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Graduate programs leading to the Master of Arts or a Doctorate of Philosophy in Communication Disorders (speech-language pathology) are offered.

**Philosophy and Objectives**
The graduate program in speech-language pathology is accredited by the Council on Academic Accreditation in Audiology and Speech-Language Pathology of the American Speech-Language and Hearing Association (ASHA). The Department is affiliated with and located in the Cleveland Hearing and Speech Center (CHSC), one of the largest centers serving children and adults with communication disorders. The Cleveland Hearing & Speech Center is a CARF accredited facility.

The program's philosophy and objective is to educate highly competent clinical practitioners and researchers in speech and language disorders. The intent is to educate all students to embody the best of the clinician's and researcher's rigorous approach to problem solving and intuitive, artful skills.

**Orientation**
Classes typically begin the first Monday of the last week in August. The Department holds an orientation session on the Thursday or Friday during the third week in August. Please mark these dates on your calendar, as you are required to attend. The orientation session will address advising and registration, as well as various topics including professional responsibilities and library resources. In addition, you will have an opportunity to interact with our faculty, staff, and current students. The department will be providing breakfast and an evening reception. Please bring a valid photo id with you to the department orientation in the form of a Driver’s Licenses, State Identification, or CASE Student Identification.
Master of Arts
The principal goal of the Master of Arts program is to develop clinical scientists who are skilled in the management of individuals with speech and language disorders. The master’s program is accredited by the American Speech-Language-Hearing Association. Upon successful completion of the Masters of Arts degree students will also meet the academic and clinical practicum requirements for certification by the American Speech-Language-Hearing Association and licensure in the State of Ohio. Degree requirements include completion of 36 credit hours of course work and clinical practicum in communication disorders. In addition, students must satisfactorily complete written and oral comprehensive exams or may elect to write a master’s thesis. Specific course requirements are determined by the student’s undergraduate background and academic and career goals.

Requirements and Procedures for Graduate Study (M.A.) in Speech-Language Pathology
General Requirements:
1. Admission to the School of Graduate Studies requires an application for admission, three letters of reference, GRE scores and transcripts from all university or colleges previously attended.
See the Case General Bulletin [link]; See the Graduate Studies website [link]; See the departmental website [link];
2. Students are responsible for observing the University’s “Academic Regulations” for graduate study as printed in the [link], as well as the Department requirements and procedures as outlined in this document. Students have the right to petition in writing for exceptions to these regulations and requirements. In such cases students should consult their advisors.
3. Any deviations from Departmental graduate coursework need written approval from the advisor and the Department Chair. The student will petition in writing the requested change and secure the signatures of the advisor and the chair as documentation of approval. If the request involves a required course, the request also must go to the Dean of Graduate Studies.
## MASTER’S DEGREE IN SPEECH-LANGUAGE PATHOLOGY: SEQUENCE OF COURSES

Minimum number of credits required for the degree is 36 credit hours. Coursework is chosen in consultation with the student's academic advisor.

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<tr>
<th><strong>First Year</strong></th>
<th><strong>Second Year</strong></th>
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<tr>
<td><strong>Fall Semester</strong></td>
<td><strong>Fall Semester</strong></td>
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<tr>
<td>ANAT 414/415 Neuroanatomy Lecture and Lab (4)</td>
<td>COSI 452 Graduate Clinical Practicum (1)</td>
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<td>COSI 452 Graduate Clinical Practicum (1) &amp; COSI 453 Articulation &amp; Phonology Disorders (3)</td>
<td>COSI 464 Diagnosis of Speech &amp; Language Disorders (3)</td>
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<td>COSI 455 Fluency Disorders (3)</td>
<td>COSI 560 Voice Disorders (3)</td>
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<tr>
<td>Second Year</td>
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<tr>
<td><strong>Spring Semester</strong></td>
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<td><strong>Based on the student’s undergraduate record, the following courses may be suggested:</strong></td>
<td><strong>Based on the student’s undergraduate record, the following course may be suggested:</strong></td>
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<tr>
<td>COSI 211 Phonetics and Phonology (3)</td>
<td>COSI 452 Graduate Clinical Practicum (1)</td>
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<tr>
<td>COSI 325 Anatomy &amp; Physiology of Speech and Hearing (3)</td>
<td>COSI 464 Diagnosis of Speech &amp; Language Disorders (3)</td>
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<td>COSI 352 Introduction to Clinical Practice (3)</td>
<td>COSI 560 Voice Disorders (3)</td>
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<td>COSI 413 Language Development (3)</td>
<td>COSI 600 Augmentative &amp; Alternative Communication (1)</td>
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<td>COSI 470 Introduction to Audiology (3)</td>
<td><strong>Based on the student’s undergraduate record, the following course may be suggested:</strong></td>
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<td><strong>Spring Semester</strong></td>
<td><strong>Based on the student’s undergraduate record, the following course may be suggested:</strong></td>
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<td>COSI 452 Graduate Clinical Practicum (1)</td>
<td>COSI 452 Graduate Clinical Practicum (1)</td>
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<td>COSI 456 Child Language Disorders (3)</td>
<td>COSI 464 Diagnosis of Speech &amp; Language Disorders (3)</td>
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<td>COSI 497 Research Methods (3)</td>
<td>COSI 560 Voice Disorders (3)</td>
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<tr>
<td>COSI 557 Acquired Adult Language &amp; Cognitive Disorders (3)</td>
<td>COSI 600 Augmentative &amp; Alternative Communication (1)</td>
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<tr>
<td>COSI 562 Dysphagia (2)</td>
<td><strong>Based on the student’s undergraduate record, the following course may be suggested:</strong></td>
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<td><strong>Summer Semester</strong></td>
<td>COSI 580 Aural Rehabilitation (3)</td>
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<tr>
<td>COSI 452 Graduate Clinical Practicum (1)</td>
<td><strong>Based on the student’s undergraduate record, the following course may be suggested:</strong></td>
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**Based on the student’s undergraduate record, the following course may be suggested:**

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<th>Course</th>
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<tr>
<td>COSI 321 Speech and Hearing Sciences (3)</td>
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Departmental Mission
The Department of Communication Sciences prepares undergraduate and graduate students to address broad issues of human communication processes and disorders through the application of cutting-edge technology and rigorous clinical training. We provide a comprehensive foundation in normal and disordered human communication and combine it with innovative interdisciplinary experiences that capitalize on the extensive resources of the University and medical community that surround this department.

Program Mission (Communication Disorders):
The mission of the graduate Communication Disorders program is to graduate future leaders in the clinical and research community of communication sciences and disorders that is in-line with the unique mission of the department. Our program objectives are: 1) To graduate students who demonstrate critical thinking skills and the ability to synthesize fundamental concepts and apply them to clinical practice at the professional level; 2) to provide students with a strong theoretical foundation utilizing state-of-the-art technology, experiential learning, and research training; 3) to provide students with a foundation in professional ethics, and understanding of the need for self-reflection, and an understanding of the importance of life-long learning.
ADVISORS & REGISTRATION

Each student is assigned to an advisor upon entry into the program. After the orientation in the first semester and at the time of registration for each subsequent semester, the student must meet with the advisor to monitor progress of their course of study.

A student may request a change of advisor during the course of study. This change must be approved by the Department Chair. A “Change of Advisor” form is available in the Department Office. English as a Second Language (ESL) Students: Case Western Reserve University has an ESL Language Center that offers intensive study of English as Second Language (30 hours per week), with student placement determined by testing prior to placement. The program includes twelve total levels, with each level taking approximately four weeks to complete. Additionally, for students who speak with a non-standard dialect and do not require the intensity of instruction that is offered through the ESL Language Center, accent modification is offered through the Cleveland Hearing and Speech Center that has clinicians that are Compton P-ESL certified. The Compton program follows either a 5-week or a 13-week course depending on the needs of the student. The additional resources that are available through ASHA are available on their website and include resources for students that have English as a Second Language or speak English with a nonstandard dialect. See http://www.asha.org/about/leadership-projects/multicultural/otherlang.htm#accent for more information.

The three areas of skills (oral communication, auditory abilities, and interpersonal skills) are considered prerequisite skills for clinical placement. The presence of these skills to a level deemed appropriate for initial entry to clinic is determined by the Clinical Program Director and the Chair.

In the event that an ESL student does not meet the above criteria, an individualized remediation program is developed which generally includes a semester of additional resources provided (as stated above) as well as independent study with the Clinical Program Director or other appropriate faculty member to measure change in the three skill areas over the course of a semester. If, at the end of the remediation plan, it is determined that the student continues to lack the necessary skills for clinical entry in the area of oral communication, auditory abilities, and interpersonal skills, the student is offered the option of completing the degree with a non-clinical focus.
Two plans of study are possible: Plan A-M.A. with a thesis based on individual research and an oral examination (thesis defense) and Plan B-M.A. without a thesis but requiring a written and oral comprehensive examination.

The program of study the student pursues will be determined in part by the student’s undergraduate background and his academic and career goals. The program of study must, however, include a minimum of four semesters (four credits) of COSI 452 GRADUATE PRACTICUM and COSI 497 METHODS OF RESEARCH.

As a program accredited by the Council on Academic Accreditation of the American Speech-Language-Hearing Association, Case’s M.A. degree in speech-language pathology fulfills the academic requirements for the Certificate of Clinical Competence. ASHA requirements are detailed in the Requirements for the Certificate of Clinical Competence which is available on the ASHA website (www.asha.org). In addition, completion of the M.A. degree requirements meets some of the requirements for state licensure in Ohio.

Whereas deficiencies in background subject matter or skills will not prevent acceptance into the graduate program, students accepted under these circumstances will be required to make up deficiencies in a manner approved by the advisor. Students entering without an undergraduate major in communication disorders will be required to take the essential undergraduate coursework in communication sciences and disorders (up to 18 hours of coursework). Students entering with an undergraduate major in communication disorders, but with deficiencies in their undergraduate program, will be required to make up the appropriate coursework. When a student is required to take courses at the undergraduate level, credits earned at the 300 level or below may not apply toward the 36 hours required under either Plan A or Plan B as described in this document.

During the first semester of study, each student will, in consultation with his/her advisor to prepare a plan of study worksheet that will be used as the guideline for subsequent registration. Students will not be permitted to register for subsequent semesters until the proposed program has been approved by the advisor. Any changes made to the proposed plan of study will need to be discussed with the academic advisor and noted in the student’s working file. The final plan of study is submitted to the graduate school in the semester of graduation.
Plan A: The M.A. Thesis:
For Master's Plan A, the student must complete either 6 credit hours of thesis research (COSI 651), and 30 semester hours of additional coursework at the 400 level or higher, or, alternatively, 9 credit hours of thesis research and 27 semester hours of coursework at the 400-level or higher.

The student’s advisor, in consultation with the student and with the approval of the graduate committee of the department will form a thesis committee. The thesis committee will consist of at least three faculty members from the department, at least one of whom must be a member of the regular faculty as defined by the College of Arts and Sciences.

The student must submit a written plan for the thesis to this committee, for its approval prior to initiating the research. This plan should include a brief literature review and rationale for the study, a proposed research method, a proposed timeline for steps involved in the research, and a brief discussion of expected results and their potential significance.

The student will present the thesis information in two forums: 1) an informal discussion with peers and members of his/her committee prior to initiating the thesis research, to obtain feedback and direction; and 2) a formal presentation of the thesis research to faculty and students. The precise format of the formal presentation will depend on the nature of the research (e.g., oral presentations, computer demonstrations of software, etc.). The presentation may be a work-in-progress colloquium to report preliminary findings and generate discussion, or may be a presentation of final results. If the formal presentation is a presentation of final results, it may serve as the public oral presentation of the thesis defense (see below).

The student must prepare a thesis describing the research and its significance and submit to an oral defense of the thesis. This will include a brief (approximately 20 minute) public oral presentation, followed by examination by the committee. The examination will be open to all members of the faculty but will be otherwise closed. Only members of the thesis committee will vote on whether the thesis and its defense satisfy the requirements of the Department and the School of Graduate Studies for the M.A. degree. If the student presents a colloquium at the conclusion of his/her research, this may serve as the oral presentation component of the defense.

The student must submit an Application to Graduate to the School of Graduate Studies in the semester in which he or she plans to graduate, and file two copies of the thesis according to the dates and guidelines of the School of Graduate Studies.

Suggested Guidelines for Students Electing a Thesis Option
A thesis provides the opportunity for those interested in research and/or planning to pursue a Ph.D. or academic career.

The process of research can begin as soon as the student is registered and should involve the following steps:

1. The identification of a broad area of research interest.
2. The selection of a thesis adviser and committee.
3. The preparation (and presentation) of a research proposal (see below).
4. Application to the IRB
5. Data collection
6. Write up
7. Oral defense and examination
8. Final submission
There should be regular meetings with the supervisor, and a contractual arrangement drawn up regarding the frequency of supervision, the roles and expectations of the parties involved, the deadlines etc.

A series of regular Departmental research seminars will be scheduled in advance (equivalent to the Brown Bag sessions) at which both Faculty members and students will be encouraged to present research ideas, research in progress, research results and trial runs for conference presentations.

The proposal/prospectus
The research proposal should comprise the following sections:
- Proposed title of research
- Background reading and rationale for study (2 pages)
- Research question
- Hypothesis
- Proposed Method (in explicit detail)
- Implications of the Study
- References consulted

This submission should coincide with the preparation of the application form for IRB.

The proposal should be presented orally to the research class and the committee. This will enable an opportunity to modify and extend some aspects before embarking on the research.

Role of research supervisor/committee
The supervisor, the student, and the committee should formalize a contract regarding regularity of meeting times, as well as the time line for the submission and return of written work. Regular written submission and feedback is recommended.

Normally the role of the committee is to advise on issues of content, research design and to provide feedback at critical times (e.g., presentation of research proposal and presentation of results). Additional external consultation (e.g., elsewhere in the University, statistician) should only be done with the full knowledge and participation of the supervisor.

Format
The end product should not exceed 30-40 typed pages and should ideally fit as closely as possible the format of a research article for submission into a selected journal. Students should select the journal in which they would like to publish their research and follow the specified format for submission.

The sections should include:
- Abstract (150 words)
- Introduction
- Methodology
- Results
- Discussion
- Conclusion
- References
- Acknowledgements
- Appendix

(see also the layout requirements of the Office of Graduate Studies)

Selection of a journal undertaken in a research article format using the exact guideline regarding length requirement, presentation of figures etc.
A disc should be submitted together with the thesis in order for immediate modification and submission to the relevant journals if this is deemed appropriate.

**Lectures**
Those students selecting this option will be required to attend a series of lectures on research methodology to support the current stages of their research process.

**Stage 1**
- Generating research ideas
- Types of research
- How to read and interpret research
- The supervisory contract

**Stage 2**
- Preparation of research proposal
- Ethics Clearance
- Methodology
- Data analysis and interpretation

**Stage 3**
Research writing

**The Thesis Timeline**
*Per Graduate Studies:* Thesis must be completed, defended, revised, approved, and submitted to Graduate Studies 6 weeks prior to anticipated graduation (approximately midterm)

**2nd Semester Graduate School (Spring):**

- **week 3-6**
  - meet with academic advisor and indicate interest in thesis and topic
  - create thesis committee and identify thesis advisor in consultation with academic advisor

- **week 8-10**
  - submit prospectus to your committee
  - present prospectus to committee and peers in open forum
  - revise as indicated

- **week 10-12**
  - complete IRB (Institutional Review Board) application for approval (minimum 1 month wait)

  Following IRB approval (at approximately 14-16 weeks)
  - begin data collection and writing under advisement of committee

**Summer and 3rd Semester (Fall):**
continue data collection and writing under committee advisement

- **week 14-16 of Fall Semester**
  - formal committee evaluation presenting pilot/preliminary results

**Semester 4 (Spring):**
- data collection should be complete at this point. Completion of written thesis and oral defense should be the focus.
**week 1-2**
- meet with thesis advisor and determine date for oral defense (by end of week 8)

**week 5**
- written thesis due to all committee members
- revisions back from committee within one week

**week 8**
- public oral defense with written thesis revisions to committee members

**week 9**
- final revision of written thesis due
- pass/no pass decision by committee

**week 10 (approximately midterm of the semester)**
- submission to graduate studies (if appropriate)

**Submission:**
In addition to the copies required by the School of Graduate Studies, additional copies should be submitted to the Department for members of the defense committee and one for the Departmental library.

**Conference presentation:**
It is recommended that research students have the opportunity to present their results (either in poster session or platform presentation form at a relevant conference, and that mechanisms be explored (through the supervisor) of funding this opportunity.

* All thesis and dissertation students must be registered during the semester in which the degree is awarded. Students also must be registered when they have their oral defense if it is not in the same semester as their graduation.
Plan B: Non-Thesis Option; Comprehensive Examinations
Requires a minimum of 36 semester hours beyond the undergraduate degree. This represents a minimum of an additional nine semester hours beyond the minimum of 27 semester hours set forth by the School of Graduate Studies. At least 30 semester hours must be at the 400 level or higher. Each candidate for the master's degree under Plan B must pass satisfactorily a final summative assessment. The assessment has written and oral components. A student must be registered during the semester in which any part of the comprehensive examination is conducted. If not registered for other courses, the student will be required to register for one semester hour of EXAM 600, Comprehensive Examination. If the student wishes to obtain ASHA certification he/she must also meet competency requirements as specified by the ASHA standards.

Comprehensive Examinations:

a. Students who choose Plan B (non-thesis option) are required to take a comprehensive examination. Students will discuss the topic of their choice with their academic advisors by the end of the first semester of study. The academic advisor will serve as the primary advisor for this process. A second faculty member, selected by the academic advisor, will serve as a grader for the project.

b. The examination includes a two-phase process. Both phases have oral and written components. The process provides an opportunity for both formative and summative assessment.

c. Phase I: Written product due the first week of class in August of the 2nd year of study. Oral presentation scheduled during the second week of class in August.

d. Phase II: Due mid-March of the 2nd year of study.

Format:
The Phase I written product is a 15-20 page paper (double spaced, APA for mat) including tables, figures and references. This paper is a comprehensive review/meta-analysis (minus the statistics) of the literature about a clinical topic of interest. The Phase I oral component is a 10 minute presentation summarizing your paper. The sections of the paper should include the following:

1. Summary of research question/problem
2. Hypothesis
3. Literature search data collection
4. Literature search data evaluation
5. References

The Phase II written product is no longer than 40 pages, includes the Phase I written product and an in-depth clinical case study (single subject or multiple case studies) and interpretation of the research. The Phase II oral component is a 15 minute presentation including a brief literature summary and review of case study with implications. The sections of the paper should include the following:

1. Summary of research question/problem
2. Hypothesis
3. Literature search data collection
4. Literature search data evaluation
5. Case study
6. Discussion
7. Conclusions
8. References
Grading:
Phase I: Formative assessment for the oral presentation will be comprised from faculty feedback and will be summarized during a meeting with your academic advisor. The grading rubric, “Comprehensive Examination Phase I Grading Rubric” is attached. The written product will be graded by two faculty members including the academic advisor according to the criteria below.

Phase II: Summative assessment – Two faculty members including the academic advisor will grade the oral and written components of the project. Grades are based on the following criteria:

   A (4.0)= Addresses critical aspects of the question. Shows clear understanding of the question and topic.
   B (3.0)= Demonstrates understanding of key concepts. Not all supporting information is included.
   C (2.0)= Demonstrates understanding of some key concepts. Lacks information or includes incorrect information.
   F (0.0)= Unacceptable. Failure to address the question. Seriously deficient in content.

   Pass= Average score of 3.0 or higher
   Fail with Remediation= Average score of 2.0
   Fail= Average score lower than 2.0

Remediation is required for a grade of “Fail with Remediation”. The remediation plan will be based on faculty feedback and discussed with the academic advisor.
Case Western Reserve University-Department of Communication Sciences

Comprehensive Examination Phase I Grading Rubric

For each of the seven criteria below, assess the work by: a) circling specific phrases that describe the work, and writing comments b) circling a numeric score.

1. Identifies, summarizes (and appropriately reformulates) the problem, question, or issue.

**Emerging Developing Mastering**

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<th>3</th>
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<td>Does not attempt to or fails to identify and summarize accurately.</td>
<td>Summarizes issue, though some aspects are incorrect or confused. Nuances and key details are missing or glossed over.</td>
<td>Clearly identifies the challenge and subsidiary, embedded, or implicit aspects of the issue. Identifies integral relationships essential to analyzing the issue.</td>
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**Comments:**

2. Identifies and considers the influence of context * and assumptions.

**Emerging Developing Mastering**

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<td>Approach to the issue is in egocentric or socio-centric terms. Does not relate issue to other contexts (cultural, political, historical, etc.). Analysis is grounded in absolutes, with little acknowledgment of own biases. Does not recognize context or surface assumptions and underlying ethical implications, or does so superficially.</td>
<td>Presents and explores relevant contexts and assumptions regarding the issue, although in a limited way. Analysis includes some outside verification, but primarily relies on established authorities. Provides some recognition of context and consideration of assumptions and their implications.</td>
<td>Analyzes the issue with a clear sense of scope and context, including an assessment of audience. Considers other integral contexts. Analysis acknowledges complexity and bias of vantage and values, although may elect to hold to bias in context. Identifies influence of context and questions assumptions, addressing ethical dimensions underlying the issue.</td>
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**Comments:**

Contexts may include:

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<th>Cultural/social</th>
<th>Scientific</th>
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<tr>
<td>Group, national, ethnic behavior/attitude</td>
<td>Conceptual, basic science, scientific method</td>
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<td>Educational</td>
<td>Economic</td>
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<td>Schooling, formal training</td>
<td>Trade, business concerns costs</td>
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<td>Technological</td>
<td>Ethical</td>
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<td>Applied science, engineering</td>
<td>Values</td>
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<tr>
<td>Political</td>
<td>Personal Experience</td>
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<tr>
<td>Organizational or governmental</td>
<td>Personal observation, informal character</td>
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3. Develops, presents, and communicates **OWN** perspective, hypothesis or position.

**Emerging Mastering**

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<td>Position or hypothesis is clearly inherited or adopted with little original consideration. Addresses a single source or view of the argument, failing to clarify the established position relative to one's own. Fails to present and justify own opinion or forward hypothesis. Position or hypothesis is unclear or simplistic.</td>
<td>Position includes some original thinking that acknowledges, refutes, synthesizes or extends other assertions, although some aspects may have been adopted. Presents own position or hypothesis, though inconsistently. Presents and justifies own position without addressing other views, or does so superficially. Position or hypothesis is generally clear, although gaps may exist.</td>
<td>Position demonstrates ownership for constructing knowledge or framing original questions, integrating objective analysis and intuition. Appropriately identifies own position on the issue, drawing support from experience, and information not available from assigned sources. Clearly presents and justifies own view or hypothesis while qualifying or integrating contrary views or interpretations. Position or hypothesis demonstrates sophisticated, integrative thought and is developed clearly throughout.</td>
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**Comments:**

4. Presents, assesses, and analyzes appropriate supporting data/evidence.

**Emerging Developing Mastering**

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<tr>
<td>No evidence of search, selection or source evaluation skills. Repeats information provided without question or dismisses evidence without adequate justification. Does not distinguish among fact, opinion, and value judgments. Conflates cause and correlation; presents evidence and ideas out of sequence. Data/evidence or sources are simplistic, inappropriate, or not related to topic.</td>
<td>Demonstrates adequate skill in searching, selecting, and evaluating sources to meet the information need. Use of evidence is qualified and selective. Discerns fact from opinion and may recognize bias in evidence, although attribution is inappropriate. Distinguishes causality from correlation, though presentation may be flawed. Appropriate data/evidence or sources provided, although exploration appears to have been routine.</td>
<td>Evidence of search, selection, and source evaluation skills; notable identification of uniquely salient resources. Examines evidence and its source; questions its accuracy, relevance, and completeness. Demonstrates understanding of how facts shape but may not confirm opinion. Recognizes bias, including selection bias. Correlations are distinct from causal relationships between and among ideas. Sequence of presentation reflects clear organization of ideas, subordinating for importance and impact. Information need is clearly defined and integrated to meet and exceed assignment, course or personal interests.</td>
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**Comments:**
5. Integrates issue using OTHER (disciplinary) perspectives and positions.

**Emerging Developing Mastering**

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<td>Deals with a single perspective and fails to discuss others’ perspectives. Adopts a single idea or limited ideas with little question. If more than one idea is presented, alternatives are not integrated. Engages ideas that are obvious or agreeable. Avoids challenging or discomfiting ideas. Treats other positions superficially or misrepresents them. Little integration of perspectives and little or no evidence of attending to others’ views. No evidence of reflection or self-assessment.</td>
<td>Begins to relate alternative views to qualify analysis. Rough integration of multiple viewpoints and comparison of ideas or perspectives. Ideas are investigated and integrated, but in a limited way. Engages challenging ideas tentatively or in ways that overstate the conflict. May dismiss alternative views hastily. Analysis of other positions is thoughtful and mostly accurate. Acknowledges and integrates different ways of knowing. Some evidence of reflection and/or self-assessment.</td>
<td>Addresses others’ perspectives and additional diverse perspectives drawn from outside information to qualify analysis. Fully integrated perspectives from variety of sources; any analogies are used effectively. Integrates own and others’ ideas in a complex process of judgment and justification. Clearly justifies own view while respecting views of others. Analysis of other positions is accurate, nuanced, and respectful. Integrates different disciplinary and epistemological ways of knowing. Connects to career and civic responsibilities. Evidence of reflection and self-assessment.</td>
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**Comments:**

6. Identifies and assesses conclusions, implications, and consequences.

**Emerging Developing Mastering**

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<tr>
<td>Fails to identify conclusions, implications, and consequences, or conclusion is a simplistic summary. Conclusions presented as absolute, and may attribute conclusion to external authority.</td>
<td>Conclusions consider or provide evidence of consequences extending beyond a single discipline or issue. Presents implications that may impact other people or issues. Presents conclusions as relative and only loosely related to consequences. Implications may include vague reference to conclusions.</td>
<td>Identifies, discusses, and extends conclusions, implications, and consequences. Considers context, assumptions, data, and evidence. Qualifies own assertions with balance. Conclusions are qualified as the best available evidence within the context. Consequences are considered and integrated. Implications are clearly developed, and consider ambiguities.</td>
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**Comments:**
7. Communicates effectively.

Emerging
In many places, language obscures meaning. Grammar, syntax, or other errors are distracting or repeated. Little evidence of proofreading. Style is inconsistent or inappropriate. Work is unfocused and poorly organized; lacks logical connection of ideas. Format is absent, inconsistent or distracting. Few sources are cited or used correctly.

Developing
In general, language does not interfere with communication. Errors are not distracting or frequent, although there may be some problems with more difficult aspects of style and voice. Basic organization is apparent; transitions connect ideas, although they may be mechanical. Format is appropriate although at times inconsistent. Most sources are cited and used correctly.

Mastering
Language clearly and effectively communicates ideas. May at times be nuanced and eloquent. Errors are minimal. Style is appropriate for audience. Organization is clear; transitions between ideas enhance presentation. Consistent use of appropriate format. Few problems with other components of presentation. All sources are cited and used correctly, demonstrating understanding of economic, legal and social issues involved with the use of information.

Overall Rating

<table>
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<tr>
<th>Criteria</th>
<th>Score</th>
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<tr>
<td>1. Identify problem, question, or issue</td>
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<td>2. Consider context and assumptions</td>
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<td>3. Develop own position or hypothesis</td>
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<tr>
<td>4. Present and analyze supporting data</td>
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<tr>
<td>5. Integrate other perspectives</td>
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<tr>
<td>6. Identify conclusions and implications</td>
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<tr>
<td>7. Communicate effectively</td>
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Comments:

Based on the Guide to Rating Critical & Integrative Thinking; Washington State University; Used by permission 8/08.
GRADUATE STUDENT PORTFOLIOS

The COSI department at Case uses portfolios assessment as part of your graduate program to document progress toward the knowledge and skill requirements that you will need to prepare you to begin your clinical fellowship experience.

**Portfolios must include the following:**
- 5 examples of work to include prevention, assessment, and treatment with at least 1 pediatric and 1 adult artifact
  - Examples of appropriate artifacts include but are not limited to:
    - Case studies that have been presented in class
    - Final diagnostic or treatment reports
    - Research, review papers
    - Prevention projects
    - Community/family education materials
- Each artifact must be accompanied by an introduction that identifies the population targeted in the artifact (peds, adult) and the target area (prevention, assessment, or treatment) and brief explanation of the goal of the artifact.
- Each artifact must also be accompanied by a self-reflection that addresses:
  - Why the artifact was selected
  - Self-identification of the strengths/weaknesses of the artifact
  - Self-identification of ways that the artifact should be improved
- In the semester that you graduate, you also must write a final self-reflection that overviews your perceived growth over the time of your academic program (this is in addition to the self-reflection that is included with your final artifact submission)

**Portfolio timeline:**
- The artifact for each semester, with introduction and self-reflection, is due by the end of the 1st week of the following semester (e.g., Fall 07 submission are due by the end of the first week of class in Jan 08)
  - **LATE ARTIFACTS WILL NOT BE ACCEPTED**
- In the semester that you graduate, your portfolio must be submitted prior to the last day that grades can be submitted and before your clinical and academic check-outs will be completed
- Artifacts are submitted to your academic advisor
- Your artifacts will be graded by your academic advisor and one other grader and you will be provided written feedback
  - Keep in mind that when an artifact is submitted in a portfolio, it serves a different purpose than it did in class/clinic; therefore, the grade that you received on the document for a class does not factor into the portfolio assessment
Content for oral and written artifacts includes: Logical organization, data gathering and analysis, application, interpretation, thoroughness, and novelty.

Reflection includes: Strengths and weaknesses, areas of growth and judgment, *influence of your future action, and *learning.

