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FOREWORD

This is a thirteenth edition of the manual for supervisors of off-campus practicum prepared by the Department of Speech Pathology and Audiology at Western Michigan University. In the distant past, we were reluctant to dictate the supervisor’s approach to the supervision of our students. However, several supervisors have indicated that they would appreciate more guidelines than they had then. Additionally, the site visitors from ASHA’s Council on Academic Accreditation at one of our review sessions suggested that a manual would be helpful. We have revised the manual used by on-campus supervisors to apply to off campus situations. This is only a model and is not intended to constrain unique activities or procedures that are valuable to you. We would encourage you to implement your own professional judgment regarding variations of the procedures herein. The manual is presently in formative stages, especially with the new ASHA standards, and we will appreciate any feedback you can give to help us create a useful document for our off-campus supervisors, who are so vital to the quality of our educational program.

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The Department of Speech Pathology and Audiology traditionally has encouraged individuality and innovation in supervisory style. Excellence in clinical education and excellence in the delivery of services are the only invariant goals. Nevertheless, effective and efficient operations as well as compliance with ASHA regulations require standardized information and certain uniform procedures. The purpose of this manual is to provide supervisors with information about procedures and policies for the Department of Speech Pathology and Audiology. The procedures are subject to change, however, and the clinic coordinators welcome your suggestions for improvement.

Goals of the Program

A basic goal of the Department of Speech Pathology and Audiology is to assure that individuals who have or are at risk for communication disorders achieve maximum communicative competence. In order to accomplish this goal, the Off Campus site will:

1. provide diagnostic and treatment services commensurate with the qualifications of its staff and the limits of its facilities;
2. refer clients for diagnostic, treatment and consultation services, which it cannot provide within the staff and time limitations of its clinic service;
3. use only supervisors who are clinically certified by the American Speech-Language-Hearing Association (ASHA);
4. assign each client to a clinically certified supervisor;
5. follow the standards set by ASHA for supervision;
6. protect the confidentiality of the client; and
7. adhere to the Code of Ethics of the ASHA.

The Council on Academic Accreditation (CAA) of the American Speech-Language-Hearing Association has accredited the department of Speech Pathology and Audiology of Western Michigan University. All supervisors are required to maintain appropriate clinical certification and to adhere to the ethical standards of ASHA (Appendix A). In addition, the supervisors may find the position paper "Clinical Supervision in Speech-Language Pathology" (Appendix A3) to be valuable. Also included is a self-evaluation tool for analyzing your own skills (Appendix A4).

Supervisor Scheduling

Ordinarily, each supervisor will be responsible for only one graduate student during any semester. Variations in student clinician proficiency and level of experience, as well as in the nature and severity of a client's problem, inevitably impose different demands on the supervisor's
time and skill. Moreover, the standards of ASHA supervision must be in real time and must never be less than 25% of the student's total contact with each client/patient.

Usually supervisors of students at off-campus sites continue serving the same clients scheduled before the student arrives. A student supervisee should not disrupt the usual schedule. Since individual student practicum requirements vary depending on what the students’ previous assignments have been, a supervisor may receive requests for special needs. Facilitating or denying these requests is the supervisor’s prerogative. The ASHA practicum requirements have changed. Instead of consisting of a minimum of 20 hours each in adult speech evaluation, child speech evaluation, adult language evaluation, child language evaluation, adult speech treatment, adult language treatment, and child language treatment, the system has become competency based. ASHA’s Council on Professional Standards in Speech-Language Pathology responded to changes in the scope of practice, need to protect consumers, and promote quality services by making changes to competency-based standards. However, ASHA still states “Practicum experiences that encompass the breadth of the current scope of practice with both adults and children (with no specific clock-hour requirements for given disorders or settings) resulting in a minimum of 400 clock hours of supervised practicum, of which 375 hours must be in direct client/patient contact and 25 in clinical observation”. An additional 25 hours can be staffing, if documented.

The graduate program leading to a Masters degree requires two years. During the first year, a graduate student normally completes practicum in the University clinic under the supervision of University supervisors. During the Summer I & II terms, a student may request an assignment off campus. Occasionally assignments are made for these first Summer terms, and Tuesday and Thursday are the days available for this experience. The usual assignment for off campus is made during the second Fall semester and is also on Tuesday and Thursday for the whole day. The Tuesday-Thursday scheduling allows the student to register for academic courses offered on Monday, Wednesday, and Friday. Unless the student and the supervisor make special arrangements, the off campus schedule conforms to the academic calendar of the University.

During the Spring semester of the student’s second year, the off-campus assignment in schools, hospitals, rehabilitation centers, or other placements requires a minimum of eight weeks, every day experience. This may require the student to forgo WMU’s mid-semester vacation break.

STUDENT RESPONSIBILITIES

The student is expected to conform to all the rules and regulations of the site at which the practicum takes place. Essentially, the student learns the role of the professional by following the model of the supervisor. The rules and expectations should be discussed from the beginning of the assignment and will vary depending on the site. In general, appearance should conform to a professional standard as required at the University Clinic (see Appendix B6).

All students can be expected to have completed 1) Cardio-Pulmonary Resuscitation (CPR) and 2) Universal Precaution instruction. Additionally, they have 1) a current negative Tuberculin skin test and 2) Hepatitis B inoculation or have signed a waiver. The individual student can present documentation for all of these. In registering for SPPA 7120, each student has been assessed a
fee to cover liability insurance (Appendix B7). The student is also responsible for completing a computerized record of hours accumulated on his/her iwebFolio. The student is also required to conduct a criminal check if needed at the site of assignment.

The student’s practicum while on-campus is designed to teach the following skills. Not all students learn everything offered. If weaknesses still exist in these areas, some time at off-campus sites could be spent in making sure the student has learned the skills. The supervisor has the ultimate responsibility for the client and, consequently, has the authority and responsibility to discontinue a client/clinician assignment at any time.

The student should possess the following skills:

1. set realistic and appropriate therapy objectives;
2. select materials and techniques for implementing the therapy objectives;
3. motivate clients;
4. manage clients’ behavior;
5. utilize a variety of appropriate clinical techniques;
6. write professional reports;
7. evaluate clients’ behavior in therapy, recognizing strengths and weaknesses as a clinician;
8. counsel parents, family members and clients; and
9. think and act like a member of the profession.

SUPERVISOR RESPONSIBILITIES TO THE STUDENT

In order to assure that the student is competent in the skills listed above, the supervisor:

1. will observe therapy frequently (direct supervision of 25% of therapy as a minimum);
2. will provide feedback, written and oral, about the adequacy of therapy plans, effectiveness of procedure, and other aspects of clinical activities;
3. will consult with student clinician about special problems as they arise;
4. may suggest alternative procedures for achieving goals;
5. will approve and sign all diagnostic or treatment reports;
6. may demonstrate therapy techniques by working directly with the client;
7. will participate in parent/family counseling sessions;
8. will give the student clinician support and direction while allowing the student clinician independence to think and plan; and
9. will conduct conferences with the student clinician as necessary or appropriate.

SUPERVISOR RESPONSIBILITIES TO THE CLIENT

The final recommendations to the parent or client are the responsibility of the supervisor. The student clinician may sit in on and participate in the conference; however, the supervisor is responsible for developing the information and recommendations transmitted to the client or parent.
UNIVERSITY COORDINATOR RESPONSIBILITIES

The university coordinator is responsible for contacting the off campus supervisor to obtain permission to assign a student to that site. Any protocol required by the site such as contact with an administrator is discussed with the supervisor at that time and such necessary arrangements are completed. The university coordinator may send a biographical data form completed by the student to the prospective supervisor if the supervisor wishes to have such information. The coordinator also acts as a liaison to ask the student to contact the supervisor for an interview prior to placement if the supervisor so desires. The supervisor should contact the university coordinator if any difficulty arises during the placement of the student at the off-campus site. Presently, Donna Oas, (616) 387-8059 or (616) 657-6309 or email dnroas@mac.com or oas@wmich.edu is the university coordinator. The university coordinator as possible schedules Field visits for any student assigned to an off-campus site. During this field visit, direct observation of therapy by the university coordinator is appropriate, but not necessary. The main goal of these visits is to determine how satisfactory the placement appears to be to both supervisor and student clinician and make suggestions for adjustment to solve any problems that have arisen. In no way is the supervisor’s authority usurped. These visits are ordinarily scheduled through the student during times the student is on-campus. If this arrangement is not satisfactory, the supervisor should contact the university coordinator. The university coordinator must submit grades given by the supervisor to the registrar during the last week of classes.

ASHA’S REQUIREMENTS FOR THE STUDENT’S ENTIRE GRADUATE PROGRAM

[Taken from Background Information and Standards and Implementation for the Certificate of Clinical Competence in Speech Language Pathology (Updated 2005, will be revised for 2014)]

STANDARDS, KNOWLEDGE, OUTCOMES

Standard III-B: The applicant must demonstrate knowledge of basic human communication and swallowing processes, including their biological, neurological, acoustic, psychological, developmental, and linguistic and cultural bases.

Implementation:

This standard emphasizes the basic human communication processes. The applicant must demonstrate the ability to integrate information pertaining to normal and abnormal human development across the life span, including basic communication processes and the impact of cultural and linguistic diversity on communication. Similar knowledge must also be obtained in swallowing processes and new emerging areas of practice. Program documentation may include transcript credit and information obtained by the applicant through clinical experiences, independent studies, and research projects.
Standard III-C: The applicant must demonstrate knowledge of the nature of speech, language, hearing, and communication disorders and differences and swallowing disorders, including the etiologies, characteristics, anatomical/physiological, acoustic, psychological, developmental, and linguistic and cultural correlates. Specific knowledge must be demonstrated in the following areas:

* articulation
* fluency
* voice and resonance, including respiration and phonation
* receptive and expressive language (phonology, morphology, syntax, semantics, and pragmatics) in speaking, listening, reading, writing, and manual modalities
* hearing, including the impact on speech and language
* swallowing (oral, pharyngeal, esophageal, and related functions, including oral function for feeding; orofacial myofunction)
* cognitive aspects of communication (attention, memory, sequencing, problem-solving, executive functioning)
* social aspects of communication (including challenging behavior, ineffective social skills, lack of communication opportunities)
* communication modalities (including oral, manual, augmentative, and alternative communication techniques and assistive technologies)

Implementation:

The applicant must demonstrate the ability to integrate information delineated in this standard. Program documentation may include transcript credit and information obtained by the applicant through clinical experiences, independent studies, and research projects. It is expected that course work addressing the professional knowledge specified in Standard III-C will occur primarily at the graduate level. The knowledge gained from the graduate program should include an effective balance between traditional parameters of communication (articulation/phonology, voice, fluency, language, and hearing) and additional recognized and emerging areas of practice (e.g., swallowing, upper aerodigestive functions).

Standard III-D: The applicant must possess knowledge of the principles and methods of prevention, assessment, and intervention for people with communication and swallowing disorders, including consideration of anatomical/physiological, psychological, developmental, and linguistic and cultural correlates of the disorders.

Implementation:

The applicant must demonstrate the ability to integrate information about prevention, assessment, and intervention over the range of differences and
disorders specified in Standard III-C above. Program documentation may include transcript credit and information obtained by the applicant through clinical experiences, independent studies, and research projects.

Standard III-E: The applicant must demonstrate knowledge of standards of ethical conduct.

Implementation:

The applicant must demonstrate knowledge of, appreciation for, and ability to interpret the ASHA Code of Ethics. Program documentation may reflect course work, workshop participation, instructional module, clinical experiences, and independent projects.

Standard III-F: The applicant must demonstrate knowledge of processes used in research and the integration of research principles into evidence-based clinical practice.

Implementation:

The applicant must demonstrate comprehension of the principles of basic and applied research and research design. In addition the applicant should know how to access sources of research information and have experience relating research to clinical practice. Program documentation could include information obtained through class projects, clinical experiences, independent studies, and research projects.

Standard III-G: The applicant must demonstrate knowledge of contemporary professional issues.

Implementation:

The applicant must demonstrate knowledge of professional issues that affect speech-language pathology as a profession. Issues typically include professional practice, academic program accreditation standards, ASHA practice policies and guidelines, and reimbursement procedures. Documentation could include information obtained through clinical experiences, workshops, and independent studies.

Standard III-H: The applicant must demonstrate knowledge about certification, specialty recognition, licensure, and other relevant professional credentials.

Implementation:

The applicant must demonstrate knowledge of state and federal regulations and policies related to the practice of speech-language pathology and credentials for
professional practice. Documentation could include course modules and instructional workshops.

STANDARDS, SKILLS, OUTCOMES

STANDARD IV: PROGRAM OF STUDY

Standard IV-A: The applicant must complete a curriculum of academic and clinical education that follows an appropriate sequence of learning sufficient to achieve the skills outcomes in Standard IV-G.

Implementation:

The applicant’s program of study should follow a systematic knowledge- and skill-building sequence in which basic course work and practicum precede, insofar as possible, more advanced course work and practicum.

Standard IV-B: The applicant must possess skill in oral and written or other forms of communication sufficient for entry into professional practice.

Implementation:

The applicant must demonstrate communication skills sufficient to achieve effective clinical and professional interaction with clients/patients and relevant others. For oral communication, the applicant must demonstrate speech and language skills in English, which, at a minimum, are consistent with ASHA’s most current position statement on students and professionals who speak English with accents and nonstandard dialects. For written communication, the applicant must be able to write and comprehend technical reports, diagnostic and treatment reports, treatment plans, and professional correspondence.

Individuals educated in foreign countries must meet the criteria required by the International Commission of Healthcare Professions (ICHP) in order to meet this standard.

Standard IV-C: The applicant for certification in speech-language pathology must complete a minimum of 400 clock hours of supervised clinical experience in the practice of speech-language pathology. Twenty-five hours must be spent in clinical observation, and 375 hours must be spent in direct client/patient contact.

Implementation:

Observation hours generally precede direct contact with clients/patients. However, completion of all 25 observation hours is not a prerequisite to begin direct client/patient contact. For certification purposes, the observation and direct
client/patient contact hours must be within the scope of practice of speech-language pathology.

For certification purposes, observation experiences must be under the direction of a qualified clinical supervisor who holds current ASHA certification in the appropriate practice area. Such direction may occur simultaneously with the student’s observation or may be through review and approval of written reports or summaries submitted by the student. Students may use videotapes of the provision of client services for observation purposes. The applicant must maintain documentation of time spent in supervised observation, verified by the program in accordance with Standards III and IV.

Applicants should be assigned practicum only after they have acquired a sufficient knowledge base to qualify for such experience. Only direct contact with the client or the client’s family in assessment, management, and/or counseling can be counted toward practicum. Although several students may observe a clinical session at one time, clinical practicum hours should be assigned only to the student who provides direct services to the client or client’s family. Typically, only one student should be working with a given client. In rare circumstances, it is possible for several students working as a team to receive credit for the same session depending on the specific responsibilities each student is assigned. For example, in a diagnostic session, if one student evaluates the client and another interviews the parents, both students may receive credit for the time each spent in providing the service. However, if one student works with the client for 30 minutes and another student works with the client for the next 45 minutes, each student receives credit for the time he/she actually provided services—that is, 30 and 45 minutes, not 75 minutes. The applicant must maintain documentation of time spent in supervised practicum, verified by the program in accordance with Standards III and IV.

Standard IV-D: At least 325 of the 400 clock hours must be completed while the applicant is engaged in graduate study in a program accredited in speech-language pathology by the Council on Academic Accreditation in Audiology and Speech-Language Pathology.

1. Evaluation:
   a. conduct screening and prevention procedures (including prevention activities)
   b. collect case history information and integrate information from clients/patients, family, caregivers, teachers, relevant others, and other professionals
   c. select and administer appropriate evaluation procedures, such as behavioral observations, nonstandardized and standardized tests, and instrumental procedures
d. adapt evaluation procedures to meet client/patient needs
e. interpret, integrate, and synthesize all information to develop diagnoses and make appropriate recommendations for intervention
f. complete administrative and reporting functions necessary to support evaluation
g. refer clients/patients for appropriate services

2. Intervention:

a. develop setting-appropriate intervention plans with measurable and achievable goals that meet clients’/patients’ needs. Collaborate with clients/patients and relevant others in the planning process.
b. implement intervention plans (involve clients/patients and relevant others in the intervention process)
c. select or develop and use appropriate materials and instrumentation for prevention and intervention
d. measure and evaluate clients’/patients’ performance and progress
e. modify intervention plans, strategies, materials, or instrumentation as appropriate to meet the needs of clients/patients
f. complete administrative and reporting functions necessary to support intervention
g. identify and refer clients/patients for services as appropriate

Interaction and Personal Qualities:

a. communicate effectively, recognizing the needs, values, preferred mode of communication, and cultural/linguistic background of the client/patient, family, caregivers, and relevant others
b. collaborate with other professionals in case management
c. provide counseling regarding communication and swallowing disorders to clients/patients, family, caregivers, and relevant others
d. adhere to the ASHA Code of Ethics and behave professionally

Implementation:

The applicant must document the acquisition of the skills referred to in this Standard applicable across the nine major areas listed in Standard III-C. Clinical
skills may be developed and demonstrated by means other than direct client/patient contact in clinical practicum experiences, such as academic course work, labs, simulations, examinations, and completion of independent projects. This documentation must be maintained and verified by the program director or official designee.

