
Handbook for Graduate Students
Communication Sciences and Disorders Program
California State University, Chico

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CSU, Chico
Communication Sciences and Disorders

Graduate Academic and Clinic Handbook

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COMMUNICATION SCIENCES AND DISORDERS
California State University, Chico
STRATEGIC PLAN
2018-2021

Vision Statement

The CMSD program is envisioned to be a model training program for developing the highest quality professionals, and to be a model clinical facility, recognized throughout the California North state for high-quality speech-language and hearing services.

Envisioned Future

From our vision statement, the CMSD program foresees the following to result from strategic planning in the next 10 years:

- A complement of six full time, tenure/tenure track faculty, with at least two part-time clinical instructors, and full time ASC dedicated to the program
- Increased graduate program size to 48
- Increased research opportunities for graduate students (joining faculty projects, theses, and conducting clinic-based single subject designs)
- State-of-the-art new clinical facility
- State-of-the-art clinical instrumentation, techniques, and specialty clinics/groups
- Increased clinical opportunities and K-12 connections through summer clinic and more varied internships
- Interdisciplinary clinical experiences at the university and through relationships with allied professionals
- Increased multicultural opportunities through participation with the International Student program and community outreach centers
- Opportunities for BA in CMSD through an SLPA program
- Innovative sequenced curriculum
- CEU provider for speech-language pathologists in the North state

Mission Statement

The mission of the Communication Sciences and Disorders (CMSD) program is to provide students with the knowledge and skills needed to enter the professions of speech-language pathology and audiology through an enriched, flexible, and innovative learning environment, both academically and clinically, that fosters quality of thought and creative, research-based problem-solving, life-long learning and consummate professionalism. To meet these ends, the program aims to employ expert, student-oriented faculty and staff. We are dedicated to program growth and to the procurement of the necessary supportive resources. We continue to enhance associations with the university and local communities to provide greater interdisciplinary and collaborative research and clinical opportunities for our students, clients, and faculty. The CMSD program is committed to being a model clinical facility, recognized

throughout the California North state for both the advancement of student learning and for high quality, state-of-the-art services, outreach, and resources to the community.

Strategic Objectives

Based on the two primary goals of excellence in academic and clinical education and excellence in clinical service in speech-language pathology, the CMSD program is committed to the following seven strategic objectives.

Objective 1) Promote and maintain a student learning environment that fosters intellectual curiosity, creative problem-solving, and use of research and technology in teaching and learning through an innovative, flexible curriculum with service learning and community service opportunities.

Objective 2) Promote the Teacher-Scholar model that encourages faculty to infuse experiential learning, evidence-based practice and peer-reviewed research into the learning process; and to disseminate basic and applied research into the community via publications, presentations, and tutorials.

Objective 3) Employ a sufficient number of expert faculty and staff in order to meet mission goals.

Objective 4) Promote scholarly growth and achievement by supporting professional education and research opportunities for faculty and local SLP professionals

Objective 5) Prepare graduate students for professional licensure, certification, and credentialing, employment in any setting, and when appropriate, doctoral level training.

Objective 6) Promote the highest standards for academics and clinical training in order to maintain national accreditation through CAA- ASHA, regional accreditation through (WASC, NCATE), and state accreditation through CCTC.

Objective 7) Through the Center for Communication Disorders, provide quality service to the North state-at large, university, and K-12 communities, through the use of technology, research, and excellence in clinical teaching, including currency in clinical knowledge and interdisciplinary approaches, through continued training of faculty and supervisors.

Objective 8) Accommodate a growing program by improving, strategically managing, and systematically evaluating adequacy of resources for faculty, staff, and facilities.

UNIVERSITY AFFILIATION

The CMSD Program is part of the Communication Arts & Sciences Department (CMAS), which is in the College of Communication and Education. The CMAS Department Office is located in THMA 201. The Department Chair is Dr. Susan Avanzino, 898-5751, savanzino@csuchico.edu.

ACCREDITATION INFORMATION

The CMSD graduate program is accredited by the following bodies:

- Council on Academic Accreditation in Audiology and Speech-Language Pathology
American Speech-Language-Hearing Association
2200 Research Blvd.
Rockville, MD 20852-3279
(301) 897-5700
ACTION CENTER (800) 498-2071 FAX: (301) 571-0457
Internet: <http://www.asha.org>

- CA Commission on Teacher Credentialing (State Credentialing Accreditation)
- National Council for Accreditation of Teacher Education (National Credentialing Accreditation)
- Western Association of Schools and Colleges (Regional University Accreditation)

FACULTY

Six tenure/tenure track faculty and full- and part-time adjunct lecturers demonstrate various areas of expertise (child speech & language disorder, literacy, autism, neurogenic communication disorders, voice, aging and hearing loss) through excellence in academic and clinical teaching, devotion to research and continuing education, and connections to the community and professional associations.

STUDENT DATA

Number of undergraduate students	180
Number of graduate students	48
Number of graduate applications	180
Number of students accepted/enrolled	33/24

Student information is based on 2016-17 data

GRADUATE PROGRAM STATISTICS

Praxis Pass Rates

CMSD Graduate students typically take the PRAXIS examination in the final semester of their program. Pass rates have been consistently at or above the national average over the past 10 years. PRAXIS pass rates for the last 3 years are as follows:

2016	87.5%
2017	96%
2018	100%

Graduation Rates

The CMSD program is designed to be completed in 2 years. Occasionally, students request to extend the program to 3 years for various personal reasons. These students are defined as Part Time (PT) below and are placed in this group when they ask to be part time within the first semester of the program. Graduation rates for the past 3 years are as follows:

Year Graduated	Full Time Students		Part Time Students
	Completed within 2 years	Completed within 3 years	
2016	24	0	0
2017	23	0	0
2018	24	1	0

Employment Rates

Master's program graduates enjoy multiple job offers and are sought across the state. Employment rates within 3 months of graduate for the past 3 years are as follows:

2016 =100%
 2017 =100%
 2018=100%

CURRICULUM

Academic Requirements

The CMSD program boasts a comprehensive, sequenced academic preparation in both undergraduate and graduate programs.

Undergraduate (UG) CMSD Units Required	Typical UG Unit Load/Semester	Graduate Units Required	Typical Grad Unit Load/Semester
54	15	56	15

Supervised Clinical Education Hours

Undergraduates complete 25 clinical observation hours. Graduate students participate in two semesters of practicum at the on-campus Center for Communication Disorders and two internships across medical, private practice and educational sites, in order to obtain a minimum of 400 required clinical education hours (this includes the 25 hours of clinical observation). Accrued hours and demonstration of a variety of specific clinical skills are required for accreditation compliance with ASHA, CCTC, and state licensure.

Evaluation of Students

Graduate students undergo Performance Reviews by the faculty in their 1st and 2nd years. Self-prepared portfolios are submitted by students as evidence of their academic and clinical performance. Results of comprehensive exams and performance on the PRAXIS are used as summative assessments. Students also undergo assessment in educational and clinical settings.