### Outcome: Competency, Knowledge, and Skills

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<tr>
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<th>NOT evident</th>
<th>Early Emerging</th>
<th>Emerging</th>
<th>CF Ready</th>
<th>Independent</th>
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<tbody>
<tr>
<td><strong>1. Content</strong></td>
<td>The artifact contained extensive frank errors and did not demonstrate knowledge and skills.</td>
<td>The artifact demonstrated incomplete understanding of knowledge/skills with omissions and errors</td>
<td>The artifact demonstrated basic understanding of knowledge/skills with the possibility of a minor error</td>
<td>The artifact demonstrated integration of knowledge/skills, without error</td>
<td>The artifact demonstrated in-depth understanding and synthesis of theoretical and clinical constructs</td>
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<tr>
<td><strong>2. Self Reflection</strong></td>
<td>The artifact reflection contains extensive frank errors and does not demonstrate any strategies for improving weaknesses.</td>
<td>The artifact reflection does not exhibit an understanding of the outcome. There is lack of clarity and/or accuracy in the description of strengths and weaknesses in relation to the outcome. Strategies for improving weaknesses are not identified.</td>
<td>The artifact reflection exhibits partial understanding of the outcome. There is some lack of clarity and/or accuracy in the description of strengths and weaknesses in relation to the standards. Strategies for improving weaknesses are not consistently addressed and/or are inappropriate.</td>
<td>The artifact reflection exhibits complete understanding of the outcome. The description of strengths and weaknesses in relation to the standards are clear and accurate. Strategies for improving weaknesses are consistently addressed and are appropriate.</td>
<td>The artifact reflection exhibits an advanced, mature understanding of the outcome. The description of strengths and weaknesses in relation to the standards are clear and insightful. Thoughtful strategies for improving weaknesses are consistently addressed and are appropriate.</td>
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<tr>
<td><strong>3. Presentation</strong></td>
<td>The artifact submitted does not meet the purpose, is not appropriate and oral presentation distracted from content</td>
<td>The artifact addressed the topic, but the presentation lacks clear focus and written/oral style distracts from content</td>
<td>The artifact addressed the topic with oral/written presentation focused on content</td>
<td>The artifact addressed the topic with oral/written presentation style enhancing audience understanding of the content</td>
<td>The artifact addressed the topic and was presented in a professional manner with a presentation style that encourages audience reflection</td>
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<td><strong>4. Mechanics</strong></td>
<td>The artifact has more than 5 errors and requires major editing and revision</td>
<td>The artifact has more than 3 errors and requires some editing and revision</td>
<td>The artifact has 2 errors and requires minimal editing and revision; overall organization and flow is adequate</td>
<td>The artifact has no errors and overall organization and flow is adequate</td>
<td>The artifact has no errors and organization and flow is superior</td>
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Mechanics for oral and written artifacts includes: Grammar, spelling, organization, formatting, punctuation, and capitalization.

Presentation includes: Selection of artifact, context appropriates (appeal to audience) effectiveness (nonverbal behavior-body language, professional attire, etc) and creativity.

Minor errors are considered errors that do not have a consequence on understanding.
The Standards for the Maintenance of Quality Point Average (Graduate Student Handbook 2007-2008):

In calculating the quality-point average, courses taken as a student in the School of Graduate Studies at the 400 level and above, as well as any courses accepted toward fulfillment of degree requirements for which quality points are given, will be counted, including courses which may need to be repeated. Unless otherwise stated by the department a minimum cumulative quality-point average of 2.75 is required for the award of the Master's degree. Any department, school, or curricular program committee may choose to establish quality standards higher than those stated above if such additional requirements are made known in writing to the students upon matriculation, and are recorded with the Dean of Graduate Studies. In that case, the departmental standards supersede the minimum standards. Students whose quality point averages fall below minimum standards (3.00 for doctoral students; 2.75 for masters) will automatically be placed on probation until the minimum standards are achieved.

Remediation Process:

In order to prove KASA competency, any one (1) course requirement earning a grade of less than B must be resubmitted to the course instructor within 2 weeks from the time it is returned to the student with all instructor comments satisfied. This resubmission will not result in a grade change. If a student receives 2 or more assignments with a grade of less then B, the student will need to see the course instructor and academic advisor to complete a remediation plan.

A student will be subject to separation from the University for any of the following reasons:

1. Failure to achieve a quality-point average of 3.0 or higher at the completion of 12 semester hours or 2 semesters of graduate study will result in separation from the university. Students must maintain a 3.0 quality-point average during succeeding semesters of enrollment. If a student's quality-point average falls below a 3.0 in any succeeding semester, the student will be separated from the university. Only 400 level courses and above or lower level courses approved to meet the M.A. semester hours requirement will be used to calculate the quality-point average.

2. Failure to receive a grade of S in thesis research 651 or dissertation research. A student who receives a grade of U in thesis or dissertation research will be placed on probation and be subject to separation. The probationary status will be recorded on the student's transcript. The student must be removed from probation by the end of the semester immediately following receipt of the grade of U by repeating the course for the same number of credit hours, and achieving a grade of S. Although removal from probation restores the student's good standing, the grade of U received will not be canceled or substituted by the grade of S subsequently received. Separation will occur if the student placed on probation receives another grade of U in the following semester; or, if the Dean of Graduate Studies, in consultation with the academic unit, determines that the student is unlikely to be successful in working independently and productively toward the completion of the thesis or dissertation research.

3. Failure to make progress towards degree completion. If the student is not making progress towards degree completion, and it has been judged that the student is unlikely to be successful in working independently and productively toward the completion of the thesis, the department and/or the Dean of Graduate Studies (in consultation with the department) can recommend academic separation.

4. In addition to disciplinary actions based on academic standards, on recommendation of the student's department or school, the Dean of Graduate Studies can suspend or separate a student from the University for failure to maintain appropriate standards of conduct and integrity. Such a suspension or separation will be implemented only for serious breaches of conduct that threaten to compromise the standards of a department or create concern for the safety and welfare of others. In the event of such suspension or separation, the student will be entitled to an appeal through the grievance procedure of the Graduate School.
GRADUATE STUDENT GRIEVANCE PROCEDURE

It is the responsibility of the School of Graduate Studies to assure that all students enrolled for graduate credit at Case Western Reserve University have adequate access to faculty and administrative consideration of their grievances concerning academic issues. Accordingly, the following three-step procedure has been established for graduate students to present complaints about academic actions they feel are unfair.

1. Students with complaints should first discuss their grievance with the person against whom the complaint is directed. The goal is for the parties to be sure they understand each other before more formal steps are taken, and to be sure that every opportunity has been taken for mutually satisfactory resolution.

2. In those instances in which discussion with the faculty member involved does not resolve a grievance to the student’s satisfaction, he or she should then present the complaint in writing to the Department Chairperson. The Chairperson will subsequently take responsibility for reviewing the complaint with the student and the faculty member in order to arbitrate the issue on the basis of all available information and the soundest judgment possible. In this process the Chairperson may consult with other faculty in the Department, submit the matter for deliberation to the Department’s tenured faculty, appoint an ad hoc committee of faculty and/or graduate students to make a recommendation, or employ other means of resolving disputes consistent with the Department’s usual ways of operating. If the complaint involves the Department Chairperson, the student may bring the matter to the Faculty Dean (e.g., Engineering, Medicine, etc.) to whom the Chair reports.

3. In the event that a decision still appears unfair to a student, the student may bring the matter to the attention of the Dean of Graduate Studies. The Dean may ask the student to put the complaint in writing for clarity and fairness to others involved. The Dean will then discuss the case with the student and the Department Chairperson to evaluate the particulars and to make a ruling on it. As the situation warrants, the Dean may appoint a Grievance Committee to recommend what action should be taken. In this event the Committee will be composed of two faculty members selected from the Committee on Graduate Studies of the Faculty Senate and two graduate students selected either from the Executive Committee of the Graduate Student Senate or from the student members of the Committee on Graduate Studies. The procedures for the Committee will be determined by the Committee itself as the circumstances warrant, but generally the student, the faculty member or department against which the accusation is raised, and other members of the University community familiar with the case will be asked to discuss the matter with the Committee. The student may request the participation of members of the University community who are familiar with his or her circumstances, but representatives from outside the University community will generally not be allowed to participate in the proceeding. Responsibility for the final decision will be in the Dean’s hands, and the ruling from the Dean’s Office will be considered final and binding on the persons involved in the grievance.

It should be understood that this grievance procedure relates solely to graduate student complaints concerning academic issues. The procedure for handling complaints about other matters is detailed in the University’s Student Services Guide.

To report a grievance that is specific to issues of accreditation of the Department of Communication Sciences at Case Western Reserve University, please contact:

Sue Flesher  
Council on Academic Accreditation  
American Speech-Language-Hearing Association  
ASHA Executive Center; 2200 Research Blvd.
Clinical education is viewed as a dynamic process which prepares practitioners who manifest the following characteristics:

- A broadly-based foundation of knowledge in communication sciences and disorders, with emphasis on a processing framework that helps the student analyze and synthesize information.
- A problem-solving attitude of inquiry and decision making as represented in the scientific method.
- A high level of applied skill competency in clinical diagnosis and treatment.
- An ability to participate in the interprofessional rehabilitation management of clients.
- The ability to communicate effectively and professionally with clients, their families and with other professionals.

Clinical education offers preparation necessary to meet requirements for the following:

1. **ASHA Certificate of Clinical Competence** in Speech-Language Pathology
2. **Ohio Licensure** in Speech-Language Pathology

Appropriate application forms and specific requirements for each of these certificates and licenses are available in the office of the Department of Communication Sciences.

**Clinic Manual Self Assessments**
On the following pages you will find 4 quizzes designed to ensure your awareness and understanding of issues critical to successful completion of the clinic education program.

All students must pass the self assessments prior to the completion of their first semester of clinic. All students must pass the self assessments to receive a clinic grade for their first semester. The standard for passing is 100% on all 4 quizzes.

Please read this clinic manual and complete each quiz.

Turn your completed quizzes in to the Coordinator of Clinical Education by mid term of your first semester of clinic.

Students who do not pass will re-write and re-submit their responses until a passing score is reached.
QUIZ 1.

1. What are the administrative requirements you must complete prior to clinic placement?

2. What is HIPPA and how does it apply to clinical work?

3. What are Universal Precautions? Why are they important?

4. Which professional behaviors do you think will most important for you to exhibit in your clinical work?

5. Clinical placements are determined by the ____________________________. I can/cannot (circle) change the terms of my clinical placement/contract as long as the clinical instructor agrees. As a student it is my responsibility to notify __________________ and __________________ in the unlikely event of an absence from my placement.

QUIZ 2

1. What is evidence based practice and why is it important?
2. How can learner outcomes be used in your clinical setting

3. Explain what you would do if you had a question about a client's diagnosis.

4. How often should you expect feedback from your clinical instructor? What would you do if this expectation is not met?

5. List the components for COSI 452 case presentation.

QUIZ 3

1. When confronted with questions regarding professional boundaries what ASHA documents should be consulted?

2. What part(s) of the ASHA Code of Ethics do you consider most important in clinical practice and why?

3. What is KASA and what does it ensure?

4. Why do you think ASHA is important?

5. Define the clinical clock hours required for ASHA and Ohio Licensure. What are the minimum requirements per category?
QUIZ 4

1. Who is responsible for ensuring that all paperwork and deadlines are met/complete for graduation?

2. What are the requirements for:
   a. taking the comprehensive examination?
   b. writing a thesis?
   c. graduation

3. Where can you access information regarding the PRAXIS exam?

4. When does the Ohio Board of Speech Pathology and Audiology meet to review applications for licensure?

5. List the steps required to ensure successful checkout from the department
SPECIFIC CLINICAL REQUIREMENTS AND PROCEDURES

STUDENT CLINICIANS
Student interns work in cooperation with certified speech-language pathologists and/or audiologists in the delivery of services to communicatively impaired persons. The practicum experience is designed to facilitate application of principles and procedures gained through academic course-work and clinical observations to the actual delivery of services. Practicum assignments are chosen to allow for the gradual development of those skills required for independent functioning as clinical speech-language pathologists. Student responsibilities during each practicum assignment are determined based on 1) guidelines set by Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA) of the American Speech-Language and Hearing Association (ASHA), 2) the student's level of competence, and 3) the policies and procedures of the facility where the student is placed.

During each semester of enrollment in the Master's degree program students are required to participate in clinical practicum and enroll in COSI 452: Graduate Clinical Practicum for 1 credit (3 semesters minimum). All Master's students must have completed an undergraduate course in Clinical Procedures before enrolling in COSI 452. If a student did not complete a Clinical Procedures course as an undergraduate, he/she must complete COSI 352: Practicum in Communication Disorders before enrolling in COSI 452.

Undergraduate students who have declared Communication Disorders as a major and who have achieved senior status have the option of participating in clinical practicum. During the Fall Semester of the senior year, students must enroll in COSI 352 INTRODUCTION TO CLINICAL PRACTICE. Practicum assignments are made through this course by the Coordinator of Clinical Education after graduate student assignments have been made.

PROCEDURES FOR OBTAINING CLINICAL ASSIGNMENTS
Clinical Assignments are made by the Coordinator of Clinical Education with CHSC Clinicians and externship Supervisors. Procedures for clinical assignments are as follows:

1. Students turn in practicum requests, class schedules, a listing of their previous clinical experience, and a listing of all courses they have completed and are currently enrolled in during the first week of classes each semester. Students also note the approximate number of hours per week they would like for their clinical assignment. This information should be completed on the Graduate Practicum Clinical Summary form located in Appendix B.

2. Students must have a 3.0 GPA to be enrolled in Clinic.

3. The Coordinator of Clinical Education contacts CHSC Clinicians and Externship Supervisors to determine potential placements.

4. Assignments are given to students by the beginning of the second week of classes. Students should contact their Clinical Supervisors immediately and make arrangements to begin clinical assignments.

5. Any revisions in schedule are completed by the end of the third week of classes.

6. Students begin clinical work by the third week of classes. Students should contact the Coordinator of Clinical Education immediately if there are any difficulties/concerns related to their clinical assignment (e.g., decrease in hours projected; change in supervisor’s schedule; concerns about skills in clinic).

7. Students terminate clinical work at the END of regularly scheduled courses. (No clinic final exam week.) Students may continue their placements for a longer period of time if approved by their supervisor and the Coordinator of Clinical Education.
8. In some cases a student’s clinical assignment may continue across a two semester period. Extension of an assignment for more than one semester should benefit the student’s training needs. Such decisions are made at the discretion of the Coordinator of Clinical Education with input from the clinical supervisor/instructor and the student.

**GRADUATE PRACTICUM COURSE REQUIREMENTS**

1. All students participating in Graduate Practicum assignments must be enrolled in COSI 452.

2. All full-time graduate students will initially be assigned to clinical duties at CHSC for approximately 4-8 hours per week. Once a student has successfully completed approximately 100 contact hours, he/she can be considered for an externship site placement. Externship placements are typically made for 20-40 hours per week during the second year of graduate work.

   During the summer semester, students are encouraged to schedule 2-4 full days per week of clinical assignments (8 weeks minimum). This allows students to simulate the professional expectations and hours of a speech-language pathologist in a typical job setting. It also allows students to complete a large number of clinical hours during a period of time when coursework is minimal.

   Externship sites vary in the time commitments required. Some sites require that students work three days per week; other site vary their expectations in relation to the goals and needs of the student. Some sites interview potential student externs from CWRU and other area programs prior to selecting the candidate for the position. Interviewing schedules will be announced during Graduate Practicum class.

3. Students enrolled in Graduate Clinical Practicum are required to attend all sessions of the practicum course. Unexcused absences from this course will result in the lowering of the student’s semester grade by one letter grade.

4. First year, second semester and second year students are required to do a formal case presentation to the Department through the COSI 452 course.

5. All students must submit two (2) completed Evaluation of videotaped/audiotaped sessions per semester.

6. Students are required to submit signed certification of practicum hours within 30 days of the completion of their clinical assignment. The clinical practicum record forms may be obtained in Appendix A.

7. Students are required to provide the Coordinator of Clinical Education with all original, signed practicum records, keep personal copies of their practicum records, and inform the Coordinator of Clinical Education as to their completion of ASHA requirements. A record of clinical hours will be kept on file by the Coordinator of Clinical Education.

8. A student’s grade for the Graduate Practicum course (COSI 452) will be determined from their clinical performance (as evaluated by their clinical supervisor(s)), their attendance at COSI 452 class, and their performance on class assignments. When students are placed with more than one supervisor, their clinic grade will be weighted in relation to the number of hours earned with each supervisor.

9. Students must meet with the Coordinator of Clinical Education 30 days prior to graduation to initiate a final clinical hours certification check.
Expectations
Students should view themselves as professionals while participating in their clinic assignments. It is assumed that graduate clinicians are responsible and will take initiative in meeting all clinical and professional expectations in their clinical assignments. Students are expected to conform to procedures used at each of their educational sites. Specific guidelines will be provided at CHSC and each externship.

Clinical Contracts
When students approach one of the Clinical Supervisors to arrange clinical assignments, THEY ARE, IN EFFECT, ENTERING INTO A VERBAL CONTRACTUAL AGREEMENT WITH THE INSTRUCTOR. Students may not alter the contract unless the changes are approved by the Clinical Supervisors and the Coordinator of Clinical Education. In addition to the verbal agreement, Clinical Supervisors will complete a written clinical contract with the student. A copy of that contract is provided in Appendix B. Despite requirements of coursework, obligations to clients and supervisors may not be offset.

Absences from Assignments
Clinical absences require notification of the Instructor (and client when appropriate) within a timely fashion. Rules regarding absence from clinical duties are as follows: with exception of illness, family emergencies, and University holidays, your contractual agreement with your Clinical Instructor must be honored. Students should inform their clinical instructors of upcoming University holidays and deadlines (i.e., date of end of the semester). Other causes for absences, such as religious holidays, will be considered on an individual basis by the Coordinator of Clinical Education and the Clinical Supervisors upon submission of absence request.

Dress Code
The first impression a person often makes about another is his/her manner of dress. This is especially true when one seeks professional services. As a clinician, it is important that your appearance underscore and not distract from your professional image. Professional dress is conservative. This professional dress must be followed when seeing clients and when observing therapy. Failure to follow dress code will result in a less favorable evaluation.

1. As of spring 2006, each student must purchase a CWRU polo shirt to be worn in clinic with khaki style/ chino style pants.
2. The polo shirt must be worn tucked into the pants. When bending over, the shirt must touch the pants.

Makeup and jewelry must be worn conservatively.

Dress should not distract or inhibit a graduate clinician’s ability to conduct clinical duties effectively. Dress codes at externships may vary from the polo shirt/ khaki pants uniform (e.g. scrubs at a hospital). Please talk with supervisors at each site to clarify dress expectations.

Professional Language
Any type of profanity or swearing is not allowed. This restriction includes swearing that may be allowed on television or PG rated movies. In addition, when dealing with clients or their families, one should be careful in using other examples of unprofessional language such as slang or inappropriate humor. Your communications with clients, their families, the clinical staff, and the secretarial staff should always be polite. All supervisors should be addressed formally; thus they should be addressed as Dr., Mrs., Ms., or Mr. at all times. Adult clients and parents of child clients should always initially be addressed formally.

Professionalism
Professionalism encompasses the above areas of professional dress and professional language. It also includes other behaviors which are expected of a professional. As you are in training to become a professional, it is essential that you develop appropriate professional behaviors. Among these professional behaviors are: 1) punctuality for meetings, deadlines, and therapy sessions, 2) dependability,
3) ability to take and act upon constructive criticism, 4) ability to voice appropriately your opinions to your supervisors, 5) being aware of what you do and do not know, 6) appropriate non-verbal behaviors, 7) self-evaluating your performance, 8) demonstrating confidence, 9) intellectual curiosity, 10) ethical behavior, 11) non-discrimination, 12) emotional control, 13) demeanor, 14) attitude. As you will throughout your career, you need to independently seek out information to improve your clinical knowledge and skills. Most importantly, professionalism entails a dedication to helping your clients improve in their ability to communicate. To that end, the American Speech Language Hearing Association has published the Code of Ethics, which serves as a guideline for professional, ethical conduct. Please review ASHA’s Code of Ethics, which can be accessed at http://www.asha.org/about/ethics/.

External Placements
External placement decisions in speech-language pathology are made by the Director of Clinical Education with advice from the supervisory staff. Students must have at least 100 clinic hours before they can be considered for most external sites. Many sites require other specific requirements such as previous hospital experience. The student must have an overall GPA of at least 3.0 to be considered for an external placement. Many sites require each student to complete a clinically oriented project as part of the practicum experience. Some externships also require that the student be interviewed before being accepted as an extern. Several factors will be taken into consideration for being given an external placement. Among them are the following:
1. Previous clinical experiences-types of clients seen
2. Number of clinical hours earned
3. Opinion of previous supervisors that you can make clinical decisions with a certain degree of independence
4. Previous coursework
5. Date of graduation-those near graduation will be given priority
6. Success in previous external practicum
7. Level of professionalism in interaction with others
8. Transportation available to site
9. Willingness and/or ability to follow requirements of the site
10. Number of hours available per week to give to site
11. Schedule flexibility
12. Interest in populations seen at a given available site

It should be stressed that being assigned any external placement is something that must be earned and is not a right. If a student has more than 50 hours from an undergraduate program other than CWRU, he or she will still be required to complete at least 25 hours in the CHSC before being considered for an external placement.

It is of paramount importance that you take full advantage of your external placements. External placements are invaluable training for future employment. Employers are highly impressed with a positive evaluation from an external supervisor. You should also remember that external supervisors are not paid for taking students and do it because they are dedicated to helping train future speech-language pathologists. They are, as a group, patient and willing to help students who demonstrate a sincere desire to improve their skills. Be sure to take advantage of attending team meetings and other experiences such as observing at other sites affiliated with your site.

From conversations with various external supervisors, the following will result in a more favorable evaluation:
- Enthusiasm toward working with the populations seen at the facility
- Completing independent reading on the types of disorders the clients at the site have
- Asking pertinent questions
- Requesting reading materials to increase fund of knowledge
- Independently searching for information for improving your therapy techniques
- Familiarizing yourself with assessment techniques used at the site
- Flexibility to changing schedules and demands

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• Willingness to change approach if client is having difficulty
• Willingness and ability to counsel the families of clients seen
• Ability to empathize with client needs
• Willingness to try new procedures
• Punctuality in all areas
• Using time effectively
• Adapting to the note and report writing style used at the site
• Presenting in a positive constructive way at interdisciplinary meetings
• Ability to interpret diagnostic information
• Demonstrating the ability to use supervisor feedback successfully
• Willingness and ability to become more independent in clinical skills as the practicum experience proceeds
• Overall professionalism while at the site

EVALUATION PROCEDURES
The following outline presents the steps for evaluating students' progress during a semester of Clinical Practicum.

1. Evaluation of clinical skills is an ongoing process throughout the student's clinical education. At any point during the course of the semester a Clinical Supervisor may request a conference to discuss a student's progress. The Clinical Supervisor needs to apprise the Coordinator of Clinical Education of any issues or concerns that arise relating to Clinical Education. (Sample forms for session feedback and midterm/end-of-semester evaluation are included in Appendix B of this document.) Students are also encouraged to make an appointment to meet with the Coordinator of Clinical Education at any time during the semester to discuss their progress and performance in their practicum assignments.

2. At the beginning of each clinic, practicum students will meet with their supervisors and complete the supervisory needs form to help identify how the supervisor can best help the student. (See Appendix B)

3. A midterm evaluation will be held by each student and supervisor to review performance and identify strengths and areas to be improved. A written copy of the midterm evaluation will be sent to the Coordinator of Clinical Education. (See Appendix B)

4. At the conclusion of the semester the following should be completed:
   a) A written evaluation of the student's progress will be completed by the Clinical Supervisor, reviewed orally with the student and sent to the Coordinator of Clinical Education.
   b) The student clinician will complete the Supervisor Evaluation Form (See Appendix B). Students can provide their clinical supervisor with a copy of the evaluation after the student's semester grade has been completed. A copy of the Supervisor Evaluation information must be given to the Coordinator of Clinical Education at the end of the semester.
   c) The student will make an appointment to meet with the Coordinator of Clinical Education to review clinical strengths and areas to improve. This meeting will also provide an opportunity to discuss upcoming clinic placements and to update the Coordinator of Clinical Education on progress toward ASHA requirements (clinical hours).

5. Within the final two weeks of the semester the Coordinator of Clinical Education and the Clinical Supervisors and Externship Clinical Supervisors will share the following information:
   a. The student's clinical strengths and weaknesses
   b. Recommendations for clinical status (as appropriate)
   c. Point value earned by the student in assignment with each supervisor

6. Clinical Remediation. Clinical practicum assignments are a privilege and students are expected to act in a professional manner. Students judged as acting in an unprofessional manner or making inadequate progress will be placed on Clinical Remediation. Clinical Remediation status will be
considered on an individual basis. When a student is placed on Clinical Remediation, the Coordinator of Clinical Education will meet with the faculty and the Clinical Supervisors to define expectations for the student. These expectations will be defined in writing on the Clinic Remediation form (Appendix B) to the student and placed in their Student File. The student's response to the requirements will determine whether he/she is returned to regular clinical status or dismissed from the clinical education program. Students who have not met the stipulations of the Clinical Remediation may not be permitted to complete their clinical requirements.

7. Grades will not be issued until all reports and clinical duties are completed to the supervisor's satisfaction. The student's grade may be lowered one letter grade each week that reports are overdue.

**CLINICAL GRADES: A STATEMENT OF PURPOSE**

The purpose of clinical grades is two-fold. First, these grades provide a system of measure for the level of clinical expertise presently maintained by the student-intern. Second, they serve to provide a continuous record of clinical performance through the student's course of study.

The goal of both students and supervisors is to have graduating clinicians performing at the A grade level at the completion of their 375 supervised clinical hours. However, some students may reach the A grade level criteria early in their clinical training. Through systematic use of the Clinical Contract and the Semester Evaluations, students can identify areas for improvement. These areas can be focused on in subsequent clinical work so that the student can achieve success.

Mid-term grade status will be communicated to the student by the Clinical Supervisor during the 8th week of the semester. Midterm grades provide a formal mechanism for identifying student strengths and areas to improve. Final Grades will be communicated at a final conference with the Clinical Instructor and Student Intern during Final Exam Week. Grades will be sent to the Coordinator of Clinical Education for placement in the clinical file. The Coordinator of Clinical Education may request a conference with Student Clinicians to discuss clinical progress at any point in the semester. Students are also encouraged to meet with the Coordinator of Clinical Education whenever the/a need

Clinical grades are included in academic averages. The grading criteria are defined on forms in Appendix B and help a student build skills towards a professional level of competence. An overall clinical grade is derived from 1) a student's participation in COSI 452 course and 2) weighted grading from clinical supervisors across assignments.

The clinical grading systems includes a three-tier system of grades. Students will be graded in relation to expectations for their level of clinical experience as follows:

- **Level I:** 0-100 hours of clinic experience in SLP
- **Level II:** 101-200 hours of clinic experience in SLP; first externship site placement
- **Level III:** 201 or more hours of clinic experience in SLP; has had at least one previous externship site experience

Letter grades are computed by the Coordinator of Clinical Education through weighted scorings on the points earned with each clinical assignment/supervisor. Clinical grades are also influenced by student participation and mandatory attendance in the COSI 452 class. A student’s grade can be lowered by one letter grade if they miss more than one class meeting of COSI 452 per semester. Students earning a grade of lower than 3.7 will be placed on Clinical Remediation.

<table>
<thead>
<tr>
<th>Grade</th>
<th>Letter</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.5+</td>
<td>A</td>
</tr>
<tr>
<td>3.7 - 4.4</td>
<td>B</td>
</tr>
<tr>
<td>3.6 - 3.0</td>
<td>C</td>
</tr>
<tr>
<td>2.3 - 2.9</td>
<td>D</td>
</tr>
<tr>
<td>Below 2.3</td>
<td>F</td>
</tr>
</tbody>
</table>
**CLINICAL REQUIREMENTS**

**NAME BADGE:** All graduate clinicians will be provided with a CWRU Name Badge at the beginning of Fall Semester. Badges must be worn whenever services are provided at CHSC. Some externship sites also require identification badges. If your clinic name badge, provided to you by the department, is lost or stolen please contact the department office for a replacement badge.

**EQUIPMENT:** All practicum students are required to have a tape recorder, microphone and audio cassettes for use in their practicum experience. Equipment should allow for quality recordings to enable students to do accurate transcription of speech/language samples.

**STUDENT LIABILITY INSURANCE:** All students participating in clinical practicum are required to purchase student liability insurance annually. Proof of insurance must be given to the Coordinator of Clinical Education and filed in the student's clinic file. Insurance may be purchased through NSSHLA or through OSHA.

**STUDENT EXTERNSHIP MEDICAL STATEMENT:** May be completed by family physician or may be completed by Case Student Health Services ([http://www.cwru.edu/stuaff/UHS/uhs.html](http://www.cwru.edu/stuaff/UHS/uhs.html); 216-368-2450) at no cost. See attached form.

**CLINICAL FEES:** Students will pay a $25 clinical fee annually (due in the Fall). This fee will be used to purchase clinical materials and forms which will be housed in the department. Signed CHSC Workforce Confidentiality Agreement (see attached form).

**STUDENT BACKGROUND CHECKS:** You must complete fingerprinting/ background check prior to clinical practicum placement. This can be completed at the university. For further information please go to [http://www.case.edu/finadmin/security/protserv/fp-gen.htm](http://www.case.edu/finadmin/security/protserv/fp-gen.htm). A copy of your completed fingerprint/ background check should be kept on file in your file in the department office.
DEPARTMENT OF COMMUNICATION SCIENCES STUDENT EXTERNSHIP MEDICAL STATEMENT

Student Name_________________________ Date of Exam____________________

Date of Birth_________________________ SSN___________________________

This is to certify that I have examined the above-named person and have found him/her to be:

1. Free from apparent communicable disease.

2. Free from tuberculosis verified by two step Mantoux skin test (except for those with documentation of previously significant reaction).

3. Physically fit for work in a health care facility.

4. Immunizations:
   a. Immunized against measles and mumps; or born before December 31, 1956; or has a disease history of measles and mumps; or exempt from this requirement for medical or religious reasons.
   b. Immunized against rubella; or has a laboratory test demonstrating detectable rubella antibodies; or exempt from this requirement for medical or religious reasons.
   c. Immunized against tetanus and diphtheria; or exempt from this requirement for medical or religious reasons.

5. List known allergies

Signature of Physician____________________________________________________

Street Address___________________________________________________________

City, State, and Zip Code____________________ Telephone No. (   ) ____________

Note: This does not take the place of a complete physical examination. The physician may exempt the student from the above immunization requirements for medical reasons. This form was adapted from the ODHS Child Care Center/Type A and Certified Type B Family Day Care Homes. (9/97)
HIPAA: General Information

http://www.asha.org/members/issues/reimbursement/hipaa/hippa_general_faq.htm

What is HIPAA?
Who needs to be in compliance and what type of information is covered?
When was the compliance deadline?
What will happen if I don’t comply?

1. What is HIPAA?
The Health Insurance Portability and Accountability Act of 1996 is designed to protect health insurance coverage for workers and their families when they change or lose their jobs. The requirements of HIPAA apply to the storage and/or electronic transmissions of patient related information, and are intended to ensure patient confidentiality for all health care related information. Although there are nine different Federal regulations to be developed by Health and Human Services (HHS) as part of the Administrative Simplification section of HIPAA, the final rules for just three have thus far been published by HHS, the electronic data interchange (EDI) rule, the privacy rule, and the security rule.