For certification purposes, only direct client/patient contact may be applied toward the required minimum of 375 clock hours of supervised clinical experience.

STANDARD V: ASSESSMENT

The applicant for certification must demonstrate successful achievement of the knowledge and skills delineated in Standard III and Standard IV by means of both formative and summative assessment.

Standard V-A: Formative Assessment

The applicant must meet the education program’s requirements for demonstrating satisfactory performance through ongoing formative assessment of knowledge and skills.

Implementation:

Formative assessment yields critical information for monitoring an individual’s acquisition of knowledge and skills. Therefore, to ensure that the applicant pursues the outcomes stipulated in Standard III and Standard IV in a systematic manner, academic and clinical educators must have assessed developing knowledge and skills throughout the applicant’s program of graduate study. Applicants may also be part of the process through self-assessment. Applicants and program faculties and clinical supervisors should use the ongoing assessment to help the applicant achieve requisite knowledge and skills. Thus, assessments should be followed by implementation of strategies for acquisition of knowledge and skills.

The applicant must adhere to the academic program’s formative assessment process and must maintain records verifying ongoing formative assessment. The applicant shall make these records available to the Council For Clinical Certification upon its request. Documentation of formative assessment may take a variety of forms, such as checklists of skills, records of progress in clinical skill development, portfolios, and statements of achievement of academic and practicum course objectives, among others.
SUPERVISION OF DIAGNOSTIC EVALUATION

It is the supervisor's responsibility to verify the practicum hours each student has earned for diagnostics. The student receives credit only for the tasks for which he/she has had the major responsibility and only for the time of direct contact with the informant and/or client. The student may claim practicum time for the parent/client interview and for the clinical evaluation. Time spent in planning or report writing or for aspects of the evaluation handled by the supervisor does not count for student hours.

RESPONSIBILITIES OF THE SUPERVISOR TO THE STUDENT IN DIAGNOSTICS

The supervisor should:
1. integrate the student into the regular diagnostic procedure of the facility;
2. familiarize students with the supervisor's approach to assessment and with the supervisor's expectations of the student;
3. help the student plan for the client evaluations, giving guidance for test selection and information gathering;
4. oversee the student's accurate recording of data and the analysis and appropriate interpretation of data;
5. encourage the student to become familiar with and competent in administering a variety of evaluation tools;
6. facilitate the student's independent planning assessment;
7. guide the student in recognizing rationale for assessment procedures;
8. provide direct supervision for at least fifty percent of the time the diagnostic is in progress, for more time, if necessary;
9. provide written or verbal feedback to the student clinician about his/her performance, giving suggestions for change and reinforcement for appropriate behaviors;
10. provide the student with direction in the writing and editing of a quality diagnostic report which presents information in a logical, concise and sequential manner, integrates pertinent information, draws appropriate conclusions and makes appropriate recommendations;
11. ensure that the diagnostic report is completed in a timely fashion;
12. provide recommendations and necessary counseling to the client at the termination of the evaluation sessions, ensuring that these recommendations are realistic in relation to the clinic program;
13. ensure that all procedures followed are in keeping with the ASHA guidelines and other principles of professional ethics;
14. assist the student to become aware of current research findings about evaluation procedures and to integrate such findings into evaluations of persons with communication disorders;
15. help the student in learning to assess his/her own performance;
16. model and facilitate professionalism in assuming responsibility, demonstrating ethical and legal conduct, meeting and respecting deadlines, maintaining professional conduct in parent counseling; and
17. determine and maintain an accurate record of each student's time spent in direct contact with the client, in consultation with the student.
AMOUNT OF SUPERVISION

ASHA standards for Council for Academic Accreditation (CAA) accreditation specify that students shall be supervised directly for twenty-five percent or more of the time they are involved with patients/clients. This time can be adjusted upward for student clinicians who require more supervisory time. This time involvement is not to be interpreted as an average but, rather, as a consistent investment of supervisory time. That is, the supervisor should not assume that because the student was supervised 100 percent of the time during the first half of the semester that supervision can be cut to less than 25 percent of the time during the last half of the semester.

SUPERVISOR ABSENCES

Supervisors, because of illness or other responsibilities, occasionally must be absent for all or a part of a therapy session. In these instances, some other person at the site should be designated to be responsible for the student and the clients. Students report that they have learned some important lessons when this situation occurs, so these potential learning opportunities can be useful. A representative of the agency, however, must take legal responsibility for this provision of service. If the site does not allow this, of course, therapy should be canceled.

COMMUNICATION BETWEEN SUPERVISOR AND STUDENT SUPERVISEE

As early as possible, the supervisor may wish to discuss the expectations for the student at the particular site. Our experience has been that the main reason for any difficulty encountered during the student placement is usually the result of a discrepancy between supervisor and student assumptions. At these early meetings, students will have questions about a variety of concerns, including the following.

1. **The supervisor's expectations** regarding therapy plans. Students will want to know when they are due, in what style (e.g., behavioral objectives) they are to be written, where they are to be delivered to the supervisor, when and where they will be returned to the student. Most supervisors require clinicians to write behavioral objectives, designate procedures and evaluate the therapy sessions. Some supervisors require therapy plans to be handed in the day before therapy and others will be satisfied if they are submitted minutes before therapy.

2. **Therapy and supervision approach.** Each supervisor has preferences about the conduct of therapy and notions concerning the supervisor's role in aiding student development as a clinician. The supervisor will want to share these views early in the semester and to help students understand the rationale for his/her approach. Some supervisors, for example, feel it necessary to enter the therapy process on occasion to get a better "feel" for the client, to demonstrate specific techniques, or to resolve a conflict. The student clinician will appreciate knowing that this intervention may occur and that it does not mean that he/she has erred. Other supervisors believe in a hands-off approach. Students will appreciate knowing the supervisor's philosophy and understanding how the supervisor will be observing and providing regular feedback.
3. **Methods for providing feedback.** Some supervisors require the student clinician to leave a duplicate of the therapy plan with them so the supervisor can write comments on the plan. Because of client confidentiality, students should not leave plans or reports where other people might have access to them. Other supervisors carry a clipboard with paper and carbon, make comments on the portion of the session observed and leave these comments with the clinician after therapy. Some supervisors meet with the students after therapy and provide verbal feedback. Whatever procedure(s) the supervisor uses, the student values receiving immediate feedback that reflects the positive aspects of performance, as well as suggestions for improvement.

4. **Administrative matters.** The students will need to know how the supervisor expects them to handle therapy reports, conferences and other routine tasks. The student needs information about the policies of the particular organization. If a Policy and Procedures Manual exists, the student should be required to read and discuss this material.

5. **Review of therapy/diagnostic materials and procedures.** If the student's adult clients fall predominantly into a specific diagnostic category (for example, adult aphasics), the supervisor may choose to assign readings applicable to problems of that group. A discussion of the material assigned would be a helpful procedure to assure that the student understands the content. If the supervisor has a particular skill or knowledge of specific clinical procedures/materials, he/she may share this knowledge with the student.

**RECORD KEEPING**

An accurate record of practicum hours (classified by disorder type, client initials, age, etc. and distributed appropriately between "evaluation" and "treatment" hours) must be reported to the Department at the end of the semester (Appendix B yellow form). The supervisor is also responsible for rating the student’s performance at the end of the semester (Appendix B blue form). This form is the standard used University wide by all departments to evaluate field placements. The student clinician completes a similar form (Appendix B pink form). Send these forms to the University during the last week of the semester, before final examination week. If the site has developed a unique method of evaluating students, a copy of that evaluation information should be included as additional feedback.

**REPORT WRITING**

Students have been informed that supervisors will differ in the report format they prefer. If the supervisor does not agree with any part of the format provided in the university preparation, the students should be so informed and provided with an alternate format. The university report format has been designed to help the student carefully think about all information. Most people recognize that the detail required on campus is not practical in the real world. The off campus placement provides practical application and acts as a bridge between the university and a professional position or experience.
On campus, students are instructed to use descriptive rather than interpretive statements in the body of the report and to be concrete rather than vague in their statements. There should be no errors in grammatical construction or clarity of writing style. Students are encouraged to use a word processor for reports in order to facilitate revision.

EQUIPMENT AND THERAPY MATERIALS

Student clinicians learn about professional practice by using equipment and therapy materials available at each site. Often these materials are more extensive than those available at the University. Your generosity in sharing the use of these materials is appreciated. The student, of course, should be responsible for proper use and care of these materials.

GRADING AND EVALUATION OF THE STUDENT

Supervisors at Western Michigan University do not have uniform criteria for grading and much variation exists among supervisors. This manual attempts to provide some evaluation tools, which may be useful. The Clinical Fellowship Skills Inventory (Appendix B5) and the other methods of evaluation are attempts to objectify variables in grading clinical practicum. Many supervisors provide an oral evaluation of the student clinician at mid-semester as well as at the end of the semester. A form, "Clinical Fellowship Skills Inventory," (Appendix B5) is available for use by the supervisor in orienting and rating student clinicians. This form was standardized by ASHA for the Clinical Fellowship, but also appears to be a good tool to use during the student experience. Another format for evaluations, developed by Andrea Tobochnik at Bronson Hospital, is also included in Appendix B6. Although not mandatory, providing a mid-semester evaluation allows the student to carry out any recommendations for improvement before it is too late to change. With the new ASHA emphasis on competencies, The “Report of Clinical Competencies” in Appendix B1 will provide the information necessary for the student to meet the standards for Clinical Certification. This is the only mandatory evaluation tool.

Some off-campus sites have their own evaluation format. Using such a process is completely acceptable by the University. If such an evaluation form is used, a copy for the University is appreciated. At the end of the semester, the supervisor submits a narrative evaluation and a letter grade for the student. A description of the grading scale is at the bottom of the blue evaluation form (Appendix B2). Even though the student’s record will show either “credit” or “no credit,” the supervisor must submit a letter grade. A grade of “B” or above will result in “credit,” and a grade of “CB” or lower will result in “no credit. The supervisor should use his/her best judgment in arriving at a letter grade. The written, narrative evaluation may be the most important credential for a prospective employer. The Report of Clinical Competencies must also be returned at the end of the semester.
SEMESTER TERMINATION

Toward the end of the semester, the supervisor performs a variety of tasks, including the following:

1. review any reports of diagnostics or therapy for content and style and compliance with high standards of reporting used by the cooperating agency.

2. verify student practicum hours by signing the yellow practicum record form, "Report of Clinical Practicum Experience-Off Campus" ( Appendix B) by signing that form. The supervisor should not sign the practicum hours form until the student has completed all activities related to the practicum. The student should divide his/her hours appropriately to document the types of disorder for which he/she is to receive credit or amount of total hours. For example, a student assigned to a client with language and articulation disorders may have accumulated twenty hours of direct contact, including seven hours of articulation therapy and thirteen hours of language therapy. If group practicum occurs, the time should be evenly divided among members of the group, for instance, 3 people receiving an hour group session would not count as 3 hours total, but one hour divided into twenty minutes per person. One hour of therapy is only one hour of therapy. The student's record should reflect this distribution of hours. The actual supervisor as assigned by the university coordinator must sign the form.

Appreciation

The Department of Speech Pathology and Audiology of Western Michigan University values its relationship with the many facilities that foster and facilitate the education of our students. The experience gained in these sites is an indispensable part of the program. Our sincere thanks goes out to all the wonderful professionals who model behaviors, provide insights, impart knowledge and add the “polish” to our students’ basic skills. We hope this manual will be a helpful guide for the experience. If you have any suggestions for improvement of this manual, please contact us.
Appendix A: ASHA Standards


2. Supervision of Student Clinicians: http://www.asha.org/policy/ET2010-00316/

3. Clinical Supervision in Speech-Language Pathology: ASHA Position Statement:

4. Competencies for Effective Clinical Supervision:
   http://www.asha.org/policy/PS1985-00220.htm#sec1.4


6. Scope of Practice in Speech-Language Pathology:
   http://www.asha.org/policy/SP2007-00283.htm
Code of Ethics

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- Rules of Ethics

Preamble

The preservation of the highest standards of integrity and ethical principles is vital to the responsible discharge of obligations by speech-language pathologists, audiologists, and speech, language, and hearing scientists. This Code of Ethics sets forth the fundamental principles and rules considered essential to this purpose.

Every individual who is (a) a member of the American Speech-Language-Hearing Association, whether certified or not, (b) a nonmember holding the Certificate of Clinical Competence from the Association, (c) an applicant for membership or certification, or (d) a Clinical Fellow seeking to fulfill standards for certification shall abide by this Code of Ethics.

Any violation of the spirit and purpose of this Code shall be considered unethical. Failure to specify any particular responsibility or practice in this Code of Ethics shall not be construed as denial of the existence of such responsibilities or practices.

The fundamentals of ethical conduct are described by Principles of Ethics and by Rules of Ethics as they relate to the responsibility to persons served, the public, speech-language pathologists, audiologists, and speech, language, and hearing scientists, and to the conduct of research and scholarly activities.

Principles of Ethics, aspirational and inspirational in nature, form the underlying moral basis for the Code of Ethics. Individuals shall observe these principles as affirmative obligations under all conditions of professional
Rules of Ethics are specific statements of minimally acceptable professional conduct or of prohibitions and are applicable to all individuals.

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

Rules of Ethics
A. Individuals shall provide all services competently.

B. Individuals shall use every resource, including referral when appropriate, to ensure that high-quality service is provided.

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

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

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

F. Individuals who hold the Certificate of Clinical Competence may delegate tasks related to provision of clinical services to assistants, technicians, support personnel, or any other persons only if those services are appropriately supervised, realizing that the responsibility for client welfare remains with the certified individual.
G. Individuals who hold the Certificate of Clinical Competence may delegate tasks related to provision of clinical services that require the unique skills, knowledge, and judgment that are within the scope of practice of their profession to students only if those services are appropriately supervised. The responsibility for client welfare remains with the certified individual.

H. Individuals shall fully inform the persons they serve of the nature and possible effects of services rendered and products dispensed, and they shall inform participants in research about the possible effects of their participation in research conducted.

I. Individuals shall evaluate the effectiveness of services rendered and of products dispensed, and they shall provide services or dispense products only when benefit can reasonably be expected.

J. Individuals shall not guarantee the results of any treatment or procedure, directly or by implication; however, they may make a reasonable statement of prognosis.

K. Individuals shall not provide clinical services solely by correspondence.

L. Individuals may practice by telecommunication (e.g., telehealth/e-health), where not prohibited by law.

M. Individuals shall adequately maintain and appropriately secure records of professional services rendered, research and scholarly activities conducted, and products dispensed, and they shall allow access to these records only when authorized or when required by law.

N. Individuals shall not reveal, without authorization, any professional or personal information about identified persons served professionally or identified participants involved in research and scholarly activities unless doing so is necessary to protect the welfare of the person or of the community or is otherwise required by law.

O. Individuals shall not charge for services not rendered, nor shall they misrepresent services rendered, products dispensed, or research and scholarly activities conducted.

P. Individuals shall enroll and include persons as participants in research or teaching demonstrations only if their participation is voluntary, without coercion, and with their informed consent.
Q. Individuals whose professional services are adversely affected by substance abuse or other health-related conditions shall seek professional assistance and, where appropriate, withdraw from the affected areas of practice.

R. Individuals shall not discontinue service to those they are serving without providing reasonable notice.

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

Rules of Ethics
A. Individuals shall engage in the provision of clinical services only when they hold the appropriate Certificate of Clinical Competence or when they are in the certification process and are supervised by an individual who holds the appropriate Certificate of Clinical Competence.

B. Individuals shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their level of education, training, and experience.

C. Individuals shall engage in lifelong learning to maintain and enhance professional competence and performance.

D. Individuals shall not require or permit their professional staff to provide services or conduct research activities that exceed the staff member's competence, level of education, training, and experience.

E. Individuals shall ensure that all equipment used to provide services or to conduct research and scholarly activities is in proper working order and is properly calibrated.

Principle of Ethics III
Individuals shall honor their responsibility to the public by promoting public understanding of the professions.
by supporting the development of services designed to fulfill the unmet needs of the public, and by providing accurate information in all communications involving any aspect of the professions, including the dissemination of research findings and scholarly activities, and the promotion, marketing, and advertising of products and services.

Rules of Ethics

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

B. Individuals shall not participate in professional activities that constitute a conflict of interest.

C. Individuals shall refer those served professionally solely on the basis of the interest of those being referred and not on any personal interest, financial or otherwise.

D. Individuals shall not misrepresent research, diagnostic information, services rendered, results of services rendered, products dispensed, or the effects of products dispensed.

E. Individuals shall not defraud or engage in any scheme to defraud in connection with obtaining payment, reimbursement, or grants for services rendered, research conducted, or products dispensed.

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

G. Individuals' statements to the public when advertising, announcing, and marketing their professional services; reporting research results; and promoting products shall adhere to professional standards and shall not contain misrepresentations.

Principle of Ethics IV

Individuals shall honor their responsibilities to the professions and their relationships with colleagues, students, and members of other professions and disciplines.
Rules of Ethics

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

B. Individuals shall prohibit anyone under their supervision from engaging in any practice that violates the Code of Ethics.

C. Individuals shall not engage in dishonesty, fraud, deceit, or misrepresentation.

D. Individuals shall not engage in any form of unlawful harassment, including sexual harassment or power abuse.

E. Individuals shall not engage in any other form of conduct that adversely reflects on the professions or on the individual's fitness to serve persons professionally.