Graduate Qualifications

Upon graduation, master's degree recipients are prepared to work with all disorder areas in medical and educational settings. Furthermore, their training satisfies all academic and program-related clinical requirements for California licensure (Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board), national certification through ASHA (CCC-SLP), and Speech-Language Pathology Services Credential (California Commission on Teacher Credentialing).

Academic Rigor Statement

Rigorous students are part of the equation of rigorous teaching and learning. A rigorous education is vigorous, difficult, and deeply satisfying work that requires a lifestyle conducive to achieving excellence. College is not a temporary diversion or a period of entertainment, but a fundamental piece of student character, citizenship, and employment future. A diploma and good grades from a demanding institution count for something.

Rigorous students:

1. Set high personal standards, develop a strong sense of purpose, come to class well-prepared, and complete assignments on time.
2. Develop an effective relationship with the instructor, in and outside of class, and make the most of University advising and other services.
3. Treat fellow students and the classroom environment with complete respect. Give each class full attention and participation. Do not miss class, arrive late, or leave early.
4. Accept continuing responsibility for learning and for grades earned.
5. Approach each class in a professional manner, as if the class were real employment. Treat a full-course load as full-time work and spend no less time on it. Determine exactly what is expected.
6. Experiment with all teaching and learning strategies used in classes, and also determine which work best for them.
7. Demonstrate complete honesty and integrity.

*Adapted from Academic Advising, California State University, Chico

CMSD Student Code of Conduct

A significant aspect of the preparation of our students for careers in communication sciences and disorders includes the expectation of the highest standards of classroom and clinical conduct. To formalize the expectations of classroom decorum the CMSD faculty require of all students, we have developed the following CMSD Code of Conduct. Your signature on this document acknowledges that you agree to abide by this code throughout your studies in the Communication Sciences and Disorders Program at the California State University, Chico. It should be pointed out that the following requirements are not all-encompassing. Basic respect for the classroom learning environment as well as consummate professional behavior shall be critical to your success in our program.

Classroom and Clinic Behavior

1. Cell phones should be turned off prior to the beginning of class/clinic.
2. Use of laptop computers for note taking is appropriate. Laptop computers shall not be used for email, IM, or any other internet communications during class.
3. Students should not work on assignments from classes other than the class currently in session.
4. Students should not be late to class.
5. Students should have class materials out and should cease all conversations when the professor begins the lesson.
6. Students should be prepared for all class sessions by having completed all assigned readings or other assignments.
7. Side-bar conversations between students will not be tolerated. When a professor is talking, students should not be. Student participation is encouraged. Raise your hand and your professor will call on you and will value your contributions to the lecture.
8. Do not put your feet up on desks. This type of behavior is clearly unprofessional and will not be tolerated.
9. Take responsibility for your own learning. Make an effort to exceed the expectations for all of your assignments and academic products.

"I have read the CMSD Student Code of Conduct, and will abide by the aforementioned code and undertake my academic work with honesty and integrity throughout my studies in the Communication Sciences and Disorders Program at the California State University, Chico."

Signature

Print

REMEDIATION PROCEDURES FOR MANAGING UNSATISFACTORY ACADEMIC PERFORMANCE

Classroom Performance: Individual student course progress in courses is monitored by the instructor through evaluation of assignments and exam performance. If a student is not acquiring academic competencies at an appropriate rate or level, the instructor will work with the student on improving performance. If performance does not improve and they receive a C- or lower, the student must retake the course.

Program Performance: Academic progress will be reviewed and evaluated at designated intervals following portfolio submission. Students with poor performance evaluations will be required to meet with the faculty as a whole to determine an academic remediation plan (e.g., retake courses, complete independent studies, complete trainings). Graduate students who fall below a 3.0 GPA will be placed on academic probation, in accordance with university guidelines. Refer to the university catalog for specifications. The faculty can require additional and specific conditions for a student on probation. The CMSD faculty will inform the student of these requirements following notification of probation from the graduate school. Students who do not meet the conditions for the probationary period will be dismissed from the CMSD program.

POLICY AND PROCEDURES FOR STUDENT COMPLAINTS

Student Grievance and Complaint Process

If a problem or conflict arises between a student and academic instructor, the two will meet to resolve the problem. If no resolution is reached, the Program Director will serve as mediator and meet individually, and, if necessary, collectively with the parties to resolve the issue. If still no solution is found, the student may pursue informal resolution through the Ombuds Office (530-898-3955) or formal grievance procedures through Student Judicial Affairs, Kendall Hall 110, (530) 898-6897.

Students with complaints about the program are advised to report their grievance to the Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA) and are provided the following contact information: CAA Office at American Speech-Language-Hearing Association, 220 Research Blvd, Rockville, MD 20852 or phone ASHA's Action Center at (800) 498-2071;

<https://caa.asha.org/?s=student+grievance>

GRADUATE SEQUENCE OF COURSEWORK 2016-2017

Completion of the comprehensive examinations/thesis/project and practicum/internship required along with a minimum of 400 clinical hours to be obtained during practicums and internships.

1st YEAR

FALL SEMESTER

CMSD 543	(3)	Autism Spectrum Disorders and Behavioral Interventions
CMSD 620	(4)	Acquired Cognitive and Language Disorders
CMSD 630	(3)	Disorders of Articulation and Phonology
CMSD 632	(2)	EBP and Experimental Design in CMSD (part 1)
CMSD 680	(1)	Community and Service Learning (<i>CR/NC; may be repeated</i>)
CMSD 684	(2-4)	Clinical Practicum – <i>1 client = 2 units, or 2 clients = 4 units</i>

Total 1st semester: 14-16 letter-graded units and 1 CR/NC unit = 15-17

SPRING SEMESTER

CMSD 631	(2)	Fluency Disorders and Counseling in CMSD
CMSD 632	(2)	EBP and Experimental Design in CMSD (part 2)
CMSD 635	(3)	Voice and Resonance Disorders
CMSD 642	(4)	Motor Speech and Swallowing Disorders
CMSD 680-01	(1)	Community and Service Learning (<i>CR/NC; may be repeated</i>)
CMSD 680-02	(1)	Community and Service Learning (<i>CR/NC; may be repeated</i>)
CMSD 684	(2-4)	Clinical Practicum – <i>1 client = 2 units, or 2 clients = 4 units</i>

Total 2nd semester units: 14-16 letter-graded units and 2 CR/NC unit = 16-18

Total 1st year: 29 letter-graded units and 3 CR/NC unit = 32 units

2nd YEAR

CMSD 689	(4,4)	Clinical Internship in SLP – 4 units <i>CR/NC taken for 2 semesters: summer, fall, or spring</i>
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FALL SEMESTER

CMSD 640	(3)	Assessment and Management of Auditory Disorders
CMSD 652	(3)	Seminar in Language Disorders in Children
CMSD 674	(1)	Methods in Speech Language Pathology in Schools
CMSD 675	(1)	Methods in Speech/Language Pathology (<i>CR/NC</i>)
CMSD 682	(0-1)	Practicum in SLP Diagnosis– <i>taken once Fall or Spring</i>
CMSD 699T/P	(1-6)	Thesis/Project – <i>optional</i>