2. Who needs to be in compliance and what type of information is covered?
In general, the rules state that any health care provider or insurance entity that maintain or transmits “individually identifiable health information”, referred to as “protected information”, about a patient or client is deemed a “covered entity” and is subject to HIPAA. In addition, “business associates” who view, manipulate or otherwise handle this protected information on behalf of a covered entity are also subject to HIPAA. The final HIPAA privacy rule covers all individually identifiable health care information in any form, electronic or non-electronic, that is held or transmitted by a covered entity. This includes information in paper records that has never been electronically store or transmitted, but could be. An entity that collects, stores, or transmits data electronically, orally, in writing or through any form of communication, including fax, is covered under the HIPAA privacy rule, as is the information itself. The electronic transmission of this information is governed by the HIPAA EDI format standards.

Within the speech, language, hearing professions, this will include all identifiable health information generated and transmitted by those in private practice, and those practicing in schools, nursing homes, hospitals and other institutional settings. Those professionals practicing as employees of covered entities are subject to the policies and procedures of those entities, which will themselves, undoubtedly, be in full compliance with HIPAA rules. It also includes any provider under contract with a covered entity such as a nursing home or rehabilitation facility. In this situation, the speech, language, hearing professional would be considered a business associate of the facility and subject to the business associates provisions of HIPAA. Although many of the privacy protocols identified by HIPAA are currently in place and routinely used by researchers, they too, may be subject to HiPAA and should conduct policy reviews to assure compliance with both sets of rules.

3. When is the compliance deadline?
The first transaction standards for the EDI rule of HIPAA was published in the Federal Register on August 17, 2000 with a compliance deadline of October 16, 2002. The privacy rule was published on December 28, 2000. Its compliance date was April 14, 2003. The deadline for compliance with the security rule was April, 2005.

4. What will happen if I don’t comply?
Penalties may be imposed if the HHS Office of Civil Rights determines that an individual’s right to privacy has been violated. EDI rule violations will be reported the Secretary of HHS. The rule provides for civil penalties of $100 per violation up to a maximum of $25,000 per year. When violations are with the intent to sell, transfer, or use individually identifiable information for commercial advantage, personal gain, or malicious harm, criminal penalties ranging from $50,000 and one year in prison to $250,000 and ten years in prison may be imposed.

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CLEVELAND HEARING & SPEECH (CHSC) WORKFORCE CONFIDENTIALITY AGREEMENT

I understand that CHSC has a legal and ethical responsibility to maintain patient privacy, including obligations to protect and safeguard the confidentiality of patient information. In addition, I understand that I may see or hear other confidential information such as financial data and operational information.

As a condition of my employment/affiliation with CHSC, I understand that I must sign and comply with this agreement. By signing this document, I understand and agree that:

I understand that any patient or confidential information that I access at CHSC does not belong to me.

I will disclose patient/confidential information only if such disclosure complies with CHSC policies and is required for the performance of my job.

I will not discuss any information pertaining to CHSC in an area where unauthorized individuals may hear (e.g., hallways, elevators, social events). I understand that it is not acceptable to discuss patient or confidential information in public areas even if specifics such as patient name are not used.

I will not make inquiries about patient or confidential information for any individual or party who does not have proper authorization to access such information.

I will not access or view any information other than what is required to do my job. If I have any question about whether access to certain information is required, I will ask my supervisor.

I will not make any unauthorized transmissions, copies, disclosures, inquiries, modifications, or purgings of patient or confidential information. Such unauthorized transmissions include, but are not limited to removing and/or transferring patient or confidential information from CHSC’s computer system to unauthorized locations (e.g., my home).

Upon termination from CHSC, I will immediately return all property (e.g., keys, documents).

I agree that my obligations under this agreement regarding patient information will continue after the termination of my employment/affiliation with CHSC.

I understand that violation of this Agreement may result in disciplinary action, up to and including termination and/or suspension, restriction or loss or privileges, in accordance with CHSC’s policies, as well as potential personal civil and/or criminal legal penalties.

My access code(s), user ID(s), password(s), etc. are kept confidential at all times.

I have read the above agreement and agree to comply with all its terms as a condition of continuing employment.

___________________________    _____________________
Signature      Date

___________________________
Name          effective 4/14/03

My personal access code(s), user ID(s), access key(s) and password(s) used to access computer systems or other equipment are kept confidential at all times.
Heath & Safety

Students should be knowledgeable about procedures that can help protect themselves and their clients from the transmission of communicable diseases. These policies have been taken from the Policies & Procedures Manual of the Cleveland Hearing & Speech Center.

Many common diseases are transmitted through contact with the body fluids of an infected person. To minimize the risk of transmission of these diseases, these guidelines describe universal precautions which are to be used with all clients at all times. *They assume that blood and other body fluids from all clients are potentially infective and that exposure to these body fluids may occur during routine performance of job duties.*

**Universal Precautions**
All students who work directly with clients in the course of Graduate Practicum must recognize that certain health risks are inherent in the practice of speech/language pathology. In order to protect themselves in this work environment, students should strictly adhere to the universal precautions which are described below. Universal precautions are recognized by infection control specialists as the best defense against the spread of infectious diseases. They are listed in the box below and described in more detail in the following sections.

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**UNIVERSAL PRECAUTIONS**

Practicum students should treat all blood and OPIM (other potentially infectious materials) as though they are infectious and use universal precautions at all appropriate times. (Saliva and gingival fluids are considered to be potentially infectious material since they often may be contaminated with blood.

1. ROUTINE HAND WASHING
2. DISPOSABLE GLOVES
3. DISINFECT

---

1. **Routine Hand Washing**
   Wash hands carefully and thoroughly:
   * **BEFORE AND AFTER EACH CLINICAL SESSION**
   * when hands become contaminated with saliva, blood, or other body fluids (e.g., after sneezing, coughing, or wiping a nose)
   * after you use the toilet or help a client with toileting
   * after diapering
   * after handling soiled items, such as used tissues or dirty toys
   * before preparing or eating food

2. **Disposable Gloves**
   Wear disposable gloves when in contact with urine, stool, blood, or saliva, such as during oral examinations, cleaning wounds, or testing blood glucose.
   * wash hands immediately after removing gloves
   * dispose of gloves in plastic-lined container
3. **Disinfect**
Sanitize potentially contaminated surfaces and objects:

* **Toys & other objects**—if soiled with blood, feces, vomit, or urine must be disinfected or discarded immediately. *Mouthed toys must be washed with soap and water or disinfected.*

* **Dishes**—wash with dishwashing liquid and hot water (120 degrees F), air dry.

* **Ear probe tips**—if contaminated with blood or other visible substance, wash with soap and water. Disinfect in 70% alcohol solution for a minimum of 30 minutes. This solution should be changed daily.

* **Diapering**—
  > Wear disposable gloves when changing child. Dispose gloves after each child has been changed.
  > Changing surfaces should be non-porous. Disinfect surface after each diaper change.
  > Place soiled clothes in plastic bag to be sent home with child.
  > Clean child with dampened paper towels. Dispose of these materials in plastic-lined container.
  > Diaper & dress child.
  > Wash child’s hands in sink.
  > Clean changing mat with disinfectant.
  > Wash your hands thoroughly with soap and water.

* **Environmental spills** of blood (e.g., nosebleeds), vomit, or other body fluids:
  > Wear disposable gloves
  > Wipe up spill with paper towels. Immediately dispose of this material in plastic-lined container
  > Wash area with soap and water
  > Douse with disinfectant or bleach (1:10 ratio of bleach to water)
  > Dispose of gloves in plastic-lined container
  > Wash hands thoroughly with soap and water

**EXPOSURE CONTROL**
The following job classifications at the Cleveland Hearing and Speech Center are at moderate risk for occupational exposure to blood or other potentially infectious materials (OPIM): Speech/Language Pathologists; Audiologists; Interpreters; and **Graduate Students** working with CHSC clients under CHSC staff supervision.

**Clinical tasks and procedures associated with occupational exposure which may occur during speech/language pathology practicum assignments:**

1. Oral Mechanism Screenings
2. Intervention that has potential for splattering (i.e., patients with tracheostomy or tracheostoma).
3. Servicing or routine cleansing of specialized medical equipment.
4. Performing dysphagia assessment and therapy.
5. Cleaning a blood of OPIM spill.
6. Coming into contact with blood or OPIM.
7. Assisting with toileting.
8. Disposing of medical waste including but not limited to blood or OPIM either in liquid, semi-liquid, or solid form.
Clonal tasks and procedures associated with occupational exposure which may occur during practicum assignments under the supervision of audiologists include the following:

1. Cleaning a blood or OPIM spill.
2. Coming into contact with blood or OPIM.
3. Disposing of medical waste including but not limited to blood or OPIM either in liquid, semi-liquid, or solid form.

HEPATITIS B VACCINE INFORMATION

Hepatitis B Infection
Hepatitis B is a major health problem in the United States. It is caused by a virus, the hepatitis B virus, and primarily affects the liver.

Acute symptomatic infection can incapacitate a person for weeks or months and can, sometimes, lead to complications or chronic disease conditions. Fortunately, most people recover fully. Fifty to sixty percent of all hepatitis B infections, however, produce no symptoms in the infected person. These cases are more likely than the symptomatic ones to progress to complications.

Some of the major chronic problems of hepatitis B infection are a chronic carrier state which develops in approximately 10% of the cases, and chronic persistent and chronic active hepatitis. Sometimes cirrhosis of the liver develops in a carrier. Also, the incidence of primary liver cancer is higher among chronic carriers than in noncarriers.

Many cases of hepatitis B can now be prevented by vaccine.

Hepatitis Risks to Students
When a person has hepatitis B, the virus is found in their blood and many other body fluids. Because of the nature of client contact and the types of clients served, some students are at a higher risk for contracting hepatitis B than others. Many studies have been done to accurately attempt to identify just which people are at highest risk. These areas include departments where there is frequent contact with the blood of clients. Frequent blood contact has been shown to be the most important factor related to risk, especially contact with the blood of clients who are at high risk for developing hepatitis B.

Hepatitis B Vaccine
A vaccine for the prevention of hepatitis B first became available in 1982. A newer vaccine became available in 1987. This new vaccine is produced in yeast cells and does not involve the blood of hepatitis carriers. The vaccine is very effective, producing protective antibodies in 91% to 98% of healthy adults vaccinated. The duration of immunity is unknown at this time. The vaccine is administered intramuscularly in the deltoid muscle of the arm. The three does necessary for complete immunization are given over a six-month period of time. Soreness at the injection site is the most common adverse reaction. Less common are fatigue/weakness and headache. Fever and infection are also uncommon reactions. No serious adverse reactions have occurred in recipients of the new vaccine. As with any vaccine, there is the possibility that broad use of the vaccine could reveal adverse reactions not observed in clinical trials.

Contraindications for use of the vaccine are any serious active infection or a hypersensitivity (allergy) to yeast.
Hepatitis B vaccine will not prevent hepatitis caused by other agents, including the hepatitis A virus, the agent(s) which cause non-A, non-B hepatitis, or other viruses known to infect the liver.

Students may want to consider having a hepatitis B vaccine series. Individuals should discuss this with their family physician. Some externship sites may require the Hepatitis B series. Please check with your hospital or skilled nursing facility extern supervisor for specific requirements.
1. **COORDINATOR OF CLINICAL EDUCATION**
The Coordinator of Clinical Education oversees all aspects of clinical education and is responsible for clinical assignments and records of all Speech-Language Pathology Students.

2. **DEPARTMENT OF COMMUNICATION SCIENCES FACULTY:**
Faculty, through coursework, assist students in developing a theoretical basis in communication sciences and disorders. They act as resources for both students and clinical instructors. As evidence of the close professional relationship between the Department of Communication Sciences and the Cleveland Hearing and Speech Center, all faculty hold appointments as consultants to the Cleveland Hearing and Speech Center staff and clinicians. The appointments enable faculty to take an active role in each student's clinical education.

3. **CLEVELAND HEARING AND SPEECH CENTER DIRECTOR OF CLINICAL SERVICES:**
The Director of Clinical Services helps develop clinicians’ schedules and serves as the supervisor for all CHSC clinicians. She holds a clinical appointment in the Department of Communication Sciences.

4. **CLINICAL SUPERVISORS:**
Clinical Instructors have broad academic and clinical bases in the area of communication disorders, as well as special areas of expertise and interest, which qualify them to educate students. Clinical education, like all teaching/learning paradigms, requires the involvement of both the instructor and the student. The clinical instruction process is characterized by exchanges between the instructor and student and is highly interactive in nature.

The skills listed here could be extended almost indefinitely since the role of Clinical Supervisor is a complex one. However, the general skill requirements for Clinical Supervisors include the ability to:

a. Assist the student in development of appropriate assessment, management, and treatment programs.

b. Serve as a resource person for the student requiring specialized knowledge related to a communication disorder.

c. Utilize a variety of instructional/supervision methods (audio- and/or video recordings, group and/or individual conference staffings, self evaluation, peer evaluation) to assist the student in developing and refining clinical skills through a supportive learning environment.

d. Observe, record, analyze and evaluate the student's clinical skills and share this information in a direct manner with the student, CHSC Department Directors, the Coordinator of Clinical Education, and the Faculty.

There are two categories of Clinical Instructor appointments within the Department of Communication Sciences:

a. **Clinical Instructors:** Cleveland Hearing & Speech Center (CHSC). The major affiliation for clinical education is with Cleveland Hearing & Speech Center. Members of the professional staff of CHSC hold appointments as Clinical Instructors in the Department of Communication Sciences at Case Western Reserve University. They are responsible for direct instruction in the student's clinical education experience. The professional staff of the CHSC may hold appointments as Adjunct Clinical Instructors at Case Western Reserve University.
b. **Adjunct Clinical Instructors**: Instructors at externship locations may hold appointments as Adjunct Clinical Instructors. Their responsibilities are also to provide direct instruction in the student's clinical education experience.
Clinical services at the Cleveland Hearing & Speech Center include:

A. **Speech-Language Pathology**
   1. **In-house Diagnosis and Treatment of:**
      - Speech Production Disorders-- Articulation Disorders, Phonological Disorders, Voice Disorders
      - Foreign Accent Reduction, and Fluency Disorders
      - Developmental Language Disorders
      - Language-Learning Disabilities
      - Aural Rehabilitation Services
      - Augmentative/Alternative Communication (AAC)
      - Neurogenic Language Disorders----Aphasia, Dysarthria, Apraxia
      - Structural/Neurologic Disorders: Craniofacial Anomalies, Laryngectomy, Brain Injury, and Neurologic Disease

   2. **Contracted Services throughout the greater Cleveland area--**
      - Provide diagnostic and treatment services in community settings. Sites include HeadStart programs, Day Care Centers, Private Elementary, and Secondary Schools.

   3. **Audiology**
      - Comprehensive Audiologic Evaluation
      - Otoacoustic Emissions Testing
      - Hearing Aid Services including consultation
      - Hearing Aid Fitting and Repairing
      - Aural Rehabilitation
      - Hearing Conservation Programs
      - Hearing Screening
      - Case Reviews

**CHSC Clinical Forms**
Students participating in practicum assignments with CHSC staff will utilize forms and procedures described in the Policies and Procedures Manual of the Cleveland Hearing & Speech Center. Clinic supervisors will review procedures which are relevant to the caseload being covered by the student’s assignment. Appendix E includes copies of CHSC forms (treatment plan/progress report, diagnostic reports, SOAP note procedures).

**Diagnostic and Therapy Materials**
The COSI Department has a collection of diagnostic and intervention materials (assessment tools stored in Room 401 and toys stored in Room 415B. Materials must be returned within a three-hour period.

Students may also use the diagnostic and therapy materials of the CHSC when working with CHSC clients. Materials must be checked out through a CHSC staff member (who has a key). Check out materials by signing your name and the name of your supervisor as follows:
CHSC PEDIATRIC MATERIALS ROOM PROCEDURES

GRADUATE STUDENTS

Check out:
1. Sign out all materials on the white bulletin board/sign out sheet and date/time checked out.
2. List your name, the name of the clinician who is supervising you, the name of the material, and date/time checked out.

For Check-in:
1. Note date returned on the right side of your name.
2. Cross out your name.
3. Return item(s) to their correct location on shelves.

The therapy materials room is located on the second floor in Room 204. Pediatric and adult diagnostic materials are housed in Room 205.

It is imperative that you sign out materials as described above. The adult materials sign-out sheet is located on the door of the room. **MATERIALS MUST BE RETURNED TO THEIR APPROPRIATE LOCATION BY THE END OF THE DAY.** Remember that the use of these materials is a privilege.

**Materials cannot be checked out overnight unless approved by a CHSC clinician. Overnight materials can be taken after 4:30 and MUST be returned by 8:30 the next morning.**

MATERIALS IN PEDIATRIC MATERIALS ROOM (ROOM 204) and Room 205

Organization of materials:

**Room 204:**
1. All toys/objects are located on the shelves (including script kits, dolls, etc. on the back wall and the right-hand side of the room). Shelves are labeled and items should be returned to their appropriate location.
2. Intervention materials are on the shelves. They are organized by topics (i.e., infant; phonology/arctic; voice; reading; writing). Please return items to their correct location.

**Room 205:**
1. The file cabinet with diagnostic forms has been reinstituted. Forms are filed in alphabetical order. **DO NOT TAKE THE LAST FORM!** Each test has 1 form (for Xeroxing only) in the file. Please do not use the forms in the test box/kit.
2. Diagnostic materials are filed alphabetically on the shelves. Please return to the appropriate location when you have finished with the materials.

Externship Sites
After students have completed approximately 100 clinical hours of service under the supervision of Cleveland Hearing & Speech Center Clinical Instructors they may begin their externship assignments. ASHA requires that during a student’s clinical training they participate in at least three different types of settings (each for a minimum of 50 hours each) The COSI Department draws upon clinical resources in University Circle and the Greater Cleveland Area offering students a diversity of settings to select from.

The following facilities are among those that serve as externship sites for clinical education:

<table>
<thead>
<tr>
<th>Facility (Type of Setting)</th>
<th>Clinical Education</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Achievement Center for Children</strong> (Center-based early intervention)</td>
<td>Diagnosis and remediation of speech and language problems of 0-5 population in a multidisciplinary team setting.</td>
</tr>
<tr>
<td><strong>Cleveland Clinic Center for Autism</strong></td>
<td>Outpatient treatment for children with autism</td>
</tr>
<tr>
<td><strong>Cleveland Veteran's Medical Center</strong> (Acute care; outpatient center)</td>
<td>Diagnosis and remediation of communication disorders with special attention to effects of drugs on communication and knowledge of medical terminology.</td>
</tr>
<tr>
<td><strong>Cuyahoga County Board of Mental Retardation</strong> (Center-based and workshop home-based early intervention; vocational setting for adults)</td>
<td>Diagnosis and remediation of children and adults with mental retardation at schools and sheltered settings and in home-based services for 0-3 years.</td>
</tr>
<tr>
<td><strong>Deepwood Center/CLEO</strong></td>
<td>Assessment and treatment therapy of adults with MR in homes and sheltered workshops.</td>
</tr>
<tr>
<td><strong>Lake County Board of Mental Retardation &amp; Developmental Disability</strong></td>
<td>Range of supported living options, speech-language screenings, evaluations and therapy services. Diagnosis and treatment therapy of adults with varying communication disorders in acute, sub-acute, and skilled nursing settings.</td>
</tr>
<tr>
<td><strong>Grace Hospital</strong> (rehab setting)</td>
<td>Specialty in patient with vents and/or tracheostomies.</td>
</tr>
<tr>
<td><strong>Menorah Park</strong> (skilled nursing facility)</td>
<td>Range of supported living options, speech-language screenings, evaluations and therapy services. Diagnosis and treatment therapy of adults with varying communication disorders in acute, sub-acute, and skilled nursing settings.</td>
</tr>
<tr>
<td><strong>Meridia Euclid Hospital</strong></td>
<td>Diagnosis and treatment therapy of adults with varying communication disorders in acute, sub-acute, and skilled nursing settings.</td>
</tr>
<tr>
<td><strong>MetroHealth Medical Center</strong> hearing (outpatient clinic)</td>
<td>Diagnosis and remediation of speech, language, and disorders and a comprehensive program for extended rehabilitation of brain injured clients.</td>
</tr>
<tr>
<td><strong>Parma Community Hospital</strong> children with (Outpatient &amp; inpatient comm. Hosp)</td>
<td>Inpatient and outpatient services for adults and varying communication disorders.</td>
</tr>
<tr>
<td><strong>Rainbow Babies &amp; Children's Hospital</strong> (outpatient rehab)</td>
<td>Assessment and treatment of infants, toddlers, and preschoolers with varying communication disorders. Feeding and craniofacial team experience.</td>
</tr>
<tr>
<td><strong>St. Vincent Charity</strong></td>
<td>Diagnosis and remediation of speech and language disorders in inpatient and outpatient settings.</td>
</tr>
<tr>
<td><strong>Southwest General Hospital</strong></td>
<td>Diagnosis and remediation of speech, language, and hearing (inpatient &amp; outpatient community hospital) disorders in children and adults in in-patient &amp; outpatient settings.</td>
</tr>
<tr>
<td>University Hospitals of Cleveland (acute care)</td>
<td>Diagnosis and treatment of communication problems in adult neurogenic and ENT patients.</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Western Reserve Speech and Language Partners</td>
<td>Individual and group Treatment for pediatric outpatients with specialty in Autism Spectrum.</td>
</tr>
</tbody>
</table>
APPENDIX A: CLINICAL DOCUMENTATION FORMS

These forms are to be used for your documentation of clinical hours for COSI 452 and observation hours for COSI 352.

INSTRUCTIONS:

- Complete the practicum log after each session to track your hours.
- Complete the Ohio Board of Speech-Language Pathology and Audiology hours sheet each semester and have your supervisor sign the hours that you attained over the course of the semester. ONLY ONE SHEET SHOULD BE USED OVER THE COURSE OF YOUR ACADEMIC/CLINICAL PROGRAM.
- Each semester/supervisor should fill one line only. See example.
- Hours should be calculated to the nearest quarter hour (e.g. 10.25, 10.5, 10.75)
- Ohio Board of Speech-Language Pathology hours sheet should be returned to the Department Assistant after review by the Coordinator of Clinical Education. Students may copy their hours sheet every semester for their records, however the original hours sheet should be kept in the student’s permanent file in the Department Office.
- Summary of Clinical Observations form- This form may be used to document any observation hours completed through CASE. The original form should be kept in the student’s permanent file in the Department Office.
PRACTICUM LOG

STUDENT ______________________  SEMESTER ______________________

NOTE DURATION OF TIME SPENT: .25, .50, .75, 1.0 etc. (hrs)

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<th>SPEECH Diag</th>
<th>Tx</th>
<th>LANG Diag</th>
<th>Tx</th>
<th>AUD/AR</th>
<th>DESCRIPTION/CLIENT</th>
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</table>
# OHIO BOARD OF SPEECH LANGUAGE PATHOLOGY & AUDIOLOGY

## CLINICAL PRACTICUM RECORD—SPEECH-LANGUAGE PATHOLOGY

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<th>DATE</th>
<th>TYPE OF CONTACT—Enter number of hours per age group and area</th>
<th>SPEECH</th>
<th>LANGUAGE</th>
<th>AUDIOLOGY</th>
<th>CLINICAL FACILITY</th>
<th>PRINT OR TYPE FULL NAME OF SUPERVISOR</th>
<th>LICENSE NUMBER OR OTHER VERIFICATION OF QUALIFICATION TO SUPERVISE</th>
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<tbody>
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<td>EVALUATION SCREENING</td>
<td>EVALUATION SCREENING</td>
<td>EVALUATION SCREENING</td>
<td>HABILITATION REHABILITATION</td>
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<td>ADULT</td>
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</tr>
</tbody>
</table>

## ACTIVITY TOTALS

Was the Speech-Language Pathology Program ESB accredited during this practicum?  □ Yes  □ No

Signature for Verification:

__________________________
University Department Chairman or Supervisor

State of ____________ County of ____________

The foregoing instrument was acknowledged before me this _______ day of _______ 19__

by

__________________________
Name of Person Acknowledging

__________________________
Signature of Notary Public

My Commission Expires ________________________
<table>
<thead>
<tr>
<th>DATE</th>
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<th>LANGUAGE</th>
<th>AUDIOLOGY</th>
<th>CLINICAL FACILITY</th>
<th>PRINT OR TYPE OF SUPERVISOR</th>
<th>LICENSE NUMBER OR OTHER VERIFICATION OF QUALIFICATION TO SUPERVISE</th>
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<td>EVALUATION</td>
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<td>EVALUATION</td>
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**EXAMPLE**

---

**Activity Totals**

- Was the Speech-Language Pathology Program ESB accredited during this practicum? [ ] Yes [ ] No

**Signature for Verification:**

---

**Univeristy Department Chairman or Supervisor**

State of: ____________________________ County of: ____________________________

The foregoing instrument was acknowledged before me this ___________ day of ___________ 19

by ____________________________

Name of Person Acknowledging

---

Signature of Notary Public

My Commission Expires ____________________________

SPA0105 Notary Seal
### SUMMARY OF CLINICAL OBSERVATIONS
UNDERGRADUATE PRACTICUM

<table>
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<tr>
<th>DATE</th>
<th>TIME SPENT (.25, .50, .75, 1.0 hours)</th>
<th>CLINICIAN SIGNATURE AND LICENSE NUMBER</th>
<th>CLIENT AGE LEVEL</th>
<th>DISORDER TYPE</th>
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</tbody>
</table>

TOTAL NUMBER OF HOURS OBSERVED THIS PAGE: ___________ HOURS
TOTAL NUMBER OF HOURS OBSERVED: ____________ (COMPLETE ON LAST PAGE ONLY)
APPENDIX B: COSI 452 CLINICAL PRACTICUM ASSIGNMENTS

INSTRUCTIONS FOR INITIAL CASE MANAGEMENT: CHSC ASSIGNMENTS

This form is designed to help students plan for their first supervisory conference, and the first session of therapy and should be completed by the student prior to the first supervisory conference.

Instructions

1. Check out your client’s case file from the front desk in the lobby. Read this file thoroughly and return it to the Records Room mailbox within 24 hours. You may complete case summaries in the graduate carrel room. Under no circumstance is a case file to leave the Cleveland Hearing & Speech Center. Violation of this rule will result in an automatic grade reduction of one letter grade for the semester.

2. Complete the Summary of Case Management side of the form from information that may be obtained through thorough review of past therapy reports, diagnostic reports, reports from other professionals, and case history information. Summarize the data that you collect. Think about the factors (e.g. cognitive, audiological, environmental etc.) that are contributing to the client’s current communication status. Record these factors on your form in the appropriate spaces. Record the client’s current communication skills on the form in the appropriate categories. This information should include, but is not limited to, testing information (i.e. standard scores and percentiles) from the previous semester report. Statements regarding the severity of the client’s disorder should also be noted (i.e. mild, moderate, severe, profound).

3. Prior to completing the reverse side of the form entitled “Assessment Plan”, think about what you now know and what you do not yet know about this client. What additional questions/measures are needed in order to have a more complete knowledge about the client? How do you plan to get this information? (e.g. standardized testing, stimulability testing, etc.) List these items/ideas/instruments on your Assessment Plan side of the form, in the appropriate categories. What are possible goals for intervention?

4. Be prepared to discuss this information in an organized manner during your first conference with your supervisor.

5. Following formulation of client goals, a treatment hierarchy should be written for each goal. This hierarchy should be used to help guide your lesson planning. Examples of hierarchies may be found in the Goldberg text (on reserve in the graduate carrel room).

6. Clinicians/supervisors should familiarize themselves with evidence based practices and apply them to clinical practice consistent with ASHA guidelines. See ASHA Preferred Practice Guidelines and Knowledge and Skills documents and Evidence Based Practice Guidelines available on ASHA website (www.asha.org).

6. Learning Outcomes for all CHSC assignments are located in Appendix D, and may be used to provide a framework for addressing clinical skills during the semester.

7. Clinical forms are located in Appendix E.

8. Suggestions for Language Sample Collection and Behavior Management are also included in this section.
SEMESTER OUTLINE OF REQUIREMENTS FOR CHSC SPEECH-LANGUAGE PATHOLOGY PRACTICUM PLACEMENTS

This form may be used by supervisor/supervisee to ensure activities are completed for each CHSC placement.

