copy of the final action, sanction, or disposition to ASHA Standards and Ethics within 30 days of self-reporting.

A comprehensive collection of ethics resources can be found at http://www.asha.org/Practice/ethics/
LICENSURE

ASHA State-by-State

ASHA's State Advocacy Team monitors state and local changes in licensing, regulations, and coordinated campaigns. The State Policy Team works with state associations and state network volunteers to coordinate grassroots advocacy, legislative action and change.

State Legislative and Regulatory Changes

- Quick Action Results in Revised Virginia Endoscopy Policy (September 02, 2010)

State Licensing Laws, Teacher Requirements and Contact Information

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State Policy Resources

- State Teacher Credentialing Requirements
- State Licensure Trends and Quarterly Updates
- State Insurance Mandates for Hearing Aids
- State Insurance Mandates for Autism Spectrum Disorder
- Early Hearing Detection & Intervention

Take Action at the local and state levels on bills that affect the professions of speech-language pathology and audiology.
Idaho    New Jersey    Wisconsin
Illinois New Mexico    Wyoming
Indiana New York
Iowa North    Overseas Association of Communication Sciences
Kansas Carolina
Kentucky North Dakota    Ohio

About the information linked above.

More State-Specific ASHA Resources

- Innovative Programs to Address Personnel Vacancies in Health Care and Education [PDF]
- Academic Program Capacity Building in Audiology and Speech-Language Pathology
- State Education Agencies Communication Disabilities Council
- Council of State Association Presidents (CSAP)

Building Blocks for State Associations section provides a variety of resources and links designed specifically to meet the needs of state association leaders.

Student Advocacy
Promote student participation in your state capitol advocacy day.

State Networks
Learn about volunteer opportunities and activities of ASHA State Networks.

- State Education Advocacy Leaders (SEALs)
- State Reimbursement Representatives (STARs) (Members-only)
- State Medicare Administrative Contractor Network (SMAC) (Members-only)

State Advocacy Events and Presentations
Maryland State Contact Information

Speech-Language-Hearing Association

Maryland Speech-Language-Hearing Association
1126 St. Andrews Court
York, PA 17408

Contact: Lisa Oriolo
Phone: 410-239-7770
E-mail: office@mdslha.org

State Regulatory Agencies

Audiology, Speech-Language Pathology, and Hearing Aid Dispenser Licensing (including School-Based)

Board of Audiologists, Hearing Aid Dispensers, and Speech-Language Pathologists
Maryland Department of Health and Mental Hygiene
4201 Patterson Avenue
Baltimore, MD 21215

Contact: Yolanda Campbell, Office Administrator
Phone: 410-764-4725
Fax: 410-358-0273
E-mail: Yolanda.Campbell@maryland.gov

Special Education Contacts

Division of Special Education/Early Intervention
Maryland Department of Education
200 West Baltimore Street
Baltimore, MD 21201

Contact: Marcella Franczkowski, Assistant State Superintendent
Phone: 410-767-0328
E-mail: mfranczkowski@msde.state.md.us

or

Contact: Marsye Kaplan, SEACDC Consultant
E-mail: Marsye.Kaplan@maryland.gov

Hearing Screening Contacts

Infant Hearing Detection and Intervention Program
Maryland Department of Health and Mental Hygiene
201 West Preston Street, Room 421A
Baltimore, MD 21201

Contact: Tanya D. Green, MS, CCC-A
Phone: 410-767-6432
Fax: 410-333-5047
Email: Tanya.green@maryland.gov
Maryland Licensing Requirements for Audiologists and Speech-Language Pathologists

The information below is collected from state licensure boards or regulatory agencies responsible for regulating the professions of speech-language pathology and/or audiology. The information is reviewed on an annual basis. Please be advised that laws, regulations, and policies may change at any time, so always check with your state for the most up-to-date information.

Initial Licensure

Audiology

1. Holds a doctoral degree from an accredited educational institution
2. Completion of the supervised professional experience
3. Passage of the national examination in audiology
4. Demonstration of oral English competency
5. Passage of an open-book jurisdictional exam

Speech-Language Pathology

1. Holds a master’s degree from an accredited educational institution
2. Completion of supervised clinical experience
3. Completion of supervised postgraduate professional experience
4. Passage of the national examination in speech-language pathology
5. Demonstration of oral English competency
6. Passage of an open-book jurisdictional exam

Exemptions

1. Federal employees
2. Students or trainees
3. Physicians
4. Volunteers working in free speech and hearing screening programs
5. Audiologists or speech language pathologists licensed in another state while waiting for Board approval of their licensure application
6. Employees of public or state schools providing speech-language pathology services that have practiced continuously on or before September 30, 2007
7. Individuals continuously employed to practice audiology since June 30, 1988, in a county or state school system.

**Reciprocity**

1. The Board may waive the examination requirement to an applicant who meets the qualifications otherwise required by this title, and is licensed in another state with equivalent standards.
2. Audiologists, speech language pathologists, and speech language pathology assistants licensed in another state may practice while their completed application for licensure is pending before the Board.

**Interim Practice**

1. The Board may issue a limited license to individuals who meet the licensure requirements except for the examination and supervised clinical training/postgraduate professional practice and:
   1. Have a master's degree in speech language pathology or a doctoral degree in audiology or both
   2. Have met the requirements the academic and practicum requirements for a Certificate of Clinical Competence or Board Certification in Audiology from the American Board of Audiology that was in effect at the time their degree was obtained
   3. Demonstrates oral English competency

A limited license expires after one year and is renewable once.
2. Applicants without a master's degrees who are enrolled in a post-baccalaureate doctoral training or hold a master’s degree from a university program that is not accredited by the CAA may seek a limited license under equivalency requirements specified by the Board in regulation.

**Continuing Education for License Renewal**

1. 30 Continuing Education Units (CEUs) per two-year renewal cycle; 50 CEUs for dual licensees
2. Continuing education credits may not be carried over from one renewal cycle to another
3. The Board will prorate CEUs for individuals newly licensed, reinstated, or transfers from other states if license is obtained between six months and two years of renewal cycle and shall waive requirements for those obtaining full licensure within six months of renewal cycle.

**Telehealth**

For information on Maryland telepractice requirements, visit State Telepractice Requirements.

**Board Oversight**
State Board of Examiners for Audiologists, Hearing Aid Dispensers, and Speech-Language Pathologists

Resources

For further information on laws and regulations for speech-language pathologists and audiologist, please visit these websites:

- Maryland Practice Act [PDF]
- Maryland Rules and Regulations [PDF]