Total 3rd semester units: 7-8 letter-graded units and 5 CR/NC unit = 12-13

SPRING SEMESTER

CMSD 633	(3)	Professional Aspects of Speech-Language Pathology
CMSD 645	(3)	Augmentative and Alternative Communication
CMSD 675	(1)	Methods in Speech/Lang Pathology (<i>CR/NC</i>)
CMSD 680	(1)	Community and Service Learning (<i>CR/NC; may be repeated</i>)
		<i>optional</i>
CMSD 682	(0-1)	Practicum in SLP Diagnosis – <i>if not taken Fall</i>
CMSD 699T/P	(1-6)	Thesis/Project – <i>optional</i>

Total 4th semester units: 6-7 letter-graded units and 5-6 CR/NC unit = 5-6

Total 2nd year: 14 letter-graded units and 10-11 CR/NC units = 24-25 units

TOTAL LETTER-GRADED UNITS 43 AND 13-14 CR/NC TOTAL UNITS: 56

**KNOWLEDGE AND SKILLS ACQUISITION (KASA) SUMMARY FORM FOR CERTIFICATION IN
SPEECH-LANGUAGE PATHOLOGY**

Knowledge Acquisition

We are accredited by the Council on Academic Accreditation in Audiology and Speech-Language Pathology through the American Speech-Language-Hearing Association (ASHA). The standards indicate that we must prove that you are achieving specific knowledge and skills. Knowledge areas are acquired in courses and skills are acquired through clinical practicum and internships. A document that indicates which classes address the knowledge you are required to obtain will be sent to each graduate student. Please print this document, review it, and put it in your portfolio.

Skills Acquisition

You must also document acquisition of skills. In order to do this, you will be required to gather signatures from your Clinical Instructors in your clinical practicum and internship placements on the Knowledge and Skills Acquisition (KASA) Tracking form found in the appendix. **You will need to print this form.** When you feel you have demonstrated a particular skill, you will need to ask your Clinical Instructor to sign in the box appropriate for the skill. This must be included in your portfolio.

PROGRAM REQUIREMENTS

Advancement to Candidacy

Graduate students come into the CMSD program as classified (some conditionally) Master's students. You are advanced to candidacy (known as a Master's Candidate) following two semesters of full time coursework and clinic and when you have been approved by the faculty for internship placement. Internship eligibility is at the discretion of the faculty, but typically occurs following two semesters of full time coursework and 50 or more supervised clinical education hours of on-campus practicum where performance has been deemed satisfactory.

Comprehensive Examinations

Comprehensive examinations are written on two consecutive days (3.5 hours each day). The exams are scheduled for the **Wednesday and Thursday** prior to the start of spring semester. Students are given three questions each day and must provide word-processed responses to all questions. Faculty collaborate in writing each question. All questions require students to integrate information chosen in any combination of the following areas:

1. Child articulation and phonological development and disorders
2. Child language development and disorders
3. Adult neurogenic communication disorders
4. Audiology/aural rehabilitation
5. Fluency disorders
6. Voice disorders
7. Dysphagia
8. Anatomical and physiological bases of speech and language

Exams are computer-based. No other papers are allowed in the examination room. Scratch paper will be provided on request. No cell phones or other electronic equipment are allowed. Water is permitted, but no other food is allowed. NO NAMES should appear on the pages; rather, students will be assigned an exam number. Each answer should begin on a new page with the following information in the upper right hand corner:

Student Number:

Day:

Question #:

The student is required to send each question to the printer prior to leaving the examination room. The Graduate Coordinator will then gather all questions.

Scoring:

The faculty member who wrote the question grades the answer. Grading is on a 4.0 scale as follows:

- 4 – High Pass** – Answered with distinction. All aspects of the question were not only thoroughly addressed, but were addressed with notable attention to detail. Superior understanding of the material was evident and breadth and depth of content covered was extensive. Writing was on point and stayed on point. Complex ideas were

presented in an understandable way. Insightful and nuanced understanding of the questions was demonstrated. Where appropriate, knowledge of peer reviewed research and Evidenced-Based Practice was demonstrated.

- 3 – Pass** – Answer was acceptable. All aspects of the question were covered, although some may have been covered more thoroughly and on target than others. Depth and breadth of topic understanding were evident and acceptable level of competence was demonstrated. Acceptable interpretation of the question was evident. Some difficulty staying on point, but overall writing demonstrated appropriate focus. Language use was adequate to address question.
- 2 – Hold** – Answer lacked clarity and/or showed a weak understanding of the content. Some aspects of the question may not have been addressed. Appropriate interpretation of the question was evident. Answer demonstrated limited focus. A meeting with the faculty member and a remedial activity will be required. See below.
- 1 – Rewrite/Fail** – Answer contained substantive content errors and/or lacked sufficient detail, organization and/or integration. There was insufficient written material to score the question. Evidence of breadth and depth of knowledge was absent or inadequate. Answer did not demonstrate knowledge of content and suggested that the clinician would not be able to provide clinical services in this area. Demonstrated an inability to translate and discuss complex ideas.

The original answers and readers' comments are given to the student upon completion of grading.

Students who receive a 2 (HOLD) on any question must contact the appropriate faculty member within one week to determine the course of action. Examples of required remedial work include, but are not limited to, oral exams, written paper, and/or rewriting the question. The faculty member will establish deadlines for completion of the work. Failure after a HOLD (i.e., the required work is not completed to satisfaction) results in a 1 (REWRITE/FAIL). Pass on the remedial work releases the hold, but the original score of 2 remains.

A student will be required to rewrite all or a portion of comprehensive exams within one year given any of the following circumstances:

1. A student fails any comprehensive question or fails after a HOLD. The student will rewrite only the failed question(s).
2. A student receives an average score of 2.0 or below on all six questions. The student will have failed comprehensives and will be required to rewrite all questions. The student may be required to retake classes as determined by the faculty.

Students may rewrite twice. If the student does not pass all comprehensive questions by the second rewrite, the student will not be granted a master's degree.

Suggestions:

1. Questions from previous comprehensive examinations will be e-mailed to students.
2. Some students report that it is helpful to form a study group.

3. During the exam, be sure to read the question carefully and address all aspects of each question in your answer.
4. Budget your time carefully to allow enough time to answer each question adequately.