Please place a check before each item when completed:

_____ 1. Summary of Case Management (Initial Meeting).
    _____ Clinical contracts should be signed at this time.

_____ 2. Baseline Data Collection (By 2nd therapy session).

_____ 3. Treatment Plan (signed following 4th therapy session).

_____ 4. Treatment Hierarchy (by 5th therapy session).

_____ 5. Midterm Grade (on or about 8th week of semester; on or about 4th-5th week of summer session).

_____ 6. Progress component of treatment plan according to client schedule.

_____ 7. Research article summary.

_____ 8. Final grade (last week of semester or finals week).
    _____ Supervisor evaluations completed at this time.

Copies of the following forms should be turned into the Coordinator of Clinical Education:

- Clinical Contract
- Mid-term Grading Form
- Final Grading Form
- Supervisor Evaluation Form
<table>
<thead>
<tr>
<th><strong>SUMMARY OF CASE MANAGEMENT</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLIENT</strong> ________________</td>
</tr>
<tr>
<td><strong>CLINICIAN</strong> ______________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Audiological/ENT/Neurological/Other Evaluations</strong></th>
<th><strong>Cognitive/Academic Considerations</strong></th>
<th><strong>Family/Parent Support System</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Include latest date of testing; any medical follow-up; Diagnoses: results; recommendations</td>
<td>Cognitive status: Indicate any presence of learning disability; emotional disturbance; developmental delay; grade in school; school classroom placement; therapy received at school</td>
<td>Indicate client’s family situation (e.g. foster care, group home, intact); family stressors; involvement of social services; incidence of communication disorder in family</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Voice/Fluency</strong></th>
<th><strong>Oral Mechanism</strong></th>
<th><strong>Articulation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Typical quality of voice; any vocal fold pathology; presence of dysfluencies: type of frequency and severity</td>
<td>Include assessment of structures and functions. Any oral/motor problems, apraxia or surgeries.</td>
<td>Include testing from last report; indicate sounds in error and severity. Include past treatment methods found to be effective in therapy.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Semantics</strong></th>
<th><strong>Syntax</strong></th>
<th><strong>Phonology</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Include test results from past report; knowledge and use of words and word relationships (vocabulary)</td>
<td>Include test results. Language sample analyses; MLU; use of simple or complex sentences; use of standard vs non-standard forms, etc.</td>
<td>Include tests and analyses from past report; list developmental and non-developmental processes displayed; statement of awareness</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Pragmatics</strong></th>
<th><strong>Comments/Special Needs</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Include analyses of conversational Skills; verbal and non-verbal interactions</td>
<td>May include clinical impressions; progress; parent-child interaction; physical limitations; recommendations from previous semester; goals not attained previous semester.</td>
</tr>
<tr>
<td><strong>ASSESSMENT</strong></td>
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<tr>
<td><strong>Audiological Evaluation</strong>&lt;br&gt;Other Referral&lt;br&gt;Including reason for referral</td>
<td><strong>Cognitive/Academic Referral/Consultation</strong>&lt;br&gt;Does this client need to be seen for psych./educational assessment? If so, note here. Also indicate need for consultation with school SLP.</td>
</tr>
<tr>
<td><strong>Social Service Referral</strong>&lt;br&gt;Does this client need to be seen by social worker or other social service agency? Do you need to consult with SW?</td>
<td></td>
</tr>
<tr>
<td><strong>Voice/Fluency Measures</strong>&lt;br&gt;Diagnostic measures of voice/fluency. Visipitch, commercially available instruments, speech sample, etc.</td>
<td><strong>Oral Mechanism</strong>&lt;br&gt;Describe procedures for oral mech. exam if needed. Need for Dental/Orthodontic/Otolaryngologic consult.</td>
</tr>
<tr>
<td><strong>Articulation</strong>&lt;br&gt;Tests to be given; other measures of articulation and intelligibility.</td>
<td><strong>Stimulability</strong>&lt;br&gt;List phonemes to be tested and reason.</td>
</tr>
<tr>
<td><strong>Semantics</strong>&lt;br&gt;Receptive&lt;br&gt;List tests to be given; contexts to investigate.</td>
<td><strong>Syntax</strong>&lt;br&gt;Receptive&lt;br&gt;List tests to be given and probes to be utilized.</td>
</tr>
<tr>
<td><strong>Expressive</strong>&lt;br&gt;List tests to be given; contexts to investigate.</td>
<td><strong>Expressive</strong>&lt;br&gt;Lists tests to be given; procedures for obtaining and scoring language sample.</td>
</tr>
<tr>
<td><strong>Phonology</strong>&lt;br&gt;List tests/analyses to be given.</td>
<td><strong>Stimulability</strong>&lt;br&gt;Phonemes to assess; phonetic contexts.</td>
</tr>
<tr>
<td><strong>Pragmatics</strong>&lt;br&gt;Conversational analysis; tests; procedures, surveys to be used.</td>
<td><strong>Interview</strong>&lt;br&gt;What questions will you ask client/family?</td>
</tr>
<tr>
<td><strong>Tentative Goals</strong>&lt;br&gt;List possible goals for intervention.</td>
<td></td>
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</table>
## SUMMARY OF CASE MANAGEMENT

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<tr>
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<th>Semester</th>
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<thead>
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<th>Clinician</th>
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### Audiological/ENT/Neurological/Other Evaluations

### Cognitive/Academic Considerations

### Family/Parent Support System

<table>
<thead>
<tr>
<th>Voice/Fluency</th>
<th>Oral Mechanism</th>
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<th>Comments/Special Needs</th>
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<th>Audiological Evaluation</th>
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<tr>
<td>Pragmatics</td>
<td>Interview</td>
<td>Tentative Goals</td>
</tr>
</tbody>
</table>

Adapted from Purdue University
**GRADUATE CLINICAL PRACTICUM SUMMARY**

**Complete and turn into Coordinator of Clinical Education to request your clinical placement**

Name: _______________________________  Phone: _______________________

Year:  Junior  Senior  Graduate: 1st year  2nd year  3rd year

Expected Date of Graduation: _______________

**COURSE WORK COMPLETED** (Note whether UG (undergraduate) or G (graduate level)

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<td>_____ Language Development</td>
<td></td>
</tr>
<tr>
<td>_____ Speech &amp; Hearing Science</td>
<td></td>
</tr>
<tr>
<td>_____ Anatomy &amp; Physiology</td>
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<tr>
<td>_____ Practicum in Communication Disorders</td>
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<td>(Clinical Procedures)</td>
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<td>_____ Communication &amp; Aging</td>
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<td>_____ Introduction to Audiology</td>
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<tr>
<td>_____ Speech Language Therapy in Schools</td>
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<tr>
<td>_____ Articulation and Phonology</td>
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</table>

<table>
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<tr>
<td>Medical Aspects I (Voice Disorders)</td>
<td>Fluency</td>
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<td>Diagnosis of Speech/Lang Disorders</td>
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<td>Methods of Research</td>
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<td>Medical Aspects II (Neuromotor and Craniofacial Anomalies)</td>
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<tr>
<td>Acquired Adult Language &amp; Cognitive Disorders</td>
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| Other: (Please List)                             |       |

**CLINICAL EXPERIENCE** (Approximate hours experience)

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<th>Required Minimum</th>
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<td>Audiological Testing*</td>
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<td>Aural Rehabilitation*</td>
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*Must have total of 20 hours in audiology or aural rehab combined

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<thead>
<tr>
<th>Experience</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Language Disorders Therapy</td>
<td>20</td>
</tr>
<tr>
<td>Adult Language Disorders Therapy</td>
<td>20</td>
</tr>
<tr>
<td>Child Speech Disorders Therapy</td>
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<td>Adult Speech Disorders Therapy</td>
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<tr>
<td>Evaluation in Child Language Disorders</td>
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<td>Evaluation in Adult Language Disorders</td>
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<tr>
<td>Evaluation in Child Speech Disorders</td>
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<tr>
<td>Evaluation in Adult Speech Disorders</td>
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</table>

Must have total of 375 clock hours in speech/language pathology (325 hours at Graduate level) with minimum levels in each disorder area as follows

**CURRENT & PAST SUPERVISORS/SITES (CHSC, Externship)/TYPE THERAPY (Group, etc.)**

**PLACEMENT PREFERENCES**

A. I would like ________ hours of clinic this semester.

B. Preferred placement -- note client types and/or settings. (Level II and III students only)

C. Priority needs (3rd and 4th semester students only)
**SCHEDULE:**

Please note courses/work schedule, etc. for when you are already booked.

<table>
<thead>
<tr>
<th>Time</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
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</table>
To be completed by each student twice during each semester of COSI 452: Graduate Practicum. Details are located on the course syllabus. Attached is an example.

Case Western Reserve University
Graduate Student Practicum
EVALUATION OF VIDEOTAPED/AUDIOTAPED SESSION

Student Clinician ___________________________ Date

Client ___________________________ Diagnosis

Age of Client ___________________________ Length of Session

Supervisor ___________________________ 1st 2nd year student (circle one)

Directions: Summarize the events taking place in your session in the space below. Next, briefly comment on each skill/behavior listed. Finally, list at least three suggestions that you believe will help you to make your next session more effective.

1. Timing of session
2. Non-verbal behavior of clinician
3. Amount of social speech
4. Introduced session goals
5. Clarity of instructions
6. Discrimination/feedback
7. Appropriate reinforcement
8. Concluded/reviewed session performance
9. Appropriate & professional interpersonal skills
10. Were session goals accomplished?

Think about three areas to improve upon for your next session. How will you affect the changes that need to be made? Write your suggestion here.
EXAMPLE EVALUATION OF VIDEOTAPED/AUDIOTAPE SESSION #1

Case Western Reserve University
Graduate Student Practicum
Evaluation of videotaped/audiotaped session

Student Clinician: __________ Date: 11-9-98

Client: "Mr. K" Diagnosis: (C) CVA / (D) MCA hemorrhages
Sex: Initially presented: (M) Sided weakness
Age of Client: 80 y.o. Length of Session: 75 minutes
Supervisor: __________ 1st (2nd year student) (circle one)

Directions: Summarize the events taking place in your session in the space below. Next, briefiy comment on each skill/behavior listed. Finally, list at least three suggestions that you believe will help you to make your next session more effective.

Mr. K. is receiving therapy for aphasia on the Subacute Rehabilitation Unit at Mt. Sinai Medical Center. Today's session targets both expressive and receptive goals which include:

1. Timing of session: SEE ATTACHED INFORMATION
2. Non-verbal behavior of clinician: ______________________
3. Amount of social speech: ______________________
4. Introduced session goals: ______________________
5. Clarity of instructions: ______________________
6. Discrimination/feedback: ______________________
7. Appropriate reinforcement: ______________________
8. Concluded/reviewed session performance: ______________________
9. Appropriate & professional interpersonal skills: ______________________
10. Were session goals accomplished?: ______________________

Think about three areas to improve upon for your next session. How will you affect the changes that need to be made? Write your suggestions here:
EXAMPLE EVALUATION OF VIDEOTAPED/AUDIOTAPED SESSION #2

1. Timing of Session:
   Mr. K was seen for a 45 minute session in the patient lounge of the Subacute Rehabilitation Unit.

2. Non-verbal behavior of clinician:
   Mr. K has been a client of the department of communicative disorders for several weeks. In this time period, I had an excellent chance to build a strong rapport with Mr. K. The session was conducted in a relaxed environment with both myself and the client sitting next to a table. Mr. K responded very well to head nods and facial expressions which were used as a means of cueing the client about the appropriateness of his answers.

3. Amount of social speech:
   Mr. K liked to talk about stimulus items (when appropriate), often adding bits and pieces of information about their relation to his own life at home when he could. I encouraged this spontaneous verbal expression as well as the social speech Mr. K made great strides in during his hospitalization. He went from his most frequent response of, “oh okay okay” to asking how I was doing in this session. He mentions several times how he will bet better little by little. On this date he told me that if he could just get back to 85-90% functioning he’d be happy. I used Mr. K’s social speech this date to expand of his expressive capabilities.

4. Introduced session goals:
   At the beginning of this session, as with all others, I provided a brief review of what we had been working on in the previous session and what other areas I might like to begin probing today. Goals for the session this date included naming common objects, naming functions of common objects, sentence completion, and matching words to their corresponding picture from a choice of two. Further probing was done by having Mr. K identify which word did not “fit” into a list of category related words. Mr. K did very well with this task and “homework” assignments regarding his reading ability were assigned. Mr. K is very motivated to complete these assignments and brings them to the next day’s session to review his work and assist in monitoring his progress.

5. Clarity of instructions:
   I presented Mr. K with instructions for the exact task I wanted him to complete at the beginning of each one. So when we begin naming objects, I talked about taking out “the box” again (Lark box), and explained I would be pulling out items one by one. As I showed him each one, I wanted him to tell me what it was. I ask Mr. K is he understands, and he responds yes and we begin. While the task isn’t always easy, he knows what he needs to do.

6. Discrimination/feedback:
   Mr. K is at a level this date where he does a lot of self-correction of his errors. Often, if he does mislabel an object, he recognizes quickly that he has done this and says “no no wait”. I give him feedback letting him know that he has indeed mislabeled but I also encourage him to realize that sometimes the error was semantically related (i.e. calling a glass a cup or a spoon a fork). If Mr. K is having difficulty, I ask him to recall the cueing strategies we work on. This date, Mr. K is making progress with using them. If the task is to identify a spoon, I prompt him to use the technique or re calling what you do with it and then rehearsing the phrase in his head to facilitate recall (i.e. you stir coffee with a …).

7. Appropriate reinforcement:
   I reinforce any part of a response that approximates the correct answer. If Mr. K is on track, I reinforce it. I remind him of the strategies that will hopefully cue the desired response. Mr. K and I talk about the difficulty of verbal expression since the stroke, but we also talk about the progress he has made since he was first admitted. This provided him with encouragement and sessions become more of challenge. One thing that we have begun doing recently and continue to do in this session is s a comparison to previous sessions’ performance. Mr. K likes the reinforcing feedback of knowing that last week, for example he was at 65% accuracy in naming and this week it’s more like 70-75%.

8. Concluded/reviewed session performance:
   Again, the comparisons to previous sessions provide Mr. K with valuable information on his performance. I let him know how he did today and point out very notable areas of improvement. For example, today Mr. k was able to spontaneously name two objects he had previously needed moderate assistance in naming. The fact that he was able to identify them independently today was a great sign of progress, so I point it out and encourage it. I also gave Mr. K some idea of what we’d work on in the next session and where I’m trying to get him to on his goals. We reviewed how important these abilities will be, especially when Mr. K goes home.
9. **Appropriate and professional interpersonal skills:**
   Working with Mr. K, in today's session, as well as on a day to day basis has given me a wonderful opportunity to strengthen my ability to relate and convey information to my client. Mr. K’s wife is present almost every session, and together we talk about challenges Mr. K will face as he returns to the home environment. While I work with Mr. K, I provide as much modeling as possible for Mrs. K so that she learns how to be an effective facilitator of communication and will be able to keep frustration for Mr. K at home to a minimum. I often encourage Mrs. K to participate in the session. On this date, Mrs. K has done a terrific job of using personally relevant information about how Mr. K uses an item at home to facilitate him being able to name it.

10. **Were session goals accomplished?**
    Mr. K made progress on all goals today. He was able to spontaneously name some items that had previously required moderate cueing. Mr. K demonstrated greater use of self-cuing and self-correction this date. Continued progress in all of these areas will facilitate improved communication in the home environment and work on more challenging functional goals in terms of reading etc.

**Think about three areas to improve upon for your next session. How will you affect the changes that need to be made?**

1. Although I provided appropriate cueing today, there are some areas in which I would like to improve. I provide Mr. K with a lot of time to respond, which is good, however, often I let him go too long without introducing some kind of cueing for assistance. Timing is an issue I would like to improve. I need to realize that while I want him to succeed independently, at this time, I need to keep expectations to a level at which Mr. K can perform. If he will be more successful with some level of cueing, I need to provide it and reinforce it until I can more gradually begin to fade the cues.

2. Another related area is in terms of the general timing of my session. At times, I tend to really get into working with my client and thus do not end the session on time. This leads to decreased time to write session notes and has at times interfered with beginning my next session on time. I ran a little over today, but nothing too significant.

3. Another thing I’d like to improve upon is in type of discrimination/feedback. I’d like to brainstorm new ways in which I can provide Mr. K with cueing etc. I tend to use the same strategies again and again. While some degree of consistency may be good, I might be able to find cueing techniques that work better for Mr. K and assist in learning their use.
GUIDELINES FOR CASE PRESENTATION
COSI 452

Requirements
All graduate students are required to complete a formal case presentation through the Graduate Practicum course one time during their graduate program. The Case Presentation should be 20-30 minutes in length. It will include a written outline for the audience and a clearly presented oral summary of the case supported by a video- or audio-taped sample of the client (when possible). Students should be able to answer questions from the audience (including faculty members, CHSC staff, and other class members enrolled in COSI 452) and provide well-thought out rationale for their clinical decision-making.

Objectives
1. To provide students a formalized opportunity to demonstrate their ability to integrate academic knowledge with clinical problem solving
2. To provide students with an opportunity to demonstrate their clinical problem solving skills and to develop skills to verbally describe and support clinical decision-making
3. To provide students a forum for increasing their verbal interaction skills (both as a presenter and as member of the audience)
4. To provide students with an opportunity to refine their case presentation skills

Suggested Organization/Components of Presentation
I. Intervention Case
   A. Summary of relevant history
   B. Description of communication skills (prior to intervention)
   C. Diagnosis and prognosis for improvement
   D. Description of intervention program (techniques, strategies, protocols) -- with rationale, description of theoretical approach, schedule of therapy, and format of therapy
   E. Presentation of results (baseline data, intervention data, end of program measures)
   F. Summary and conclusions

II. Diagnostic Case Presentation
   A. Summary of relevant history and background information
   B. Presentation of hypotheses concerning the client
   C. Diagnostic plan that was prepared
   D. Summary of procedures used and results
   E. Interpretation of results--description of areas of strength, weaknesses, areas not measured completely, diagnosis, and prognosis
   F. Recommendation with detailed plan of how intervention should be approached including identification of specific goals, therapy schedule, strategies and techniques to be used
   G. Case Disposition--description of status of client after the diagnostic (i.e., enrolled in therapy, case closed, transferred to another agency)

For each presentation, the student should complete a relevant article summary. See following pages.

Schedule of Presentation
Students should plan to complete their case presentation during the 3rd or 4th semester of their graduate program. Before the first day of class in the semester they wish to present, they should inform the instructor of Graduate Clinical Practicum of their intent to present. The instructor will determine the specific date of the presentation and will incorporate it into the syllabus plans for that semester. Students are responsible for informing the faculty and CHSC staff of the day/time of their presentation at least 2 weeks before the scheduled date so that interested staff can make plans to attend the presentation.
Evaluating Research

Beliefs are tentative, not dogmatic; they are based on evidence, not on authority. - Bertrand Russell (1945) History of Western Philosophy

Consumers of Research

- Critical Readers
  - "Simply understanding journal reports of research is not sufficient, we must be able to evaluate them critically" (Minifie, Mison, and Williams, 1973)
  - Critical "involving skillful judgement as to truth, merit, etc... as in critical analysis (American College Dictionary, 1963)

Consumers of Research

- "Clinicians need to have enough familiarity with research to judge whether the claims are reasonable and to determine just how closely the proposed clinical procedures adhere to the research methods and the underlying theory. Informed clinicians need not be sophisticated researchers, but they should have had first-hand experience with research during their graduate education to help them understand the possibilities of research and the decisions that face researchers at so many turns in their conduct." (Seigel, 1993)

Consumers of Research

- Information provided in textbooks?
- Information from workshops (continuing education)?
- Information provided from web pages?
- Information provided from research articles?
Consumers of Research

• Steps in Research
  – Statement of a problem(s) to be investigated
  – Delineation of a method to solve the problem
  – Presentation of the results of the investigation
  – Drawing conclusions from the results about the problem

• Statement of a problem
  – Clear statement
  – Rationale
    • Why is it important; why is it being done?
    • Establishing a rationale
      – Literature review
      – Showing a need for this research

• Method of Investigation
  – Strategy of investigation
  – How was the study carried out to answer the problem?
  – Parts
    • Subjects (participants)
    • Materials (instrumentation, training, tests)
    • Procedures

• Results of Investigation
  – Summary of data
    • Presented in a meaningful way
    • Presented in Tables and Figures
    • Statistics
      – Descriptive
      – Inferential

• Conclusions
  – Draws conclusions from results that reflect on the original statement of the problem.
  – Discussion in relation to:
    • Previous research
    • Theoretical constructs
    • Practical Implications
    • Future Research
### ARTICLE SUMMARY FORM

**Research Questions/Purpose**

Authors generally state these quite clearly and you can copy these verbatim from the article. Knowing the questions and purpose will help you organize and evaluate the results.

**Subjects**

List the important information about participants-group, number of participants, criteria for participant selection, ages, gender, and so on.

**Results**

Summarize the results. It is important to include data as well as whether the results were statistically significant. Dat-group means, standard deviations, etc.

Here and throughout you will want to use bulleted points. You want to make this document easy to read and refer to later on, hence prose are not most beneficial.

**Discussion/Implications**

From the article, what do the authors reveal as to the summary of their major findings and the implication of these findings. How do these findings relate to other literature? You might want to make bulleted points that are easy to refer back to.

**Procedures**

Describe the procedures for the study...how was the date collected? How were the variables derived?

You do not need to summarize reliability.

**Questions/Critique**

What questions do you have after reviewing this study? This is for your critique of the study and presentation of the study, not for the limitations raised by the authors.
<table>
<thead>
<tr>
<th>Research Questions/Purpose</th>
<th>Results</th>
<th>Discussion/Implications</th>
</tr>
</thead>
</table>

**Subjects**

**Procedures**

**Questions/Critique**
CASE PRESENTATION FEEDBACK FORM

Student: ________________________________  Date: ________________

Case Description:  Adult  Child  Therapy  Diagnostic

Diagnosis: _________________________________________________

Key:   + = Excellent    OK=Adequate     NI = Needs to be Improved

NOTE: Provide Feedback in areas relevant to the student’s presentation. All slots do not need to be filled-in.

____ 1.  Presents information in an organized manner
____ 2. Appropriate nonverbal behaviors utilized (loudness, rate, eye contact)
____ 3. Case presentation is complete and thorough:
   ___ Case History   ___ Diagnostic measures   ___ Description of tx strategies
   ___ Prognosis    ___ Severity Level(s)     ___ Summary of progress
   ___ Contributing factors   ___ Plan of Treatment
   Other_____________________________________________________

____ 4. Includes analysis of variables affecting client behavior
____ 5. Clearly summarizes info from at least one article
____ 6. Cites research appropriately
____ 7. Describes how the research article relates to the case
____ 8. Demonstrates ability to critically evaluate research related to case
____ 9. Able to respond to question-answer sequences
____ 10. Able to reflect on current clinical strengths/areas to improve

COMMENTS:

Adapted from CPR-#2 Feedback Form
CSD Clinic Committee  University of Pittsburgh
Clinical Remediation Plan

Case Western Reserve University - Department of Communication Sciences

Areas Requiring Attention

Student: ________________________________  Course: ________________________________
Academic Advisor: ______________________  Instructor/ Supervisor: ______________________
Semester: ________________________________

Area(s) Needing Attention:

Recommendations: ___________________________  Date: ______________________

Student Signature: _________________________  Advisor: _________________________  I/S: _________________________
Outcome: _________________________

Achieved: (Yes/No)  Date: _________________________

Comments: _________________________

Signatures: _________________________  Date: _________________________
Student:
Advisor:
Instructor/ Supervisor:

Adapted from University of Memphis Department of Audiology and Speech Language Pathology.
SUPERVISION

INTRODUCTION:

At the beginning of each placement, it is your responsibility to give your supervisor a Supervisor Packet. This includes:

- Thank You letter from the Coordinator of Clinical Education
- Academic Calendar
- Clinical Evaluation Forms
- Clinical Evaluation Scoring Systems
- Supervisory Needs Rating Scale
- Supervisory Expectations Rating Scale
- Session feedback form
- Clinical Contract

The following is an EXAMPLE of a packet. Copy/download the appropriate forms for each supervisor.
Dear

Thank you for agreeing to supervise a graduate student clinician from our Department. Below is information concerning the student assigned to you:

<table>
<thead>
<tr>
<th>Student:</th>
<th>Phone:</th>
<th>Email:</th>
</tr>
</thead>
</table>

Approximate number of clinical hours already completed:

Prior externship site experiences:

The assignment should extend from the week of __________ through __________.

Students are expected to complete at least two days per week with a schedule that meets your needs. Please contact me if there are any difficulties with this. I can be reached via e-mail (kmm20@case.edu) or at (216) 231-8787 x 279. Please do not hesitate to contact me with any questions or concerns.

Attached, please find paperwork requirements for the semester. There is also a calendar that defines deadlines and holidays. After the student has completed two weeks of their assignment with you, please complete the clinical contract form and return a copy to me. This form allows you to define your expectations during the training period. A clinical evaluation form for the mid-semester review is also enclosed. Your student will bring another copy of the form for the end of semester grading. Please complete this form using the numeric clinical evaluation scoring system attached—you are not required to provide a letter grade. We have also enclosed a Student and Supervisor Information form. These forms may be completed at your first meeting as a means to share information.

In addition, to ensure compliance with ASHA regulations, a Clinical Supervisor Form is enclosed. Please take a moment to complete this form including your current ASHA certification and Ohio Licensure information. Please fax your completed form to our Department Assistant, Bridget Chapman, at (216) 368-6078 by the second week of the semester.

Thank you for participating in our student-training program. The success of our graduate program is highly dependent on the excellent clinical training that students receive at externship sites by the site supervisors. In addition, if our faculty can be of assistance to you or your department, please let us know.

Sincerely,

Kay McNeal, M.S., CCC-SLP
Coordinator of Clinical Education
CLINICAL EVALUATION FORM  -- Level I (0-100 hours)

<table>
<thead>
<tr>
<th>Student Clinician</th>
<th>Clinical Supervisor</th>
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<tr>
<td>Date</td>
<td>Clinical Site</td>
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</table>

1 = Poor  2 = Needs to Improve  3 = Adequate  4 = Good  5 = Very Good  NA = Does Not Apply

### I. INTERPERSONAL SKILLS

**A. With Client**

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<tr>
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<tbody>
<tr>
<td></td>
<td>1. Relates comfortably to client</td>
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<td>2. Attends to client’s total behavior with emphasis on interaction with client</td>
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<td>3. Keeps personal concerns and problems from interfering with therapy</td>
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<td>4. Maintains a confident image while working with client</td>
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<td>5. Demonstrates sensitivity to cultural/linguistic differences</td>
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**B. With Others (professionals and family members)**

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<tbody>
<tr>
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<td>1. Clearly explains therapy goals and progress</td>
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<td>2. Responds appropriately to feedback</td>
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<td>3. Uses language appropriate to the listener (i.e. professional vs family members)</td>
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<td>4. Demonstrates sensitivity to cultural/linguistic differences</td>
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### II. TECHNICAL SKILLS

**A. Therapy Planning**

1. Short term

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<tr>
<td></td>
<td>a. Formulates behavioral objectives on a session-to-session basis</td>
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<td>b. Uses materials that are motivating and appropriate for the client</td>
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<td></td>
<td>c. Has rationale for selected procedures consistent with evidence based practices</td>
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<td></td>
<td>d. Structures plan to obtain maximum number of responses</td>
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<td>e. Modifies program when change is indicated</td>
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<td>f. Organizes therapy setting (room &amp; materials) to enhance therapy effectiveness</td>
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2. Long Term:

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<tr>
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<tr>
<td></td>
<td>Formulates reasonable long term objectives</td>
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**B. Therapy Execution**

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<th>COMMENTS</th>
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<tr>
<td></td>
<td>1. Uses appropriate language for client’s abilities</td>
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<td>2. Obtains appropriate number of client responses per session</td>
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<td>3. Gives client sufficient time to respond</td>
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<td>4. Discriminates errors from target behavior</td>
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<td>5. Uses appropriate correction techniques</td>
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<td>6. Gives meaningful and motivating feedback</td>
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<td>7. Accurately records responses</td>
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<td>8. Appropriate ratio of clinician-client talk time</td>
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<td>9. Demonstrates flexibility when following lesson plan</td>
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<td>10. Able to make smooth transitions between activities</td>
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<td>11. Modifies activities when appropriate and provides a rationale for modifications</td>
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</tbody>
</table>
1 = Poor  2 = Needs to Improve  3 = Adequate  4 = Good  5 = Very Good  NA = Does Not Apply

C. Behavior Management
   _____ 1. Manipulates the environment in order to facilitate optimal performance
   _____ 2. Deals appropriately with unacceptable behavior

D. Daily Clinical Documentation
   _____ 1. Develops data collection procedures to measure client progress
   _____ 2. Accurately records responses
   _____ 3. Writes accurate and complete SOAP notes

E. Professional Responsibilities
   1. Observes rules:
      _____ a. Dresses appropriately
      _____ b. Respects guidelines of facility (e.g. returning materials, files, etc.)
      _____ c. On time for therapy and meetings
      _____ d. Paperwork submitted in a timely fashion
      _____ e. Respects client confidentiality
   _____ 2. Prepares for supervisor conference
   _____ 3. Identifies alternative procedures during discussion of clients
   _____ 4. Demonstrates ability to problem solve after session, making appropriate changes in therapy plan
   _____ 5. Identifies strengths and weaknesses of session

III.  CLINICAL REPORTING
   _____ A. Uses appropriate clinical language in reports
   _____ B. Documents pertinent, accurate, and complete information
   _____ C. Logical organization is used (i.e. examples of behaviors, avoids excessive use of professional jargon)
   _____ D. Makes appropriate and specific recommendations for client
   _____ E. Incorporates supervisor’s suggestions in drafts of report
   _____ F. Proofreads report for errors before turning it in

Score: Total points/# Items Scored ______/ 47  = ______

Strengths:

Areas to improve:

Suggestions for improving these areas:

______________________________________ / ______  ____________________________ / ______
Student Clinician                                      Date                                     Supervisor                               Date
### CLINICAL EVALUATION FORM -- Level II (101 - 225 hours)

**Student Clinician**

**Clinical Supervisor**

<table>
<thead>
<tr>
<th>Date</th>
<th>Clinical Site</th>
<th># Clinical Hours</th>
<th>Evaluated</th>
</tr>
</thead>
</table>

1 = Poor  
2 = Needs to Improve  
3 = Adequate  
4 = Good  
5 = Very Good  
NA = Does Not Apply

### I. INTERPERSONAL SKILLS

#### A. With Client

1. Relates comfortably to client
2. Keeps personal concerns and problems from interfering with therapy
3. Demonstrates appropriate initiative
4. Demonstrates ability and willingness to function independently
5. Deals with attitudes and behaviors displayed by clients
6. Projects confident, professional image in clinical setting
7. Demonstrates sensitivity to cultural/linguistic differences

#### B. With Others (professionals and family members)

1. Interacts appropriately with other professionals
2. Conveys therapy goals and progress
3. Responds appropriately to feedback
4. Uses language appropriate to the listener (i.e. professional vs family member)
5. Demonstrates sensitivity to cultural/linguistic differences

### II. TECHNICAL SKILLS

#### A. Daily Planning

1. Short term
   - a. Objectives and materials are appropriate
   - b. Has rational for selected procedures consistent with evidence based practices
   - c. Structures plan to obtain maximum number of client responses
   - d. Initiates proposals for changes in program when appropriate
2. Long term planning (e.g. semester)
   - a. Formulates reasonable long term objectives
   - b. Able to plan sequential steps to lead to long term objectives

#### B. Therapy Execution

1. Activities are appropriate for client’s objectives and abilities
2. Uses appropriate language for client’s developmental and language abilities
3. Elicits and cues client appropriately when needed
4. Identifies target behavior
5. Gives client sufficient time to respond
6. Discriminates error from target behavior
7. Uses appropriate correction techniques and feedback
8. Demonstrates flexibility responding to client needs and improvises procedures when necessary
9. Makes smooth transitions between activities
10. Initiates contacts with other professionals involved with the client
<table>
<thead>
<tr>
<th>1 = Poor</th>
<th>2 = Needs to Improve</th>
<th>3 = Adequate</th>
<th>4 = Good</th>
<th>5 = Very Good</th>
<th>NA = Does Not Apply</th>
</tr>
</thead>
</table>

**C. Behavior Management**
- 1. Structures environment in order to facilitate optimal performance
- 2. Deals appropriately with unacceptable behavior
- 3. Develops strategies to deal with behavior issues

**D. Clinical Documentation**
- 1. Develops data collection procedures to measure client progress
- 2. Collects accurate baseline measures
- 3. Accurately records responses on-line during session
- 4. SOAP notes completed independently
- 5. Demonstrates ability to interpret data for use in evaluating therapy progress and changes therapy plan accordingly
- 6. Demonstrates ability to interpret data accurately

**E. Additional Practicum Responsibilities**
- 1. Prepares for supervisory conference
- 2. Identifies alternative procedures during discussion of client
- 3. Demonstrates ability to problem solve during and after session
- 4. Recognizes own strengths, weaknesses and professional limitations

**III. ORAL AND WRITTEN REPORTING**
- A. Writes report with clarity and organizes information appropriately
- B. Report contains pertinent, accurate, and complete information
- C. Includes all necessary information with accuracy and completeness
- D. Demonstrates ability to interpret information and make appropriate recommendations for the client’s needs
- E. Appearance of report is professional (e.g. spelling, punctuation, grammar, neatness, proofreading, etc.)