F. Individuals shall not engage in sexual activities with clients, students, or research participants over whom they exercise professional authority or power.

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

H. Individuals shall reference the source when using other persons' ideas, research, presentations, or products in written, oral, or any other media presentation or summary.

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

J. Individuals shall not provide professional services without exercising independent professional judgment, regardless of referral source or prescription.

K. Individuals shall not discriminate in their relationships with colleagues, students, and members of other professions and disciplines on the basis of race or ethnicity, gender, gender identity/gender expression, age, religion, national origin, sexual orientation, or disability.

L. Individuals shall not file or encourage others to file complaints that disregard or ignore facts that would
disprove the allegation, nor should the Code of Ethics be used for personal reprisal, as a means of addressing personal animosity, or as a vehicle for retaliation.

M. Individuals who have reason to believe that the Code of Ethics has been violated shall inform the Board of Ethics.

N. Individuals shall comply fully with the policies of the Board of Ethics in its consideration and adjudication of complaints of violations of the Code of Ethics.

Index terms: ethics


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Supervision of Student Clinicians

Board of Ethics

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About This Document

This Issues in Ethics statement is a revision of *Supervision of Student Clinicians* (2003). The Board of Ethics reviews Issues in Ethics statements periodically to ensure that they meet the needs of the professions and are consistent with ASHA policies.

Issues in Ethics Statements: Definition

From time to time, the Board of Ethics determines that members and certificate holders can benefit from additional analysis and instruction concerning a specific issue of ethical conduct. Issues in Ethics statements are intended to heighten sensitivity and increase awareness. They are illustrative of the Code of Ethics and intended to promote thoughtful consideration of ethical issues. They may assist members and certificate holders in engaging in self-guided ethical decision-making. These statements do not absolutely prohibit or require specified activity. The facts and circumstances surrounding a matter of concern will determine whether the activity is ethical.

Introduction

This Issues in Ethics statement is presented for the guidance of American Speech-Language-Hearing Association (ASHA) members and certificate holders in matters relating to supervision of students engaged in the provision of clinical services during practicum experiences. ASHA members and certificate holders are
employed in a variety of work settings and are required by their employers, by their states, and by
governmental agencies, as well as by ASHA, to comply with prescribed personnel standards related to
certification and licensure. Although the specific standards of these groups can and do differ, under the Code
of Ethics, members and certificate holders delivering or supervising clinical services must hold ASHA
certification in the area of their clinical or supervisory work regardless of the work setting, state, or jurisdiction
in which they are employed. Further, ASHA-certified individuals engaged in supervision of student clinicians
are bound to honor their responsibility to hold paramount the welfare of persons they serve professionally and
to ensure that services are provided competently by students under their supervision.

Discussion

The Board of Ethics cites and interprets the following sections of the Code of Ethics (2010) that pertain to the
supervision of student clinicians:

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

- **Principle of Ethics I, Rule A**: Individuals shall provide all services competently.

- **Principle of Ethics I, Rule D**: Individuals shall not misrepresent the credentials of assistants,
  technicians, support personnel, students, Clinical Fellows, or any others under their supervision, and they
  shall inform those they serve professionally of the name and professional credentials of persons providing
  services.

- **Principle of Ethics I, Rule G**: Individuals who hold the Certificates of Clinical Competence may
  delegate tasks related to provision of clinical services that require the unique skills, knowledge, and
  judgment that are within the scope of their profession to students only if those services are appropriately
  supervised. The responsibility for client welfare remains with the certified individual.

- **Principle of Ethics II, Rule A**: Individuals shall engage in the provision of clinical services only when
  they hold the appropriate Certificate of Clinical Competence or when they are in the certification
  process and are supervised by an individual who holds the appropriate Certificate of Clinical
  Competence.
- **Principle of Ethics II, Rule B:** Individuals shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their level of education, training, and experience.

- **Principle of Ethics IV, Rule B:** Individuals shall prohibit anyone under their supervision from engaging in any practice that violates the Code of Ethics.

ASHA-certified individuals who supervise students cannot delegate the responsibility for clinical decision making and management to the student. The legal and ethical responsibility for persons served remains with the certified individual. However, the student can, as part of the educational process, make client management recommendations and decisions pending review and approval by the supervisor. Further, the supervisor must inform the client or client's family of the qualifications and credentials of the student supervisee involved in the provision of clinical services.

All supervised clinical activities provided by the student must fall within the scope of practice for the specific profession to count toward the student's certification. The supervisor must achieve and maintain competency in supervisory practice as well as in the disability areas for which supervision is provided. The amount of supervision provided by the ASHA-certified supervisor must be commensurate with the student's knowledge, experience, and competence to ensure that the welfare of the client is protected. The supervisor must also ensure that the student supervisee maintains confidentiality of client information and documents client records in an accurate and timely manner.

Discrepancies may exist among state requirements for supervision required for teacher certification in speech-language pathology and audiology, state licensure in the professions of speech-language pathology and/or audiology, and ASHA certification standards. In states where credential requirements or state licensure requirements differ from ASHA certification standards, supervised clinical experiences (including student practica for teacher licensing) will count toward or may be applied toward ASHA certification (CCC) requirements only if those practicum hours have been supervised by ASHA-certified personnel.

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**Guidance**

ASHA-certified individuals who supervise students should possess or seek training in supervisory practice and provide supervision only in practice areas for which they possess the appropriate knowledge and skills. The supervisor must oversee the clinical activities and make or approve all clinical decisions to ensure that the
welfare of the client is protected. The supervisor should inform the client or the client's family about the
supervisory relationship and the qualifications of the student supervisee.

The supervisor must provide no less than the level of supervision that is outlined in the current certification
standards and increase supervision if needed based on the student's knowledge, experience, and competence.
The supervisor should document the amount of direct and indirect supervision provided, and design and
implement procedures that will protect client confidentiality for services provided by students under
supervision.

ASHA members and certificate holders engaged in the preparation, placement, and supervision of student
clinicians must make reasonable efforts to ensure that direct practicum supervision is provided by professionals
holding the appropriate CCC. They must inform students who engage in student practica for teacher licensing,
or other clinical practica under a non-ASHA-certified supervisor that these experiences cannot be applied to
ASHA certification. ASHA-certified personnel cannot sign for clinical practicum experiences that were
actually supervised by non-ASHA-certified individuals. It is unethical for certificate holders to approve or sign
for clinical hours for which they did not provide supervision.

Index terms: supervision, students, ethics


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American Speech-Language-Hearing Association
Position Statement

Clinical Supervision in Speech-Language Pathology

Ad Hoc Committee on Supervision in Speech-Language Pathology

About this Document
This position statement is an official policy of the American Speech-Language-Hearing Association. It was developed by the Ad Hoc Committee on Supervision in Speech-Language Pathology. Members of the committee were Lisa O'Connor (chair), Christine Baron, Thalia Coleman, Barbara Conrad, Wren Newman, Kathy Panther, and Janet E. Brown (ex officio). Brian B. Shulman, vice president for professional practices in speech-language pathology (2006–2008), served as the monitoring officer. This document was approved by the Board of Directors on March 12, 2008.

Position Statement
The position statement Clinical Supervision in Speech-Language Pathology and Audiology was approved in 1985. This new position statement updates that document with respect to the profession of speech-language pathology. Although the principles of supervision are common to both professions, this position statement addresses only speech-language pathology because of differences in pre-service education and practice between the two professions.

It is the position of the American Speech-Language-Hearing Association that clinical supervision (also called clinical teaching or clinical education) is a distinct area of practice in speech-language pathology and that it is an essential component in the education of students and the continual professional growth of speech-language pathologists. The supervisory process consists of a variety of activities and behaviors specific to the needs, competencies, and expectations of the supervisor and supervisee, and the requirements of the practice setting. The highly complex nature of supervision makes it critically important that supervisors obtain education in the supervisory process. Engaging in ongoing self-analysis and self-evaluation to facilitate the continuous development of supervisory skills and behaviors is fundamental to this process. Effective supervision facilitates the development of clinical competence in supervisees at all levels of practice, from students to certified clinicians. Clinical supervision is a collaborative process with shared responsibility for many of the activities involved in the supervisory experience. The supervisory relationship should be based on a foundation of mutual respect and effective interpersonal communication. Clinical supervisors have an obligation to fulfill the legal requirements and ethical responsibilities associated with state, national, and professional standards for
supervision.

Index terms: supervision


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Clinical Supervision in Speech-Language Pathology and Audiology

Committee on Supervision

Resolution

WHEREAS, the American Speech-Language-Hearing Association (ASHA) needs a clear position on clinical supervision, and

WHEREAS, the necessity for having such a position for use in student training and in professional, legal, and
governmental contexts has been recognized, and

WHEREAS, the Committee on Supervision in Speech-Language Pathology and Audiology has been charged to recommend guidelines for the roles and responsibilities of supervisors in various settings (LC 14-74), and

WHEREAS, a position statement on clinical supervision now has been developed, disseminated for both select and widespread peer review, and revised; therefore

RESOLVED, that the American Speech-Language-Hearing Association adopts “Clinical Supervision in Speech-Language Pathology and Audiology” as the recognized position of the Association.

Introduction

Clinical supervision is a part of the earliest history of the American Speech-Language-Hearing Association (ASHA). It is an integral part of the initial training of speech-language pathologists and audiologists, as well as their continued professional development at all levels and in all work settings.

ASHA has recognized the importance of supervision by specifying certain aspects of supervision in its requirements for the Certificates of Clinical Competence (CCC) and the Clinical Fellowship Year (CFY) (ASHA, 1982). Further, supervisory requirements are specified by the Council on Professional Standards in its standards and guidelines for both educational and professional services programs (Educational Standards Board, ASHA, 1980; Professional Services Board, ASHA, 1983). State laws for licensing and school certification consistently include requirements for supervision of practicum experiences and initial work performance. In addition, other regulatory and accrediting bodies (e.g., Joint Commission on Accreditation of Hospitals, Commission on Accreditation of Rehabilitation Facilities) require a mechanism for ongoing supervision throughout professional careers.

It is important to note that the term clinical supervision, as used in this document, refers to the tasks and skills of clinical teaching related to the interaction between a clinician and client. In its 1978 report, the Committee on Supervision in Speech-Language Pathology and Audiology differentiated between the two major roles of persons identified as supervisors: clinical teaching aspects and program management tasks. The Committee emphasized that although program management tasks relating to administration or coordination of programs may be a part of the person's job duties, the term supervisor referred to “individuals who engaged in clinical teaching through observation, conferences, review of records, and other procedures, and which is related to the interaction between a clinician and a client and the evaluation or management of communication skills” (Asha, 1978, p. 479). The Committee continues to recognize this distinction between tasks of administration or

http://www.asha.org/policy/PS1985-00220.htm
program management and those of clinical teaching, which is its central concern.

The importance of supervision to preparation of students and to assurance of quality clinical service has been assumed for some time. It is only recently, however, that the tasks of supervision have been well-defined, and that the special skills and competencies judged to be necessary for their effective application have been identified. This Position Paper addresses the following areas:

- tasks of supervision
- competencies for effective clinical supervision
- preparation of clinical supervisors

Tasks of Supervision

A central premise of supervision is that effective clinical teaching involves, in a fundamental way, the development of self-analysis, self-evaluation, and problem-solving skills on the part of the individual being supervised. The success of clinical teaching rests largely on the achievement of this goal. Further, the demonstration of quality clinical skills in supervisors is generally accepted as a prerequisite to supervision of students, as well as of those in the Clinical Fellowship Year or employed as certified speech-language pathologists or audiologists.

Outlined in this paper are 13 tasks basic to effective clinical teaching and constituting the distinct area of practice which comprises clinical supervision in communication disorders. The committee stresses that the level of preparation and experience of the supervisee, the particular work setting of the supervisor and supervisee, and client variables will influence the relative emphasis of each task in actual practice.

The tasks and their supporting competencies which follow are judged to have face validity as established by experts in the area of supervision, and by both select and widespread peer review. The committee recognizes the need for further validation and strongly encourages ongoing investigation. Until such time as more rigorous measures of validity are established, it will be particularly important for the tasks and competencies to be reviewed periodically through quality assurance procedures. Mechanisms such as Patient Care Audit and Child Services Review System appear to offer useful means for quality assurance in the supervisory tasks and competencies. Other procedures appropriate to specific work settings may also be selected.

The tasks of supervision discussed above follow:
Competencies for Effective Clinical Supervision

Although the competencies are listed separately according to task, each competency may be needed to perform a number of supervisor tasks.

- 1.0 Task: Establishing and maintaining an effective working relationship with the supervisee.

  Competencies required:
1.1 Ability to facilitate an understanding of the clinical and supervisory processes.

1.2 Ability to organize and provide information regarding the logical sequences of supervisory interaction, that is, joint setting of goals and objectives, data collection and analysis, evaluation.

1.3 Ability to interact from a contemporary perspective with the supervisee in both the clinical and supervisory process.

1.4 Ability to apply learning principles in the supervisory process.

1.5 Ability to apply skills of interpersonal communication in the supervisory process.

1.6 Ability to facilitate independent thinking and problem solving by the supervisee.

1.7 Ability to maintain a professional and supportive relationship that allows supervisor and supervisee growth.

1.8 Ability to interact with the supervisee objectively.

1.9 Ability to establish joint communications regarding expectations and responsibilities in the clinical and supervisory processes.

1.10 Ability to evaluate, with the supervisee, the effectiveness of the ongoing supervisory relationship.

2.0 Task: Assisting the supervisee in developing clinical goals and objectives.

Competencies required:

2.1 Ability to assist the supervisee in planning effective client goals and objectives.

2.2 Ability to plan, with the supervisee, effective goals and objectives for clinical and professional growth.

2.3 Ability to assist the supervisee in using observation and assessment in preparation of client goals and objectives.

2.4 Ability to assist the supervisee in using self-analysis and previous evaluation in preparation of goals and objectives for professional growth.

2.5 Ability to assist the supervisee in assigning priorities to clinical goals and objectives.
2.6 Ability to assist the supervisee in assigning priorities to goals and objectives for professional growth.

3.0 Task: Assisting the supervisee in developing and refining assessment skills.

Competencies required:

- 3.1 Ability to share current research findings and evaluation procedures in communication disorders.
- 3.2 Ability to facilitate an integration of research findings in client assessment.
- 3.3 Ability to assist the supervisee in providing rationale for assessment procedures.
- 3.4 Ability to assist supervisee in communicating assessment procedures and rationales.
- 3.5 Ability to assist the supervisee in integrating findings and observations to make appropriate recommendations.
- 3.6 Ability to facilitate the supervisee's independent planning of assessment.

4.0 Task: Assisting the supervisee in developing and refining management skills.

Competencies required:

- 4.1 Ability to share current research findings and management procedures in communication disorders.
- 4.2 Ability to facilitate an integration of research findings in client management.
- 4.3 Ability to assist the supervisee in providing rationale for treatment procedures.
- 4.4 Ability to assist the supervisee in identifying appropriate sequences for client change.
- 4.5 Ability to assist the supervisee in adjusting steps in the progression toward a goal.
- 4.6 Ability to assist the supervisee in the description and measurement of client and clinician change.
- 4.7 Ability to assist the supervisee in documenting client and clinician change.
- 4.8 Ability to assist the supervisee in integrating documented client and clinician change to evaluate progress and specify future recommendations.

5.0 Task: Demonstrating for and participating with the supervisee in the clinical process.
Competencies required:

- 5.1 Ability to determine jointly when demonstration is appropriate.

- 5.2 Ability to demonstrate or participate in an effective client-clinician relationship.

- 5.3 Ability to demonstrate a variety of clinical techniques and participate with the supervisee in clinical management.

- 5.4 Ability to demonstrate or use jointly the specific materials and equipment of the profession.

- 5.5 Ability to demonstrate or participate jointly in counseling of clients or family/guardians of clients.

- 6.0 Task: Assisting the supervisee in observing and analyzing assessment and treatment sessions.

  Competencies required:

  - 6.1 Ability to assist the supervisee in learning a variety of data collection procedures.

  - 6.2 Ability to assist the supervisee in selecting and executing data collection procedures.

  - 6.3 Ability to assist the supervisee in accurately recording data.

  - 6.4 Ability to assist the supervisee in analyzing and interpreting data objectively.

  - 6.5 Ability to assist the supervisee in revising plans for client management based on data obtained.

- 7.0 Task: Assisting the supervisee in development and maintenance of clinical and supervisory records.

  Competencies required:

  - 7.1 Ability to assist the supervisee in applying record-keeping systems to supervisory and clinical processes.

  - 7.2 Ability to assist the supervisee in effectively documenting supervisory and clinically related interactions.

  - 7.3 Ability to assist the supervisee in organizing records to facilitate easy retrieval of information concerning clinical and supervisory interactions.

  - 7.4 Ability to assist the supervisee in establishing and following policies and procedures to protect the
confidentiality of clinical and supervisory records.

- 7.5 Ability to share information regarding documentation requirements of various accrediting and regulatory agencies and third-party funding sources.

- 8.0 Task: Interacting with the supervisee in planning, executing, and analyzing supervisory conferences.