PRAXIS Examination

The PRAXIS is the national examination in speech-language pathology. You must take this test in order to apply for ASHA certification, licensure and the credential. **It is strongly recommended that the PRAXIS be taken late in your final semester of graduate school.**

This will enable you to incorporate academic and clinical information from your final semester courses and internship into your overall knowledge and skills in communication sciences and disorders. Study in detail across all academic areas including normal aspects of speech, swallowing, language, cognition and hearing. Focus as well on clinical methods, drawing from your academic preparation, on-campus practicum and internships experiences. A purchased study guide is strongly recommended. For information about how to prepare for the test, please visit <http://www.ets.org/s/praxis/pdf/5331.pdf>. You will receive more information about studying for the PRAXIS in your 2nd year. Make sure you have your PRAXIS results sent to CSU, Chico's CMSD program (Code R0015), ASHA (for national certification – Code R5031), Department of Consumer Affairs (for state license – Code 8544), and California Commission on Teacher Credentialing (Code 8541). If you do not, you will be required to pay extra to have your results sent at a later date. Information for registering for the test can be found at <http://www.ets.org/praxis/asha>

Performance Review and the Portfolio

Performance Reviews

Performance Reviews constitute a formative assessment as they are designed to give students feedback on the quality of their achievements and rate of growth over time. For first year grads, the review will be in the form of a progress report from the faculty, which you will receive in April/May. Second year grads will also receive a progress report in December/January. Students with poor evaluations will be required to meet with the faculty as a whole. The third and final review is part of your exit interview at the end of the last semester. Your competence will be evaluated using a rubric of 4 levels:

-Superior -Effective -Adequate -Inadequate

The portfolio will be the documentation you provide at your Performance Reviews to serve as evidence of your acquisition of knowledge and skills over time due date. Approximate portfolio due dates: Monday after spring break (1st years); Monday after Thanksgiving break (2nd years).

Description of the Portfolio

Throughout your program in Communication Sciences and Disorders, you will be acquiring the knowledge, clinical skills, professional dispositions, critical thinking and problem solving skills necessary to become a competent speech-language pathologist. Traditionally, grades have been the primary measure to document your progress. Now you will have an additional means through which you can demonstrate and present your professional competences – your portfolio.

Your portfolio is a formative compilation of documents that you need to appropriately, accurately, and continually maintain in order to receive your master's degree. It is a collection of

artifacts that should “tell a story” about your intellectual, clinical, and ethical growth and achievements over the course of your academic and clinical experiences. It is accompanied by a narrative, which will reflect your unique strengths and serve as a statement of who you are as a beginning professional. Importantly, through your portfolio you can demonstrate how you have achieved all the certification standards of the Council on Academic Accreditation in Speech-Language Pathology (CAA) of the American Speech-Language-Hearing Association.

Portfolio Nuts and Bolts

The portfolio is a representation of you and your hard work. Make sure that it reflects thought and organization in its preparation. Models will be available.

Format & Organization

1. Develop as a hardcover three ring binder.
2. Label the front and side with your name. Please ensure the font is professional. Please avoid happy faces, flowers, etc. This is a professional tool.
3. Labeled tabbed dividers and high coverage pockets should be used for organization.
4. Please do not use plastic sheet protectors (we need to be able to have easy access to your papers and have the ability to mark on them).
5. Include 3 major sections: Overall Development, Knowledge, and Clinical Skills

Section I: Overall Development

1. Table of Contents
2. Integrative Essay (see final page for description)
3. Resume
4. Official Documents
 - a. Recent transcripts
 - b. Undergraduate transcripts
 - c. Credential: Certificate of Clearance
 - d. NSSLHA membership card
 - e. Liability insurance
 - f. CPR training
 - g. TB test results
 - h. CBEST results
 - i. PRAXIS results
 - j. Clock Observation Hours

Section II: Knowledge/Skills

1. Master’s Degree Program Plan
2. Knowledge area
 - a. KASA template
 - b. CCTC standards form- completed
3. Evidence of Writing Skills
 - a. Any major undergraduate papers
 - b. Research Methods paper
 - c. One paper from each of your graduate courses.

4. Evidence of Oral skills
 - a. Instructor feedback
 - b. Peer feedback (summarize)
 - c. Self-evaluation
 - d. From (e.g.) Communication & Aging, Hearing loss lectures from retirement facility, Fluency course, etc.

Section III: Clinical Skills

1. KASA skills supplement, with signatures accrued to date
2. Clinical Instructor evaluations (e.g., Clinical Instructor evals, internship evals)
3. Self-evaluations
4. Clinic reports. Black out or redact any identifying information, including names, addresses, phone numbers, etc.
 - a. First draft and final draft of both Initial and Final Case Reports
 - b. Include the number of drafts required for the final draft at the upper right hand corner.
 - c. One from each Clinical Instructor
5. Evidence-based practice: include and **describe how you employed** research articles used to support your clinical decision-making for each client
6. Simulations (e.g., AR final project to satisfy aspect of pediatric AR): description of activity, skill area acquired, and course number
7. ASHA supervised clinical education hours accrued to date

KASA Skills Signature Form

Students are responsible for having their KASA skills form signed each semester, when appropriate. A rating of 4 or 5 on the Clinical Instructor Evaluation of Student Form completed by each Clinical Instructor would constitute enough skill attainment to get a signature on the KASA for that particular skill.

Students will be given simulations or other activities for those experiences not typically encountered during campus clinic and internships. Ultimately the student is responsible for knowing what areas in which they do not have experience (a signature on the KASA) and approach faculty to address this issue.

* The KASA signature form for clinical skills is a document that you must safeguard. Always know where it is, and keep it in a secured location.

Integrative Essay Description

The exercise of reflecting and integrating is critical to learning. In narrative format you will integrate your academic and clinical experiences and describe your development and performance. Reflect on your strengths and weaknesses, and describe a plan to remediate any problem areas. Where appropriate, include information on evidence-based practice, scope of practice, and code of ethics in the description of your clinical work. You will need to update your essay each time you turn in your portfolio. College level writing is expected.

NOTE: Please keep copies of all documents you submit in your portfolio.

GRADUATE STUDENT CHECKLIST

NOTE: It is your responsibility to make copies for required items to be turned in and to keep copies for your portfolio.

First Semester

- Turn in the following to office personnel:
 - Copy of TB test prior to practicum
 - Copy of Liability insurance prior to practicum
 - Copy of national NSSLHA membership card
 - Copy of Certificate of Clearance
 - Copy of unofficial transcripts for B.A.
 - Copy of CPR card
 - Copy of Wildcat card – front and back
- Complete Graduate School Program Plan - Mid semester
- Obtain Graduate Coordinator's signature

Submit a copy to the Graduate Coordinator and original to the Office of Graduate Studies

- Obtain KASA signatures after practicum and practical classroom experiences
- Hours log – Hard Copy and DMS
- Clinical Instructor Evaluation – on DMS

Second Semester

- Portfolio due Monday after Spring Break to clinic office. Performance Review progress reports, based on Portfolios and performance in classroom and clinic, are given in April/May.
- Obtain KASA signatures after practicum and practical classroom experiences or simulations

Summer Between 1st and 2nd years

- Internship Documentation: Complete on Data Management System:
 - ✓ Hours log
 - Document hours during internship (generally weekly)
 - At end of internship, print final hours and have Clinical Instructor initial and sign
 - Turn in original **signed** copy of hours log to office personnel and make a copy for your portfolio
 - Input hours on DMS
 - ✓ Evaluations – DMS
 - Clinical Instructor Evaluation of Student (Clinical Instructor completes)
 - ❖ Turn in original **signed** copy of evaluation form to office personnel and make a copy for your portfolio