Score: Total points/# Items Scored $$\frac{\text{_____}}{46}$$ = _____

**Strengths:**

**Areas to improve:**

**Suggestions for improving these areas:**

$$\frac{\text{___________________________}}{______}$$

Student Clinician Date Supervisor Date
CLINICAL EVALUATION FORM -- Level III (226+ hours)

Student Clinician ___________________________  Clinical Supervisor ___________________________

Date ______________  Clinical Site ___________________________  # Clinical Hours ____________

Evaluated __________

1 = Poor  2 = Needs to Improve  3 = Adequate  4 = Good  5 = Clinical Competence  NA = Does Not Apply

<table>
<thead>
<tr>
<th>I. PROFESSIONAL SKILLS</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. With Client</td>
<td></td>
</tr>
<tr>
<td>1. Demonstrates initiative and independence</td>
<td></td>
</tr>
<tr>
<td>2. Recognizes strengths, weaknesses and professional limitations</td>
<td></td>
</tr>
<tr>
<td>3. Deals with attitudes displayed by clients</td>
<td></td>
</tr>
<tr>
<td>4. Maintains confident, professional image in clinical setting</td>
<td></td>
</tr>
<tr>
<td>5. Demonstrates sensitivity to cultural/linguistic differences</td>
<td></td>
</tr>
<tr>
<td>B. With Others (professionals and family members)</td>
<td></td>
</tr>
<tr>
<td>1. Interacts appropriately with other professionals</td>
<td></td>
</tr>
<tr>
<td>2. Able to handle confrontations</td>
<td></td>
</tr>
<tr>
<td>3. Responds appropriately to feedback</td>
<td></td>
</tr>
<tr>
<td>4. Presents appropriate information clearly</td>
<td></td>
</tr>
<tr>
<td>5. Demonstrates sensitivity to cultural/linguistic differences</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>II. TECHNICAL SKILLS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Therapy Planning</td>
<td></td>
</tr>
<tr>
<td>1. Daily Planning</td>
<td></td>
</tr>
<tr>
<td>a. Objectives and materials are appropriate</td>
<td></td>
</tr>
<tr>
<td>b. Establishes priorities</td>
<td></td>
</tr>
<tr>
<td>c. Evaluates and modifies program as needed</td>
<td></td>
</tr>
<tr>
<td>2. Long Term Planning (e.g. semester)</td>
<td></td>
</tr>
<tr>
<td>a. Applies theoretical knowledge of disorders to therapeutic practice</td>
<td></td>
</tr>
<tr>
<td>b. Incorporates prognostic indicators in long term planning</td>
<td></td>
</tr>
<tr>
<td>B. Therapy Execution</td>
<td></td>
</tr>
<tr>
<td>1. Uses language appropriate for client(s)</td>
<td></td>
</tr>
<tr>
<td>2. Discriminates errors</td>
<td></td>
</tr>
<tr>
<td>3. Creates maximal opportunities for client to communicate</td>
<td></td>
</tr>
<tr>
<td>4. Gives consistent, concrete and concise feedback</td>
<td></td>
</tr>
<tr>
<td>5. Encourages client to self-evaluate (as appropriate)</td>
<td></td>
</tr>
<tr>
<td>6. Alters pace of session in relation to client needs</td>
<td></td>
</tr>
<tr>
<td>7. Resolves unexpected problems</td>
<td></td>
</tr>
<tr>
<td>8. Demonstrates flexibility in responding to client needs</td>
<td></td>
</tr>
<tr>
<td>9. Initiates and pursues contacts with other professionals involved with client</td>
<td></td>
</tr>
<tr>
<td>C. Behavior Management</td>
<td></td>
</tr>
<tr>
<td>1. Initiates and carries through a behavior management program</td>
<td></td>
</tr>
<tr>
<td>2. Systematically alters behavior program when needed</td>
<td></td>
</tr>
</tbody>
</table>
1 = Poor 2 = Needs to Improve 3 = Adequate 4 = Good 5 = Clinical Competence NA = Does Not Apply

D. Clinical Documentation
   _____ 1. Obtains and records accurate baseline measures
   _____ 2. Accurately records responses on-line during session
   _____ 3. Develops data collection procedures which measure client progress
   _____ 4. Demonstrates ability to interpret data for use in evaluating therapy/progress and changes therapy plan accordingly

E. Supervisory Conference
   _____ 1. Prepares for conference
   _____ 2. Identifies alternative procedures
   _____ 3. Evaluates own clinical performance
   _____ 4. Identifies and implements strategies for improvement
   _____ 5. Requests help as needed

III. ORAL AND WRITTEN REPORTING
   _____ A. Writes reports with clarity and organizes information appropriately
   _____ B. Report contains pertinent, accurate, and complete information
   _____ C. Makes appropriate, specific recommendations for the client’s needs
   _____ D. Overall appearance of the report is professional (i.e. spelling neatness, grammar, proofreading, etc.)
   _____ E. Completes reports independently and efficiently with minimal revisions
   _____ F. Oral case presentations are well organized, accurate, and professionally presented

Score: Total points/# Items Scored _____ / 41 = _____

Strengths:

Areas to improve:

Suggestions for improving these areas:

__________________________________/______
_________________________________/_______

Student Clinician __________________ Date ____________ Supervisor __________________ Date ____________
CLINICAL EVALUATION SCORING SYSTEMS

Level I* (0 - 100 clinical hours)

5 = Very good. Displays minor technical problems which do not hinder the therapeutic process. Demonstrates the behavior consistently and frequently.

4 = Good. Frequently demonstrates the clinical behavior. Exhibits awareness of the need to monitor and adjust and make changes. Modifications are generally effective.

3 = Adequate. The clinical skill/behavior is emerging. Efforts to modify may result in varying degrees of success.

2 = Needs to improve. With supervisor input, implements the behavior/skill with difficulty. Efforts to modify are generally unsuccessful.

1 = Poor. The clinical behavior is not evident. Unable to modify behavior when directed by supervisor repeatedly. Little awareness of need to change behavior.

Level II* (101 - 225 hours)

5 = Very good. Appropriately implements the clinical skills/behavior. Beginning to initiate some independent and creative problem solving.

4 = Good. Displays minor technical problems which do not hinder the therapeutic process. Beginning to show some independence and initiative in clinical duties.

3 = Adequate. Inconsistently demonstrates the clinical behavior. Exhibits awareness of the need to monitor and adjust and make changes. Modifications are generally effective. Demonstrates basic understanding of clinical problems and/or procedures.

2 = Needs to Improve. The clinical skill/behavior is beginning to emerge. Efforts to modify may result in varying degree of success. Incomplete understanding of clinical problems and/or procedures.

1 = Poor. Implements the skill with difficulty. Efforts to modify are generally unsuccessful.

Level III** (226 + hours)

5 = Independent. Demonstrates professional behavior. Demonstrates independence by taking initiative and completing both assigned and unassigned duties. Demonstrates good understanding of clinical problems and meets the individual needs of clients. Displays superior competencies in ability to evaluate self/client accurately. Makes changes as needed.

4 = CF Ready. Demonstrates beginning CF level skills, but needs general direction from supervisor to improve clinical skills and to evaluate self/client accurately. Beginning to show initiative in planning and knows how to assign priorities. Thoughtful application of therapy techniques but needs further refinement in understanding of clinical problems or application of clinical procedures.

3 = Emerging. Needs general and some specific direction from supervisor to perform clinical skills and evaluate self/client accurately. Student demonstrates basic understanding of treatment principles and the needs of the client.

2 = Early emerging. Needs repeated specific direction and/or demonstration from supervisor to perform clinical tasks and to evaluate self/client accurately. Incomplete understanding of clinical problems, the needs of client(s) or treatment procedures. Difficulty in defining goals and/or assigning priorities for treatment.

1 = Not evident. Specific direction from supervisor does not alter unsatisfactory performance skills. Despite repeated input from supervisor, is unable to alter own performance adequately. Unable to relate effectively with the client(s) and is inadequately prepared for sessions. Does not seek guidance or does not implement suggestions appropriately.

*Adapted from Leith, McNiece & Fusilier (1989)

**Adapted from K. Chapman (Dx format) and Chris McDonald/Mt. Sinai grading protocol
COSI 452: Clinical Practicum in Speech Language Pathology

Student Information Form

Student Name:

Semester/ Year:

Please comment on the following items, so that your supervisor may have a better understanding of your experience prior to the beginning of clinic.

1.) General Clinical Experience _____________________________________________________________

2.) Experience working with people _________________________________________________________

3.) Experience with clients with _______________________ disorder? _____________________________

4.) Academic Coursework _________________________________________________________________

5.) Perceptions of Strengths/ Needs re: client/ disorder _________________________________________

6.) Anxieties about client/ disorder _________________________________________________________

7.) Previous supervisory experience _________________________________________________________

8.) Perception of self in terms of independence/ dependence _______________________________________

9.) Perceptions of responsibility for bringing data & questions to the supervisory conference _____________

10.) Expectations for learning or modification of clinical skills ________________________________

11.) Perception of need from feedback ______________________________________________________
Please comment on the following items so that your student may have a better understanding of clinical and professional roles/ expectations.

1. General clinical and supervisory experience

2. Experience with types of clients/ disorders

3. Theoretical and practical approaches to clients/ disorders

4. Preferred or customary supervision style

5. Expectations of students
DEPARTMENT OF COMMUNICATION SCIENCES
CLINICAL CONTRACT

Student _________________________   Supervisor ________________________
Semester/Year ____________________  Facility ________________________________

The following document is to be completed by the clinical instructor in consultation with the student clinician. The original is to be retained by the clinical instructor and returned to the Coordinator of Clinical Education, as quickly as possible. The student may wish to make a copy to serve as a guide. In addition to the general performance criteria outlined in the Semester Evaluation Form, this contract is designed to provide specific requirements for each practicum assignment. Revisions may be agreed upon during the course of the semester. Questions should be directed to the Coordinator of Clinical Education.

Contract Points:

STUDENT SCHEDULE (days/times):

STUDENT RESPONSIBILITIES & TIME LINE (lesson plans, report due dates, lesson materials, outside readings, self evaluation, etc.):

EVALUATION DATES/PROCEDURES (i.e., midterm eval):

STUDENT CLINICAL GOALS:

OTHER COMMENTS:

We, the undersigned, agree to meet the above stated contract:

Initial conference date ______________________

Student _________________________________ Instructor ____________________________
Case Western Reserve University  
Department of Communication Sciences  

EVALUATION OF CLINICAL SUPERVISOR  
(Adapted from Emerson College School of Communication Sciences and Disorders)  

Supervisor's Name ______________________________ Term ___________  

Student’s name (optional) ________________________________  

Number of clients for which supervisor is responsible ________________  

Please mark your degree of satisfaction with your supervisor in each of the following categories. Provide comments about supervisory behavior in the spaces provided. If you choose #1 or #2 as a rating, we strongly urge you to elaborate below the category or at the end of the form. Please return THE FORM TO THE COORDINATOR OF CLINICAL EDUCATION’S MAILBOX as soon as possible. Please make a copy to give to your supervisor during your final meeting of the semester.  

RATING SCALE-Select from categories 0-5 and insert number on blank line.  

0-not applicable  
1-not at all  
2-less than adequate  
3-adequate  
4-better than adequate  
5-very satisfied  

A. Discussion at the beginning of the term.  
1. Did discussion of case help you prepare to begin therapy? ___________  
2. If you requested, were you directed to additional resources? ___________  

B. Case Management  
1. Were case management conferences held regularly and on time? ___________  
2. Did she/he help you formulate appropriate rationale for procedures? ___________  
3. Did she/he provide adequate information regarding the therapy process? ___________  
4. Did she/he provide adequate information regarding the diagnostic process (e.g., hypothesis formulation testing, standardized/non-standardized testing/analysis, family counseling, written report, etc.) ___________  
5. Was supervisor’s involvement helpful in therapy sessions? ___________  
6. Was feedback regarding reports and lesson plans adequate and constructive? ___________  
7. Did she/he appear knowledgeable about subject matter or willing to guide students to other sources? ___________  
8. Do you feel your time in case management conferences was worthwhile? ___________  

Comments:  

1. Describe one or more aspects of your student-supervisor interaction that you found valuable.  
2. Please provide one or more suggestions for improving your student-supervisor interaction.
APPENDIX C: COSI 464 DIAGNOSTIC CLINICAL PRACTICUM

REQUIREMENTS
1. Each student must participate in/complete 5 evaluations to receive a grade in COSI 464.

2. As students are primarily working in teams, student responsibilities will be divided as follows:
   a. Interviewer: Responsible for information getting and information giving interviews;
      Responsible for history, summary, prognosis and recommendations/plan of care section
      of report.
   b. Tester: Responsible for all standardized and non-standardized testing including hearing screening and
      oral mechanism evaluation.
      Responsible for scoring, interpretation of standardized and non-standardized assessments and
      those parts of the report.
   Roles will alternate weekly For those students not partnered, the supervisor may act as the partner for the
   first two-three weeks, or for the entire experience. This should be worked out according to the student's skill
   level and should be left to the supervisor's discretion.

3. Students are required to complete the long form of the evaluation report (see attached). The first draft should
   be turned in 48 hours after the evaluation. Requests for re-writes from the supervisor should be made in as
   timely a manner as possible. The goal is to have one week's diagnostic report out prior to the next diagnostic
   session.

4. Students should meet with their supervisors prior to the diagnostic, if possible, to review the diagnostic plan.
   Students should complete the case history review form to aid in this process.

5. Students should complete self supervision forms weekly.

6. Students should review test manuals and practice tests during the month of September. It is expected that
   students know that they are required to demonstrate proficiency with the tests in order to remain as part of
   the diagnostic team in each evaluation. Students should practice tests no less than 3 times prior to
   administering them to patients/clients.

7. Grades will be determined by the COSI course instructor. Please turn a copy of each diagnostic grade sheet
   in to her.
CASE SUMMARY SHEET

CLIENT NAME: ___________________  DOB/AGE: _____/_______  CASE #:

FAMILY MEMBER: ___________________  STUDENT CLINICIAN REVIEWING FILE:

PHONE CONTACT MADE? YES  NO (circle)  REFERRED BY:

STATEMENT OF PROBLEM(s):

CASE HISTORY REVIEW

Child currently communicates using (circle all relevant)
- Sentences
- Phrases
- Single words
- Vocalizations/gestures

Medical History:

Developmental History:

Family/Social History:

Other:

AREAS TO BE Explored FURTHER
ISSUE OF CLIENT CONFIDENTIALITY

Remember that all information obtained during the diagnostic process is confidential. That is, the information should not be discussed in public unless you have the written permission of the client/family. You may discuss issues related to the client with others (i.e., fellow students, faculty members), without mentioning personal information about the client (including name, address, phone, etc.)

You can only discuss results and recommendations of the diagnostic with other professionals, when you have family permission.

With each diagnostic, you should check to be sure that you have a signed release of information form (see attached). Ask the family if there are any other people who should receive a copy of the report. You might specifically ask if there is a doctor who should receive a copy, or whether the school should (as appropriate).
SELF-CRITIQUE FORM
Diagnostic Practicum

Name: ___________________________ Date of Evaluation: ___________________________

Age of Client: ______________________ Disorder: ___________________________

CLINICAL AREAS OF STRENGTH:

CLINICAL AREAS TO IMPROVE:

PLAN OF ACTION FOR IMPROVING AREAS OF WEAKNESS:
DIAGNOSTIC SESSION SELF-SUPERVISION FORM
(Leith, McNiece & Fusilier, 1989)

NAME ________________________ CLINICAL LEVEL* __________________ DATE ______________
CLIENT ________________________ SUPERVISOR __________________ AGENCY ______________

*Clinical Level: B/beginning (0-100 hours); I/intermediate (100-200 hours); A/advanced (200-300 hours)
P/professional: CFY or beyond

NOTE:  1. Rate only pertinent behaviors. Use "Key to Clinical Competencies" to rate amount of supervision (S), first column, and quality of performance (P), second column. 5 = Very Good, 4 = Good, 3 = Satisfactory, 2 = Less Than Satisfactory, 1 = Poor
2. Numbers in () refer to the description of the particular behavior in the "Behavioral Descriptors."
3. SO = Significant Others
4. For rating conference, use Clinical Session Self-Supervision form, "C" items.

PLANNING

<table>
<thead>
<tr>
<th>S</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Did you read the case history and select an appropriate test battery? (5)</td>
</tr>
<tr>
<td></td>
<td>Did you meet with the diagnostic supervisor before the diagnostic and present a rationale for a selected test battery? (5)</td>
</tr>
</tbody>
</table>

INTERACTIONS

|   | Did you relate information to client/SO in an organized and professional manner? (10) |
|   | Did you maintain a confident image with clients/SO/other professionals/fellow students during the diagnostic? (14) |
|   | Did you interact appropriately with other professionals involved? (17) |

MANAGEMENT

|   | Did you manipulate the clinical environment so that it was conducive to testing? Did you present the test instructions/materials appropriately? (19) |
|   | Did you effectively deal with any behavior problems? Did you use a consistent reward/penalty system? (20) |
|   | Did you maintain the client's attention and motivation? Did your client exhibit approach motivation? (21) |

PROCEDURES

|   | Did you present instructions so that the client clearly understood the goals of the session? (22) |
|   | Did you use rewards and penalties that were appropriate, consistent, verified? (30) |
|   | Did you determine and implement an effective and accurate behavioral data collection system? (33) |
|   | Did you administer all formal tests accurately and efficiently? (35) |
|   | Did you demonstrate accurate clinical observation skills with sensitivity to and awareness of all relevant client behaviors? (36) |
|   | Did you elicit and evaluate all appropriate speech/language/hearing behaviors? Did you accurately interpret test results and make all appropriate recommendations? (37) |

REPORT WRITING (38)

|   | Did you report formal and informal test results accurately? |
|   | Did you describe all aspects of communicative behaviors using terminology that would be clearly understood by those reading it? |
|   | Did you organize your report according to established guidelines? |
|   | Did you use correct syntax, spelling, punctuation? |
|   | Did you make recommendations and referrals that were appropriate, specific, and complete? |
|   | Did you make necessary revisions and resubmit the report on time? |

OTHER DIAGNOSTIC RESPONSIBILITIES

|   | Were you prompt and professional in sending information to outside agencies/individuals? (42) |
|   | Did you evaluate your own diagnostic performance and set goals for your professional development? (43) |

GOALS FOR DEVELOPMENT:
INVENTORY OF DIAGNOSTIC SKILLS  
(Syracuse University: format adapted from the W-PACC/University of Wisconsin-Madison)

Clinician ___________________________  Supervisor(s) ___________________________

Date ___________________  Age(s) of Client(s) ___________________________

**Preparation (score 1-5)**

- [ ] Reads folder thoroughly
- [ ] Suggests appropriate evaluation procedures based on client information and knowledge of communication problem
- [ ] Is able to explain rationale for tests and procedures suggested
- [ ] Contributes equally to diagnostic team effort during pre-staffing
- [ ] Prepares diagnostic setting to meet client and observer needs

**Diagnostic (score 1-5)**

- [ ] Establishes professional test atmosphere with client
- [ ] Explains rationale for assessment to client/family
- [ ] Explains rationale for assessment to client/family in language appropriate to their level of understanding
- [ ] Administers tests according to standardized procedures
- [ ] Administers tests in critically important order for client and problem
- [ ] Adaptable -- makes modifications in assessment based on client performance or parent information
- [ ] Administers appropriate feedback or reinforcement consistent with test procedures
- [ ] Increases/decreases rate of time for test administration
- [ ] Removes distracting items during testing
- [ ] Scores tests/records unobtrusively, accurately, quickly
- [ ] Handles and manipulates test equipment efficiently
- [ ] Uses language and intonation appropriate to the age and functioning level of the client
- [ ] Is able to informally assess (nonstandard measures) skills comparably assessed on formal measures
- [ ] Demonstrates trial teaching techniques within the diagnostic setting

**Interviewing (score 1-5)**

- [ ] Begins and ends the interview gracefully
- [ ] Uses interpersonal skills/professional demeanor appropriate for informant
- [ ] Prepares the clinical setting for the interview
- [ ] Questions are formed clearly and are productive in terms of the quality/quantity of informant's response
- [ ] Sequences and switches topics smoothly
- [ ] Extracts pertinent/accurate information from the interviewer
- [ ] Demonstrates sensitivity to cultural/linguistic differences

**Postdiagnostic (score 1-5)**

- [ ] Is able to interpret test findings
- [ ] Offers information or comments to team members based on own observations of client performance
- [ ] Qualifies assumptions with observed behaviors in report
- [ ] Is able to integrate information observations from team members
- [ ] Makes appropriate recommendations and suggestions based on diagnostic team findings
- [ ] Is able to relate interpreted test findings to family/client
- [ ] Reports information in written form that is accurate and inclusive
- [ ] Reports information in written form that is pertinent
- [ ] Incorporates recommended treatment/management suggestions in report
- [ ] Clinician self-evaluates strengths and weaknesses

**Personal Qualities (score S [Satisfactory], U [Unsatisfactory], I [Inconsistent], LI [Lack of Information], DNA [Does Not Apply])**

- [ ] Punctual for prestaffing
- [ ] Punctual for diagnostic evaluation
- [ ] Appears to recognize professional limitations
- [ ] Prepares for diagnostic by setting up materials and equipment
- [ ] Returns test equipment and materials after diagnostic evaluation
- [ ] Dress, voice and manner is appropriate for evaluation
- [ ] Meets deadlines for reports

**Rating Code:**
NA  Not Applicable

1  Specific direction from supervisor does not alter unsatisfactory performance/evaluation skills; inability to make change.

2  Needs repeated specific direction and/or demonstration from supervisor to perform competently and evaluate self/client accurately.

3  Needs general and some specific direction from supervisor to perform competently and evaluate self/client accurately.

4  Demonstrates independence but needs general direction from supervisor to perform competently and evaluate self/client accurately.

5  Demonstrates independence by taking initiative; displays superior competencies and evaluates self/client accurately.

**PREPARATION (P)  ___

**DIAGNOSTIC (D)  ___

**INTERVIEWING (I)  ___

**POSTDIAGNOSTIC (PD)  ___

AVERAGE  P + D + I +PD  ___

**PERSONAL QUALITIES SUMMARY**
Number of “SATISFACTORY” items  ___

Number of “INCONSISTENT” items  ___

Number of “UNSATISFACTORY” items  ___

Number of “LACK OF INFORMATION” items  ___

Number of “DOES NOT APPLY” items  ___

**SCORE = SUM OF SCORED ITEMS / NUMBER OF ITEMS SCORED**

________________________________________ / ______________________________ =
DIAGNOSTIC SKILLS

DESCRIPTORS

PREPARATION
1. Reads client folder thoroughly.
   • The clinician can extract and summarize pertinent and accurate information from available background information for supervisor/team members.

2. Suggests appropriate evaluation procedures based on client information and knowledge of communication problem.
   • The clinician is able to list and enumerate possible evaluation procedures specific to the problem.

3. Is able to explain rationale for tests and procedures suggested.
   • The clinician is able to explain why one assessment procedure is preferable over another, taking into account the following factors:
     o evaluation procedure(s) specific to problem(s)
     o validity/reliability of standardized tests
     o developmental age appropriateness
     o formal vs informal procedures
     o test is suitable in view of other handicapping conditions
     o knows when alternate form of test should be given

4. Contributes equally to diagnostic team effort during pre-staffing.
   • The clinician's verbal input is comparable to other team members' input.
   • The clinician evaluates and questions other team members' input.
   • Prepares a flexible outline for order of test administration.

5. Prepares diagnostic setting to meet client and observer needs.
   • The environment is pleasant to the eye (clutter free), distractable objects removed.
   • The informant is made physically comfortable.
   • Prepares diagnostic setting to meet observer needs.
   • Materials/tests are readily available and organized.
   • Audio/video taping equipment is set up.

DIAGNOSTIC
   • The clinician introduces himself/herself.
   • The clinician engages in social conversation to reduce test anxiety if applicable.
   • The clinician briefly outlines the diagnostic format when appropriate.
   • The clinician demonstrates warmth, appropriate eye contact, ease and sensitivity to the client's feelings.

7. Explains rationale for assessment to client/family.
   • The clinician initiates an explanation of why a particular test is being given.
   • The clinician is able to answer client/family questions as to why a test is being given.

8. Explains rationale for assessment to client/family in language appropriate to their level of understanding.
   • Clinician defines terms, provides examples to facilitate parent/family understanding of diagnostic procedure(s).

9. Administers tests according to standardized procedures.
   • Clinician gives appropriate directions.
   • Clinician uses basal and ceiling levels.
   • Clinician adheres to time limitations.

10. Administers test in critically important order for client and problem.
    • Clinician administers tests most critical to assessing presenting problems when client is fatigued, disinterested, distractable, or physically limited (e.g., clinician administers auditory perception or discrimination tests after the client's auditory acuity has been assessed).
• When appropriate, clinician adjusts or changes pre-staffing diagnostic outline.

   • Clinician introduces or modifies type or schedule of reinforcement to increase client on-task behavior.
   • Clinician changes from using formal to using less formal assessment when client's off-task behavior increases.
   • Clinician discusses client's hobbies, skills, social interests to informally assess articulation syntactic structure, language comprehension, etc.
   • Clinician spontaneously introduces new procedures.

12. Administers appropriate feedback or reinforcement consistent with test procedures.
   • Clinician gives social approval ("good, that's a good answer:"); smiles, nods, encourages, ("try, just do your best," "you're doing well").
   • Clinician reinforces on a variable schedule without patterning or cueing the client (e.g., nodding for only correct responses, allowing delay after incorrect client response for client to change answer).
   • Clinician may tally and show correct responses to client to reinforce on-task test performance.
   • Clinician knows when to use and change and/or eliminate token/food reinforcers when inappropriate to client's interest or developmental level.
   • Clinician is familiar with instructions for reinforcement when these are specified in the test manual.

13. Increases/decreases rate of time for test administration. Speeds up or slows down the "pace of the session.
   • When no time limit is specified for test/subtest administration, clinician modifies rate of test time presentation when appropriate.
   • Clinician allows reasonable time for client to respond after stimulus is presented.

14. Removes distracting items during testing.
   • No descriptors.

15. Scores tests/records responses unobtrusively, accurately, quickly.
   • Clinician fills in pertinent identification information on test form.
   • Clinician accurately scores tests according to test manual instructions.
   • Clinician scores both correct and incorrect responses to avoid cueing client.
   • Clinician relates information/data obtained to some standardized/developmental age reference norm.

16. Handles and manipulates test equipment efficiently.
   • Materials are organized sequentially for facile test administration.
   • Clinician knows how to operate test equipment (tape recorder, videotape, pitch meter, spectrogram, accelerometer, etc.)
   • Clinician co-ordinates test material presentation and scoring.

17. Uses language and intonation appropriate to age and functioning level of the client.
   • No descriptors.

18. Is able to informally access (non-standardized measures) skills comparably assessed on formal measures.
   • Clinician is familiar with source for developmental norms (e.g., phonological or language development norms).
   • Clinician records observations of client behaviors which are not being directly assessed.

19. Demonstrates trial teaching techniques within the diagnostic setting.
   • Clinician attempts to recommend management strategies/techniques based on observed test performance.
   • Clinician uses several methods/approaches to stimulate sound production.
   • Clinician models language structures to determine client's ability to acquire and retain skills on a short term basis.
   • Clinician presents same concept(s) through various modalities (auditory, visual combined) for suggestions for possible therapeutic approaches.

20. Begins and ends the interview gracefully.
   a. Beginning the interview
• The interviewer establishes a professional/supportive atmosphere during the initial greeting (introduction).

b. **Ending the interview**
• The interviewer expresses appreciation for informant's cooperation.
• The interviewer asks for further information/questions in relation to the problem.

21. **Uses interpersonal skills/professional demeanor appropriate for informant.**
- Interviewer uses adequate eye contact.
- Listens carefully and talks with the client, not at or down to the client.
- Reacts appropriately during client expressions of emotion (responds to the emotion expressed rather than to the answer to the question).

22. **Prepares the clinical setting for the interviewer.**
- The environment is pleasant to the eye (clutter free).
- The informant(s) is/are made physically comfortable.
- Audio-recording equipment is properly assembled.
- Question guideline is prepared.

23. **Questions are formed clearly and are productive in terms of the quality/quantity of informant's response.**
- Double or multiple questions are avoided.
- Appropriate vocabulary is used; terms are defined when necessary.
- Questions are not "leading" or "loading" (i.e., wording that would suggest what would be an acceptable answer).
- An appropriate variety of questions are used, preferable open-ended ones.
- The rationale for questions asked is understood by the clinician.

24. **Sequences and switches topics smoothly.**
- Obtains neutral, factual information before emotionally laden information.
- Follows a reasonable chronology of questioning.
- Uses transitional statements when changing the topic or area of questioning.

25. **Extracts pertinent/accurate information from the interview.**
- Probing questions are appropriately used to obtain information about a relevant topic.
- Appropriate amount of time is spent for questions in important and less important areas.
- The informant's interpretation of events is obtained.
- Details are "pinned down" by relating events to significant family milestones.
- Causal relationships are defined in terms of time and space.
- Unobtrusive checking of inconsistent responses.
- Gets the informant "back on track" without discouraging free expression.

**POST DIAGNOSTIC**

26. **Is able to interpret test findings.**
- Clinician scores test(s) before post diagnostic meeting.
- Clinician correctly scores individual tests and procedures according to test standards.
- Clinician takes into consideration additional factors (i.e., client's fatigue, attention to task, understanding of instructions).

27. **Offers information or comments to team members based on own observations of client performance.**
- Clinician suggests management approaches, recommendations, or referral services based on client behavior which was observed or reported.
- Clinician is able to make general summary statements about the client/family based on specific examples of client/family behavior.
- Clinician can suggest if therapy or subsequent services are recommended based on client-demonstrated performance.

28. **Qualifies assumptions with observed behaviors in report.**
- See 27
29. Is able to integrate informational observations from team members.
   - Clinician displays skills in integrating the information (informal/formal tests, case history, 
     observations, previous evaluations) gathered to determine nature and severity of the client’s problem.