  Competencies required:

  - 8.1 Ability to determine with the supervisee when a conference should be scheduled.
  - 8.2 Ability to assist the supervisee in planning a supervisory conference agenda.
  - 8.3 Ability to involve the supervisee in jointly establishing a conference agenda.
  - 8.4 Ability to involve the supervisee in joint discussion of previously identified clinical or supervisory data or issues.
  - 8.5 Ability to interact with the supervisee in a manner that facilitates the supervisee's self-exploration and problem solving.
  - 8.6 Ability to adjust conference content based on the supervisee's level of training and experience.
  - 8.7 Ability to encourage and maintain supervisee motivation for continuing self-growth.
  - 8.8 Ability to assist the supervisee in making commitments for changes in clinical behavior.
  - 8.9 Ability to involve the supervisee in ongoing analysis of supervisory interactions.

- 9.0 Task: Assisting the supervisee in evaluation of clinical performance.

  Competencies required:

  - 9.1 Ability to assist the supervisee in the use of clinical evaluation tools.
  - 9.2 Ability to assist the supervisee in the description and measurement of his/her progress and achievement.
  - 9.3 Ability to assist the supervisee in developing skills of self-evaluation.
  - 9.4 Ability to evaluate clinical skills with the supervisee for purposes of grade assignment, completion
of Clinical Fellowship Year, professional advancement, and so on.

10.0 Task: Assisting the supervisee in developing skills of verbal reporting, writing, and editing.

Competencies required:

- 10.1 Ability to assist the supervisee in identifying appropriate information to be included in a verbal or written report.
- 10.2 Ability to assist the supervisee in presenting information in a logical, concise, and sequential manner.
- 10.3 Ability to assist the supervisee in using appropriate professional terminology and style in verbal and written reporting.
- 10.4 Ability to assist the supervisee in adapting verbal and written reports to the work environment and communication situation.
- 10.5 Ability to alter and edit a report as appropriate while preserving the supervisee's writing style.

11.0 Task: Sharing information regarding ethical, legal, regulatory, and reimbursement aspects of the profession.

Competencies required:

- 11.1 Ability to communicate to the supervisee a knowledge of professional codes of ethics (e.g., ASHA, state licensing boards, and so on).
- 11.2 Ability to communicate to the supervisee an understanding of legal and regulatory documents and their impact on the practice of the profession (licensure, PL 94-142, Medicare, Medicaid, and so on).
- 11.3 Ability to communicate to the supervisee an understanding of reimbursement policies and procedures of the work setting.
- 11.4 Ability to communicate a knowledge of supervisee rights and appeal procedures specific to the work setting.

12.0 Task: Modeling and facilitating professional conduct.

Competencies required:
12.1 Ability to assume responsibility.

12.2 Ability to analyze, evaluate, and modify own behavior.

12.3 Ability to demonstrate ethical and legal conduct.

12.4 Ability to meet and respect deadlines.

12.5 Ability to maintain professional protocols (respect for confidentiality, etc.)

12.6 Ability to provide current information regarding professional standards (PSB, ESB, licensure, teacher certification, etc.).

12.7 Ability to communicate information regarding fees, billing procedures, and third-party reimbursement.

12.8 Ability to demonstrate familiarity with professional issues.

12.9 Ability to demonstrate continued professional growth.

13.0 Task: Demonstrating research skills in the clinical or supervisory processes.

Competencies required:

13.1 Ability to read, interpret, and apply clinical and supervisory research.

13.2 Ability to formulate clinical or supervisory research questions.

13.3 Ability to investigate clinical or supervisory research questions.

13.4 Ability to support and refute clinical or supervisory research findings.

13.5 Ability to report results of clinical or supervisory research and disseminate as appropriate (e.g., in-service, conferences, publications).

Preparation of Supervisors

The special skills and competencies for effective clinical supervision may be acquired through special training
which may include, but is not limited to, the following:

1. Specific curricular offerings from graduate programs; examples include doctoral programs emphasizing supervision, other postgraduate preparation, and specified graduate courses.

2. Continuing educational experiences specific to the supervisory process (e.g., conferences, workshops, self-study).

3. Research-directed activities that provide insight in the supervisory process.

The major goal of training in supervision is mastery of the “Competencies for Effective Clinical Supervision.” Since competence in clinical services and work experience sufficient to provide a broad clinical perspective are considered essential to achieving competence in supervision, it is apparent that most preparation in supervision will occur following the preservice level. Even so, positive effects of preservice introduction to supervision preparation have been described by both Anderson (1981) and Rassi (1983). Hence, the presentation of basic material about the supervisory process may enhance students' performance as supervisees, as well as provide them with a framework for later study.

The steadily increasing numbers of publications concerning supervision and the supervisory process indicate that basic information concerning supervision now is becoming more accessible in print to all speech-language pathologists and audiologists, regardless of geographical location and personal circumstances. In addition, conferences, workshops, and convention presentations concerning supervision in communication disorders are more widely available than ever before, and both coursework and supervisory practicum experiences are emerging in college and university educational programs. Further, although preparation in the supervisory process specific to communication disorders should be the major content, the commonality in principles of supervision across the teaching, counseling, social work, business, and health care professions suggests additional resources for those who desire to increase their supervisory knowledge and skills.

To meet the needs of persons who wish to prepare themselves as clinical supervisors, additional coursework, continuing education opportunities, and other programs in the supervisory process should be developed both within and outside graduate education programs. As noted in an earlier report on the status of supervision (ASHA, 1978), supervisors themselves expressed a strong desire for training in supervision. Further, systematic study and investigation of the supervisory process is seen as necessary to expansion of the data base from which increased knowledge about supervision and the supervisory process will emerge.

The “Tasks of Supervision” and “Competencies for Effective Clinical Supervision” are intended to serve as the
basis for content and outcome in preparation of supervisors. The tasks and competencies will be particularly useful to supervisors for self-study and self-evaluation, as well as to the consumers of supervisory activity, that is, supervisees and employers.

A repeated concern by the ASHA membership is that implementation of any suggestions for qualifications of supervisors will lead to additional standards or credentialing. At this time, preparation in supervision is a viable area of specialized study. The competencies for effective supervision can be achieved and implemented by supervisors and employers.

Summary
Clinical supervision in speech-language pathology and audiology is a distinct area of expertise and practice. This paper defines the area of supervision, outlines the special tasks of which it is comprised, and describes the competencies for each task. The competencies are developed by special preparation, which may take at least three avenues of implementation. Additional coursework, continuing education opportunities and other programs in the supervisory process should be developed both within and outside of graduate education programs. At this time, preparation in supervision is a viable area for specialized study, with competence achieved and implemented by supervisors and employers.

Bibliography


**Index terms:** supervision


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<thead>
<tr>
<th>Competency</th>
<th>Name:</th>
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<tbody>
<tr>
<td><strong>1.0 Task: Establishing and maintaining an effective working relationship with the supervisee.</strong></td>
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<tr>
<td>Competencies required:</td>
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<tr>
<td>1.1 Ability to facilitate an understanding of the clinical and supervisory processes.</td>
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<tr>
<td>1.2 Ability to organize and provide information regarding the logical sequences of supervisory interaction, that is, joint setting of goals and objectives, data collection and analysis, evaluation.</td>
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<td>1.3 Ability to interact from a contemporary perspective with the supervisee in both the clinical and supervisory process.</td>
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<td>1.4 Ability to apply learning principles in the supervisory process.</td>
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<td>1.5 Ability to apply skills of interpersonal communication in the supervisory process.</td>
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<td>1.6 Ability to facilitate independent thinking and problem solving by the supervisee.</td>
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<td>Competency</td>
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<tr>
<td>1.7 Ability to maintain a professional and supportive relationship that allows supervisor and supervisee to grow.</td>
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<td>1.8 Ability to interact with the supervisee objectively.</td>
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<td>1.9 Ability to establish joint communications regarding expectations and responsibilities in the clinical and supervisory processes.</td>
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<tr>
<td>1.10 Ability to evaluate, with the supervisee, the effectiveness of the ongoing supervisory relationship.</td>
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</table>

**2.0 Task:** Assisting the supervisee in developing clinical goals and objectives.

**Competencies required:**

2.1 Ability to assist the supervisee in planning effective client goals and objectives.

2.2 Ability to plan, with the supervisee, effective goals and objectives for clinical and professional growth.

2.3 Ability to assist the supervisee in using observation and assessment in preparation of client goals and objectives.
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<thead>
<tr>
<th>Competency</th>
<th>Does Not Meet</th>
<th>Needs Improvement</th>
<th>Meets Requirements</th>
<th>Exceeds Requirements</th>
<th>Far Exceeds Requirements</th>
<th>Comments</th>
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<tbody>
<tr>
<td>2.4 Ability to assist the supervisee in using self-analysis and previous evaluation in preparation of goals and objectives for professional growth.</td>
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<td>2.5 Ability to assist the supervisee in assigning priorities to clinical goals and objectives.</td>
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<tr>
<td>2.6 Ability to assist the supervisee in assigning priorities to goals and objectives for professional growth.</td>
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<td><strong>3.0 Task:</strong> Assisting the supervisee in developing and refining assessment skills.</td>
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<td>Competencies required:</td>
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<tr>
<td>3.1 Ability to share current research findings and evaluation procedures in communication disorders.</td>
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<td>3.2 Ability to facilitate an integration of research findings in client assessment.</td>
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<td>3.3 Ability to assist the supervisee in providing rationale for assessment procedures.</td>
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<td>3.4 Ability to assist supervisee in communicating assessment procedures and rationales.</td>
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<tr>
<td>3.5 Ability to assist the supervisee in integrating findings and observations to make appropriate recommendations.</td>
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<td>3.6 Ability to facilitate the supervisee's independent planning of assessment.</td>
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<td><strong>4.0 Task:</strong> Assisting the supervisee in developing and refining management skills.</td>
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<tr>
<td>4.1 Ability to share current research findings and management procedures in communication disorders.</td>
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<td>4.2 Ability to facilitate an integration of research findings in client management.</td>
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<td>4.3 Ability to assist the supervisee in providing rationale for treatment procedures.</td>
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<td>4.4 Ability to assist the supervisee in identifying appropriate sequences for client change.</td>
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<td>4.5 Ability to assist the supervisee in adjusting steps in the progression toward a goal.</td>
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<td>4.6 Ability to assist the supervisee in the description and measurement of client and clinician change.</td>
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<td>4.7 Ability to assist the supervisee in documenting client and clinician change.</td>
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<td>4.8 Ability to assist the supervisee in integrating documented client and clinician change to evaluate progress and specify future recommendations.</td>
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**5.0 Task:** Demonstrating for and participating with the supervisee in the clinical process.

**Competencies required:**

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<th>Competency</th>
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<tbody>
<tr>
<td>5.1 Ability to determine jointly when demonstration is appropriate.</td>
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<td>5.2 Ability to demonstrate or participate in an effective client-clinician relationship.</td>
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<td>5.3 Ability to demonstrate a variety of clinical techniques and participate with the supervisee in clinical management.</td>
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<td>5.4 Ability to demonstrate or use jointly the specific materials and equipment of the profession.</td>
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<tr>
<td>5.5 Ability to demonstrate or participate jointly in counseling of clients or family/guardians of clients.</td>
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<td><strong>6.0 Task:</strong> Assisting the supervisee in observing and analyzing assessment and treatment sessions.</td>
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<tr>
<td>6.1 Ability to assist the supervisee in learning a variety of data collection procedures.</td>
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<tr>
<td>6.2 Ability to assist the supervisee in selecting and executing data collection procedures.</td>
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<td>6.3 Ability to assist the supervisee in accurately recording data.</td>
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<td>6.4 Ability to assist the supervisee in analyzing and interpreting data objectively.</td>
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<td>6.5 Ability to assist the supervisee in revising plans for client management based on data obtained.</td>
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<td><strong>7.0 Task:</strong> Assisting the supervisee in development and maintenance of clinical and supervisory records.</td>
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### Competencies for Effective Clinical Supervision

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<th>Far Exceeds Requirements</th>
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<tbody>
<tr>
<td>7.1 Ability to assist the supervisee in applying record-keeping systems to supervisory and clinical processes.</td>
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<td>7.2 Ability to assist the supervisee in effectively documenting supervisory and clinically related interactions.</td>
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<tr>
<td>7.3 Ability to assist the supervisee in organizing records to facilitate easy retrieval of information concerning clinical and supervisory interactions.</td>
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<td>7.4 Ability to assist the supervisee in establishing and following policies and procedures to protect the confidentiality of clinical and supervisory records.</td>
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<td>7.5 Ability to share information regarding documentation requirements of various accrediting and regulatory agencies and third-party funding sources.</td>
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### 8.0 Task: Interacting with the supervisee in planning, executing, and analyzing supervisory conferences.

Competencies required:
<table>
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<tr>
<th>Competency</th>
<th>Does Not Meet</th>
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<th>Far Exceeds Requirements</th>
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<tbody>
<tr>
<td>8.1 Ability to determine with the supervisee when a conference should be scheduled.</td>
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<td>8.2 Ability to assist the supervisee in planning a supervisory conference agenda.</td>
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<td>8.3 Ability to involve the supervisee in jointly establishing a conference agenda.</td>
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<td>8.4 Ability to involve the supervisee in joint discussion of previously identified clinical or supervisory data or issues.</td>
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<td>8.5 Ability to interact with the supervisee in a manner that facilitates the supervisee's self-exploration and problem solving.</td>
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<td>8.6 Ability to adjust conference content based on the supervisee's level of training and experience.</td>
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<td>8.7 Ability to encourage and maintain supervisee motivation for continuing self-growth.</td>
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<td>8.8 Ability to assist the supervisee in making commitments for changes in clinical behavior.</td>
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<td>8.9 Ability to involve the supervisee in ongoing analysis of supervisory interactions.</td>
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<td><strong>Competencies for Effective Clinical Supervision</strong></td>
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<td><strong>9.0 Task:</strong> Assisting the supervisee in evaluation of clinical performance.</td>
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<tr>
<td>9.1 Ability to assist the supervisee in the use of clinical evaluation tools.</td>
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<td>9.2 Ability to assist the supervisee in the description and measurement of his/her progress and achievement.</td>
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<td>9.3 Ability to assist the supervisee in developing skills of self-evaluation.</td>
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<td>9.4 Ability to evaluate clinical skills with the supervisee for purposes of grade assignment, completion of Clinical Fellowship Year, professional advancement, and so on.</td>
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<td><strong>10.0 Task:</strong> Assisting the supervisee in developing skills of verbal reporting, writing, and editing.</td>
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<td>10.1 Ability to assist the supervisee in identifying appropriate information to be included in a verbal or written report.</td>
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<td>10.2 Ability to assist the supervisee in presenting information in a logical, concise, and sequential manner.</td>
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<td>10.3 Ability to assist the supervisee in using appropriate professional terminology and style in verbal and written reporting.</td>
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<td>10.4 Ability to assist the supervisee in adapting verbal and written reports to the work environment and communication situation.</td>
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<td>10.5 Ability to alter and edit a report as appropriate while preserving the supervisee's writing style.</td>
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<td><strong>11.0 Task:</strong> Sharing information regarding ethical, legal, regulatory, and reimbursement aspects of the profession.</td>
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<tr>
<td>11.1 Ability to communicate to the supervisee a knowledge of professional codes of ethics (e.g., ASHA, state licensing boards, and so on).</td>
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<td>11.2 Ability to communicate to the supervisee an understanding of legal and regulatory documents and their impact on the practice of the profession (licensure, PL 94-142, Medicare, Medicaid, and so on).</td>
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<td>11.3 Ability to communicate to the supervisee an understanding of reimbursement policies and procedures of the work setting.</td>
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<td>11.4 Ability to communicate to the supervisee rights and appeal procedures specific to the work setting.</td>
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<td><strong>12.0 Task</strong>: Modeling and facilitating professional conduct.</td>
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<td>12.1 Ability to assume responsibility.</td>
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<td>12.2 Ability to analyze, evaluate, and modify own behavior.</td>
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<td>12.3 Ability to demonstrate ethical and legal conduct.</td>
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<td>12.4 Ability to meet and respect deadlines.</td>
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<td>12.5 Ability to maintain professional protocols (respect for confidentiality, etc.)</td>
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<td>12.6 Ability to provide current information regarding professional standards (PSB, ESB, licensure, teacher certification, etc.).</td>
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<td>12.7 Ability to communicate information regarding fees, billing procedures, and third-party reimbursement.</td>
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<td>12.8 Ability to demonstrate familiarity with professional issues.</td>
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<td>12.9 Ability to demonstrate continued professional growth.</td>
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**13.0 Task:** Demonstrating research skills in the clinical or supervisory processes.

**Competencies required:**

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<tr>
<td>13.1 Ability to read, interpret, and apply clinical and supervisory research.</td>
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<td>13.2 Ability to formulate clinical or supervisory research questions.</td>
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<td>13.3 Ability to investigate clinical or supervisory research questions.</td>
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<td>13.4 Ability to support and refute clinical or supervisory research findings.</td>
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<td>13.5 Ability to report results of clinical or supervisory research and disseminate as appropriate (e.g., in-service, conferences, publications).</td>
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**Name:**

**Date:**
CMS Clarifies Student Participation in Medicare Part B Services

While at the ASHA Convention in New Orleans, ASHA President John Bernthal received a letter dated November 9, 2001, from the Centers for Medicare and Medicaid Services (CMS) clarifying that speech-language pathology and audiology students can participate in providing Medicare covered services to Part B beneficiaries. Please feel free to share it with clinical practicum site supervisors.