- Student Evaluation of Internship Site and Clinical Instructor (student completes on DMS)
- Do Not Forget to obtain KASA skills signatures from intern Clinical Instructors
- Renew Student Liability Insurance

Third Semester

- Complete Mid-Program evaluation (TBA)
- Turn in to office personnel a copy of Liability Insurance policy- renewal
- Turn in Portfolio: Due Monday after Thanksgiving break to clinic office
- You may register online for PRAXIS – though the faculty suggest you wait until your 4th semester to take the test (passing score not a graduation requirement; however, need passing score of 162 to apply for licensure/certification/credential)
 - List CSU, Chico (0015); ASHA (5031); CCTC (8541) ; and CA licensing board (8544) as score recipients;
 - Print admission ticket
 - Exam offered several times
 - Approximate Fee: \$120.00
- Obtain KASA signatures after practicum and practical classroom experiences
- Internship: Complete on Data Management System:
 - ✓ Hours log –
 - Document hours during internship (generally weekly)
 - At end of internship print final hours and have Clinical Instructor initial and sign
 - Turn in original **signed** copy to Jackie and make a copy for your portfolio
 - Input to the Data Management System
 - ✓ Evaluations – on DMS
 - Clinical Instructor Evaluation of Student (Clinical Instructor completes)
 - ❖ Turn in original **signed** copy of evaluation form to office personnel and make a copy for your portfolio
 - Student Evaluation of Internship Site and Clinical Instructor (student completes)
- Do Not Forget to obtain KASA skills signatures from intern Clinical Instructors

Fourth Semester

January

- Comp exams: Wed & Thurs prior to 1st week of school, 9:00am-12:45pm
- Take CBEST (or other qualifying exam- TBA) for credential requirement

February

- Apply for graduation (Mid February)
http://www.csuchico.edu/graduatestudies/filing_for_graduation/forms.shtml

Approximate Fee: \$48

Packet sent by mail in April. RSVP by 1st week May to participate in ceremony

Tickets; pick up early May

Cap and gown: rent in AS Bookstore: mid May

Approximate Fee: \$43.95

- Register for PRAXIS (passing score not a graduation requirement; however, need passing score of 162 to apply for licensure/certification/credential):
 - List CSU, Chico (0015); ASHA (5031); CCTC (8541) ; and CA licensing board (8544) as score recipients
 - Print admission ticket
 - Exam offered several times
 - Approximate Fee: \$120.00

March/April

- Prepare Paperwork: Credential, Licensure, and Certification
- Credential (CA Speech-Language Pathology Services Credential)
 - Due in 3rd week in April
 - Submit information sheet to Credentialing Services (898-6455), CBEST score, (keep in mind that these cost money and take time to order)
 - Approximate Fee: \$25 Processing Fee (university) + credentialing fees (about \$60 online)
- Licensure/Required Professional Experience (similar to Clinical Fellowship- ASHA)
 - Complete temp license forms ASAP to begin work immediately after graduation
 - Download forms: www.slpab.ca.gov
 - Go to License info, forms/applications, RPE packets
 - Approximate Fee: \$60.00
 - Requires fingerprint scan
 - Approximate Fee: \$81.00
- ASHA Certification
 - Application found at www.asha.org
 - Fill out in black and submit the entire application.
 - Submit official graduate transcripts
- Take PRAXIS in April or May

May

- Obtain KASA signatures upon completion of clinical experiences
- Internship: Complete on Data Management System:
 - ✓ Hours log –
 - Document hours during internship (generally weekly)
 - At end of internship print final hours and have Clinical Instructor initial and sign
 - Turn in original **signed** copy to Jackie and make a copy for your portfolio
 - Input to the Data Management System
 - ✓ Evaluations – on DMS
 - Clinical Instructor Evaluation of Student (Clinical Instructor completes)

- ❖ Turn in original **signed** copy of evaluation form to office personnel and make a copy for your portfolio
 - Student Evaluation of Internship Site and Clinical Instructor (student completes)
- Do Not Forget to obtain KASA skills signatures from intern Clinical Instructors
- Submit the following completed forms to Jackie McMillan (together in a packet) by Monday 5 pm of Finals Week (or sooner, if possible – 1st come, 1st served)
 - ✓ KASA Skills: all sections signed off
 - ✓ ASHA Application for Certification – Pages 1, 2, 3, and Signature page
 - ✓ California License application – Report of Clinical Practicum – Signature page 3
 - ✓ MA Transcript, Graduate courses (unofficial)
 - ✓ Copy of all Clinical Instructor evaluation forms: Clinical Instructor Evaluation of Student and self-evaluations
- File Review:
- All forms will be checked and hours verified by office personnel and program director: ASHA, CCTC, and state licensure paperwork with be signed after:
 - Verification of clinic hours
 - Verification that all Clinical Instructor Evaluation of Student forms are on the DMS
 - Verification that all Student Evaluation of Internship Site and Clinical Instructor are on the DMS
 - Exit Survey has been completed on DMS

PART II

CLINIC HANDBOOK

The purpose of this part of the handbook is to acquaint students with policies and procedures related to clinical practicum, and to guide and facilitate the experience in the Communication Sciences and Disorders (CMSD) program. During their two-year graduate program, students participate in clinical practicum including on-campus and off-campus experiences with a variety of communication disorders. On-campus practicum includes therapy with designated clients, speech-language diagnostics and hearing screenings. Off-campus experiences include internships in medical, private practice, and educational settings. Students are required to enroll in at least three practica over the first two semesters, followed by two internships, one in each of two of three possible semesters (Summer, Fall, Spring). One school placement is required (100 hours minimum), the second placement will either be medical, or other (100 hours minimum).

Center for Communication Disorders

Center for Communication Disorders (CCD)

The on-campus clinic provides over 1,500 speech, language, and hearing diagnostic and treatment sessions in an academic year to diverse populations across the North State. The clinic is technologically equipped for audiologic assessment, computerized speech analysis, and computer-based therapy. CCD is utilized as a center for resources and referrals by the university and community.

Equity Statement

Students, faculty, staff and persons served in the program's clinic are treated in a nondiscriminatory manner – that is, without regard to race, color, religion, sex, national origin, participation restriction, age, sexual orientation, or status as a parent. The institution and program comply with all applicable laws, regulations, and executive orders pertaining thereto.

Clients typically are referred to the CSUC Center for Communication Disorders by teachers, speech-language pathologists in the field, doctors, or they are self-referred. Upon referral, the Center office sends out a case history form to be completed by the client and schedules an appointment for a diagnostic evaluation. Clinical Instructors may mail out additional forms in advance. More detailed examples of child and pediatric intake questionnaires are available; see your Clinical Instructor for those forms. After completing the diagnostic evaluation, the diagnostic team analyzes the clinical behaviors with the Clinical Instructor, generates impressions in writing, and, if intervention is warranted, the clinicians recommend the client be placed on the eligibility list for therapy. Clients are selected from the eligibility list based on the needs of the clinic, including variety of ages, and types and severity of disorders, times available, and number of clients needed.