30. Makes appropriate recommendations and suggestions based on diagnostic team findings.
   - Clinician displays skills in generating appropriate recommendations and possible referrals based on 
   information gathered and on the needs of the client.
   - Clinician knows when to initiate these contacts with appropriate referrals.

31. Is able to relate interpreted test findings to family/client.
   - Clinician relates information using appropriate vocabulary, clear concise language.
   - Clinician displays skills in relating relevant and organized facts while counseling parents and/or clients.
   - Clinician displays skills in sequencing positive aspects of client behavior before negative.
   - Clinician is able to appropriately respond to questions asked by the parent/client in relation to his/her 
     problem/prognosis.

32. Reports information in written form that is accurate and inclusive.
   - Clinician’s first draft includes information that is well organized, chronologically appropriate and 
     grammatically correct, concise, and clear.
   - Clinician summarizes all aspects of the diagnostic and integrates information given by additional team 
     members.
   - Clinician researches the problem and reads sample reports before writing and handing in the report to the 
     supervisor.

33. Reports information in written form that is pertinent.

34. Incorporates recommended treatment/management suggestions in report.
   - Clinician includes information concerning the types of tests (informal vs formal) administered, purpose of 
     test, results, possible therapy plans and recommendations.
   - Clinician exhibits adequate theoretical background in the particular disorder.
   - Clinician suggests and specifies objective criteria for achievement of goals.
   - Clinician suggests appropriate type and variety of materials/programs.

35. Clinician self evaluates strengths and weaknesses.
   - Clinician is able to indicate assets of his/her diagnostic performance.
   - Clinician perceives areas for modification and suggests alternate ways of improving future performance.
DESCRIPTION OF PROGNOSTIC LEVELS
SPEECH-LANGUAGE PATHOLOGY and AUDIOLOGY

In keeping with standards for increased accountability, it is necessary to provide for each client a prognosis for improvement. The words traditionally used to describe prognosis, along with a brief description, are as follows:

**Excellent** - This prognosis statement indicates that the client has a high likelihood of improving significantly. All indicators are positive for significant improvement. This classification can be used for clients who may require only a short period of therapy.

**Good** - Choosing this option indicates that the client can be expected to make reasonable progress toward improving functional communication. This statement may be qualified to state that the prognosis for achieving a limited set of goals is good. The person may have positive and negative influences on their likelihood to improve but a majority of the indicators are positive.

**Fair** - This term may be used for the client that has a similar number of both positive and negative prognostic indicators. The person may still be considered a candidate for therapy if the clinician determines that improvement is possible.

**Poor** - This term is used for the client who is not likely to demonstrate functional improvement from therapeutic intervention. This client has more negative than positive indices for improvement. This designation is used for the person who is not going to be enrolled in therapy or should be discontinued from therapy because he/she is not expected to continue to demonstrate progress. The clinician should provide the reason(s) for the poor prognosis.

The following are a list of common influences on a person's prognosis for improvement:

- Age
- Severity of impairment
- Cognitive abilities including memory
- Oral/motor control
- Hearing status
- Visual impairment
- Motivation
- Level of family involvement
- Family attitudes
- Client's emotional reaction to disorder
- Auditory comprehension
- Auditory discrimination
- Pre-requisite language skills
- Health factors
- Intensity, duration of previous therapy
- Appropriateness of previous therapy
- Integrity of neurological system
- Integrity of oral/facial structures
- Psychological difficulties
- Ability to self-monitor
- Ability to self-correct
- Previous response to therapy
- Willingness to work on communication outside clinical setting
- Professional/personal reasons for wanting to change behavior
- Ability to attend sessions regularly
- Transportation readily available to attend sessions
- Time since onset of disorder
- Stimulability
- Non-verbal interaction with others
- Play behavior
- Response to clinician's cues
- Ability to focus attention
Ability to sustain attention
Ability to sustain attention with possible distractions
Client willing to change aspects of lifestyle
Pre-morbid personality characteristics
Level of daily communicative interaction with others
Interest in attending therapy
Client's belief that therapy will result in improvement
Environmental factors
Interest in interacting with others

Additional Audiology Prognostic Indicators -- In addition to the prognostic indicators given for speech and language clients, manual dexterity must also be considered for audiology clients, especially for the purposes of hearing aid and battery manipulation, sign language and Cued Speech use.

In stating the audiology prognosis, indicate clearly which aspect of communication to which you are referring (e.g.: development of oral communication, use of a hearing aid or assistive listening device, progression of hearing loss, etc.).

Use the terms "Excellent, Good, Fair or Poor" as described in the description of Prognostic Levels. The progress may also be described. "Guarded" if it presently appears "poor," but may improve significantly after either medical intervention or fitting of appropriate amplification.

In the case of a client who requires medical evaluation or intervention, you may state that "the prognosis is being withheld, pending medical consultation."

from
T. Threats/ K. McNeal 1991
SEVERITY RATING INFORMATION

This information serves to provide general guidelines for severity ratings assigned to clients with communication disorders. This information may be applied to categories of impairment, handicap and disability that you may encounter through various managed health care organizations.

Within Normal Limits

- No noticeable impairment in this area
- This classification can be used for the following types of clients:
  1. Proficiency in this area is technically within normal limits but is near the lower boundaries of what is considered normal. For a child, a recommendation may be to monitor and/or to follow-up with a consultation at some specified time in the future.
  2. Someone who subjectively reports some effort in performing the skill but this difficulty is not evident to the listener.
  3. Foreign dialect client whose dialect never or rarely interferes with intelligibility.

Mild

In general, a classification of either of the mild ratings indicates a disorder which may be evident but does not significantly reduce the ability to be an effective communicator. In other words, there is a disorder but it does not interfere with everyday, functional communication. For a child, this classification would include those who are six to eight months below age expectancy in functional communication ability.

- Examples of the use of this classification include the following:
  1. Disorder is noticeable to a trained listener, may not be apparent to casual observer in a limited context.
  2. Persons who have difficulty only in a few specific demanding situations.
  3. Persons who have no or little difficulty with everyday, functional communication but may experience minor difficulty in several demanding situations such as a high level contextual conversation or in the presence of competing stimuli.
  4. Persons who require some increased effort to communicate resulting in rarely noticed reduced facility of speech/language without significant decrease in ability to comprehend and/or express wants and thoughts.

Moderate

In general, this category represents the level in which a disorder of comprehension or expression becomes a definite impairment in communication. However, the skill level still enables the communicatively-impaired person to effectively communicate in many structured and/or limited contexts. For a child, this level would be used to describe one who is eight to twelve months below age expectancy in functional communicative ability.

- Examples of the use of this classification include the following:
  1. A person whose disorder is readily apparent to even the casual conversational partner. The impairment makes it somewhat more effortful to communicate with the communicatively-impaired person.
  2. A person who shares the burden of communication with the listener but the listener is still sometimes required to fill in the blanks.
  3. A person whose disorder is readily apparent. This person’s conversation partner finds that it is effortful to communicate with the person, especially when not dealing with everyday topics or with unknown referent.
  4. A child who is clearly below normal limits on a given communicative skill but retains enough functional ability in this area to get across basic wants and needs.
  5. A communicatively-impaired person who shares the burden of communication with others at least half of the time. The conversational partner is often required to fill in gaps.

Severe

In general, this classification should be used to describe the client who often does not equally share the burden of communication with his/her partner. The person has limited ability to express basic wants and needs and is not usually able to participate in an actual conversation. The client’s prognosis for developing any of these skills may range from poor to good. For the child, this level would be used to describe the child who 12 months or more below age expectancy level for functional communication.

- Examples of this classification could include the following:
1. A person whose communication impairment interferes with all but the most elementary and routine conversational exchanges such as responding appropriately to How are you?
2. A person who can only be understood in limited contexts with referent known.
3. A child or adult with limited ability to express basic wants and needs. May be able to communicate some desires via sample verbal or non-verbal means.
4. A person whose communication impairment makes it difficult to communicate even with routine exchanges.
5. A person who has difficulty being understood even in limited contexts with referent known.
6. A child or adult with limited ability to express even the most basic of needs by any means.

**Profound**
This category denotes no observable ability in functional communication.

*From T. Threats/K. McNeal 1991*
LANGUAGE SAMPLE COLLECTION: SOME TECHNIQUES, AND CONSIDERATIONS FOR INTERVENTION

The clinician who needs to collect a representative spontaneous language sample from a child faces no small test. Beginning student clinicians may have the notion that language sampling procedures involve little advance thought and planning, just some sharpened pencils for transcription, a working recording device and some toys or books to “make the child want to talk”. Experience has shown that collecting a spontaneous language sample from children is a challenge. The language measures derived when the sample is analyzed will be as valid as the sample is both accurate and representative. Therefore, it is important that we consider the following:

1. When interacting with a child, do I share information as well as the opportunity to generate the topic of conversation?
2. Am I able to converse at an interest level appropriate for the child?
3. Do I constrain the child’s productions by using too many interrogative forms? Are there ways of increasing the open-endedness of questions?
4. How often do I tell children what to do, think or feel rather than give opportunities for them to tell me?
5. Do I really listen when children speak to me? Am I sure that my “listening behavior” is evident to the client?
6. How often do I use incomplete sentences, sentence fragments and automatic (stereotypical) speech? Do I sound redundant?
7. Do I set up activities conducive to speech and thus, exchange of information?
8. How many different speaking environments do I provide for the child with different settings, expectations and listeners?
9. Are the situations I choose reality-based? Do they lead to positive feeling between client and clinician?

Several types of intervention strategies follow. Many are fancy labels for sensical, natural dialogues which occur daily at home or in the classrooms. Two categories of strategies, adult initiated and child initiated, are delineated.

Adult Initiated

1. Parallel Talk: As the adult and child are interacting together in an activity such as water play or making juice, the adult describes the activities, names the objects, etc., which correspond with the immediate situation: “Sherry is stirring the juice”, “You are pushing the boat”, and so on. The adult could also narrate what she/he is doing as they interact together: “I’m using the big white spoon”, or could narrate the actions of a doll, puppet, etc., “The girl jumped in the water”. The child could be nonverbally cued (a nod, glance) to join in the verbalizing. A more direct procedure would be warmly instructing the child to: “Tell about what you are doing”.

2. Question-Answer-Question: To insure a more positive situation for question answering, this technique provides the child a question, the answer, the question again and his/her opportunity to spontaneously respond correctly: “What is on the table? A cup is on the table. What is on the table?” Child response.

3. Answer-Question: A variation on the preceding is offering the answer, asking the question and giving the child the opportunity to spontaneously answer: “this is a toy dog. What is this?” Child response: “"".

4. Close Technique or Open Ended: When beginning a project such as making playdough, the adult could begin with an open-ended comment such as:
   - Adult: “Let’s make playdough...we’ll need uh...”
   - Child: “spoo”, etc., or
   When the adult and child are prepared for an activity and have materials spread out, the adult might say:
   - Adult: “We have a lot of stuff; I wonder what we could do with it...”
   - Child: “Cut,” etc.

5. Backward Chaining: The adult provides a picture or object stimulus. The child should be familiar with the label/action represented. The sentence presented by the adult has the target deleted at the end. The follow-up offering by the adult omits the final two words, and so on. The sequence builds to the entire sentence being given by the child:
   - Adult: “This is a blank” Child: “car”, etc.
   - Adult: “This is blank” Child: “a car”, etc.
   - Adult: “This blank” Child: “is a car”, etc.
   - Adult: No verbal output but holds the item. Child: “This is a car”, etc.
**Child Initiated**

Note: Each of these procedures requires at least a single-word utterance generated by the child.

1. **Expansion**: This form of parent-child verbal interaction has been found to be very natural and frequent. Brown and Bellugi (1964) noted the manner in which parents spontaneously complete the child’s original utterance by adding the deleted syntactical elements. This is an immediate measure to acknowledge and expand the child’s reduced comment at the time when it was uttered to insure relevance. An example could be:
   
   “Car go” (child)
   “Yes, the car is going” (adult)

   There seems to be some controversy over the usefulness of this technique. Some pitfalls of this intervention strategy have been suggested. First, because this technique focuses heavily upon structure, it may restrict the idea/intent of the child rather than extend it. Secondly, as the adult builds upon the child’s utterance through the addition of grammatical elements, the final product may not represent the child’s intent. An utterance such as “car go” could mean a variety of things and the adult’s expansion may not focus upon the accurate intention of the child. Thirdly, the child’s attention span may not accommodate an overabundance of expansions since he would be hearing basically an instant replay of his original utterance in a grammatically correct form. No new information of interest would have been added. Thus, this method has been shown more successful in the building of syntax than in enhancing the child’s semantic variety.

2. **Expatiation or Semantic Extension**: Cazden (1965) used the term “Modeling” then later shifted to extension to cover the same technique. Muma offers expatiation as a parallel term. This procedure frequently occurs with expansion in parent-child verbal interactions. When the two procedures, extension and expansion, were artificially separated in Cazden’s study with preschoolers in 1965, extension was found to be more successful than syntactical expansion. This seems to be a higher level of intervention strategy.

   Example: Child  “ball roll”
   Adult  “The ball is red and round. It rolls on the floor or you could throw it. I like to play with the ball.”

   Once again, it is important to bear in mind that the two procedures, expansion and expatiation, occur naturally together. Expatiation or semantic extension addresses itself to areas of syntax and semantics and supplies experience in the instrumental employment of language, rather than being restricted to syntax only as in expansion.

3. **Interrogative Stimulus/Divergent Thinking Model**: The adult encourages the child’s ability to think abstractly. Alternative means of expressing a thought are the target. No attempt is made to correct syntax.

   Example: Child: “car go”
   Adult: “Is it a fast car or a slow one? Why do cars go?”

**Combination of Techniques**

Scene: Child and adult are using the water table together.

Adult: “I’m pushing my boat.” (Parallel Talk)
Child: “Me boat.” (holds boat close to self to indicate possession)
Adult: “Yes, that’s your boat.” (Expansion)
   “Here’s my boat.” (adult draws boat close to self to indicate possession)
Adult: “What are you doing? Pushing. What are you doing?” (Question-Answer-Question)
Child: “Push”
Adult: “You are pushing the boat in the water.” (Expansion, Expatiation, Parallel Talk)
Child: “Me push.” (child says as she/he pushes boat again)
Adult: “Look at the waves you make when you push your boat.” (Expatiation)
Adult: “Ah, here’s a duck. I wonder what I could do with it...I could...” (Close Technique)
Child: “Put in water.”
Adult: “The duck and the boat are both in the water now.” (Expansion, Expatiation, Parallel Talk)
SOME ADDITIONAL HELPFUL HINTS FOR LANGUAGE SAMPLE COLLECTION

1. Ask the parent or teacher about areas of interest the child has. Perhaps the child has a favorite toy, a pet, a favorite television show, a special occasion may be coming.

2. Use age-appropriate materials.

3. Present only a few items at a time to the child, and avoid overloading the child with either materials or questions. Let the child make a selection from the several items presented.

4. Demonstrate what you would like the child to do if s/he fails to initiate with some language and/or activity.

5. Vary situations, materials, listeners. Avoid very specific questions, asking the child to tell you very familiar stories, using stimulus materials that limit both vocabulary and syntax as well as "boy-like" or "girl-like" toys or pictures.

6. Be aware of the different language constructions you want to target and before the collection session, think through methods which might elicit such constructions.

**This handout pulled together information from several others. Acknowledgments are due to Nancy E. Green and Joan G. Erickson among others, for materials compiled while affiliated with the University of Illinois.**
BEHAVIOR MANAGEMENT PRINCIPLES

1. Observe behaviors that are conducive to therapy and learning. Catch the child being “good” and reinforce. Praise the behavior not the whole child. As much as possible, ignore inappropriate behavior.

2. Observe behaviors which are disruptive to therapy and learning. Look for reasons why these behaviors may be occurring: task too difficult, materials distracting, drill too slow, etc.

   Restructure the therapy environment to eliminate these.

3. Do not allow blank spaces between activities. Children dink around and “get in trouble” when they have nothing to do.

4. Don’t ask for cooperation if you aren’t willing to accept “no” for an answer. That is, don’t say “Will you sit down” if you really mean “Sit down!” A good way to handle this firmly but fairly is to give the child a choice: “Do you want to sit in this chair or that chair?”

5. Establish the “rules” behavioral limits, early with children. Also, establish the “punishment” for breaking the rules- we’ll use Time-Out from group activities. The idea is to be fair.

6. Establish the contingencies for getting a reward. “If you want to play with the car, then do this.” “After we do this, then we’ll blow bubbles.”

   IF YOU USE TIME-OUT

7. When a child is acting as a disruptor of group activities or a therapy activity, give him a warning or choice. Examples: “You have a choice. You can sit at the table and play with us, or you can sit in the corner by yourself.” “If you don’t stop whistling, you’ll have to sit in the corner.”

8. Act immediately and be consistent with behavior management.

9. Check periodically on the child in Time-Out, saying “When you’re ready to follow the rules, you may come back and join us.”

10. Follow through!

11. Use activities, tokens, etc., that the child considers reinforcing. Group activities must be FUN, or else Time-Out won’t work, for example.

12. Apply Time-Out matter-of-factly. Always separate “bad behavior” from “bad child.” If the limits are clearly established and you apply the consequences immediately, then you’ll be less likely to get angry and violate this principle.

13. Above all, respect children as people who have rights to fair treatment.

Steps to Follow in Dealing with Inappropriate Behavior

1. Give clear directions to the child. State the rule simply.

2. Reinforce those who have followed directions, ignore inappropriate behavior at this time, excepting situations of danger.

3. Restate the rule.

4. Model desired behavior.

5. Remove materials. (“When you’re ready to sit in your chair, you can have this back.”)
6. Move chair slightly away from table or push chair slightly away from group. (We'd really like you to be here with us. When you're ready to sit in your chair, you can push it back and join us at the table.)

7. Provide an alternative for him. (“Either you sit in your chair with us, or you'll have to sit there by yourself.”)

8. Remove child from the group or reinforcing situation. (Time-Out)

9. Remove child from the classroom.

10. Reinforce appropriate behavior whenever possible.

**Prevention Techniques**

1. Provide many, clear directions.

2. Make sure each child knows where he is supposed to be and what he is supposed to be doing at all times. Gestures or physical guidance may be necessary with some of them. Don’t assume he understands until you get sufficient feedback.

3. Designate a specific place for each child to sit. (“Here’s your place on the floor,” while pointing to his spot or “This is your chair.”)

4. Call on children individually to direct, instead of directing them as a group.

5. Call on children at the beginning who may have difficulty waiting for their turn. Giving them an extra turn during games or songs often helps.

6. During games, remind children that everyone will get a turn.

7. Utilize teacher aides. Call on them first to stand by the door or to go to a certain place before directing the children. Use them as models to go through the process as visual reinforcement for your “clear” directions.

8. When directing an activity, center yourself with the bulk of the children. Direct your aides to help a child having difficulty.

9. Have your children seated were you want them before you bring out materials. Bring out only the materials you need at one given time; replace them before bringing out others.

10. Seat yourself at a place at the table where you can easily reach all children. This will help you assist all the children, promotes more interactions, and puts you in a spot for easy intervention.

11. Keep all materials out of children’s reach unless you want them to be touched.

12. Careful planning is a great preventive measure. Have everything you need on your tray so you won’t have to leave the group.

13. Remind children when it is almost time to finish an activity so they have time to finish up and prepare for the next activity. Give them time to do this for themselves. Be aware of their timing as well as your schedule.

14. Keep the children occupied and interested. Make use of emergency equipment (books, play doh, puppets, etc.)

15. If a child finishes an activity sooner than the others and is having a hard time waiting, give him a special job (wiping the table, collecting papers, gathering equipment, helping others).
16. Keep things moving. There’s no excuse for nothing to do. Everything is intriguing to preschoolers if you work through the tips they give you.

17. Use much eye contact, especially while reinforcing.

18. If you need to refocus a child’s attention, calling his name and directing a question to him usually helps. A gentle pat on the back or pat on the leg adds a personal touch.

19. If necessary, casually separate children who set each other off. Seat such children apart and you in the middle if needed.

20. Your voice and mood will be a key factor in the children’s reactions to an activity. (If an activity is boring to you, it will probably be boring to them, too.) Putting a little pizzazz in your voice helps get the kids more excited. Don’t be afraid to smile and laugh with them when appropriate and don’t be afraid to use firmness. Talking quietly and slowly sets another mood.

21. Be absolutely sure all behavior expectations are feasible for each child. Avoid setting demands for the children; give them choices. Make sure you always follow through with any demands you have made. (Threats without follow-through can do more harm than good.)

22. Don’t be over stifled by structure! If a lesson plan calls for 3 turns and you can see it’s bombing after 1, go on to something else; make the session interesting, but try to stick to the main objective. Flow with the kids.

23. Try to out guess certain behaviors to avoid a conflict situation. If someone always goes to his favorite toy, stand by the toy shelf and assume he is on his way to the appropriate place.

24. Positive reinforcement cannot be overemphasized. Children are innocent until proven innocent! It’s a circular phenomenon, using it will probably alleviate most of your problems before they even occur.

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APPENDIX D: LEARNING OUTCOMES/SESSION FEEDBACK FORMS/SUPERVISORY CONFERENCE OUTLINES

The following outlines are the learning outcomes for clinical placements at CHSC, suggested topics for supervisory meetings, and the new session evaluation forms. Please take a moment to review those learning outcomes that correspond with your clinical placements. Students, as a reminder, required reading (noted on the supervisory outlines in your packet) to help you achieve the learning outcomes is located in the big white binder in the graduate carrel room.

Session evaluation forms are designed to help the student/supervisor partners focus, in written form, on the attainment of specific learning outcomes. Please copy those forms that you will need for the semester.
LEARNING OUTCOMES FOR INDIVIDUAL SESSIONS

In accordance with Evidence Based Practices, by the end of this semester, you will attain proficiency in the following:

1. Read relevant literature, review chart.
2. Collect and analyze data.
3. Demonstrate sensitivity to cultural/linguistic differences.
4. Formulate goals, initiate treatment plan.
5. Modeling and cueing target behavior
6. Increase client response rate.
7. Corrective feedback.
8. Explaining goals, rationale, and techniques to client/parent(s).
9. Writing daily progress notes (complete treatment plan).
10. Develop home program/homework assignments.
11. Introduce and conclude therapy goals/activities.
SESSION FEEDBACK FORM: INDIVIDUAL SESSIONS

Supervisor:
Circle appropriate learning outcome (2-3 per session)
1. Read relevant literature, review chart.
2. Collect and analyze data.
3. Demonstrate sensitivity to cultural/linguistic differences.
4. Formulate goals, initiate treatment plan.
5. Modeling and cueing target behavior.
6. Increase client response rate.
7. Corrective feedback.
8. Explaining goals, rationale, and techniques to client/parent(s).
9. Writing daily progress notes (complete treatment plan).
10. Develop home program/homework assignments.
11. Utilize behavior management techniques effectively.
12. Introduce and conclude therapy goals/activities.

Strengths

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Areas for Improvement

Suggestions for next session

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Supervisor Signature

Student Clinician Signature

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LEARNING OUTCOMES FOR PARENT TODDLER GROUP

In accordance with Evidence Based Practices, by the end of the semester, you will attain proficiency in the following:

1. Collecting and analyzing data.
2. Formulating treatment goals consistent with evidence based practices.
3. Demonstrate sensitivity to cultural/linguistic differences.
5. Managing challenging behavior.
6. Delivering corrective feedback.
7. Leading group therapy.
8. Leading parent discussion.
9. Explaining therapy goals and techniques to parents.
10. Introduce and conclude therapy goals/activities.
### SESSION FEEDBACK FORM: PARENT TODDLER GROUP

**Supervisor:** Circle appropriate learning outcome (2-3 per session)

1. Collecting and analyzing data.
2. Formulating treatment goals consistent with evidence based practices.
3. Demonstrate sensitivity to cultural/linguistic differences.
5. Managing challenging behavior.
6. Delivering corrective feedback.
7. Leading group therapy.
8. Leading parent discussion.
9. Explaining therapy goals and techniques to parents.
10. Demonstrate effective behavior management strategies.
11. Introduce and conclude therapy goals/activities.

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Supervisor Signature  
Student Clinician Signature
LEARNING OUTCOMES FOR LANGUAGE LEARNING DISABLED GROUP

In accordance with Evidence Based Practices, by the end of the semester you will have gained proficiency in the following:

1. Completing a review of pertinent LLD literature.
2. Collecting and analyzing data in a group setting.
3. Demonstrate sensitivity to cultural/linguistic differences.
4. Leading group therapy.
5. Using a commercially available Written Language Program.
6. Delivering corrective feedback.
7. Using appropriate behavior management techniques.
8. Modeling a variety of conversational skills.
10. Discussing LLD issues with parents.
11. Explaining goals and progress to parents and school personnel.
12. Introduce and conclude therapy goals/activities.
SESSION FEEDBACK FORM: LANGUAGE LEARNING DISABLED GROUP

**Supervisor:** Circle appropriate learning outcome (2-3 per session)

1. Completing a review of pertinent LLD literature...
2. Collecting and analyzing data in group setting.
3. Demonstrate sensitivity to cultural/linguistic differences.
4. Leading group therapy.
5. Using a commercially available Written Language Program
6. Delivering corrective feedback...
7. Using appropriate behavior management techniques.
8. Modeling a variety of conversational skills.
9. Formulating long and short term goals
10. Discussing LLD issues with parents.
11. Explaining goals and progress to parents and school personnel.
12. Introduce and conclude therapy goals/activities.

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LEARNING OUTCOMES FOR SCHOOL AGED FLUENCY GROUP

In accordance with Evidence Based Practices, by the end of this semester, you will attain proficiency in the following:

1. Collecting and analyzing speech samples.
2. Formulating semester goals.
3. Demonstrate sensitivity to cultural/linguistic differences.
4. Implementing a commercially available fluency treatment program.
5. Implementing appropriate behavior management strategies.
6. Modeling a variety of fluency shaping strategies.
7. Delivering corrective feedback.
8. Collecting data in a group setting.
9. Leading group therapy.
10. Leading parent group discussion/education sessions.
11. Explaining therapy goals and techniques to parents.
12. Introduce and conclude therapy goals/activities.
**SESSION FEEDBACK FORM: SCHOOL AGED FLUENCY GROUP**

**Supervisor:** Circle appropriate learning outcome (2-3 per session)

1. Collecting and analyzing speech samples.
2. Formulating semester goals.
3. Demonstrate sensitivity to cultural/linguistic differences.
4. Implementing a commercially available fluency treatment program.
5. Implementing appropriate behavior management strategies.
6. Modeling a variety of fluency shaping strategies.
7. Delivering corrective feedback.
8. Collecting data in a group setting.
9. Leading group therapy.
10. Leading parent group discussion/education sessions.
11. Explaining therapy goals and techniques to parents.
12. Introduce and conclude therapy goals/activities.

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Supervisor Signature  
Student Clinician Signature
LEARNING OUTCOMES FOR ADOLESCENT FLUENCY GROUP

In accordance with Evidence Based Practices, by the end of this semester, you will attain proficiency in the following:

1. Collecting and analyzing speech samples.
2. Formulating semester goals.
3. Demonstrate sensitivity to cultural/linguistic differences.
4. Modeling a variety of fluency shaping strategies.
5. Delivering corrective feedback.
7. Leading group therapy.
8. Leading parent group discussion.
9. Explaining therapy goals and techniques to parents.
10. Introduce and conclude therapy goals/activities.
**SESSION FEEDBACK FORM: ADOLESCENT FLUENCY GROUP**

**Supervisor:** Circle appropriate learning outcome (2-3 per session)

1. Collecting and analyzing speech samples.
2. Formulating semester goals.
3. Demonstrate sensitivity to cultural/linguistic differences.
4. Modeling a variety of fluency shaping strategies.
5. Implementing appropriate behavior management strategies.
6. Delivering corrective feedback.
7. Leading relaxation exercises.
8. Leading group therapy.
9. Leading parent group discussion.
10. Explaining therapy goals and techniques to parents.
11. Introduce and conclude therapy goals/activities.

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**Supervisor Signature**

**Student Clinician Signature**
LEARNING OUTCOMES FOR PRESCHOOL SPEECH GROUP

In accordance with Evidence Based Practices, by the end of the semester, you will have attained proficiency in the following:

1. Demonstrating knowledge of basic characteristics of developmental apraxia, phonological processes, and pre-reading skills.
2. Collecting and analyzing data.
3. Demonstrate sensitivity to cultural/linguistic differences.
4. Formulating treatment goals.
5. Applying cueing hierarchy to elicit accurate responses.
7. Delivering corrective feedback.
8. Leading group therapy activities.
9. Explaining therapy goals/progress and techniques to parents.
10. Developing a home practice program.
11. Implementing a commercially available phonological awareness program.
12. Introduce and conclude therapy goals/activities.
SESSION FEEDBACK FORM: PRESCHOOL SPEECH GROUP

Supervisor: Circle appropriate learning outcome (2-3 per session)

1. Demonstrating knowledge of basic characteristics of developmental apraxia, phonological processes, and pre-reading skills.
2. Collecting and analyzing data.
3. Demonstrate sensitivity to cultural/linguistic differences
4. Formulating treatment goals.
5. Applying cueing hierarchy to elicit accurate responses.
7. Using appropriate behavior management techniques.
8. Delivering corrective feedback.
9. Leading group therapy activities.
10. Explaining therapy goals/progress and techniques to parents.
11. Developing a home practice program.
12. Implementing a commercially available phonological awareness program.
13. Introduce and conclude therapy goals/activities.

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LEARNING OUTCOMES FOR HEAD START SERVICES LANGUAGE CLASSROOM

In accordance with Evidence Based Practices, by the end of this semester, you will attain proficiency in the following:

1. Demonstrate knowledge of theoretical underpinnings of the Prevention Model.
2. Demonstrate knowledge of Head Start services and placement in language classroom.
3. Demonstrate sensitivity to cultural/linguistic differences.
5. Collaborate with teachers/parents and administrators.
6. Structure the environment toward effective service delivery.
7. Create/implement age appropriate lesson plans which target skills in the small group setting.
8. Demonstrate effective behavior management strategies.
9. Promote communication development in the classroom and home (creating parent/teacher handout).
10. Data keeping in a small group format.
11. Introduce and conclude therapy goals/activities.
Supervisor: Circle appropriate learning outcome (2-3 per session)
1. Demonstrate knowledge of theoretical underpinnings of the Prevention Model.
2. Demonstrate knowledge of Head Start services and placement in language classroom.
3. Demonstrate sensitivity to cultural/linguistic differences.
5. Collaborate with teachers/parents and administrators.
6. Structure the environment toward effective service delivery.
7. Create/implement age appropriate lesson plans which target skills in the small group setting.
8. Demonstrate effective behavior management strategies.
9. Promote communication development in the classroom and home (creating parent/teacher handout).
10. Data keeping in a small group format.
11. Introduce and conclude therapy goals/activities.