The letter from Terrence L. Kay, Director of the Division of Practitioner and Ambulatory Care in the Center for Medicare Management, requires that the qualified practitioner must be "in the room guiding the student in service delivery when the graduate student is participating in the provision of services, and the practitioner is not engaged in treating another patient or doing other tasks at the same time." Mr. Kay’s letter also states, "The qualified practitioner is responsible for the services and as such, signs all documentation." He adds parenthetically that the student may also sign the documentation if desired. All six points for ensuring coverage of Medicare Part B when a graduate student is involved with service delivery must be followed.

Mr. Kay included two scenarios, one for speech-language pathology services and one for audiology services, to illustrate Medicare Part B billable services. They are:

A speech-language pathologist is seeing a Medicare Part B beneficiary who has aphasia. The speech-language pathologist, with the graduate student’s participation, develops a treatment plan for the session and both see the patient with the speech-language pathologist controlling the services rendered. The speech-language pathologist is in the room and engaged only in that patient’s treatment at all times.

An audiologist is assessing the hearing of a Medicare Part B beneficiary who was referred because of hearing loss and vertigo. The graduate student participates in conducting the pure tone and speech audiometry. The audiologist is in the room and engaged only in that patient’s assessment at all times.

ASHA is pleased that CMS has removed any doubt that speech-language pathology and audiology graduate students can participate in covered services rendered to Medicare Part B beneficiaries. For further information or additional information, contact Steve White through the Action Center at 800-498-2071, ext. 4126, or by email at swhite@asha.org.

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Scope of Practice in Speech-Language Pathology

Ad Hoc Committee on the Scope of Practice in Speech-Language Pathology

About this Document

This scope of practice document is an official policy of the American Speech-Language-Hearing Association (ASHA) defining the breadth of practice within the profession of speech-language pathology. This document was developed by the ASHA Ad Hoc Committee on the Scope of Practice in Speech-Language Pathology. Committee members were Kenn Apel (chair), Theresa E. Bartolotta, Adam A. Brickell, Lynne E. Hewitt, Ann W. Kummer, Luis F. Riquelme, Jennifer B. Watson, Carole Zangari, Brian B. Shulman (vice president for professional practices in speech-language pathology), Lemmietta McNeilly (ex officio), and Diane R. Paul (consultant). This document was approved by the ASHA Legislative Council on September 4, 2007 (LC 09-07).

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- Resources
  - ASHA Cardinal Documents
  - General Service Delivery Issues
  - Clinical Services and Populations
  - Health Care Services
  - School Services
Introduction

The *Scope of Practice in Speech-Language Pathology* includes a statement of purpose, a framework for research and clinical practice, qualifications of the speech-language pathologist, professional roles and activities, and practice settings. The speech-language pathologist is the professional who engages in clinical services, prevention, advocacy, education, administration, and research in the areas of communication and swallowing across the life span from infancy through geriatrics. Given the diversity of the client population, ASHA policy requires that these activities are conducted in a manner that takes into consideration the impact of culture and linguistic exposure/acquisition and uses the best available evidence for practice to ensure optimal outcomes for persons with communication and/or swallowing disorders or differences.

As part of the review process for updating the *Scope of Practice in Speech-Language Pathology*, the committee made changes to the previous scope of practice document that reflected recent advances in knowledge, understanding, and research in the discipline. These changes included acknowledging roles and responsibilities that were not mentioned in previous iterations of the *Scope of Practice* (e.g., funding issues, marketing of services, focus on emergency responsiveness, communication wellness). The revised document also was framed squarely on two guiding principles: evidence-based practice and cultural and linguistic diversity.

Statement of Purpose

The purpose of this document is to define the *Scope of Practice in Speech-Language Pathology* to

1. delineate areas of professional practice for speech-language pathologists;

2. inform others (e.g., health care providers, educators, other professionals, consumers, payers, regulators, members of the general public) about professional services offered by speech-language pathologists as qualified providers;

3. support speech-language pathologists in the provision of high-quality, evidence-based services to individuals with concerns about communication or swallowing;

4. support speech-language pathologists in the conduct of research;
5. provide guidance for educational preparation and professional development of speech-language pathologists.

This document describes the breadth of professional practice offered within the profession of speech-language pathology. Levels of education, experience, skill, and proficiency with respect to the roles and activities identified within this scope of practice document vary among individual providers. A speech-language pathologist typically does not practice in all areas of the field. As the ASHA Code of Ethics specifies, individuals may practice only in areas in which they are competent (i.e., individuals’ scope of competency), based on their education, training, and experience.

In addition to this scope of practice document, other ASHA documents provide more specific guidance for practice areas. Figure 1 illustrates the relationship between the ASHA Code of Ethics, the Scope of Practice, and specific practice documents. As shown, the ASHA Code of Ethics sets forth the fundamental principles and rules considered essential to the preservation of the highest standards of integrity and ethical conduct in the practice of speech-language pathology.

Figure 1. Conceptual Framework of ASHA Practice Documents

Speech-language pathology is a dynamic and continuously developing profession. As such, listing specific areas within this Scope of Practice does not exclude emerging areas of practice. Further, speech-language pathologists may provide additional professional services (e.g., interdisciplinary work in a health care setting,
collaborative service delivery in schools, transdisciplinary practice in early intervention settings) that are necessary for the well-being of the individual(s) they are serving but are not addressed in this Scope of Practice. In such instances, it is both ethically and legally incumbent upon professionals to determine whether they have the knowledge and skills necessary to perform such services.

This scope of practice document does not supersede existing state licensure laws or affect the interpretation or implementation of such laws. It may serve, however, as a model for the development or modification of licensure laws.

Framework for Research and Clinical Practice

The overall objective of speech-language pathology services is to optimize individuals' ability to communicate and swallow, thereby improving quality of life. As the population profile of the United States continues to become increasingly diverse (U.S. Census Bureau, 2005), speech-language pathologists have a responsibility to be knowledgeable about the impact of these changes on clinical services and research needs. Speech-language pathologists are committed to the provision of culturally and linguistically appropriate services and to the consideration of diversity in scientific investigations of human communication and swallowing. For example, one aspect of providing culturally and linguistically appropriate services is to determine whether communication difficulties experienced by English language learners are the result of a communication disorder in the native language or a consequence of learning a new language.

Additionally, an important characteristic of the practice of speech-language pathology is that, to the extent possible, clinical decisions are based on best available evidence. ASHA has defined evidence-based practice in speech-language pathology as an approach in which current, high-quality research evidence is integrated with practitioner expertise and the individual's preferences and values into the process of clinical decision making (ASHA, 2005). A high-quality basic, applied, and efficacy research base in communication sciences and disorders and related fields of study is essential to providing evidence-based clinical practice and quality clinical services. The research base can be enhanced by increased interaction and communication with researchers across the United States and from other countries. As our global society is becoming more connected, integrated, and interdependent, speech-language pathologists have access to an abundant array of resources, information technology, and diverse perspectives and influence (e.g., Lombardo, 1997). Increased national and international interchange of professional knowledge, information, and education in communication sciences and disorders can be a means to strengthen research collaboration and improve clinical services.
The World Health Organization (WHO) has developed a multipurpose health classification system known as the International Classification of Functioning, Disability and Health (ICF; WHO, 2001). The purpose of this classification system is to provide a standard language and framework for the description of functioning and health. The ICF framework is useful in describing the breadth of the role of the speech-language pathologist in the prevention, assessment, and habilitation/rehabilitation, enhancement, and scientific investigation of communication and swallowing. It consists of two components:

- **Health Conditions**

  - **Body Functions and Structures:** These involve the anatomy and physiology of the human body. Relevant examples in speech-language pathology include craniofacial anomaly, vocal fold paralysis, cerebral palsy, stuttering, and language impairment.

  - **Activity and Participation:** Activity refers to the execution of a task or action. Participation is the involvement in a life situation. Relevant examples in speech-language pathology include difficulties with swallowing safely for independent feeding, participating actively in class, understanding a medical prescription, and accessing the general education curriculum.

- **Contextual Factors**

  - **Environmental Factors:** These make up the physical, social, and attitudinal environments in which people live and conduct their lives. Relevant examples in speech-language pathology include the role of the communication partner in augmentative and alternative communication, the influence of classroom acoustics on communication, and the impact of institutional dining environments on individuals' ability to safely maintain nutrition and hydration.

  - **Personal Factors:** These are the internal influences on an individual's functioning and disability and are not part of the health condition. These factors may include, but are not limited to, age, gender, ethnicity, educational level, social background, and profession. Relevant examples in speech-language pathology might include a person's background or culture that influences his or her reaction to a communication or swallowing disorder.

The framework in speech-language pathology encompasses these health conditions and contextual factors. The health condition component of the ICF can be expressed on a continuum of functioning. On one end of the continuum is intact functioning. At the opposite end of the continuum is completely compromised functioning. The contextual factors interact with each other and with the health conditions and may serve as facilitators or
barriers to functioning. Speech-language pathologists may influence contextual factors through education and advocacy efforts at local, state, and national levels. Relevant examples in speech-language pathology include a user of an augmentative communication device needing classroom support services for academic success, or the effects of premorbid literacy level on rehabilitation in an adult post brain injury. Speech-language pathologists work to improve quality of life by reducing impairments of body functions and structures, activity limitations, participation restrictions, and barriers created by contextual factors.

Qualifications
Speech-language pathologists, as defined by ASHA, hold the ASHA Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP), which requires a master's, doctoral, or other recognized postbaccalaureate degree. ASHA-certified speech-language pathologists complete a supervised postgraduate professional experience and pass a national examination as described in the ASHA certification standards. Demonstration of continued professional development is mandated for the maintenance of the CCC-SLP. Where applicable, speech-language pathologists hold other required credentials (e.g., state licensure, teaching certification).

This document defines the scope of practice for the field of speech-language pathology. Each practitioner must evaluate his or her own experiences with preservice education, clinical practice, mentorship and supervision, and continuing professional development. As a whole, these experiences define the scope of competence for each individual. Speech-language pathologists may engage in only those aspects of the profession that are within their scope of competence.

As primary care providers for communication and swallowing disorders, speech-language pathologists are autonomous professionals; that is, their services are not prescribed or supervised by another professional. However, individuals frequently benefit from services that include speech-language pathologist collaborations with other professionals.

Professional Roles and Activities
Speech-language pathologists serve individuals, families, and groups from diverse linguistic and cultural backgrounds. Services are provided based on applying the best available research evidence, using expert clinical judgments, and considering clients' individual preferences and values. Speech-language pathologists address typical and atypical communication and swallowing in the following areas:
- speech sound production
  - articulation
  - apraxia of speech
  - dysarthria
  - ataxia
  - dyskinesia

- resonance
  - hypernasality
  - hyponasality
  - cul-de-sac resonance
  - mixed resonance

- voice
  - phonation quality
  - pitch
  - loudness
  - respiration

- fluency
  - stuttering
  - cluttering

- language (comprehension and expression)
  - phonology
- morphology
- syntax
- semantics
- pragmatics (language use, social aspects of communication)
- literacy (reading, writing, spelling)
- prelinguistic communication (e.g., joint attention, intentionality, communicative signaling)
- paralinguistic communication

- cognition
  - attention
  - memory
  - sequencing
  - problem solving
  - executive functioning

- feeding and swallowing
  - oral, pharyngeal, laryngeal, esophageal
  - orofacial myology (including tongue thrust)
  - oral-motor functions

Potential etiologies of communication and swallowing disorders include

- neonatal problems (e.g., prematurity, low birth weight, substance exposure);
- developmental disabilities (e.g., specific language impairment, autism spectrum disorder, dyslexia, learning disabilities, attention deficit disorder);
- auditory problems (e.g., hearing loss or deafness);
- oral anomalies (e.g., cleft lip/palate, dental malocclusion, macroglossia, oral-motor dysfunction);
- respiratory compromise (e.g., bronchopulmonary dysplasia, chronic obstructive pulmonary disease);
- pharyngeal anomalies (e.g., upper airway obstruction, velopharyngeal insufficiency/incompetence);
- laryngeal anomalies (e.g., vocal fold pathology, tracheal stenosis, tracheostomy);
- neurological disease/dysfunction (e.g., traumatic brain injury, cerebral palsy, cerebral vascular accident, dementia, Parkinson's disease, amyotrophic lateral sclerosis);
- psychiatric disorder (e.g., psychosis, schizophrenia);
- genetic disorders (e.g., Down syndrome, fragile X syndrome, Rett syndrome, velocardiofacial syndrome).

The professional roles and activities in speech-language pathology include clinical/educational services (diagnosis, assessment, planning, and treatment), prevention and advocacy, and education, administration, and research.

Clinical Services

Speech-language pathologists provide clinical services that include the following:

- prevention and pre-referral
- screening
- assessment/evaluation
- consultation
- diagnosis
- treatment, intervention, management
Examples of these clinical services include

1. using data to guide clinical decision making and determine the effectiveness of services;

2. making service delivery decisions (e.g., admission/eligibility, frequency, duration, location, discharge/dismissal) across the lifespan;

3. determining appropriate context(s) for service delivery (e.g., home, school, telepractice, community);

4. documenting provision of services in accordance with accepted procedures appropriate for the practice setting;

5. collaborating with other professionals (e.g., identifying neonates and infants at risk for hearing loss, participating in palliative care teams, planning lessons with educators, serving on student assistance teams);

6. screening individuals for hearing loss or middle ear pathology using conventional pure-tone air conduction methods (including otoscopic inspection), otoacoustic emissions screening, and/or screening tympanometry;

7. providing intervention and support services for children and adults diagnosed with speech and language disorders;

8. providing intervention and support services for children and adults diagnosed with auditory processing disorders;
9. using instrumentation (e.g., videofluoroscopy, electromyography, nasendoscopy, stroboscopy, endoscopy, nasometry, computer technology) to observe, collect data, and measure parameters of communication and swallowing or other upper aerodigestive functions;

10. counseling individuals, families, coworkers, educators, and other persons in the community regarding acceptance, adaptation, and decision making about communication and swallowing;

11. facilitating the process of obtaining funding for equipment and services related to difficulties with communication and swallowing;

12. serving as case managers, service delivery coordinators, and members of collaborative teams (e.g., individualized family service plan and individualized education program teams, transition planning teams);

13. providing referrals and information to other professionals, agencies, and/or consumer organizations;

14. developing, selecting, and prescribing multimodal augmentative and alternative communication systems, including unaided strategies (e.g., manual signs, gestures) and aided strategies (e.g., speech-generating devices, manual communication boards, picture schedules);

15. providing services to individuals with hearing loss and their families/caregivers (e.g., auditory training for children with cochlear implants and hearing aids; speechreading; speech and language intervention secondary to hearing loss; visual inspection and listening checks of amplification devices for the purpose of troubleshooting, including verification of appropriate battery voltage);

16. addressing behaviors (e.g., perseverative or disruptive actions) and environments (e.g., classroom seating, positioning for swallowing safety or attention, communication opportunities) that affect communication and swallowing;

17. selecting, fitting, and establishing effective use of prosthetic/adaptive devices for communication and swallowing (e.g., tracheoesophageal prostheses, speaking valves, electrolarynges; this service does not include the selection or fitting of sensory devices used by individuals with hearing loss or other auditory perceptual deficits, which falls within the scope of practice of audiologists; ASHA, 2004);

18. providing services to modify or enhance communication performance (e.g., accent modification, transgender voice, care and improvement of the professional voice, personal/professional communication
Prevention and Advocacy

Speech-language pathologists engage in prevention and advocacy activities related to human communication and swallowing. Example activities include

1. improving communication wellness by promoting healthy lifestyle practices that can help prevent communication and swallowing disorders (e.g., cessation of smoking, wearing helmets when bike riding);

2. presenting primary prevention information to individuals and groups known to be at risk for communication disorders and other appropriate groups;

3. providing early identification and early intervention services for communication disorders;

4. advocating for individuals and families through community awareness, health literacy, education, and training programs to promote and facilitate access to full participation in communication, including the elimination of societal, cultural, and linguistic barriers;

5. advising regulatory and legislative agencies on emergency responsiveness to individuals who have communication and swallowing disorders or difficulties;

6. promoting and marketing professional services;

7. advocating at the local, state, and national levels for improved administrative and governmental policies affecting access to services for communication and swallowing;

8. advocating at the local, state, and national levels for funding for research;

9. recruiting potential speech-language pathologists into the profession;

10. participating actively in professional organizations to contribute to best practices in the profession.
Education, Administration, and Research

Speech-language pathologists also serve as educators, administrators, and researchers. Example activities for these roles include

1. educating the public regarding communication and swallowing;
2. educating and providing in-service training to families, caregivers, and other professionals;
3. educating, supervising, and mentoring current and future speech-language pathologists;
4. educating, supervising, and managing speech-language pathology assistants and other support personnel;
5. fostering public awareness of communication and swallowing disorders and their treatment;
6. serving as expert witnesses;
7. administering and managing clinical and academic programs;
8. developing policies, operational procedures, and professional standards;
9. conducting basic and applied/translational research related to communication sciences and disorders, and swallowing.