Once selected for therapy, clients are assigned to student clinicians on a semester basis. Each client is seen by a student clinician twice a week for fifty minute sessions. These times may vary depending on the client type. Students work under the direct instruction of licensed and certified

Clinical Instructors. The university clinic may provide therapy for a client up to a maximum of four semesters. Exceptions to this limit are based on the needs of the training program.

Supervised Clinical Education Hours

By fulfilling program requirements, students simultaneously meet requirements for California State Licensure, ASHA Certificate of Clinical Competence (CCC), and the Speech-Language Pathology Services Credential. Program requirements are designed to meet the highest standard for each category. A total of *400 supervised clinical education hours* are required.

Observation Hours

Students complete 25 hours of observation of clients who have a communication disorder within the scope of practice of speech-language pathology. These observations must be under the direction of a Clinical Instructor who holds CCC-SLP. Students who have completed their baccalaureate degree at CSU, Chico will have accrued these observations hours as part of the course requirements in specified courses. It is the student's responsibility to maintain the log sheet during the semesters s/he is completing the observations. Prior to beginning the graduate program, logs containing original instructor signatures must be submitted to the Administrative Support Coordinator. These will become part of each individual's practicum (clock hours) file, maintained in the program office.

Direct Supervised Clinical Education Hours

Students must earn at least 375 supervised **direct patient contact** hours, in addition to the 25 observation hours, of supervised clinical practicum that concerns the evaluation and treatment of children and adults with disorders of speech, language, swallowing and hearing. Practicum must include experience with client population across the life span and from culturally and linguistically diverse backgrounds. Practicum must include experiences with client populations with various types and severities of communication and/or related disorders, differences and disabilities as reflected in the ASHA Scope of Practice for Speech-Language Pathology (articulation, fluency, voice and resonance, receptive and expressive language, hearing, swallowing, cognitive aspects of communication, social aspects of communication, and communication modalities). Students must also **demonstrate in writing and with the approval of their Clinical Instructor utilization of evidence based practices (EBP) when determining therapy treatments for their clients.**

Of the 400 clinical education hours, the following criteria must be met:

- **THREE DIFFERENT SETTINGS:** You must have experience in THREE different settings. This is met by participating in the university clinic during the 1st year and completing two internships during the 2nd year: school setting and non-school setting.
- **NUMBER OF HOURS:** ASHA requires that you must complete at least 50 supervised clinical education hours in each of the three types of clinical settings indicated above.
- **NUMBER OF HOURS IN PUBLIC SCHOOLS:** CTCC requires that at least 100 supervised clinical education hours be completed in the public schools. This qualifies you for the Speech-Language Pathology Services Credential.

**CENTER FOR COMMUNICATION DISORDERS
PROCEDURES AND CONDUCT**

Confidentiality

Confidentiality of client information is of utmost importance and must be maintained. Client privacy rights are stipulated in federal legislation (HIPAA)¹ and the ASHA Code of Ethics. Students are expected to adhere to these regulations as outlined below:

1. **The client's master file may not be removed from the clinic.** However, students may check out a file to take to the clinician preparation rooms (AJH 104, 104B, 105 or 112F) or to the Clinical Instructor's office.
2. Photocopying of any information in the file is not allowed.
3. All client related documents and notes must remain in the file cabinet of your assigned student lab.
4. No client documents or notes are allowed outside of designated student rooms and must remain in the locked file cabinet at the end of the day.
5. All rough drafts or any documents containing the client's personal information must be destroyed once no longer needed. (For educational purposes, students may retain drafts in which protected patient information has been deleted.)
6. Student clinicians may not invite visitors to the clinic.

While it is appropriate for students to share information regarding their clients, including diagnostic information and therapy techniques, they must take care not to discuss their clients in the reception area or outside of the clinic. See the following Employee/Student Confidentiality Form.

CSU, Chico, Employee/Student Confidentiality Form

Use and/or disclosure of protected health information (PHI) or patient identifiable information is strictly prohibited. The California State University, Chico Communication Sciences and Disorders Program adheres to the regulations of the California Medical Information Act (CMIA) and the Health Insurance Portability and Accountability Act (HIPAA).

Prior to starting clinical practicum, students must signed the confidentiality acknowledgment form (**appendix**) and successfully pass a HIPAA compliance quiz.

Code of Ethics

The ASHA Code of Ethics published by the American Speech-Language Hearing Association is to be followed by the clinicians. Please read and follow the [ASHA Code of Ethics](#). Should a question arise in regards to ethics, particularly when it is directly related to clinical conduct, the clinician is expected to ask the Clinical Instructor for direction.

Certain professional standards are expected of students in training. Clinicians are to maintain a professional relationship with clients and their caregivers. While clinicians are encouraged to

¹ Health Insurance Portability and Accountability Act

seek pertinent information in regards to their clients and how their disorder manifests itself in other environments, clinicians should not become “friends” with the client or caregiver. For example, it would not be appropriate to start going out for coffee, dinner, etc. and calling the client or caregiver just to “chat.”

Attendance

Students should be set up at least 10 minutes prior to the beginning of the session. Clinical Instructors will be present and prepared to observe. Students are expected to have in place audio recording systems, all intervention materials for the session, and a clean and organized therapy room. They are expected to meet clients *promptly* for therapy and work with them for the entire 50 minute session. If a student is late to set up and be prepared for a session after one warning from the Clinical Instructor, that student will be required to meet with the Clinic Director (CD) and may forfeit that client and clinic for the semester. Clinical Instructor approval is required to shorten a therapy session. There is no reason to arbitrarily shorten a therapy session. Only personal illness or other extenuating circumstances are acceptable reasons for clinician absences. The clinician is responsible for contacting the client, the clinic office, and his/her Clinical Instructor prior to the scheduled appointment time when s/he meets for therapy. The clinician should have the client’s phone number(s) available for use in such emergencies.

Note: Students are required to provide a medical note to the CD if a session is missed. Greater than 3 sessions missed will entail meeting with the CD and will require repeating CMSD 684.

Dress Code

A professional appearance as well as a professional attitude is expected of all student clinicians. A simple rule is to dress as if you were interviewing for your first SLP job. CCD Clinical Instructors and the Clinic Director will make final decisions regarding inappropriate dress. Jeans are appropriate if they are nicely tailored. The following items are **not** to be worn in or in the vicinity of clinic; **shorts (unless they are knee length), tank tops, tube tops, tops that are shoulderless/strapless, expose backs, midriffs, underwear, or are low-cut and considered to be revealing. This standard exists whether or not you have therapy that day.** Flip-flops are not appropriate; however, sandals can be worn if they are not noisy and stay on your feet. Visible body piercings and tattoos are not allowed. If you are in doubt, it is advisable to err in the conservative direction. If dress is inappropriate on the day of therapy, that session will be forfeited and the student will be required to meet with the CD.