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Supervisor Signature  
Student Clinician Signature
LEARNING OUTCOMES FOR HEAD START SERVICES FOR THERAPY

In accordance with Evidence Based Practices, by the end of this semester, you will attain proficiency in the following:

1. Read and summarize relevant research/literature.
2. Collaborate with parents/teachers and administrators.
3. Demonstrate sensitivity to cultural/linguistic differences.
4. Structure the environment toward effective service delivery.
5. Demonstrate the ability to take the child’s perspective.
6. Establish age appropriate therapy goals.
7. Formulate relevant lesson plans for therapy.
8. Increase response rate.
10. Collaborate with parents, teacher, and administrators.
11. Demonstrate effective behavior management strategies.
12. Introduce and conclude therapy goals/activities.
### Supervisor: Circle appropriate learning outcome (2-3 per session)
- Read and summarize relevant research/literature.
- Collaborate with parents/teachers and administrators.
- Demonstrate sensitivity to cultural/linguistic differences.
- Structure the environment toward effective service delivery.
- Demonstrate the ability to take the child’s perspective.
- Establish age appropriate therapy goals.

### Strengths

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### Areas for Improvement

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### Suggestions for next session

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LEARNING OUTCOMES FOR HEAD START SERVICES SCREENING/EVALUATION

In accordance with Evidence Based Practices, by the end of this semester, you will attain proficiency in the following:

1. Collect and analyze speech samples.
2. Administer and score screening and evaluation instruments.
3. Demonstrate sensitivity to cultural/linguistic differences.
4. Structure the environment toward effective service delivery.
5. Demonstrate the ability to take the child’s perspective.
6. Interpret test results.
7. Write cohesive/concise evaluation reports.
8. Demonstrate effective behavior management strategies.
9. Collaborate with parents, teachers, and administrators.
### SESSION FEEDBACK FORM: HEAD START SERVICES SCREENING/EVALUATION

**Supervisor:** Circle appropriate learning outcome (2-3 per session)

1. Collect and analyze speech samples.
2. Administer and score screening and evaluation instruments.
3. Demonstrate sensitivity to cultural/linguistic differences.
4. Structure the environment toward effective service delivery.
5. Demonstrate the ability to take the child’s perspective.
6. Interpret test results.
7. Write cohesive/concise evaluation reports.
8. Demonstrate effective behavior management strategies.
9. Collaborate with parents, teachers, and administrators.

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Supervisor Signature

Student Clinician Signature
LEARNING OUTCOMES FOR DEAF/HARD OF HEARING LANGUAGE GROUP

In accordance with Evidence Based Practices, by the end of this semester, you will attain proficiency in the following:

1. Demonstrate knowledge of various deaf/HH information (methodology, language facilitation in sign vs. oral modes, speech, listening/auditory mode).

2. Demonstrate use of sign in language facilitation techniques.

3. Demonstrate sensitivity to cultural/linguistic differences.

4. Collect and analyze data.

5. Formulate therapy goals of deaf/HH clients.


7. Demonstrate effective behavior management strategies.

8. Deliver corrective feedback.

9. Lead group therapy.

10. Explain therapy goals and techniques to parents.

11. Introduce and conclude therapy goals/activities.
**SESSION FEEDBACK FORM: DEAF/HARD OF HEARING LANGUAGE GROUP**

**Supervisor:** Circle appropriate learning outcome (2-3 per session)

1. Demonstrate knowledge of various deaf/HH information (methodology, language facilitation in sign vs. oral modes, speech, listening/auditory mode).
2. Demonstrate use of sign in language facilitation techniques.
3. Collect and analyze data.
4. Formulate therapy goals of deaf/HH clients.
5. Model language facilitation techniques.
6. Demonstrate effective behavior management strategies.
7. Deliver corrective feedback.
8. Lead group therapy.
9. Explain therapy goals and techniques to parents.
10. Introduce and conclude therapy goals/activities.

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**Supervisor Signature** ____________________________  **Student Clinician Signature** ____________________________
## Collecting and Analyzing Data

**LEARNING OUTCOME:** Collecting and analyzing data.

**PREPARATION:**

1. Read Miller Ch. 1, 2, and PLS-3 supplemental measure; language sample checklist.
2. Student will analyze their data collection system used in Tx and develop ideas for revision.
4. Continue to revise systems needed and increase client response rate.

**DISCUSSION:**

1. **First Meeting:**
   - Any questions from readings.
   - Determining method of data collection, e.g. on-line vs. taping.
   - Discuss system of data collection to be used in the next session, e.g. chart with targets listed.

2. **Second Meeting:** Discuss specific requirements with supervisor.

3. **Meeting to discuss results and develop strategies for increasing client response rate.**
## SUPERVISORY CONFERENCE OUTLINE: FORMULATING TX GOALS

### Practicum Placement ____________

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|      | Formulating Tx goals | Research  
Review info of client-specific dev. milestones (normative data)  
Review chart/eval/SOAP notes  
Complete case management sheet.  
Refer to and review info on Tx hierarchy (Planning Curriculum Goals) (PA)  
Goldberg Ch. 6 p. 199 (Silver book)  
Choose a goal and develop Tx hierarchy.  
Review info on goal writing and planning—Hedge Ch. 7 p. 167  
Curriculum goals (P.A.) Fey ch.5  
Student writes Tx plan (because goals are measurable) | Meeting: bring and summarize material found on normative development.  
Meeting: present on highlights of case management sheet—current levels, strengths/weaknesses  
Explain rationale for steps of hierarchy for part. goal. Revise as needed following discussion with supervisor.  
Student will discuss with supervisor, target areas to develop goals for.  
Review with supervisor and revise. |
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<td>Implement language facilitation techniques.</td>
<td>Birth-3 packet HC/ES. Hedge Ch. 8 COSI 352 methods material. Pick 1-2 specific tech. to focus on in Tx sessions. Repeat as needed for subsequent techniques. Develop carryover activity, e.g. handout to be used with parents/caregivers of self or commercial. Watch videotape or ongoing Tx and identify specific techniques used by SLP or student clinician or alternative strategies not implemented.</td>
<td>Role play with peer or supervisor various techniques. Report in self-evaluation on 1-2 specific techniques used in Tx session. Repeat as needed for subsequent techniques. Review with supervisor. Get parent/caregiver feedback. With supervisor or prior to meeting as needed.</td>
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|      | Deliver corrective/reinforcing feedback. | • Review literature pertinent to disorder/client (corrective/positive feedback).  
• Observe Tx/watch video and ID techniques used.  
• Tape self and complete KISS corrective feedback, p. 325.  
• Tape self and complete KISS on positive reinforcement. | Discussion to review comments/questions  
Present findings and suggestions  
Present findings. |
### SUPERVISORY CONFERENCE OUTLINE: MANAGE CHALLENGING BEHAVIOR

**Practicum Placement**

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<td>Complete a review of pertinent LLD literature</td>
<td>Read: Wallach &amp; Butler, Chs. 1,9,10 Merritt &amp; Culatta, Ch. 7</td>
<td>Discuss: Any questions concerning reading material.</td>
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**SUPERVISORY CONFERENCE OUTLINE: DISCUSS LLD ISSUES WITH PARENTS**

**Practicum Placement**

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|      | Discuss LLD issues with parents. | 1. Locate resources for parent education (internet, LDA CCSERC, IDA)  
2. Read material.  
3. Choose material to share with parents  
4. Highlight pertinent information. | Review #3 & 4 from preparation; role play information dissemination. |
## Supervisory Conference Outline: Use commercially available therapy/treatment program

**Practicum Placement**

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<td>Use commercially available therapy/treatment program.</td>
<td>Read: Manuals specified by your supervisor.</td>
<td>Discuss: Any questions.</td>
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<td>Applications:</td>
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<td>Lead group therapy.</td>
<td>Read: Wiig &amp; Semel, Ch. 2</td>
<td>Discuss: Discuss with supervisor differences in learning styles and implications for leading a group.</td>
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<td>Applications: LLD group</td>
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SUPervisory Conference Outline: Lead Group Therapy (LLD Group)
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|      | Administering and scoring screening and evaluation instruments. | Familiarize self with test protocols appropriate for client.  
Observe SLP or video tapes conducting evaluation.  
Administer Dx tool as determined by SLP.  
Implement strategies discussed on next administration of test.  
Become familiar with scoring procedures.  
Identify strengths/weaknesses.  
Determine severity level (formal with informal info) | Rec evaluation tools to be used and discuss with supervisors.  
Comments/ Questions following evaluation with supervisor.  
Supervisor will provide feedback on adm. skills (test specific strategies) |
## SUPERVISORY CONFERENCE OUTLINE: INTERPRETING TEST RESULTS

**Practicum Placement**

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|      | Interpreting test results. | • Read Test manuals to be familiar with scoring and test interpretation  
• Review GFTA scoring sheet re: dialectal differences  
• Review sample reports and scored tests  
• Complete first draft of report to be turned into supervisor. | • Meet with supervisor to discuss test interpretation.  
• Review comments/changes to first draft and revise. |
<table>
<thead>
<tr>
<th>DATE</th>
<th>LEARNING OUTCOME</th>
<th>PREPARATION</th>
<th>DISCUSSION</th>
</tr>
</thead>
</table>
|      | Collaborating with teachers & administrators. | • Elicit information relative to child’s disorder from teacher  
• Formulate questions and hypothetical situations to be asked of teacher. Revise Teacher questionnaire p. 129 Naidecker/Blosser  
• Schedule meeting time with teacher  
  - during teacher meeting, gather and document information relative to child.  
  - interpret information gathered and compile additional information to be shared with teacher.  
• Schedule follow up meeting with teacher and disseminate info. | • Share with supervisor.  
• Interpret information gathered and compile additional information to be shared with teacher.  
• Role play teacher/clinician information sharing re: child’s performance in assessment/therapy.  
• Repeat as necessary and update goals/objective if necessary. |

**Overall Reading Assignment:**  
p. 249-252 LOWE
<table>
<thead>
<tr>
<th>DATE</th>
<th>LEARNING OUTCOME</th>
<th>PREPARATION</th>
<th>DISCUSSION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Explain goals and progress to parents and school personnel.</td>
<td>Prepare script.</td>
<td>Role play script with supervisor/peer.</td>
</tr>
</tbody>
</table>
### SUPERVISORY CONFERENCE OUTLINE: STRUCTURING THE ENVIRONMENT TOWARD EFFECTIVE SERVICE DELIVERY

**Practicum Placement _______________________________**

<table>
<thead>
<tr>
<th>DATE</th>
<th>LEARNING OUTCOME</th>
<th>PREPARATION</th>
<th>DISCUSSION</th>
</tr>
</thead>
</table>
|      | Structuring the environment toward effective service delivery. | • Visit room and document physical structure of room as well as auditory and visual distractions.  
• Separate into positive and negative aspects of environment.  
• Develop strategies to further enhance/modify environment to best meet student needs.  
• Request changes to environment on-site and give to appropriate personnel.  
• Modify as necessary | • Share with supervisor.  
• Share with supervisor  
• See Preparation  
• See Preparation. |
## SUPERVISORY CONFERENCE OUTLINE: COLLECT AND ANALYZE SPEECH SAMPLES

**Practicum Placement _______________________________**

<table>
<thead>
<tr>
<th>DATE</th>
<th>LEARNING OUTCOME</th>
<th>PREPARATION</th>
<th>DISCUSSION</th>
</tr>
</thead>
</table>
|      | Collect and analyze speech samples. | • Prepare stimulus materials for at least 2 audio/videotaped spontaneous speech samples and 2 reading samples (if appropriate). (samples should be at least 200 syllables each)  
• Review frameworks for speech sample analysis (rate and type)  
e.g.:  
1) Shipley & McAfee pp. 227-232  
2) Gregory & Hill | • Play samples of tape to verify accuracy of analysis with supervisor.  
• Utilize results to prepare baseline data collection plans. |
### SUPERVISORY CONFERENCE OUTLINE: MODELING A VARIETY OF FLUENCY SHAPING TECHNIQUES

**Practicum Placement**

<table>
<thead>
<tr>
<th>DATE</th>
<th>LEARNING OUTCOME</th>
<th>PREPARATION</th>
<th>DISCUSSION</th>
</tr>
</thead>
</table>
|      | Modeling a variety of fluency shaping techniques. | • Review fluency training packet material on fluency shaping (e.g. continuous phonation, easy onset, etc.)  
• Choose most appropriate techniques for client (based on speech sample analysis, past therapy outcomes, results of baseline data)  
• Practice techniques (with supervisor approval) in front of mirror and while taping yourself, review and check for accuracy.  
• Write script to explain techniques to client. | Practice technique prior to therapy session with supervisor. |
<table>
<thead>
<tr>
<th>DATE</th>
<th>LEARNING OUTCOME</th>
<th>PREPARATION</th>
<th>DISCUSSION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Leading relaxation exercises.</td>
<td>• Collect information on relaxation strategies (e.g. “Progressive Relaxation” in Daly &amp; Burnett, relaxation response, etc.).&lt;br&gt;• Practice relaxation technique at home (including visual imagery)&lt;br&gt;• Prepare therapy room.&lt;br&gt;• Implement strategies with client.&lt;br&gt;• Solicit client’s feedback (subjective) about benefit of relaxation.</td>
<td>• Analyze time spent on relaxation and benefit for client.&lt;br&gt;• Adjust as necessary to maximize benefit for client.</td>
</tr>
</tbody>
</table>
**LEADING GROUP THERAPY (ADOLESCENT FLUENCY GROUP)**

<table>
<thead>
<tr>
<th>DATE</th>
<th>LEARNING OUTCOME</th>
<th>PREPARATION</th>
<th>DISCUSSION</th>
</tr>
</thead>
</table>
|      | Leading group therapy. | • Read Ramig et al. article in fluency training packet.  
|      | Applications:  
|      | • Adolescent fluency group. | • Establish purpose/goals of group therapy.  
|      |         | • Incorporate individual fluency goal(s) into group setting as appropriate.  
|      |         | • Formulate group therapy hierarchy.  
|      |         | • Establish schedule of clinicians to lead activities/group. | Discuss each preparation step with clinician group prior to meeting with supervision. |
APPENDIX E: CHSC CLINIC FORMS

- CHSC Treatment Plan/Progress/Discharge Form
- Lesson Plan
- CHSC Progress Notes Speech Language Pathology
- Sample Lesson Plans
- Head Start Forms

You will find the treatment plan/progress report in each client’s working file. The clinician lists goals for the given semester on this form and records attained progress on these goals.
### SPEECH-LANGUAGE TREATMENT PLAN/PROGRESS SUMMARY/DISCHARGE

**Client:**

**DOB/Age:**

**Onset Date:**

**Therapy Initiated:**

**Case #:**

**Phone #:**

**Caregiver:**

**Medical Dx:**

**Therapy Format:**

**Individual**

**Group**

**Treatment Period:**

**time(s) per**

**for**

**minutes per session for a minimum of**

**week/months.**

**Status at Beginning of Treatment**

**Primary Comm. Disorder:**

**Secondary Comm. Disorder:**

**Desired Discharge Outcome:**

**Severity at Beginning of Treatment**

Initial Severity: 1 2 3 4 5 6 7 8

**Treatment Plan**

**Prognosis with intervention and follow-through**

- [ ] excellent
- [ ] good
- [ ] fair
- [ ] guarded

**Treatment Plan #:**

**Dates of Therapy →**

**Performance Data**

**Insurance Co:**

**Authorization Period:**

**PCP Prescription on File:**

- [ ] Yes
- [ ] No
- [ ] N/A

**Referral on File:**

- [ ] Yes
- [ ] No
- [ ] N/A

**# visits:**

**Short Term Objectives**

1. Patient/caregiver verbalizes understanding of/demonstrates skill with

2. 

3. 

4. 

5. 

**Attendance**

**Client Cancellation(s) Dates:**

**No Show/No Call Dates:**

**Clinician Cancellation(s) Dates:**

**Graduate Intern Signature:**

**Evidence of Carryover:**

**Activity/Comments**

### Key for Severity & Performance Levels

1. Total assistance required (0-25% accuracy)
2. Maximal assistance required (25-49% accuracy)
3. Moderate assistance required (50-74% accuracy)
4. Minimal assistance required (75-89% accuracy)
5. Standby assistance required (approx. 90% accuracy)
6. Modified independence (91% accuracy)
7. Independent (consistently accurate)
8. N/A: Not Addressed

### Intervenor Notes

---

*8 wk tx plan written style rev. 2/28/03*
Client Name: ____________________________

SPEECH-LANGUAGE PATHOLOGY
TREATMENT PLAN/PROGRESS/DISCHARGE

Certification of Understanding: Treatment Plan: I have read the Treatment Plan outlined on page one. It is agreeable to me. I understand that it may be changed as treatment progresses. If that becomes necessary, I understand that I will be informed and will have input and final approval of the modified plan. I may question any procedures used during therapy and I can expect that my questions and concerns will be addressed by the staff serving me. If I have signed an annual treatment plan, I realize I will not be required to sign the five-week plan, but will be apprised of progress on a regular basis.

Clinician Signature: ____________________ Date: _____________
Patient/Guardian Signature: _______________ Date: _____________

PROGRESS THIS INTERIM
Client attended ____ of ____ scheduled sessions this therapy period and ____ of ____ total therapy sessions.

Referral(s) made to: ______________________ Follow-through: ☐Yes ☐No ☐In Process ☐N/A
Patient/Parent received information regarding resources including:

<table>
<thead>
<tr>
<th>Goal</th>
<th>Goal Attained</th>
<th>Progress</th>
<th>No Progress</th>
<th>Not Addressed</th>
<th>Additional Comments/Functional Abilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
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<td>3</td>
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<td>4</td>
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</tr>
<tr>
<td>5</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Ongoing Needs/Function Limitations

Outcomes Measurement at ________ month review (completed every 6 months after treatment begins and/or at discharge)

Initial Outcome: Demonstrates acquisition of skills to enhance communication ☐Yes ☐No
Intermediate Outcome 1: Applies skills and knowledge outside of therapy setting ☐Yes ☐No
Intermediate Outcome 2: Has gained knowledge of available community resources regarding needs ☐Yes ☐No ☐N/A

Recommendations: ☐Continue with current plan & goals.
☐Continue with changed/adjusted goals, see next treatment plan.
☐Discharge from therapy, see report below.

DISCHARGE REPORT
Onset Date: ______________ Admission Date: ______________ Discharge Date: ______________

Pertinent History:

Initial Status:

Course of Treatment: The client was seen for _____ minute individual/group sessions _____ times per week/month for _____ weeks/months.

Discharge Status:
Primary Comm. Disorder: ______________________ Final Severity: 1 2 3 4 5 6 7
Secondary Comm. Disorder: ______________________ Final Severity: 1 2 3 4 5 6 7

Additional Recommendations:
Reason for Discharge: ______________________ Case Disposition: ______________________

Date: ______________

Graduate Intern Signature
Date: ______________

Clinician Signature/Credentials/OH SP#

8 wks tx plan written style rev. 2/28/03
LESSON PLANS

Lesson plans must be completed and turned into your supervisor prior to your clients’ sessions according to the schedule outlined in your clinical contract. Failure to turn in lesson plans for any session will result in loss of clinical hours for that session. You are to complete your analysis of the session including session strengths, areas to improve and suggestions, and turn it into your supervisor following the session.

Progress notes are to be completed after each session following the SOAP format and should be attached to the client’s working file.
# Detailed Lesson Plan Form

## Lesson Plan (Detailed)

<table>
<thead>
<tr>
<th>Client</th>
<th>Clinician</th>
<th>Date</th>
<th>Time</th>
<th>Supervisor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Short Term Objectives:**

1. 
2. 
3. 
4. 

<table>
<thead>
<tr>
<th>Antecedent Events</th>
<th>Subsequent Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Procedures/ Materials</td>
<td>Cues</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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STRENGTHS:

AREAS TO IMPROVE:

SUGGESTIONS TO IMPROVE THOSE AREAS:
**SAMPLE DETAILED LESSON PLAN #1**

**Client:** Tiara  
**Clinician:**  
**Date:**  
**Time:**  
**Supervisor:**

**Short Term Objectives:**
1. Tiara will spontaneously produce **50 different words** in a 30 minute play session.
2. Tiara will ID core vocabulary with 90% accuracy during the therapy session.
3. Tiara will follow 2-part commands with 90% accuracy given auditory and visual cues during the therapy session.
4. Tiara will spontaneously produce an MLU of at least 2.8 morphemes.

<table>
<thead>
<tr>
<th><strong>ANTECEDENT EVENTS</strong></th>
<th><strong>RESPONSE DEFINITION</strong></th>
<th><strong>SUBSEQUENT EVENTS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Treatment Procedures/Materials</strong></td>
<td><strong>Verbal cue</strong></td>
<td><strong>Response Level and Conditions</strong></td>
</tr>
<tr>
<td>1. Scripted play formats of everyday activities e.g., washing baby, feeding baby. Materials: toys reflecting baby.</td>
<td>verbal</td>
<td>Tiara will produce remaining 4 words spontaneously with at least 70% accuracy for a total of 12 spontaneous productions. In addition, she will initiatively produce 4 new vocabulary words with 70% accuracy.</td>
</tr>
<tr>
<td>2. Reading baby script to introduce 4 novel vocabulary items. Materials: 4 objects within play script.</td>
<td>verbal vary visual</td>
<td>Tiara will ID 4 novel core vocabulary words in a restricted play setting with 90% accuracy during the session.</td>
</tr>
<tr>
<td>3. Try to achieve this while in different play scripts. Materials: toy of a script if client gets restless, could play game with commands e.g., “Simon says...”</td>
<td>auditory cue - 2 visual cues</td>
<td>Tiara will respond to 2-part commands with 70% accuracy with 3 cues during the therapy session.</td>
</tr>
<tr>
<td>4. Scripted play formats i.e., washing baby, feeding baby. Materials: toys reflecting baby, book representing script.</td>
<td>verbal cues - 2 visual cues per response</td>
<td>Tiara will produce 2-word combinations in response to requests, or to comment on objects or actions.</td>
</tr>
</tbody>
</table>
**LESSON PLAN (Detailed)**

**Ent. Tiara**  \(\underline{\text{Clinician}}\)  \(\underline{\text{Date}}\)  \(\underline{\text{Time}}\)  \(\underline{\text{Supervisor}}\)

**Term Objectives:**
1. Tiara will spontaneously produce 50 different words in a 30 minute play session.
2. Tiara will ID core vocabulary with 90% accuracy during the therapy session.
3. Tiara will follow 2-part commands with 90% accuracy given auditory and visual cues during the therapy session.

<table>
<thead>
<tr>
<th>PRECEDENT EVENTS</th>
<th>RESPONSE DEFINITION</th>
<th>SUBSEQUENT EVENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(\text{Clinician Response if target behavior is not produced})</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item Procedures/Materials</th>
<th>Cues</th>
<th>Session Behavioral Objective Response Level and Conditions</th>
<th>Feedback &amp; Reinforcement</th>
<th>Reinforcement Schedule</th>
<th>Clinician Response if target behavior is not produced</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Scripted play formats e.g., kitchen activities, feeding baby</td>
<td>Verbal cue for initiation production</td>
<td>Tiara will spontaneously produce 16 core vocabulary words with 70% accuracy, and 4 new words initiatively with 70% accuracy.</td>
<td>Social reinforcement when client produces word we want, repeat and expand word.</td>
<td>Continuous</td>
<td>If spontaneous words don't occur, provide increased cueing.</td>
</tr>
<tr>
<td>2. Kitchen activities script with 6 novel vocab. items (not included from previous 20 words), above</td>
<td>Verbal, visual</td>
<td>Tiara will ID 6 novel core vocabulary words in a restricted play setting with 90% accuracy.</td>
<td>Social reinforcement - repeat specific response and expand on it.</td>
<td>Continuous</td>
<td>If no response, or incorrect response, model the correct response.</td>
</tr>
<tr>
<td>3. Baby feeding script (because goal wasn't achieved using this on previous lesson plan).</td>
<td>Tactile cues</td>
<td>Tiara will respond to 2-part commands with 70% accuracy with 3 cues during a therapy session.</td>
<td>Social reinforcement</td>
<td>Continuous</td>
<td>If tactile cues don't elicit response, model correct response.</td>
</tr>
</tbody>
</table>
PROBLEM ORIENTED PROGRESS NOTES FOR SOAPS

Problem oriented progress notes include four components:

S = subjective information
O = objective information
A = assessment of the objective information
P = a plan

The initial goal is to identify a problem list which provides for initial format for long range planning. This list will define every problem the child has which may potentially interfere with or relate to the communication process. Thus, although you may not treat all of the problems, you will list all of them. A sample problem list appears elsewhere in this handout.

Once you have devised the problem list, you then write a SOAP for each problem. Even though you may not immediately or ever treat each problem, you should write a SOAP on it. For example, one problem may be "Velopharyngeal incompetency due to an unrepaired cleft," where the child is also under the care of a physician who will soon be performing the necessary surgical repair work. You would write a initial SOAP describing this problem. Since you are not directly treating the problem, follow-up SOAP would not be required.

For problems/objectives that you are treating, a SOAP will take the place of daily logs. SOAPS are written and provide subjective, objective, assessment, and planning information for each objective targeted in a session.

Subjective (S) data: List subjective impressions of the particular objective. This may include your feelings and impressions (or mother, father, or child's feelings) with respect to the problem. Generally, this will consist of information which may account for unexpected changes, either negative or positive, in your O data. Examples can be found on in following pages.

Objective (O) data: The information is to be written in operational, objective terms. This means that anyone could examine the measures and come up with the same information. This may include percentages, numbers, amount of time engaged in particular behavior, etc. Complete sentences are not necessary. No interpretation of the data is necessary - rather, just report the results.

Assessment (A): This is where you interpret your O as well as your S data. You make judgments as to whether the child is regressing, improving or maintaining. This is also the place where you will indicate changes in treatment goals. For example, if you had been working on establishing an SVO syntactic structure on which the child had achieved productivity as indicated in the O data, you might have the following statement: As productivity has been achieved on SVO, this structure will no longer be the main focus of treatment." Note that you will not specify what the new treatment goal will be; that information belongs in the plan.

Plan (P): A concise, complete statement of a) the behavior to be established, and b) the means to be used to establish the behavior. SOAPS will be short if they are stated concisely. Remember not to be redundant. You will probably not have totally new S, O, A and P information each week. In fact, your plan will probably frequently stay the same. In this case, all you need is, "same as SOAP dated...." Since you will be obtaining weekly language samples, your O and A data will probably always change. Remember, every time you have O data you will need to have A data. Your subjective information will probably not change significantly unless you have weeks where your child does not seem to feel well and you think it is important to mention this. Your plan will only change as criteria for targets is reached and you need to establish new targets or if there is no change in behavior and you need to modify your means for establishing a behavior.
S and P may or may not change.
O and A usually change.

SAMPLE PROBLEM LIST

P₁ Semantic/syntactic abilities not age-appropriate
P₂ Inappropriate social-interactive skills with peers
P₃ Disruptive crying behavior
P₄ Fluctuating conductive hearing loss
P₅ Vocabulary size not age-appropriate

EXAMPLES OF SOAPS

P₁

S -- Child seemed very shy and rarely talked directly to clinician. Generally talked to a doll.
O -- MLU = 1.43. One-word declarative statements comprised 75% of the 100 utterance sample. In the remaining 25 utterances, the following semantic relations were present. Nomination - 15%; Recurrence - 50%; Notice - 10%; Action & Object - 15%; Agent & Action - 10%. Of the relations expressed, only nomination was productive. There was no evidence of the heuristic or informative social language functions. No grammatical morphemes or transformations evidenced in sample.
A -- Child exhibits severe delay in semantic/syntactic skills. MLU should be 3.5 for age level. Further, all grammatical morphemes as well as the question, negative, and imperative transformations should be present.
P -- Target: Establish productive use of the following two-term semantic relations: recurrence, action, object, and agent. Procedure: Following child's lead in imitative play and modeling appropriate target structures. Treatment on grammatical morphemes and more complex structures will be delayed until prerequisite syntactic (i.e., two-term relations) have been established. Target behaviors to be established by (date).

P₂

S -- Mother very defensive about child's social behavior: claims "she's shy and will outgrow it."
O -- 30 minutes of 30-minute group session spent alone in corner. Tantrumed every time effort (6 times) was made to require group participation.
A -- Child attended to activity while in the corner. However, a child of this age should be actively participating with peers.
P -- Target: Establish 10 minutes of group participation by (date). Procedure: Engage in imitative play with child and model introduction of other children into activity. If child resists, physical manipulation will be used to keep her in proximity to other children.

P₃

S -- Child did not seem scared, rather was angry, at having to stay in individual treatment instead of going to large play room.
O -- Cried 20 of 30 minute individual session.
A -- Child does not cry in group treatment. Seems to use crying as a manipulation behavior to obtain own way.
P -- Target: Eliminate crying by (date). Procedure: Clinician will ignore child when crying and immediately attend when crying ceases.

P₄

S -- Mother reports "frequent" ear infections
O -- Audiometric evaluation reported a mild (30 db) bilateral conductive hearing loss due to fluid in ears.
A -- None
P -- Child currently under care of physician. No direct treatment in this clinic.
P5

S -- None
O -- TTR of .10
A -- This is a low ratio of new words to total number of utterances.
P -- Target: To increase number of lexical terms. Procedure: While engaging in imitative play and modeling, two-term semantic relations, clinician will also model a variety of lexical terms
APPENDIX F: ASHA MEMBERSHIP & CERTIFICATION/ OHIO BOARD OF SPEECH LANGUAGE PATHOLOGY AND AUDIOLOGY LICENSING

Information on the academic and clinical requirements in order to become eligible for applying for the ASHA Certificate of Clinical Competence and licensure by the Ohio Board of Speech Language Pathology and can be found on the ASHA website at http://www.asha.org/about/credential.ng/cert/.

Information on how to apply for certification and licensure at the end of your master’s program will be included in Appendix J: Guidelines for Graduate Students.

After reviewing this information you should be able to answer the following questions:

- What is ASHA?
- What is the Certificate of Clinical Competence (CCC)?
- What is membership in ASHA?
- What must I do to obtain membership and certification?
- What is a clinical fellow?
- What is the National Examination in Speech-Language Pathology and how do I take it?

As a student, you will be most concerned with section III. Standards and Implementation Procedures for the Certificate of Clinical Competence which outlines all academic and clinical requirements to become certified in Speech-Language Pathology. READ THIS INFORMATION CAREFULLY.