Practice Settings

Speech-language pathologists provide services in a wide variety of settings, which may include but are not exclusive to

1. public and private schools;
2. early intervention settings, preschools, and day care centers;
3. health care settings (e.g., hospitals, medical rehabilitation facilities, long-term care facilities, home health agencies, clinics, neonatal intensive care units, behavioral/mental health facilities);
4. private practice settings;

5. universities and university clinics;

6. individuals' homes and community residences;

7. supported and competitive employment settings;

8. community, state, and federal agencies and institutions;

9. correctional institutions;

10. research facilities;

11. corporate and industrial settings.

References


Resources
ASHA Cardinal Documents


General Service Delivery Issues

Admission/Discharge Criteria

Autonomy

Culturally and Linguistically Appropriate Services


Definitions and Terminology


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**Evidence-Based Practice**


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**Private Practice**


Professional Service Programs

Speech-Language Pathology Assistants


Supervision


Clinical Services and Populations
Apraxia of Speech
Auditory Processing


Augmentative and Alternative Communication (AAC)


Aural Rehabilitation

Autism Spectrum Disorders


Cognitive Aspects of Communication


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**Deaf and Hard of Hearing**


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**Dementia**


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**Early Intervention**


Fluency

Hearing Screening


Language and Literacy


---

**Mental Retardation/Developmental Disabilities**


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**Orofacial Myofunctional Disorders**


Prevention


Severe Disabilities


Social Aspects of Communication


Swallowing


American Speech-Language-Hearing Association. (2004). Speech-language pathologists training and supervising other professionals in the delivery of services to individuals with swallowing and feeding

---

**Voice and Resonance**


American Speech-Language-Hearing Association. (2005). *The role of the speech-language pathologist, the
Health Care Services

Business Practices in Health Care Settings


Multiskilling


Neonatal Intensive Care Unit


Sedation and Anesthetics

Telepractice


School Services
Collaboration

Evaluation
Facilities

Inclusive Practices

Roles and Responsibilities for School-Based Practitioners

“Under the Direction of” Rule


Workload


Index terms: scope of practice


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Appendix B: Clinical Forms

1. Report of Clinical Competencies

2. Supervisor’s Evaluation of Off-campus Practicum

3. Student’s Evaluation of Off-campus Practicum


4. Clinical Fellowship Skills Inventory:

   http://www.asha.org/uploadedFiles/CFSISLP.pdf

6. Bronson Hospital Student Performance Evaluation

7. Clinic Dress and Personal Guidelines

8. Liability Insurance
WESTERN MICHIGAN UNIVERSITY
Report of Clinical Competencies
SPPA 7120

STUDENT NAME: _________________________  SEMESTER/YEAR: _______________

FACILITY: _______________________________  SUPERVISOR: _______________________

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<th>Competency Rating Scale</th>
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<td>5 =</td>
<td>Demonstrates the behavior consistently and independently; ready for Clinical Fellowship</td>
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<td>4 =</td>
<td>Demonstrates independence but needs supervisor’s general direction</td>
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<tr>
<td>3 =</td>
<td>Demonstrates the behavior but needs specific guidance</td>
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<tr>
<td>2 =</td>
<td>Demonstrates the behavior with repeated specific direction</td>
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<tr>
<td>1 =</td>
<td>Fails to demonstrate the behavior regardless of amount of supervisor’s input</td>
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<tr>
<td>DNA =</td>
<td>No evidence of skill has been demonstrated or no opportunity at this facility</td>
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Disorder Types (circle all that apply)

- Articulation
- Fluency
- Voice and resonance, including respiration and phonation
- Receptive and expressive language (phonology, morphology, semantics, and pragmatics) in speaking, listening, reading, writing and manual modalities
- Hearing, including the impact on speech and language
- Swallowing (oral, pharyngeal, esophageal, and related functions, including oral function for feeding; orofacial myofunction)
- Cognitive aspects of communication (attention, memory, sequencing, problem-solving, executive functioning)
- Social aspects of communication, including challenging behavior, ineffective social skills, lack of communication opportunities
- Communication modalities, including oral, manual, augmentative, and alternative communication techniques and assistive technologies

STUDENT COMPETENCY RATINGS

**Area 1: Knowledge Base** Use the Competency Rating Scale

- Demonstrated knowledge of the nature of the communication disorder, including etiology, characteristics, anatomical/physiological, acoustic, psychological, developmental, linguistic, and cultural correlations (IIIC) ______

- Demonstrated knowledge of the principles and methods of prevention, assessment, and intervention, including consideration of anatomical/physiological, developmental, linguistic, and cultural correlates of the disorder (IIID) ______

- Demonstrated knowledge of standards of ethical conduct (IIIE) ______

- Demonstrated knowledge of processes used in research, and integration of research principles into evidence-based clinical practice (IIIF) ______
Demonstrated knowledge of contemporary professional issues _____

Comments regarding student’s knowledge base at this facility: (attach any additional comments)

Area II: Supervised Intervention/Therapy Experience (IVG)

Developed appropriate intervention plans with measurable and achievable goals, collaborated with client/caregiver and relevant others in the planning process _____

Implemented intervention plans; involved client/caregiver in the intervention process _____

Selected/developed and used appropriate materials and instrumentation for prevention/intervention _____

Measured and evaluated clients’ performance and progress _____

Modified/adapted intervention plans, strategies, materials, or instrumentation for prevention and intervention _____

Completed administrative and reporting functions necessary to support intervention in a timely manner _____

Identified and referred clients for services when appropriate _____

Comments regarding student’s intervention skills with these clients: (attach any additional comments)

Student’s Overall Interaction and Professional Qualities:

Communicated effectively, recognizing the needs, values, preferred mode of communication and cultural/linguistic background of the client, family, caregiver, relevant others _____

Collaborated with other professionals in case management _____

Provided counseling and supportive guidance regarding communication/swallowing disorders to client/family/caregiver/relevant others _____

Adhered to ASHA Code of Ethics and professional standards, maintained client confidentiality _____

Attended to administrative details with punctuality and care _____

Prepared written reports with accuracy and appropriate writing skills _____

Comments regarding student’s interaction and professional qualities in the facility: (attach any additional comments)

__________________________________  ____________________________________  ________________
Supervisor’s signature  Student’s signature  Date
STUDENT NAME: _________________________  SEMESTER/YEAR: _________________________

FACILITY: _____________________________  SUPERVISOR: _____________________________

1. Description of student’s activities and related clinical/educational experience:

2. Evaluation of the student’s performance:

Total number of clinical hours: __________

Letter Grade Evaluation (circle appropriate grade): A, BA, B, CB, C, DC, D, E (see grading explanation on the bottom of this sheet)

__________________________  ___________________
Off-campus clinical supervisor’s signature  Date

Please return completed form by the first day of examination week directly to: Department of Speech Pathology and Audiology, Western Michigan University, Kalamazoo, MI 49008-5355. The student will receive a copy from the department.

Western Michigan University Grading for CR or NC – Credit or No Credit

The credit/no credit grading system (A, BA, B = credit; CB, C, DC, D, E = no credit) is used in all 7000 level courses, as well as some departmental courses and programs approved by the Graduate Studies Council. The student’s permanent record will indicate ‘CR’ when the course is passed and ‘NC’ when the course is incomplete or failed.
WESTERN MICHIGAN UNIVERSITY
SPEECH PATHOLOGY AND AUDIOLOGY
Student’s Evaluation of Off-campus Practicum

STUDENT NAME: ___________________________ SEMESTER/YEAR: ________________

FACILITY: ___________________________ SUPERVISOR: ___________________________

1. Evaluation of the experience (positive and negative):

2. Suggestions for the improvement of the experience:

__________________________________________  ____________________________
Student’s signature                        Date

Please complete this form immediately upon completion of the practicum assignment and return directly
to: Department of Speech Pathology and Audiology, Western Michigan University, Kalamazoo, MI
49008-5355. The off-campus supervisor will receive a copy from the department.
the mechanism whereby the clinical fellow receives feedback

- the clinical fellowship supervisor's commitment to complete and sign the Clinical Fellowship Report within 30 days of completion of the CF experience

- a mechanism for terminating the clinical fellowship if it becomes necessary before the expected completion date

- an account of the direct expenses for which the clinical fellowship supervisor will be reimbursed (e.g., transportation, meals, lodging, telephone, etc.)

- the payment schedule for reimbursement of direct expenses incurred by the clinical fellowship supervisor (Payment must not be conditional upon the clinical fellowship supervisor's recommendation for approval of the clinical fellowship.)

- a statement that both the supervisor and the clinical fellow have verified that the clinical fellowship supervisor's certification is current throughout the clinical fellowship.

2. Expenses should be reimbursed at a reasonable level. Reasonable refers to the exact expenses incurred for transportation, meals, lodging, telephone, and postage.

3. If the clinical fellow and the clinical fellowship supervisor work for the same employer or institution, there shall be no remuneration.

**Evaluation of Clinical Fellows**

The Standards for the Certificates of Clinical Competence require the clinical fellowship supervisor to conduct periodic formal evaluations of the clinical fellow. On page 26 the section on “Clinical Fellowship Skills Inventory (CFSI-QLP)” contains instructions for use during the formal evaluations. It is the responsibility of the clinical fellow and the clinical fellowship supervisor to make certain that they follow the instructions in these sections and that the clinical fellowship supervisor uses the CFSI-QLP (see Form E and Appendix 5) to complete the mandatory evaluations. As stated in the CCB Implementation Procedures, the clinical fellowship supervisor must use the current evaluation instrument at least once during each of the three segments of the clinical fellowship. That is, the supervisor must conduct at least three formal evaluations using the Clinical Fellowship Skills Inventory, spaced uniformly throughout the clinical fellowship. No later than 4 weeks after the clinical fellowship is completed, the clinical fellow and the clinical fellowship supervisor must sign, date, and submit to the National Office for review by the CCB a Clinical Fellowship Report and the Clinical Fellowship Skills Inventory Rating Form reflecting the three formal evaluations.

If a clinical fellow is supervised by multiple individuals, it is the responsibility of one clinical fellowship supervisor to collate the evaluations of all supervisors and to verify that the policies governing supervision and evaluation have been met. All clinical fellowship supervisors must hold a current CCC in the area in which certification is sought, and they must maintain this certification throughout the period of supervision.

**Ongoing Feedback.** Because one purpose of the clinical fellowship is to improve the clinical effectiveness of the clinical fellow, supervisors must provide performance feedback to the clinical fellow throughout the clinical fellowship. Feedback and goal-setting require two-way communication whereby both the clinical fellowship supervisor and the clinical fellow share important information about the clinical fellow’s performance of clinical activities. A specific time should be set aside for each performance feedback session at the end of each of the three segments of the clinical fellowship. This session should be used to identify performance strengths and weaknesses and, through discussion and goal-setting, to assist the clinical fellow in developing the required skills.

If the clinical fellowship supervisor anticipates at any time during the clinical fellowship that the clinical fellow under supervision will fail to meet requirements, the clinical fellowship supervisor must counsel the clinical fellow both orally and in writing and maintain written records of all contacts and conferences over the ensuing months. If the clinical fellowship experience is terminated at any time before completion of the clinical fellowship, or if the clinical fellowship supervisor does not recommend approval of the clinical fellowship experience at the end of the clinical fellowship, he/she must so indicate in Section 8 of the Clinical Fellowship.
Report. Within 30 days of making the negative recommendation, the clinical fellowship supervisor must submit to the CCB (a) a letter of explanation and supporting documentation, (b) a signed Clinical Fellowship Report completed for the portion of the clinical fellowship he/she supervised, and (c) a signed Clinical Fellowship Skills Inventory Rating Form completed for the portion of the clinical fellowship he/she supervised. This information must be shared with the clinical fellow. Following a negative recommendation, the clinical fellow may complete an entirely new clinical fellowship, a portion of the clinical fellowship, and/or request a Special Review by the CCB.

Special Review. To request a Special Review, the clinical fellow must submit to the CCB within 30 days of the negative recommendation (a) the completed and signed Clinical Fellowship Report, (b) the completed and signed Clinical Fellowship Skills Inventory Rating Form (if the supervisor has not submitted either or both), and (c) a letter of explanation and supporting documentation to indicate why the clinical fellowship should be accepted. The CCB may share this information with the clinical fellowship supervisor and may solicit any additional information the supervisor wishes to provide. The decision to approve the clinical fellowship rests solely with the CCB. The CCB will review all information submitted to determine if the clinical fellowship experience will be approved, in part or in full. (For more information see Section VII. Procedures for Appeal on page 37).

Clinical Fellowship Skills Inventory (CFSI-SLP). The CFSI-SLP provides the means for determining whether the clinical fellow can satisfactorily perform the skills necessary for independent practice and addresses the need to assess the clinical fellow in developing these skills. The CFSI-SLP stresses the need for both the clinical fellowship supervisor and the clinical fellow to identify performance areas in which improvement is needed and then to develop and implement performance improvement plans. This approach to the performance appraisal process includes the following features: (a) a standardized system for reviewing the clinical work of all clinical fellows at regularly scheduled intervals, (b) a procedure to ensure that the clinical fellow has the skills for independent practice, (c) a means by which the clinical fellowship supervisor can meaningfully supervise the clinical fellow's progress in attaining and improving skills, (d) a process by which the clinical fellow gains experience in the self-evaluation of his or her skills, and (e) a collaborative effort in which the clinical fellowship supervisor and the clinical fellow are encouraged to work together to make the clinical fellowship a valuable learning experience. Performance appraisal protects the public interest and serves as a clinical teaching and learning tool.

The CFSI-SLP consists of 18 skill segments covering four areas. The skills selected for inclusion in the CFSI-SLP are derived from a role delineation and validation study conducted for ASHA by the Professional Examination Service. Following is a general description of each of the four performance areas:

- **Evaluation** (5 skills): selection, adaptation, administration of an assessment battery and interpretation of results
- **Treatment** (5 skills): selection, development, adaptation, and implementation of treatment plans and intervention strategies
- **Management** (3 skills): service activities and compliance with administrative and policy requirements
- **Interaction** (5 skills): communication skills and collaboration with other professionals

The rating scale for each skill has been designed along a 5-point continuum, ranging from “5” (representing the most effective performance) to “1” (representing the least effective performance). The clinical fellowship supervisor will match the clinical fellow's performance to the descriptors for each skill. The ratings for one skill may not be the same as the ratings for other skills. For each skill included on the CFSI-SLP the clinical fellowship supervisor will have to decide which point on the scale best reflects the performance of the clinical fellow during the segment being rated. The category “Not Applicable (NA)” appears on two items of the rating scale and may be used only for these items. **NA should be used only if the facility does not provide an opportunity for the clinical fellow to perform the skill during the segment.** However, the clinical fellowship supervisor is encouraged to coordinate the observation schedule to ensure that all applicable skills are observed and evaluated.

The clinical fellowship supervisor must use the rating scale at least once during each of the three segments of the clinical fellowship. This evaluation must be shared and discussed with the clinical fellow, and the CFSI Rating Form (Form E) must be signed and dated by
both. Supervisors must follow the instructions below to complete the rating process at the end of each segment.

Instructions for the Rating Process

- The clinical fellowship supervisor completes the machine-scannable CFSI Rating Form (Form E) to rate the performance of the clinical fellow on each of 18 skills.

- Both the clinical fellowship supervisor and the clinical fellow sign the CFSI Rating Form and note the dates when the performance feedback sessions were held.

- At the end of the clinical fellowship, the clinical fellowship supervisor mails the completed CFSI Rating Form and the completed Clinical Fellowship Report to the Certification office at ASHA.

The clinical fellowship supervisor retains a photocopy of the completed CFSI Rating Form.

At the beginning of the first segment of the clinical fellowship, the clinical fellowship supervisor and the clinical fellow should meet to discuss assigned work responsibilities, performance expectations, and the requirement that regularly scheduled performance appraisals be conducted during the clinical fellowship. They should review the CFSI-SLP to ensure that both the skills to be evaluated and the rating scale are understood and to determine if there is a particular skill or skill area requiring a special focus. Setting goals at this time to prepare for the second and third segments will give the clinical fellowship supervisor and the clinical fellow an opportunity to discuss concerns that have arisen and to plan new performance goals before the beginning of another segment. Goal setting also encourages the supervisor and fellow to consider realistically how much improvement can be achieved from one performance assessment to another. It is an important component in the performance appraisal process—one that requires collaboration between the clinical fellowship supervisor and the clinical fellow. The clinical fellow should prepare for each performance feedback session by reviewing the CFSI-SLP (i.e., the performance skills and rating scale). It is also recommended that the clinical fellow conduct a self-evaluation using the CFSI-SLP. Self-evaluation can provide the clinical fellow with important insights to use in improving performance. The clinical fellow can then compare his or her own ratings with those given by the clinical fellowship supervisor.

Minimum Rating for Core Skills. Core skills must be assessed during at least one segment of the clinical fellowship, and each skill must receive a rating of at least a “3” on a 5-point scale during the last segment in which the core skill is rated. The core skills are 2-5, 8-11, and 14-17 and are so noted on the list of skills found in Appendix 5.

For clinical fellowships initiated as of September 1, 1997, a minimum rating of “3” on core skills during the last segment in which the core skill was rated will be required for approval of the fellowship.

Supervisors may rate the clinical fellow only on the clinical skills identified in the CFSI. If a rating of “3” is achieved for each of the core skills during the last segment in which the core skill was rated, the supervisor must include in the final Clinical Fellowship Report a positive recommendation for certification or provide a specific rationale and documentation for why the fellow is not being recommended for certification.