Dress codes for off-campus placements will vary depending on the setting and Clinical Instructor. Please consult with off-campus Clinical Instructors before an initial visit.

Identification

Student clinicians are required to wear their ID when conducting sessions.

Liability Insurance

Student clinicians are required to hold professional liability insurance, which is available at a discounted rate. Incoming students will receive information regarding insurance prior to beginning their clinical experience. Second year students are responsible for renewing their

insurance before it expires. Proof of insurance must be provided to the ASC for placement in the clinician's file.

Infection Control

To aid in the prevention of sickness and infection, the following procedures should be followed in the Center for Communication Disorders:

- Clinicians wash their hands prior to and following all clinical sessions.
- Clinicians are also responsible for wiping down the tables and chairs with disinfectant in the therapy rooms after each session. Disinfectant and paper towels should be available in all therapy rooms. (Notify ASC if supplies are missing.)
- Any materials that have come in contact with a client's mouth, bodily fluids, etc. must be disinfected prior to returning them to shelves. For example, this may necessitate washing toys in hot soapy water before re-shelving them.
- Probe tips for tympanometry must be wiped with alcohol following use.
- When performing oral motor exercises or diagnostics, gloves (provided in the clinic office) should be used at all times.
- Any item such as a tongue depressor, facial tissue, gloves, etc. which comes in contact with the client's bodily fluids shall be disposed of properly.
- If a client contaminates (vomits, urinates, has a nose bleed or has an accident that results in bleeding) the therapy room, place a note on the door indicating people are not to enter, and contact the Clinical Instructor and the ASC immediately to make arrangements for room cleaning.
- Both clinicians and clients who are experiencing a contagious illness should refrain from therapy.

At off-campus placements, students will follow applicable infection control procedures for the site. It is required that students receive Hepatitis B vaccination series prior to enrolling in a CSU medical placement. These shots are available "at cost" (approximately \$35 per shot/3 shot series) at the CSUC Student Health Center, and require approximately 6 months to complete the series. A TB skin test is also required before beginning clinical practicum and may also be obtained at the University Health Center.

CLINICAL ASSIGNMENTS

This section is intended to describe on-campus and off-campus clinical assignments including preparing for the first session, planning lessons, charting, and paperwork. The following sections are organized by placement and type of practicum. On-campus placements are discussed first, including clients, speech-language diagnostics and audiology practicum. Off-campus placement information includes internships in both the medical and educational settings.

On-Campus Client

Student-clinicians will provide clinical services to **three on-campus clients** at the Center for Communication Disorders during their first year. Clinicians are assigned based on the students' training, class schedule, Clinical Instructors' schedules, and room availability. Students may

receive two clients in the fall of the first year and one in the spring of the first year, or vice versa. The decision is made by the CD and ACD. It is expected that students will be available for clinic Monday through Thursdays from 8am to 6pm. Extenuating circumstances (e.g., family obligations) must be discussed with the CD. Work schedules are expected to be worked around clinical schedules.

Clinicians are assigned to a Clinical Instructor for each client. The clinician is required to consult with the Clinical Instructor regarding ANY clinical decisions, particularly during diagnostics, or when considering a different approach to therapy or dismissal. **Clinicians are required to attend the weekly Clinical Instructor meetings that are scheduled by the Clinical Instructor.** If a conflict in meeting times occurs, this must be resolved within the first week. If disagreements arise between the student and Clinical Instructor, the student should attempt to resolve the problem directly with the Clinical Instructor. If the problem cannot be resolved, the Clinic Director will serve as mediator. Students should not consult with other Clinical Instructors or faculty regarding their clients unless authorized to do so by the Clinical Instructor in charge of the case.

Getting Started

Upon being assigned a client, the student-clinician will study the case history, original diagnostic report, and other reports and/or summaries of prior therapy contained in the client's file. Once previous reports have been reviewed, it is the clinician's responsibility (with the approval of the Clinical Instructor) to ensure that valid formal/informal assessment instruments be administered. It is the clinician's responsibility to:

1. **Review** and discuss with your Clinical Instructor the administration of formal and/or informal measures appropriate for your client. Write a **rationale for each assessment or subtest**. For example, why are you administering the *Boston Naming Test*? What are you hoping to learn from administering this instrument?
2. **Perform a review of the literature and collect at least two evidence-based assessment and/or approaches to supplement the program from the previous semester.** The student will synthesize this information in writing and present to his/her Clinical Instructor at least one week prior to interacting with the client for the first time. The synopsis is also to be included in lesson plans and the ICR and FCR.
3. Share findings with other student-clinicians. Ideally, group meetings will be held once per week with your Clinical Instructor; if logistics are difficult, individual meetings with the Clinical Instructor are acceptable.

Planning for Therapy

The student will meet with his/her assigned Clinical Instructor to discuss test results and preliminary plans for therapy. These plans should follow the format outlined in the appendices. The plan that evolves will be modified as necessary based on results of the first several therapy sessions. This will constitute the overall approach to therapy for the semester and will be the basis for the Initial Case Report (ICR). See appendices for several examples of ICRs.

Based on the semester goals, weekly objectives and rationales will be described in the form of weekly lesson plans. Requirements for these plans will vary depending on the Clinical Instructor. Lesson plans are generated each week and are to be turned in **prior to therapy sessions** during the week. Lesson plans should include statements regarding the goal, rationale supporting that goal based on EBP, responses to be elicited, stimuli to be used, criteria level of performance, as well as a reinforcement schedule. In addition, all materials to be used in that session must be included in the 3 segment pendaflex binder so your Clinical Instructor may review and respond to the degree of appropriateness prior to therapy. In planning therapy, students are encouraged to ‘over plan’ so that there will be plenty of activities to maintain the client’s participation and interest.

All therapy sessions will be audio/video recorded via the ISR system. Student clinicians may also consider using audio recording devices in their therapy sessions when appropriate. EBP has clearly demonstrated that immediate or carefully selected intermediate biofeedback is instrumental in rapid and positive increases in the variable of interest. That is, when the client hears his or her response, he or she can more easily modify it. Clinicians will be informed of appropriate audio feedback devices.

Infusing Evidence-based Practice (EBP) Into Clinical Practicum

ASHA (<http://www.asha.org/Research/EBP/>) describes evidence-based practice as the following: “The goal of EBP is the integration of: (a) clinical expertise/expert opinion, (b) external scientific evidence, and (c) client/patient/caregiver values to provide high-quality services reflecting the interests, values, needs, and choices of the individuals we serve...”

“Because EBP is client/patient/family centered, a clinician's task is to interpret best current evidence from systematic research in relation to an individual client/patient, including that individual's preferences, environment, culture, and values regarding health and well-being. Ultimately, the goal of EBP is providing optimal clinical service to that client/patient on an individual basis. Because EBP is a continuing process, it is a dynamic integration of ever-evolving clinical expertise and external evidence in day-to-day practice.”

For example, if you are working on articulation therapy, you need to investigate Bankson and Bernthal or another text or journal article and write the plan so that the goal is supported by EBP. If it is dysfluency, you can review Barry Guitar text or another text, find the section on Easy Onset, and locate a peer reviewed article to support the approach in the chapter reference section.