At the end of your program, you will need to complete the “Application for Membership/Certification”. A current copy of the Membership and Certification Handbook and the “Application for Membership/Certification” can be found on ASHA’s website www.ASHA.org.
In addition to ASHA certification, most states require a license to practice speech-language pathology. Ohio is one of these states. At the end of your master’s program, you will apply for a conditional license in Ohio or the state in which you will practice. Below are the requirements you will meet throughout your master’s program that will allow you to apply for licensure in Ohio. If you intend on practicing in another state, you must check with their governing board for the appropriate requirements.

Information regarding Licensure can be found at [http://slpaud ohio.gov/application2.htm](http://slpaud ohio.gov/application2.htm). Applications are reviewed for approval on the 1st and 15th of each month.
### MASTER OF ARTS IN SPEECH-LANGUAGE PATHOLOGY: ASHA CERTIFICATION WORKSHEET

<table>
<thead>
<tr>
<th>Name</th>
<th>Advisor</th>
<th>Dated</th>
</tr>
</thead>
</table>

75 semester credit hours in Academic Coursework-MINIMUM*

27 semester credits-BASIC SCIENCE COURSEWORK-MIN*

36 semester credits-PROFESSIONAL COURSEWORK-MIN*

30 semester cr-Graduate

21 semester cr-Professional Area

<table>
<thead>
<tr>
<th>6 credits Biological/Physical Sciences: 1 course</th>
<th>6 credits Behavioral and/or Social Sciences</th>
<th>15 credits Basic Communication Processes</th>
<th>6 credits Audiology</th>
<th>6 credits Language Disorders</th>
<th>6 credits Speech Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>COSI 109 Introduction to Communication Disorders (3) F/S</td>
<td>COSI 405 Neuroscience of Communication Disorders (3) F</td>
<td>COSI 321 Speech &amp; Hearing Science (3) S</td>
<td>COSI 3/470 Introduction to Audiology (3) F</td>
<td>COSI 445 Communication &amp; Aging (3) S</td>
<td>COSI 453 Articulation &amp; Phonology (3) F</td>
</tr>
<tr>
<td>COSI 220 Introduction to American Sign Language I (3) F/S</td>
<td>COSI 211 Phonetics &amp; Phonology (3) F</td>
<td>COSI 313 Language Development (3) F</td>
<td>COSI 580 Aural Rehabilitation (3) S</td>
<td>COSI 456 Child Language Disorders (3) S</td>
<td>COSI 455 Fluency Disorders (3) Su</td>
</tr>
<tr>
<td>COSI 260 Multicultural Aspects of Human Communication (3) F</td>
<td>COSI 324</td>
<td>COSI 317</td>
<td>COSI 560 Neuromotor &amp; Craniofacial Anomalies (3) S</td>
<td>COSI 561 Voice Disorders (3) F</td>
<td>COSI 562 Dysphagia (2) S</td>
</tr>
</tbody>
</table>

1 course in each area-minimum

* A MINIMUM of 6 semester credits of practicum may be applied to the 36 semester credits MINIMUM Professional Coursework, but PRACTICUM MAY NOT BE USED TO SATISFY minimum requirements in AUDIOLOGY or LANGUAGE or SPEECH

OTHER:  
COSI 352 Introduction to Clinical Practice (3) F  
COSI 452 Graduate Clinical Practicum A-E (1) F/S/Su  
COSI 463 SLP in Educational Settings (3) F  
COSI 497 Methods of Research (3) F  
COSI 500 Counseling (1) Su

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STEPS TOWARD CERTIFICATION, AND LICENSURE


II. OHIO License: Obtain Ohio Board of Speech-Language Pathology and Audiology application for licensure from website: http://slpaud.ohio.gov/

Upon Completion of Comprehensive Exams and coursework:

1. Complete final course and practicum requirements. Make sure you have signatures from ALL of your supervisors and their license numbers. Once you have completed your coursework, final practicum, and have all of the required signatures, neatly hand-write or type a new copy of your Ohio Board hours sheet. Do Not Total the Columns. Make 3 photocopies of this new sheet.

2. Make an appointment to meet with Coordinator of Clinical Education for a final check on practicum requirements. This meeting should be held 1-2 weeks prior to the deadline for submitting application materials to the Ohio Board. The Ohio Board reviews applications on the 1st and 15th of every month. All application materials must be received 5 business days prior to the review date.

3. After meeting with the Coordinator of Clinical Education, your clinical hours sheets will be forwarded to the Department Assistant for signature and notarization. She will notify you when they are available for pick-up.

THE DEPARTMENT UNDERSTANDS THAT YOU ARE EAGER TO BEGIN YOUR PROFESSIONAL CAREER, HOWEVER, IT IS YOUR RESPONSIBILITY TO MAKE SURE THAT YOU HAVE ALL APPLICATION MATERIALS TOGETHER AND SUBMITTED TO THE APPROPRIATE PEOPLE IN A TIMELY MANNER. NO EXCEPTIONS!
INSTRUCTION FOR OBTAINING AND MAINTAINING ASHA CERTIFICATION

The Certificates of Clinical Competence in Speech-Language Pathology (CCC-SLP) and Audiology (CCC-A) are awarded by ASHA's Council For Clinical Certification (CFCC) to applicants who hold a graduate degree and who have successfully completed (a) all academic course work and clinical practicum, (b) a clinical fellowship, and (c) the national examination in the area in which certification is sought, as specified in the Standards and Implementation Procedures for the Certificates of Clinical Competence (SCCC) in Speech-Language Pathology and Audiology (see Section III of this Handbook). The applicant must submit an application completed as specified, the appropriate dues and fees, and the supporting documents required for processing the application. Maintaining the CCC-SLP is contingent upon the timely payment of annual dues and fees, and beginning in January 1, 2005, completion of 30 contact hours of continuing professional development. Individuals who are in the certification process, hold the CCC, and/or are members of the Association must abide by ASHA's Code of Ethics. All applicants for certification must meet the currently published standards, policies, and procedures.

STEPS FOR OBTAINING AND MAINTAINING THE CERTIFICATES OF CLINICAL COMPETENCE

1. Application Materials. Submit to the ASHA Certification office one complete packet including the following:
   a properly completed and signed application
   verification of receipt of graduate degree (Individuals should not submit the application until the graduate degree has been awarded. Those individuals who graduate from a program that has only one graduation per year may apply before receipt of the degree if all graduate course work and graduate level practicum have been completed.)
   course descriptions or transcripts, if required
   appropriate payment, by either check or charge (VISA or MasterCard only). [See the "Schedule of Required Dues and Fees,"]

   No individual documents should be submitted to the ASHA Certification office before submission of the application for certification. Items received before receipt of the application will be returned to the sender. Please note that individuals who wish to be certified in both audiology and speech-language pathology must meet the standards and requirements in both professional areas.

2. Clinical Fellowship (CF) Experience. After verifying that you meet the requirements for state licensure (see "State Licensure/Regulatory Requirements" in Section IV. Clinical Fellowship: Requirements and Procedures), begin the clinical fellowship experience. Both the fellow and the supervisor are responsible for verifying that the supervisor's certification remains valid throughout the entire clinical fellowship period. (For more information about verifying supervisors' certification, see "Clinical Fellows").

3. Clinical Fellowship Evaluations and Observations. During the CF experience, the clinical fellowship supervisor must complete (a) at least three formal evaluations of the clinical performance using the CFSI-SLP, and (b) at least 18 on-site observations, 6 per segment, and 18 other monitoring activities, 6 per segment (see Section IV. Clinical Fellowship: Requirements and Procedures for specific information.)

4. Clinical Fellowship Report and Rating Form. At the completion of the CF experience, the clinical fellowship supervisor must complete and submit the Clinical Fellowship Report and Rating Form (Form
D) to the CFCC within 4 weeks of the date the clinical fellowship is completed. Both the supervisor and fellow must sign the report and rating form.

5. Examination. Obtain a passing score on the national examination. Exam results must be sent directly from the Educational Testing Service (ETS) in order to be applicable toward certification. When you register to take the exam, request that your score be reported directly to ASHA. ETS charges an additional fee to report scores after the examination has been taken. To assist the National Office in processing your examination information, it will be helpful if you submit a copy of the report sent to you by the testing service when you submit your application for certification. However, please note that this copy will not be used as official verification of completion of the examination requirement.

6. Certificate. Once certification has been awarded, ordering the certificate is optional. If one is desired, complete and return the certificate order form sent to you with your notification. The certificate will be sent approximately 8 weeks after the certificate order is received in the ASHA National Office.

7. Renew Certification and Membership. Pay annual dues and fees when the annual invoice is received. Maintenance of certification and/or membership is contingent upon the timely payment of annual dues and fees and, beginning January 1, 2005, completion of 30 contact hours of continuing professional development activities. (See ASHA's Certification section for specific information.)

Application Instructions "Pass-Through" Applicants
You will be considered a "pass-through" applicant if you initiated and completed your graduate education at a program accredited by the Council on Academic Accreditation (CAA). Such applicants are not required to complete the entire application if the program director verifies that all course work and practicum requirements have been met and if the application is submitted no more than 3 years from the date the degree was awarded (see Section III. Standards and Implementation Procedures for the Certificates of Clinical Competence, for specific information). However, if you do not meet these requirements or received your education in a foreign country, you will not be considered a 'pass-through' applicant and will be required to complete the entire application as noted in the section below regarding 'Non-Pass-Through' applicants.

"Pass-through" applicants should adhere to the following procedures: Program Director Signature. Have the director of your graduate program review and sign section 21 of the application (Form A). Your program director must verify that all requirements for graduate course work and practicum have been met. Of vital importance are the date on which the course work requirements were completed and the date on which the practicum requirements were completed. Also complete sections 1 through 6 and 19 through 21 of the application.

Degree Verification. If the graduate degree has been officially conferred, completion of Section 20.C and the signature of the program director will serve as verification that the applicant has a graduate degree. No additional verification of degree is required; transcripts do not have to be submitted if the degree has been conferred at the time the application is signed by the program director.

Degree Conferred in Future. If the graduate degree will be conferred after the application is signed by the program director, verification of actual receipt of the graduate degree is required. Verification can be submitted in any one of the following ways: (a) an official transcript with the degree date imprinted, (b) an unofficial transcript or a photocopy of a transcript with the degree date imprinted, (c) a letter signed by the graduate program director verifying the date on which the graduate degree was awarded, or (d) a letter from the registrar verifying the degree and the date it was awarded. Certification will not be awarded until verification of receipt of the graduate degree has been received by the Certification unit of the National Office.

Examination. Exam results must be sent directly from the Educational Testing Service (ETS) in order to be applicable toward certification. When you register to take the exam, request that your score be
reported directly to ASHA. ETS charges an additional fee to report scores after the examination has been taken. To assist the National Office in processing your examination information, it will be helpful if you submit a copy of the report sent to you by the testing service when you submit your application for certification. However, please note that this copy will not be used as official verification of completion of the examination requirement.

**Application Checklist.** Finally, before you submit your application materials to the National Office, review the Application Checklist (Form F) to confirm that you have completed all the requirements for certification. Incomplete applications will be returned to the applicant.

**“Non-Pass-Through” Applicants**

You will be considered a ‘non-pass-through’ applicant if you (a) apply more than 3 years after the date your degree is awarded by an institution in which a CAA-accredited program is housed, (b) were enrolled in a CAA-accredited program that had its accreditation withdrawn before you graduated, (c) completed your graduate course work and practicum in the area in which you seek certification in a program that held candidacy status for accreditation, (d) completed your graduate course work and practicum in the area in which you seek certification in a CAA-accredited program but did not receive your graduate degree from the accredited program or received your graduate degree in a related area or received your graduate degree from an institution outside the United States and are not currently certified by an agency that has a reciprocal certification agreement with ASHA. Such applicants must complete the Membership/Certification Application (Form A) in its entirety and must follow the instructions below. Official graduate and undergraduate transcripts must be submitted before the CFCC will evaluate the application. Official transcripts can be submitted either from the applicant or directly from colleges/universities. (Also see Section III. Standards and Implementation Procedures for the Certificate of Clinical Competence, Standard I, for additional information regarding who must complete the entire application.) Complete sections 1 through 18 of the application. Have the director of your graduate program verify your graduate practicum hours at the end of section 18 and complete sections 19 through 21 of the application.

List all course work in semester hours. If you earned credit on the quarter-hour system, use the conversion chart to convert quarter hours to semester hours. If you received some other type of credit, you must submit information from your university which equates the credit you earned to the semester-hour system. Applicants must have at least 75 semester credit hours combined over all course work. Only 6 semester credit hours of clinical practicum hours will be accepted within this overall total.

Provide the course number and title as listed on your transcripts. If a course title is general or vague, submit a copy of the course description from the college/university catalog to clarify course content.

If you wish to receive credit for a thesis/dissertation, you must submit an abstract. Do not send a copy of the entire thesis; materials are not returned to applicants.

Be sure to check the appropriate columns for graduate credit, practicum credit, courses with culturally diverse populations, and courses in development and behavior across the life span.

In completing the practicum section of the application, cite only those clock hours that were supervised by the indicated supervisor.

Double check your math on the hours listed in the practicum sections.

Have the application reviewed and signed by the authorized signer at the program where the graduate course work and practicum were completed. Sections 19-21 must be completed. Incomplete applications or those that bear invalid signatures will be returned to the applicant.
Exam results must be sent directly from the Educational Testing Service (ETS) in order to be applicable toward certification. When you register to take the exam, request that your score be reported directly to ASHA. ETS charges an additional fee to report scores after the examination has been taken. To assist the National Office in processing your examination information, it will be helpful if you submit a copy of the report sent to you by the testing service when you submit your application for certification. However, please note that this copy will not be used as official verification of completion of the examination requirement.

Finally, before you submit your application materials to the National Office, review the Application Checklist (Form F) to confirm that you have completed all the requirements for certification. Incomplete applications will be returned to the applicant.

**CFCC Interpretations on Course Work.** Credit for a course is allowed only if an official transcript shows a passing grade for the course. Course credits should not be split unless it is absolutely necessary. If necessary, a course may be credited to no more than two categories, with no less than 1 semester hour credit assigned to each category. For courses with vague titles, such as "Directed Study," "Independent Study," "Speech Pathology I," "Audiology II," etc., the applicant must submit a copy of the catalog description. Copies of abstracts of projects, theses, or dissertations also must be submitted to the CFCC in order to be counted for credit. The CFCC may request further information on course content or projects if needed for the evaluation.

**Instructions for Dues and Fees.** Refer to section 2 of the application form (Form A) and the current 'Schedule of Required Dues and Fees' (Form B) to determine the amount you must submit with your application. The entire payment must be submitted with the application. Applications received without payment will be returned. All fees must be paid in U.S. currency.

Payment may be made by check, money order, or credit card (VISA or MasterCard). Do not send cash.

Applications and payments received between January 1 and August 31 are processed for the year in which they are received; individuals will receive an invoice in October for dues and fees for the following year. Applications and payments received between September 1 and December 31 are processed for the following year, and applicants will receive complimentary membership from the time of application through the remainder of that year. Date of receipt is determined by the received date stamped in ASHA’s Postal Operations center. Certification staff will not hold applications that arrive before August 31, but will process them as they are received. Dues and fees are based on a calendar year. The required renewal dues and fees must be paid annually upon receipt of the invoice in order to maintain membership, certification, or certification-in-process status.

If you are unclear about the fees that you should submit with your application, please contact ASHA’s Action Center (1-800-498-2071) for assistance.

**ABOUT THE PRAXIS EXAM**

The Praxis Examinations in Speech-Language Pathology and Audiology are a major component for ASHA certification and most state licensing requirements for audiologists and speech-language pathologists. The active participation of faculty and students in ensuring the success of the Praxis experience is essential to the future of each profession. To ensure success, it is essential that students prepare for the examinations and that faculty assist them with their preparation activities.

The Praxis Series Specialty Area Tests in Speech-Language Pathology and Audiology are developed and owned by the Educational Testing Service (ETS). The exam is designed to provide a system of thorough, fair, and carefully validated tests and assessments.
HOW IS THE TEST SCORED?
Only questions answered correctly count toward the reported score. Therefore, it is better to guess than to leave an answer blank.

There are several versions for each Praxis examination in speech-language pathology or audiology. The questions on one edition may be slightly more difficult (or easier) than those on another edition. ETS uses statistical methods to ensure that the various scores earned on editions of the active tests are comparable to each other.

The passing score for ASHA certification is 600 out of a possible 800 for both Speech Language Pathology and Audiology.

Each state determines its passing score for professional licensure and teacher certification. Most states use the same score of 600 as required for ASHA certification. However, in some states the Praxis examination score for licensure or teacher certification may be higher or lower than the ASHA minimum passing score.

Typically, 80% of students in both speech-language pathology and audiology pass the Praxis examination on their first attempt.

For the academic year 1998-1999, the mean score in audiology was 628, and the mean score in speech-language pathology was 651.

Speech-language pathology and audiology test takers who have not earned a passing score have no limitation for a two-year period on the number of times that the Praxis examination can be taken. If the examination is not passed successfully within a 2-year period, the applicant's certification file will be closed. If the examination is passed at a later date, the individual will have to reapply for certification under the standards in effect at the time of reapplication.

It is recommended that students register and take the examination no earlier than the completion of their graduate coursework and graduate clinical practicum or during the CF experience.

WHO WRITES THE PRAXIS QUESTIONS?
Several groups of individuals are involved in developing the questions to be included in each Praxis examination. ETS has a test development committee comprised of faculty and clinicians in speech-language pathology and a separate ETS test development committee for audiology. These individuals are well versed in developing test questions in specific content areas. In addition, ETS staff have specific responsibilities in developing and evaluating the Praxis questions. The ETS staff work very closely with staff members at ASHA's National Office who are involved in the areas of academic affairs, academic program accreditation and clinical certification. The following is a general overview of the role of the ETS Test Development Committees, ETS staff and ASHA staff.

The Role of ASHA National Office Staff

- Make recommendations to ETS about potential test development committee members
- Contract with ETS every 5 to 7 years to conduct a job analysis and skills validation study for each profession
- Identify the knowledge and skills necessary for entry-level practitioners to practice either speech-language pathology or audiology, based on the job analysis and skills validation study.

The Role of ETS Staff
• Develop contracts with each test development committee member
• Review individual test questions from both content and statistical perspectives
• Develop and/or modify a pool of questions
• Review any questions identified as potentially flawed during a particular test administration
• Assemble tests to conform to rigorous test standards and analyses of test questions
• Provide differential statistical analyses to remove any cultural bias and to ensure a representative reflection of the multicultural nature of our society
• Respond to questions raised by test takers, faculty and/or administrators
• ETS will conduct cut-score studies for professional certification and licensure

The Role of the ETS Test Development Committee

• Provide feedback on the current scope of practice in the profession and changing demands of clinical practitioners

For more information about the Praxis exam, see www.ets.org/praxis.

FREQUENTLY ASKED QUESTIONS ABOUT THE PRAXIS EXAM
Is it possible to study for the Praxis exam in Speech-Language Pathology or Audiology?
Yes. Reviewing your course materials, becoming familiar with the test, and taking practice exams are all effective ways to prepare for the Praxis exams. This will help you to pace yourself, improve your score, and understand the questions that are asked.

What is the format of the Praxis exam?
The Praxis exams are 2-hour, multiple-choice tests. Multiple-choice questions based on case studies are included in the exams. There are no essay questions on the examinations.

Is there a penalty for guessing on the Praxis exam?
No. Only correct answers count toward your score. Leave NO question blank. It is to your advantage to guess!

Is it true that as long as you get good grades in your courses and clinical practica you will pass the Praxis exam?
No. You must be able to integrate this information and draw from your coursework and clinical experiences to pass the Praxis examination.

Are there accommodations available for students with disabilities?
Yes. See www.ets.org/praxis/prxdsabl.html for details.

Can you cancel your score once you sit for the exam?
Yes. If ETS receives a written request to cancel your score within one week of your test date, your score can be canceled. For special circumstances see www.ets.org/praxis/praxcrs.html for more information about score reporting.

Do you have to pass the Praxis exam in order to be eligible for ASHA's Certificate of Clinical Competence (CCC) in Speech Language Pathology or Audiology?
Yes. ASHA has set a passing score of 600 as one requirement for the CCC-SLP and CCC-A.

If your primary language is not English, can you request special testing conditions?
Yes. If your primary language is not English, you may be eligible for an alternate test site and/or extended time. Monday testing is available for those individuals unable to take a Saturday exam for religious reasons or because they are in the U.S. Armed Forces. Find out more details from www.ets.org/praxis.

Is the Praxis exam culturally and linguistically fair?
Yes. Each question undergoes a rigorous review for sensitivity and differential item analysis to ensure that no question favors or disfavors any group of test-takers by race, gender, or ethnicity. Also, each test is reviewed by a team of linguists with specific training in sociolinguistics to ensure accessibility.

Does a Praxis score belong to ASHA once you take the test?
No. You have the right to control the information that ETS has regarding your test score. No one will see your scores unless you designate them as a score recipient.

SPEECH-LANGUAGE PATHOLOGY EXAM CONTENT

Topics Covered
The following list represents the topics covered the Speech Language Pathology Exam that is currently being administered. These topics are consistent with standards for clinical certification set by the American Speech-Language-Hearing Association.

Basic Human Communication Processes

- Language acquisition and learning theory
  - normal development of speech and language
  - developmental norms in phonology, syntax, semantics, and pragmatics
  - theoretical models of learning related to language and cognition
  - behavior management and modification
  - cognitive development
  - developmental, motor, and linguistic processes
- Language science
  - the structure of language
  - the phonetic and phonological representations of speech sounds
  - phonological theory as it relates to normal development
  - grammatical categories
  - morphology, syntax, semantics, and pragmatics, as these fields relate to normal language processing and production
- Learning theory
  - theoretical models of learning related to language and the effective treatment of disorders
  - models of behavior management and modification
  - theories of cognitive development
- Multicultural awareness
  - applications of theoretical models of language in society to a variety of linguistic and cultural groups
  - cultural and socioeconomic factors that influence speech and language
  - communicative differences between speakers of the same language, including idiolectal and dialectal distinctions
  - differentiation between first language/dialect interference and speech/language disorders
  - cultural differences in the use of nonverbal communication
- Speech science
  - speech perception
  - physiological phonetics
  - acoustic phonetics
anatomy and physiology, as related to the production, reception, and processing of speech, language, and hearing
- neural bases of speech and hearing

**Phonological and Language Disorders Assessment and Treatment**

- **Phonological disorders**
  - articulation disorders as influenced by anomalous, oral-motor, dental, learning, or behavioral factors
  - phonological process disorders
- **Language disorders**
  - developmental, motor, and linguistic processes
  - differentiation of normal, delayed, and disordered language development
  - the nature of expressive and receptive language disorders
  - treatment of language delays and language disorders

**Speech Disorders: Identification, Assessment, Treatment, and Prevention**

- **Fluency disorders**
  - theories of fluency
  - neurological and psychological factors
  - assessment, treatment, and prevention of fluency disorders
- **Resonance disorders**
  - resonance, as influenced by congenital anomalies, neuralgic disorders, disease, trauma, and behavioral factors
  - assessment, treatment, and prevention of resonance disorders
- **Voice disorders**
  - phonation, as influenced by respiratory, laryngeal, and airway problems resulting from malformations, neuralgia, disease, trauma, and behavioral factors
  - alaryngeal speech
  - assessment, treatment, and prevention of voice disorders

**Neurogenic Disorders**

- **Neurological disorders**
  - aphasia
  - progressive disorders
  - motor speech disorders
  - traumatic brain injury
  - cognitive communication disorders
- **Dysphagia**
  - the process of swallowing
  - causes and effects of swallowing disorders
  - assessment and treatment of swallowing disorders

**Audiology/Hearing**

- **Hearing science**
  - principles of hearing
• anatomy and physiology of the hearing mechanism
• congenital and acquired hearing loss in children and adults

• Audiological assessment
  o hearing screening for clients of all ages
  o interpretation of audiograms and tympanograms
  o referrals to appropriate professionals

• Auditory habilitation and rehabilitation
  o management of clients with hearing loss
  o issues of intervention relevant to the practice of speech-language pathology

Clinical Management

• Alternative/augmentative communication
  o assessment and use of alternative/augmentative communication devices
  o determining candidacy for alternative/augmentative devices

• Counseling
  o communicating assessment and treatment plans, progress, and results to clients and appropriate professionals
  o interpersonal communication and counseling techniques

• Documentation and monitoring client progress
  o collecting and using information from other agencies
  o communicating to other professionals concerning the client's history
  o data gathering and interpretation
  o determining termination criteria based on prognosis, progress, and motivation
  o procedures for referral and follow-up
  o writing professional reports

• Efficacy
  o demonstration of results of clinical services in relation to speech, language, and hearing
  o determining and communicating information about the outcomes of assessment and treatment

• Instrumentation
  o instrumentation used in speech and language analysis
  o the purpose, use, and applications of technological developments with respect to assessment and treatment of speech and language disorders

• Speech-language assessment
  o establishing clients' past and present status
  o formulating recommendations, including impact of life conditions, type of treatment, and service-delivery models
  o identifying individuals at risk for communication disorders
  o interviewing techniques and interpersonal skills
  o procedures for screening clients of all ages
  o selection and administration of standardized evaluation procedures, such as formal tests
  o selection and administration of non-standardized procedures, such as language samples and behavioral observations
• Speech-language intervention
  o diagnostic intervention
  o selecting activities appropriate to the client's age, sociocultural membership, and disorder
  o implementing remediation methods and strategies for disorders

• Syndromes and genetics
  o basic principles of genetics
  o syndromic and nonsyndromic inherited and developmental conditions
  o influence of syndromic and nonsyndromic conditions on hearing, speech and language
    development, production, and processing

Professional Issues/Psychometrics/Research

• Ethical practices
  o understanding standards for professional conduct
  o making referrals, obtaining permissions, keeping and using client records
  o ensuring client privacy
  o handling staffing issues in a professional and legally prudent manner

• Research methodology/psychometrics
  o criteria for selection of test materials
  o determining the reliability of assessment procedures
  o models of research design
  o test construction principles

• Standards and laws
  o designing appropriate assessment and treatment through knowledge of governmental
    regulations and professional standards
  o federal laws and regulations impacting delivery of services
  o reporting requirements of governmental agencies

SOURCES FOR THE NATIONAL EXAMINATION IN SPEECH LANGUAGE PATHOLOGY AND AUDIOLOGY

Although there are no specific study guides for the examinations, some individuals have reported the
following sources to be helpful. (If you know of additional helpful review materials or courses, please
notify the Certification Section in the National Office.)

ASHA does not have these publications available. To receive additional information on how to obtain
these books, please contact your local bookstore or library, or the publisher directly.

comprehensive volume covering the latest information on processes/pathologies of speech, language and
hearing.

Bacon.

Examination*. Mosby Co. Out of Print. May be available at local libraries.

<table>
<thead>
<tr>
<th>WHEN</th>
<th>CASE</th>
<th>ASHA CERTIFICATION</th>
<th>OHIO LICENSURE</th>
<th>DESCRIPTION/ACTIVITY</th>
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<tbody>
<tr>
<td>First Semester</td>
<td>X</td>
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<td></td>
<td>Complete initial Plan of Study with advisor.</td>
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<td>If you are interested in School Certification, please see Coordinator of Teacher Licensure.</td>
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<tr>
<td>Throughout Program</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Completion of required academic coursework and clinical hours.</td>
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<td>3rd Semester or Semester Before Comprehensive Exams</td>
<td>X</td>
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<td>Begin preparing for comprehensive exam process.</td>
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<td>Organize notes, articles, etc. for each area.</td>
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<td>By the middle of the semester, you should meet with your advisor to discuss strategies for studying and to discuss comprehensive exam process. Begin studying.</td>
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<td>Complete practice questions and get feedback from faculty members.</td>
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<td>Successfully complete comprehensive exams.</td>
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<tr>
<td>4th Semester or Semester of Comprehensive Exams</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Apply for Graduation.</td>
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<tr>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Take the PRAXIS Exam. Have scores sent to Case, Ohio Board of Speech Language Pathology and Audiology, ASHA, and Ohio Department of Education if filing for Teacher Licensure.</td>
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<td>Request “Conditional License” application materials from the Ohio Board of Speech Language Pathology and Audiology (<a href="http://www.state.oh/us/slp">www.state.oh/us/slp</a>)</td>
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<tr>
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<td>X</td>
<td>X</td>
<td></td>
<td>Complete final academic and clinical requirements.</td>
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<td>Prepare resume for job search process.</td>
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<td>X</td>
<td>Obtain a CFY position and a CFY supervisor.</td>
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<td></td>
<td>Complete application materials for Ohio Board of Speech Language Pathology and Audiology.</td>
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Certification and Licensure

Upon completion of the M.A. program in Speech-Language Pathology, graduate students are eligible for state licensure through the Ohio Board of Speech-Language Pathology and Audiology and certification through the American Speech-Language-Hearing Association. As graduation approaches in each semester, the Department Assistant should work with the Coordinator of Clinical Education in assisting students complete the necessary paperwork for certification and licensure. The following is a memo distributed to students outlining the process (can be found on Department Assistant’s computer):

Steps Toward Certification and Licensure


II. OHIO License: Obtain Ohio Board of Speech-Language Pathology and Audiology application for licensure from website: http://slpaud.ohio.gov/

Upon Completion of Comprehensive Exams and coursework:

1. Complete final course and practicum requirements. Make sure you have signatures from ALL of your supervisors and their license numbers. Once you have completed your coursework, final practicum, and have all of the required signatures, neatly hand-write or type a new copy of your Ohio Board hours sheet. **Do Not Total the Columns.** Make 3 photocopies of this new sheet.

2. Make an appointment to meet with Coordinator of Clinical Education for a final check on practicum requirements. This meeting should be held 1-2 weeks prior to the deadline for submitting application materials to the Ohio Board. The Ohio Board reviews applications on the 1st and 15th of every month. All application materials must be received 5 business days prior to the review date.

3. After meeting with the Coordinator of Clinical Education, your clinical hours sheets will be forwarded to the Department Assistant for signature and notarization. She will notify you when they are available for pick-up.

4. Each student will complete a final check-out with the program director.

*THE DEPARTMENT UNDERSTANDS THAT YOU ARE EAGER TO BEGIN YOUR PROFESSIONAL CAREER, HOWEVER, IT IS YOUR RESPONSIBILITY TO MAKE SURE THAT YOU HAVE ALL APPLICATION MATERIALS TOGETHER AND SUBMITTED TO THE APPROPRIATE PEOPLE IN A TIMELY MANNER, NO EXCEPTIONS! You will not be permitted to begin your career until all of these procedures have been completed.*