Clinical Fellowship Report

Upon completion of the clinical fellowship, a conference must be held to provide the clinical fellow the opportunity to discuss the evaluation with the supervisor. The supervisor and the clinical fellow must complete, sign, and submit the Clinical Fellowship Report (CF Report) and the Clinical Fellowship Skills Inventory Rating Form to the CCB as soon as possible after completion of the clinical fellowship. If the application for certification has not been submitted to the National Office, it must be filed at this time.

If a change is made in the clinical fellowship site, clinical fellowship supervisor, or category of hours worked per week, the clinical fellowship supervisor must submit to the CCB, within 4 weeks of the change, the completed and signed Clinical Fellowship Skills Inventory Rating Form and the Clinical Fellowship Report for the portion of the clinical fellowship that was completed. Remember—a separate CF Report must be submitted for each component of the clinical fellowship that involved a change of site, supervisor, or work schedule.
Clinical Fellowship Skills Inventory (CFSI)

Speech-Language Pathology

Description Of The Inventory
The CFSI consists of 18 skill statements covering four areas: (a) evaluation, (b) treatment, (c) management, and (d) interaction. The rating scale for each skill has been designed along a 5-point continuum, ranging from “5” (representing the most effective performance) to “1” (representing the least effective performance). Approval of the clinical fellowship requires a minimum rating of “3” on the core skills during the last segment in which the core skill is rated. Core skills are noted on the inventory with an asterisk (*). The clinical fellowship supervisor will match the clinical fellow’s performance to the descriptor for each skill. The rating for one skill need not be the same as the ratings for other skills. For each skill included on the CFSI the CF supervisor will decide which point on the scale best reflects the performance of the clinical fellow during the segment being rated. (Because the clinical fellowship is divided into three equal segments, each segment represents one third of the total experience.) The fellowship supervisor must complete the inventory at least once during each of the three segments of the clinical fellowship. The category “Not Applicable (NA)” appears on two items of the rating scale and may be used only for these items. NA should be used only if the facility does not provide an opportunity for the fellow to perform the skill during the segment. However, the CF supervisor is encouraged to coordinate the observation schedule to ensure that all applicable skills are observed and evaluated.

Rating Tips
To determine the rating for each skill, consider the fellow’s effectiveness in working with specific client populations in terms of client’s (a) age (infants, children, adults), (b) type and severity of communication disorder, (c) physical limitations, (d) cultural background, (e) English proficiency, (f) literacy level, and (g) alternative communication system use. In addition to considering these factors for all skills, Skill 4 and Skill 10 have been included to evaluate the clinical fellow’s ability to adapt all testing and treatment procedures on the basis of these factors.

To distinguish among the fellow’s performance levels (from 5, representing most effective performance, to 1, representing least effective performance), read the descriptors carefully and consider the following four factors, when applicable, in relation to the skill being rated:

- **Accuracy**—the degree to which the clinical fellow performs a skill without error
- **Consistency**—the degree to which the clinical fellow performs a skill at the same level of proficiency across cases
- **Independence**—the degree to which the clinical fellow performs a skill in a self-directed manner
- **Supervisory Guidance**—the degree to which the clinical fellow seeks consultations when needed

Rating accuracy depends upon the frequency, duration, and range of the fellowship supervisor’s observations of the fellow’s performance. One of the most important factors associated with rating accuracy is the opportunity to observe relevant behaviors. Rating accuracy will be greatest when the supervisor and the fellow interact frequently on the job and the fellowship supervisor has many opportunities to observe critical work behaviors.

Rating accuracy also depends upon the familiarity of the fellowship supervisor and the fellow with the Clinical Fellowship Skills Inventory. The fellowship supervisor must observe the on-the-job performance of the fellow, and both supervisor and fellow must understand the rating process and procedures described in the Handbook.

Choose the one descriptor that best describes the clinical fellow’s performance and circle the corresponding number on the Clinical Fellowship Report form. Options are available (ratings 4 and 2) for describing performance that falls between two adjacent descriptors.

Do not submit the following form. Use the Clinical Fellowship Report and Rating Form (Form D) to record fellows’ rating on each skill.
# Evaluation Skills

## 1. Implements screening procedures.

<table>
<thead>
<tr>
<th>RATING</th>
<th>DESCRIPTOR</th>
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<tbody>
<tr>
<td>□ 5</td>
<td>CF independently and accurately matches and/or adapts screening procedures to all populations, selects appropriate screening criteria, administers and scores screening instrument(s) efficiently, interprets results, and makes appropriate recommendations. CF seeks supervisory guidance if needed.</td>
</tr>
<tr>
<td>□ 4</td>
<td>CF independently and accurately matches and/or adapts screening procedures to most populations, selects appropriate screening criteria, administers and scores screening instrument(s), interprets results, and makes appropriate recommendations. CF usually seeks supervisory guidance when needed.</td>
</tr>
<tr>
<td>□ 3</td>
<td>CF requires supervisory guidance to accurately match and/or adapt screening procedures to populations and to select appropriate screening criteria. CF may demonstrate difficulty in administering and scoring screening instrument(s), and/or interpreting results, and making appropriate recommendations. CF does not seek supervisory guidance when needed.</td>
</tr>
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<td>□ 2</td>
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</table>

## 2. Collects case history information and integrates information from client, family, caregivers, significant others, and professionals.

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<thead>
<tr>
<th>RATING</th>
<th>DESCRIPTOR</th>
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</thead>
<tbody>
<tr>
<td>□ 5</td>
<td>CF independently and accurately selects case history or other interview formats with consideration for all relevant factors. CF efficiently collects and spontaneously probes for additional relevant information, obtains information from other sources, and integrates data in order to identify etiologic and/or contributing factors. CF seeks supervisory guidance if needed.</td>
</tr>
<tr>
<td>□ 4</td>
<td>In most situations, CF independently and accurately selects case history or other interview formats with consideration for all relevant factors. CF collects and probes for additional information, obtains information from other sources, and integrates data to identify etiologic and/or contributing factors. CF usually seeks supervisory guidance when needed.</td>
</tr>
<tr>
<td>□ 3</td>
<td>CF requires supervisory guidance to accurately select case history or other interview formats with consideration for all relevant factors. CF collects case history information that is incomplete or lacking in relevance. CF is unable to integrate data to identify etiologic and/or other contributing factors and does not seek supervisory guidance when needed.</td>
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</table>

*Core skill*
**3. Selects and implements evaluation procedures (nonstandardized tests, behavioral observations, and standardized tests).**

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<tr>
<th>RATING</th>
<th>DESCRIPTOR</th>
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<tbody>
<tr>
<td>□ 5</td>
<td>CF independently selects a comprehensive assessment battery with consideration for all relevant factors. CF efficiently and accurately administers the battery and consistently scores tests accurately. CF seeks supervisory guidance if needed.</td>
</tr>
<tr>
<td>□ 4</td>
<td>In most situations, CF independently selects an adequate assessment battery (i.e., basic procedures needed to define problem adequately) with consideration for all relevant factors. CF administers the battery, scores tests accurately, and usually seeks supervisory guidance when needed.</td>
</tr>
<tr>
<td>□ 3</td>
<td>CF requires supervisory guidance to select evaluation procedures that are appropriate and complete. CF may administer and/or score tests inaccurately and does not seek supervisory guidance when needed.</td>
</tr>
<tr>
<td>□ 2</td>
<td>CF independently and accurately recognizes when testing procedures need to be adapted to accommodate needs unique to specific clients. Effectively implements appropriate adaptations, and makes maximum use of all available resources to provide for unusual situations. CF seeks supervisory guidance if needed.</td>
</tr>
<tr>
<td>□ 1</td>
<td>In most situations CF independently and accurately recognizes when testing procedures need to be adapted to accommodate needs unique to specific clients and implements appropriate modifications. May need assistance in accessing available resources. CF usually seeks supervisory guidance when needed.</td>
</tr>
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</table>

**4. Adapts interviewing and testing procedures to meet individual client needs.**

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<tr>
<th>RATING</th>
<th>DESCRIPTOR</th>
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<tbody>
<tr>
<td>□ 5</td>
<td>CF independently and accurately recognizes when testing procedures need to be adapted to accommodate needs unique to specific clients. Effectively implements appropriate adaptations, and makes maximum use of all available resources to provide for unusual situations. CF seeks supervisory guidance if needed.</td>
</tr>
<tr>
<td>□ 4</td>
<td>In most situations CF independently and accurately recognizes when testing procedures need to be adapted to accommodate needs unique to specific clients and implements appropriate modifications. May need assistance in accessing available resources. CF usually seeks supervisory guidance when needed.</td>
</tr>
<tr>
<td>□ 3</td>
<td>CF requires supervisory guidance to recognize the need for and/or to adapt procedures to accommodate individual needs. CF does not seek supervisory guidance when needed.</td>
</tr>
<tr>
<td>□ 2</td>
<td>CF requires supervisory guidance to select evaluation procedures that are appropriate and complete. CF may administer and/or score tests inaccurately and does not seek supervisory guidance when needed.</td>
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</table>

*Core skill*
5. Interprets and integrates test results and behavioral observations, synthesizes information gained from all sources, develops diagnostic impressions, and makes recommendations.

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<tr>
<th>RATING</th>
<th>DESCRIPTOR</th>
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<tr>
<td>□ 5</td>
<td>CF consistently, independently, and accurately interprets and integrates test results and behavioral observations to define the client’s communicative functioning, which includes relating etiologic factors to observed behaviors and test results. CF consistently develops diagnostic impressions and makes comprehensive recommendations leading to appropriate case management. CF seeks supervisor guidance if needed.</td>
</tr>
<tr>
<td>□ 4</td>
<td>In most situations, CF independently and accurately interprets and integrates test results and behavioral observations to define the client’s communicative functioning. CF develops diagnostic impressions and makes basic recommendations that are consistent with evaluation results and that are adequate for case management. CF usually seeks supervisory guidance when needed.</td>
</tr>
<tr>
<td>□ 3</td>
<td>CF requires supervisory guidance to interpret diagnostic data and/or behavioral observations accurately. Diagnostic impressions and/or recommendations are either absent, inappropriate, or inconsistent with evaluation results. CF does not seek supervisory guidance when needed.</td>
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**Treatment Skills**

6. Develops and implements specific, reasonable, and necessary treatment plans.

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<th>RATING</th>
<th>DESCRIPTOR</th>
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<tr>
<td>□ 5</td>
<td>CF independently and accurately establishes a treatment plan appropriate for the client. CF consistently develops specific and reasonable treatment plans that include long-term goals and measurable short-term objectives which reflect appropriate learning sequence, identifies the most appropriate settings for service, explores all alternative service delivery options, and effectively implements plans. CF seeks supervisory guidance if needed.</td>
</tr>
<tr>
<td>□ 4</td>
<td>In most situations, CF independently and accurately establishes treatment plans appropriate for the client. The treatment plan includes long-term goals and measurable short-term objectives, which usually reflect a logical sequencing of learning steps. CF generally identifies the need to explore alternative service delivery options, but may need help in selecting the most appropriate options. CF can effectively implement planned procedures. CF usually seeks supervisory guidance when needed.</td>
</tr>
<tr>
<td>□ 3</td>
<td>CF requires supervisory guidance to accurately develop a treatment plan appropriate for the client. The treatment plan may include adequate long-term goals, but objectives are not measurable and/or do not reflect logical sequencing of learning steps. CF cannot identify appropriate service delivery options and, even with guidance, may not effectively implement treatment plans. CF does not seek supervisory guidance when needed.</td>
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*Core skill*
7. **Selects/develops and implements intervention strategies for treatment of communication and related disorders.**

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<tr>
<td>□ 5</td>
<td>CF independently selects/develops and implements comprehensive intervention strategies that take into consideration all unique characteristics and communication needs of the client. CF seeks supervisory guidance if needed.</td>
</tr>
<tr>
<td>□ 4</td>
<td>In most situations, CF independently selects/develops and implements intervention strategies relevant to the communication disorder and the unique characteristics of the client. CF usually seeks supervisory guidance when needed.</td>
</tr>
<tr>
<td>□ 3</td>
<td>CF requires supervisory guidance to select/develop and/or implement intervention strategies relevant to the needs of the client. CF does not seek supervisory guidance when needed.</td>
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*8. **Selects/develops and uses intervention materials and instrumentation for treatment of communication and related disorders.**

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<tr>
<td>□ 5</td>
<td>CF independently and consistently selects/develops materials and instrumentation for which there is a clear rationale and uses these materials and instrumentation creatively and effectively to enhance the treatment process. CF seeks supervisory guidance if needed.</td>
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<tr>
<td>□ 4</td>
<td></td>
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<tr>
<td>□ 3</td>
<td>In most situations, CF independently selects/develops materials and instrumentation that are relevant to the communication disorder and uses materials and/or instrumentation effectively. CF usually seeks supervisory guidance when needed.</td>
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<tr>
<td>□ 1</td>
<td>CF requires supervisory guidance to select materials and/or instrumentation that are appropriate to the treatment objectives, client, and/or the activity. Once selected, CF may not use materials and/or instrumentation effectively. CF does not seek supervisory guidance when needed.</td>
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*Core skill*
**9.** Plans and implements a program of periodic monitoring of the client’s communicative functioning through the use of appropriate data collection systems. Interprets and uses data to modify treatment plans, strategies, materials, and/or instrumentation to meet the needs of the client.

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<tr>
<td>□ 5</td>
<td>CF independently develops and implements a comprehensive program of periodic monitoring of the client’s communicative functioning and collects and interprets data accurately. Uses this information to effectively modify treatment plans, strategies, materials, and/or instrumentation to meet the needs of the client. CF seeks supervisory guidance if needed.</td>
</tr>
<tr>
<td>□ 4</td>
<td>In most situations, CF independently develops and implements a program of periodic monitoring of the client’s communicative functioning. Collects and interprets data accurately and uses this information to modify treatment plans, strategies, materials, and/or instrumentation to meet the needs of the client. CF usually seeks supervisory guidance when needed.</td>
</tr>
<tr>
<td>□ 3</td>
<td>CF requires supervisory guidance to plan and implement a program of periodic monitoring of the client’s communicative functioning. CF does not collect useful and/or accurate data in order to modify treatment plans, strategies, materials, and/or instrumentation to meet the needs of the client. CF does not seek supervisory guidance when needed.</td>
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**10.** Adapts intervention procedures, strategies, materials, and instrumentation to meet individual client needs.

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<th>RATING</th>
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<tbody>
<tr>
<td>□ 5</td>
<td>CF independently and consistently adapts intervention procedures, strategies, materials, and instrumentation to accommodate needs unique to specific clients. Makes maximum use of all available resources to provide for unusual situations. CF effectively implements appropriate adaptations and seeks supervisory guidance if needed.</td>
</tr>
<tr>
<td>□ 4</td>
<td></td>
</tr>
<tr>
<td>□ 3</td>
<td>CF recognizes when intervention procedures, strategies, materials, and/or instrumentation need to be adapted to accommodate needs unique to specific clients. May need assistance in making appropriate adaptations. CF usually seeks supervisory guidance when needed.</td>
</tr>
<tr>
<td>□ 2</td>
<td></td>
</tr>
<tr>
<td>□ 1</td>
<td>CF requires supervisory guidance to recognize the need for adaptation of intervention procedures, strategies, materials, and/or instrumentation to accommodate needs unique to specific clients. CF may have difficulty implementing identified adaptations and does not seek supervisory guidance when needed.</td>
</tr>
</tbody>
</table>

*Core skill*
### Management Skills

#### 11. Schedules and prioritizes direct and indirect service activities, maintains client records, and documents professional contacts and clinical reports in a timely manner.

<table>
<thead>
<tr>
<th>RATING</th>
<th>DESCRIPTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 5</td>
<td>CF independently and consistently prioritizes activities, schedules client contacts and meetings, maintains client records accurately, and makes and documents professional contacts in a timely manner. CF seeks supervisory guidance if needed.</td>
</tr>
<tr>
<td>☐ 4</td>
<td>CF independently prioritizes most activities, consistently schedules client contacts and meetings, maintains client records accurately, and usually makes and documents professional contacts in a timely manner. CF usually seeks supervisory guidance when needed.</td>
</tr>
<tr>
<td>☐ 3</td>
<td>CF requires supervisory guidance to prioritize activities, schedule client contacts and meetings, maintain client records, and make professional contacts in a timely manner. CF does not seek supervisory guidance when needed.</td>
</tr>
<tr>
<td>☐ 2</td>
<td>CF requires supervisory guidance to prioritize activities, schedule client contacts and meetings, maintain client records, and make professional contacts in a timely manner. CF does not seek supervisory guidance when needed.</td>
</tr>
<tr>
<td>☐ 1</td>
<td>CF requires supervisory guidance to prioritize activities, schedule client contacts and meetings, maintain client records, and make professional contacts in a timely manner. CF does not seek supervisory guidance when needed.</td>
</tr>
</tbody>
</table>

#### 12. Complies with program administrative and other regulatory policies such as required due process documentation, reports, service statistics, and budget requests.

<table>
<thead>
<tr>
<th>RATING</th>
<th>DESCRIPTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 5</td>
<td>CF independently and consistently complies with administrative and regulatory policy requirements and does so in a timely and accurate manner. CF seeks supervisory guidance if needed.</td>
</tr>
<tr>
<td>☐ 4</td>
<td>In most situations, CF independently complies with administrative and other regulatory policy requirements, although CF may need help with complex reports. Most information requested is provided in an accurate and timely manner. CF usually seeks supervisory guidance when needed.</td>
</tr>
<tr>
<td>☐ 3</td>
<td>CF requires supervisory guidance to comply with administrative and other regulatory policy requirements. Information requested may be inaccurate and/or does not meet established time lines. CF does not seek supervisory guidance when needed.</td>
</tr>
<tr>
<td>☐ 2</td>
<td>CF requires supervisory guidance to comply with administrative and other regulatory policy requirements. Information requested may be inaccurate and/or does not meet established time lines. CF does not seek supervisory guidance when needed.</td>
</tr>
<tr>
<td>☐ 1</td>
<td>CF requires supervisory guidance to comply with administrative and other regulatory policy requirements. Information requested may be inaccurate and/or does not meet established time lines. CF does not seek supervisory guidance when needed.</td>
</tr>
</tbody>
</table>

*Core skill*
13. **Uses local, state, national, and funding agency regulations to make decisions regarding service eligibility and, if applicable, third-party reimbursement.**

<table>
<thead>
<tr>
<th>RATING</th>
<th>DESCRIPTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 5</td>
<td>CF independently and accurately makes service eligibility decisions that are based on appropriate regulations and follows applicable mandates. CF seeks supervisory guidance if needed.</td>
</tr>
<tr>
<td>☐ 4</td>
<td>In most situations, CF independently and accurately makes service eligibility decisions that are based on appropriate regulations and follow applicable mandates. CF usually seeks supervisory guidance when needed.</td>
</tr>
<tr>
<td>☐ 3</td>
<td>CF requires supervisory guidance to make service eligibility decisions that are based on appropriate regulations. May not be able to follow applicable mandates even with direction. CF does not seek supervisory guidance when needed.</td>
</tr>
<tr>
<td>☐ 2</td>
<td></td>
</tr>
<tr>
<td>☐ 1</td>
<td></td>
</tr>
<tr>
<td>☐ NA</td>
<td>Not applicable. Skill not performed by CF at this facility</td>
</tr>
</tbody>
</table>

*Core skill*
Interaction Skills

*14. Demonstrates communication skills (including listening, speaking, nonverbal communication, and writing) that take into consideration the communication needs as well as the cultural values of the client, the family, caregivers, significant others, and other professionals.

<table>
<thead>
<tr>
<th>RATING</th>
<th>DESCRIPTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 5</td>
<td>CF independently presents information accurately, clearly, logically, and concisely. Oral communications, written reports, and letters are always appropriate for the needs of the audience. CF uses terminology and phrasing consistent with the semantic competency of the audience and includes accurate and complete information, listens carefully to clients and others, takes initiative in providing appropriate clarifications when needed, and demonstrates appropriate nonverbal communication style. CF seeks supervisory guidance if needed.</td>
</tr>
<tr>
<td>□ 4</td>
<td>CF usually presents information clearly, logically, and concisely. Oral communications, written reports, and letters are appropriate in most situations in that terminology and phrasing are consistent with the semantic competency of the audience. CF includes information that is accurate and/or complete. Listens to clients and others but may have difficulty providing appropriate clarification when needed. CF acknowledges the impact of one’s nonverbal communication style but may have difficulty demonstrating this consistently. CF usually seeks supervisory guidance when needed.</td>
</tr>
<tr>
<td>□ 3</td>
<td>CF does not present information clearly, logically, and concisely. Oral communication, written reports, and letters are inappropriate for the needs of the audience. CF uses terminology and phrasing consistent with the semantic competency of the audience and includes information that is inaccurate and/or incomplete. Does not listen carefully to clients and others and fails to provide appropriate clarification when needed. CF demonstrates inappropriate nonverbal communication style. CF does not seek supervisory guidance when needed.</td>
</tr>
</tbody>
</table>

*Core skill
*15. Identifies and refers clients for related services including audiological, educational, medical, psychological, social, and vocational, as appropriate.

<table>
<thead>
<tr>
<th>RATING</th>
<th>DESCRIPTOR</th>
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</thead>
<tbody>
<tr>
<td>□ 5</td>
<td>CF consistently identifies the need for and makes appropriate client referrals. CF seeks supervisory guidance if needed.</td>
</tr>
<tr>
<td>□ 4</td>
<td>In most situations, CF identifies the need for client referrals but may need some assistance in locating specific referral sources. CF usually seeks supervisory guidance when needed.</td>
</tr>
<tr>
<td>□ 3</td>
<td>CF requires supervisory guidance to identify the need for client referrals and/or to make appropriate referrals. CF does not seek supervisory guidance when needed.</td>
</tr>
<tr>
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</tbody>
</table>

*16. Collaborates with other professionals in matters relevant to case management.

<table>
<thead>
<tr>
<th>RATING</th>
<th>DESCRIPTOR</th>
</tr>
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<tbody>
<tr>
<td>□ 5</td>
<td>CF consistently listens to input from others, makes appropriate decisions based on shared information, and initiates activities and contributes information that promotes mutual problem solving. CF seeks supervisory guidance if needed.</td>
</tr>
<tr>
<td>□ 4</td>
<td>In most situations, CF listens carefully to input from others, makes appropriate decisions based on shared information, usually participates in activities and contributes information that promotes mutual problem-solving. CF usually seeks supervisory guidance when needed.</td>
</tr>
<tr>
<td>□ 3</td>
<td>CF requires supervisory guidance to effectively identify the need to consult or collaborate with other professionals in case management activities. Does not make decisions based on shared information and/or focus on mutual problem-solving activities. CF does not seek supervisory guidance when needed.</td>
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</tbody>
</table>

*Core skill
**17. Provides counseling and supportive guidance regarding the client’s communication disorder to client, family, caregivers, and significant others.**

<table>
<thead>
<tr>
<th>RATING</th>
<th>DESCRIPTOR</th>
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<tbody>
<tr>
<td>□ 5</td>
<td>CF listens, reflects, and explains information using terminology appropriate to the audience. CF monitors understanding by asking questions and encouraging interaction among all participants. Engages client/family in problem-solving activities. CF seeks supervisory guidance if needed.</td>
</tr>
<tr>
<td>□ 4</td>
<td>CF listens but may show some difficulty reflecting and/or explaining information using terminology appropriate to the audience. CF monitors understanding by asking questions but may have some difficulty encouraging interaction among all participants. CF attempts to engage client/family in problem-solving activities. CF usually seeks supervisory guidance when needed.</td>
</tr>
<tr>
<td>□ 3</td>
<td>CF does not listen, reflect, and/or explain information appropriately and does not use terminology appropriate to the audience. CF does not monitor understanding by asking questions and/or encouraging interaction among all participants. Does not engage client/family in problem-solving activities. CF does not seek supervisory guidance when needed.</td>
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<tr>
<td>□ NA</td>
<td>Not applicable. Skill not performed by CF at this facility.</td>
</tr>
</tbody>
</table>

**18. Plans and implements educational programs for other professionals and the general public to facilitate acceptance and treatment of disabilities associated with communication disorders.**

<table>
<thead>
<tr>
<th>RATING</th>
<th>DESCRIPTOR</th>
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<tbody>
<tr>
<td>□ 5</td>
<td>With consideration of the needs of the audience, CF independently and consistently provides clear and meaningful educational information to facilitate the acceptance and treatment of disabilities associated with communication disorders. CF seeks supervisory guidance if needed.</td>
</tr>
<tr>
<td>□ 4</td>
<td>In most situations, CF considers the needs of the audience and independently provides clear and meaningful educational information to facilitate the acceptance and treatment of disabilities associated with communication disorders. CF usually seeks supervisory guidance when needed.</td>
</tr>
<tr>
<td>□ 3</td>
<td>CF does not consider the needs of the audience and requires supervisory guidance to provide educational information that facilitates the acceptance and treatment of disabilities associated with communication disorders. CF does not seek supervisory guidance when needed.</td>
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*Core skill*
**BRONSON HOSPITAL**

**STUDENT PERFORMANCE EVALUATION**

Adapted from *Knowledge and Skills Acquisition (KASA) Summary Form for Certification in Speech-Language Pathology*, ASHA, March 2003 and *W-PACC, Clinical Appraisal Form*, Univ. of Wisconsin - Madison

<table>
<thead>
<tr>
<th>EVALUATION SKILLS</th>
<th>Does Not Apply</th>
<th>Specific direction from supervisor does not alter unsatisfactory performance and inability to make changes</th>
<th>Needs specific direction and/or demonstration from supervisor to perform effectively</th>
<th>Needs general direction from supervisor to perform effectively</th>
<th>Demonstrates independence by taking initiative; makes changes when appropriate and is effective</th>
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</thead>
<tbody>
<tr>
<td>Conduct screening and prevention procedures (including prevention activities)</td>
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<tr>
<td>Collect case history information and integrate information from clients/patients, family, caregivers, teachers, relevant others, and other professionals</td>
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<tr>
<td>Select and administer appropriate evaluation procedures, such as behavioral observations, nonstandardized and standardized tests, and instrumental procedures</td>
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<tr>
<td>Adapt evaluation procedures to meet client/patient needs</td>
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<tr>
<td>Does Not Apply</td>
<td>Specific direction from supervisor does not alter unsatisfactory performance and inability to make changes</td>
<td>Needs specific direction and/or demonstration from supervisor to perform effectively</td>
<td>Needs general direction from supervisor to perform effectively</td>
<td>Demonstrates independence by taking initiative; makes changes when appropriate and is effective</td>
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<tr>
<td>Interpret, integrate, and synthesize all information to develop diagnoses and make approp. recommendations for intervention</td>
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<tr>
<td>Complete administrative and reporting functions necessary to support evaluation</td>
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<tr>
<td>Refer clients/patients for appropriate services</td>
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<tr>
<td><strong>INTERVENTION</strong></td>
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<tr>
<td>Develop setting-appropriate intervention plan with measurable, achievable goals that meet clients'/patients' needs. Collaborate with clients/patients and relevant others in the planning process</td>
<td></td>
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<tr>
<td>Implement interventions plans (involve clients/patients and relevant others in the intervention process)</td>
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<tr>
<td>Select or develop and use approp. materials and instrumentation for prevention and intervention</td>
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</tr>
<tr>
<td>Does Not Apply</td>
<td>Specific direction from supervisor does not alter unsatisfactory performance and inability to make changes</td>
<td>Needs specific direction and/or demonstration from supervisor to perform effectively</td>
<td>Needs general direction from supervisor to perform effectively</td>
<td>Demonstrates independence by taking initiative; makes changes when appropriate and is effective</td>
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<tr>
<td>Measure and evaluate clients'/patients' performance and progress</td>
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</tr>
<tr>
<td>Modify interventions plans, strategies, materials or instrumentation as appropriate to meet the needs of clients/patients</td>
<td></td>
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<tr>
<td>Complete administrative and reporting functions necessary to support intervention</td>
<td></td>
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<tr>
<td>Identify and refer clients/patients for services as appropriate</td>
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<tr>
<td><strong>INTERACTION AND PERSONAL QUALITIES</strong></td>
<td></td>
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</tr>
<tr>
<td>Communicate effectively, recognizing the needs, values, preferred mode of communication, and cultural/linguistic background of the client/patient, family, caregivers, and relevant others</td>
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<tr>
<td>Comments/Goals</td>
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<td>----------------</td>
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</tr>
<tr>
<td><strong>Collaborate with other professionals in case management</strong></td>
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</tr>
<tr>
<td><strong>Provide counseling regarding communication/swallowing disorders to clients/patients, family, caregivers, and relevant others</strong></td>
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<tr>
<td><strong>Adhere to ASHA Code of Ethics and behave professionally</strong></td>
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</tr>
<tr>
<td><strong>Attend to administrative details with punctuality and care</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>Prepare written reports with accuracy and appropriate writing skills</strong></td>
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</tbody>
</table>
Clinic Dress and Personal Appearance Guidelines for Supervisors and Clinicians

The Charles Van Riper Language, Speech and Hearing Clinic provides professional speech-language and hearing services to the public. As representatives of the Department of Speech Pathology and Audiology at Western Michigan University, supervisors and student clinicians are expected to present a well-groomed appearance, adhering to general standards of professional dress, using the following guidelines:

Attire should be neat, clean, moderate in style and appropriate for a professional work setting. Professional attire excludes wearing of denim jeans and apparel considered for casual non-clinical activities, for example, midriff tops, low-cut tops, spaghetti straps, extreme dress/skirt lengths and slits, or tight-fitting tops. When deciding to what to wear for your clinic work, consider the view of your client and individuals in the observation room as you sit, bend over or lean forward.

Sandals can be appropriate, but they should be dressier and cover more of the foot than beachwear. Tennis shoes are too casual for work in the clinic. Outdoor apparel, such as snow boots and hats, needs to be removed in the clinic.

Jewelry and body art should be consistent with the professional work environment and must not be distracting. For example, nose rings/studs, or piercings other than the ears are not acceptable. Multiple piercings are likely not acceptable. Exposed body art, such as a tattoo, is not appropriate for this professional work environment; tattoos must be concealed by clothing to the extent possible. A survey of local hospitals and other clinical work environments revealed that most have dress codes that prohibit exposed non-traditional piercings and tattoos.

Nail length must not interfere with manipulation of therapy materials or placement of equipment on the body (e.g. electrodes, hearing aids, or headphones).

Please do not wear perfumes, colognes or scented lotions/aftershaves, as they may be offensive to others and potentially harmful to individuals who have allergies.

Each supervisor/student must wear an identification badge during work in the clinic.

A clinical supervisor or clinic coordinator will address concerns related to personal appearance with individuals on a case-by-case basis. If problems cannot be resolved at that level, they will be addressed by the Academic and Clinical Education Committee (ACEC) of the Department of Speech Pathology and Audiology.

Clinic Appearance Policy
Approved by ACEC January 21, 2003
MARSH USA INC.  EVIDENCE OF COVERAGE CONTRACTS

This evidence is issued as a matter of information only and confers no rights upon the holder. It does not affirmatively or negatively amend, extend or alter the coverage afforded by the contracts below. This does not constitute a contract between the facility, authorized representative or producer, and the holder. Important: If the holder is an additional insured, the contract must be endorsed. If subrogation is waived, subject to the terms and conditions of the contract, certain contracts may require an endorsement. A statement on this evidence does not confer rights to the below holder in lieu of such endorsement(s).

PRODUCER
MARSH USA INC.
600 RENAISSANCE CENTER
SUITE 2100
DETROIT, MI 48243

INSURED
WESTERN MICHIGAN UNIVERSITY
ATTN: LAURA VINE
2324 SIEBERT ADMINISTRATION BLDG.
KALAMAZOO, MI 49008

COVERAGE:

THIS IS TO CERTIFY THAT THE CONTRACTS LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE CONTRACT PERIOD INDICATED.

NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS MAY BE ISSUED OR MAY PERTAIN, THE COVERAGE AFFORDED BY THE CONTRACTS DESCRIBED HEREIN IS SUBJECT TO ALL OTHER TERMS, EXCLUSIONS AND CONDITIONS OF SUCH CONTRACTS. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

<table>
<thead>
<tr>
<th>CO</th>
<th>TYPE OF COVERAGE</th>
<th>CONTRACT NUMBER</th>
<th>EFFECTIVE DATE</th>
<th>EXPIRATION DATE</th>
<th>LIMITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>GENERAL LIABILITY</td>
<td>GL712012</td>
<td>7/1/2012</td>
<td>7/1/2013</td>
<td>GENERAL AGGREGATE $6,000,000</td>
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<td></td>
<td>EACH OCCURRENCE $2,000,000</td>
</tr>
<tr>
<td></td>
<td>AUTO LIABILITY</td>
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<td></td>
<td>COMBINED SINGLE LIMIT</td>
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<td>EXCESS LIABILITY</td>
<td></td>
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<td></td>
<td>EACH OCCURRENCE AGGREGATE</td>
</tr>
<tr>
<td>A</td>
<td>OTHER</td>
<td>GL712012</td>
<td>7/1/2012</td>
<td>7/1/2013</td>
<td>AGGREGATE $6,000,000</td>
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<tr>
<td></td>
<td>STUDENTS/MEDICAL PROFESSIONAL &amp; GENERAL LIABILITY (OCCURRENCE COVERAGE)</td>
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<td></td>
<td></td>
<td>EACH OCCURRENCE $2,000,000</td>
</tr>
<tr>
<td>B</td>
<td>MEDICAL PROFESSIONAL (EXCLUDING STUDENTS)</td>
<td>FLPO08105-07</td>
<td>7/1/2012</td>
<td>7/1/2013</td>
<td>AGGREGATE $6,000,000</td>
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<td></td>
<td>EACH OCCURRENCE $2,000,000</td>
</tr>
</tbody>
</table>

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/SPECIAL ITEMS (LIMITS MAY BE SUBJECT TO DEDUCTIBLES OR RETEENTIONS)

EVIDENCE HOLDER

For Informational Purposes Only

CANCELLATION
NONE OF THE ABOVE DESCRIBED COVERAGE CONTRACTS CAN BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF.

MARSH USA INC
BY: JERRY J. MCKAY

VALID AS OF