In addition to using references in textbooks, ASHA offers a comprehensive website of Systematic Reviews. Just go the ASHA, type in systematic reviews and voila! Please use these resources and consult your Clinical Instructors about his/her specific expectations for EBP.

Lesson Plans and EBP rationales and SOAP notes (Record Keeping)

Student clinicians are expected to establish EBP goals for their clients and are expected to chart client responses during the session in the form of SOAP notes. Student clinicians are encouraged to record the session digitally so that he or she can score responses off-line after the therapy

session. With time, off-line record keeping can be minimized as the clinician gains more skills recording online. But for new clinicians, online scoring during both assessment and intervention tasks is not only tedious and time consuming; it also disconnects the clinician from the client and task at hand.

Clinical decisions for subsequent sessions are typically based on previous performance. Thus, accuracy in record keeping is essential. A weekly report of session outcomes is required (SOAPs). The exact format and frequency will be explained by the individual Clinical Instructors; however, a number of good examples are included in the appendices. Students should maintain records all semester so that Final Case Reports (FCRs) can include progress reports. See appendices for lesson plans, SOAPs and selected charting forms. Other charting forms will be created by the clinician to capture the data of interest.

Recording Supervised Clinical Education Hours

Clinicians will track client attendance in the binder provided in the clinic office. Students are to initial the attendance sheet as well as log their hours on the appropriate disorder log sheet. Only direct contact with the client or the client's family in assessment, management, and/or counseling can be counted toward practicum. A hours log will be sent to you via email at the beginning of the semester.

Reports

Each semester, the student will generate two clinical reports: the Initial Case Report (ICR) and the Final Case Report (FCR). Sample report formats are provided in the **Student Handbook appendices**. However, please consult with your Clinical Instructor regarding preferred report format.

All client reports must be generated in your assigned student lab. You may not work on reports on any other computer than the one assigned to you.

The first draft of the ICR may be due to the Clinical Instructor as early as after the third therapy session. **DRAFT COPIES OF ALL REPORTS SHOULD BE DOUBLE SPACED WITH AT LEAST 1" MARGINS** to provide room for written comments by the Clinical Instructor. **Final copies are single spaced.** The final (ORIGINAL) copy may be due as early as the end of the second week of therapy. At the end of the semester, the draft of the FCR is typically due the first day of the week preceding final examinations. The final (ORIGINAL) copy is due by the end of the same week. **Earlier or later due dates will be specified by individual Clinical Instructors.** There are child and adolescent and adult ICRs and FCRs in the appendices. During the semester, the student will prepare, at the discretion of the Clinical Instructor, daily logs, weekly lesson plans and/or a semester therapy plan.

A master file is maintained for each client seen for an evaluation or therapy. These files are located in the file cabinet ("Current Clients") in the Clinic office. The student clinician is responsible for maintaining the client's file in an orderly fashion. The file will contain Authorization for Release of Information, Request for Information, Case History, Diagnostic Report, test and evaluation data, ICRs and FCRs, and correspondence arranged in chronological

order from bottom to top. Stapled to the left side of the master file is a Record of Client Transactions sheet. The clinic staff, Clinical Instructor and/or student will record all actions concerning the client, such as pertinent information provided from incoming or outgoing phone calls, referrals, and other pertinent communications.

AT NO TIME WILL THE CLIENT'S MASTER FILE BE REMOVED FROM THE CLINIC. The file may be checked out from the clinic office (to your assigned student lab or the Clinical Instructor's office) for use in report preparation by placing an "IN/OUT" card in the hanging file folder for the particular file needed. The file is to be returned immediately after use. Files are not to be taken to class or into the therapy session.

Students and their Clinical Instructors are required to schedule 15 minutes at the beginning and at the end of the semester to meet with the client and family in the clinic room to discuss initial and final testing results and those implications (ICRs and FCRs). It is the students' responsibility to contact his or her Clinical Instructor to ensure that the Clinical Instructor is aware of the meeting, is available, and has approved the ICR and FCR.

Audiology Clinical Education Hours

There is no specified number of audiology clinical education hours required by ASHA, CA Licensure Board, or the CA credential board. However, students must demonstrate mastery of pure tone screening and aural rehabilitation. These skills will be developed and demonstrated in clinic, screenings, and specified course work simulation. Hours accrued in clinic, internships, or community screening activities will be counted towards the 400 Clinical Education Hours required.

Speech-Language Diagnostics

Qualified clinicians are assigned to teams of two with one Clinical Instructor to accommodate ASHA's Dynamic Assessment model. These assignments remain the same for the entire semester. Speech diagnostic sessions are scheduled in two-hour time blocks one time per week for each team. Appointments are tracked in the Speech Diagnostics binder in the clinic office, and students are responsible for determining if they have a client scheduled during each week. Clients may be scheduled up to 48 hours in advance.

Prior to each evaluation, the student clinician team meets to review case history information if it is returned to the clinic prior to the evaluation. Based on the available information, the diagnostic team develops an appropriate interview and assessment plan. This plan is then discussed and revised with the Clinical Instructor. Typically, a diagnostic session includes an interview, oral peripheral examination, hearing screening, appropriate tests for primary area of concern, **as well as methods to evaluate all speech-language areas** (articulation/phonology, voice, fluency, language) at least briefly.

Students are responsible for tracking their hours in the Diagnostics Log in the clinic office. The clinicians write a disposition in the space provided on the client's information sheet in the diagnostics binder.

Reports

Following each diagnostic session a diagnostic report is prepared and submitted to the Clinical Instructor. **This rough draft should be double-spaced with 1-inch margins.** These reports are typically due four days after the diagnostic session and the final draft one week after the diagnostic evaluation. Clinical Instructors will establish an appropriate time line for report writing. Test protocols should be included with the rough draft. The format(s) and an outline for diagnostic reports are contained in the appendices.

Screening

The clinic may occasionally provide opportunities for students to obtain additional diagnostic hours through screenings located at schools, health fairs, and retirement homes in Chico and the surrounding areas. This includes the annual Speech and Hearing Fair. Qualified students may participate in these screenings. Diagnostic credit is given on an hour-for-hour basis. These hours may be in audiology or speech and language for all ages.

CCD CLINICAL INSTRUCTION

All Clinical Instructors hold the Certificate of Clinical Competence from ASHA and a California license. Each Clinical Instructor will vary in Clinical Instruction techniques as well as requirements from the clinicians. However, a minimum of 25% of each student's total hours of therapy and 50% of each diagnostic session will be directly observed in the university setting. The amount of instruction must be appropriate to the student's level of knowledge, expertise and competence.

Clinical Instructors perform the following tasks:

- Evaluate the clinician's level of performance and develop a plan to assist the student in moving to a higher level of performance.
- Provide assistance to ensure student learning and quality client care.
- Regularly observe the student to identify skills and areas of improvement.
- Provide appropriate instruction, opportunity for practice, and timely and accurate feedback to the student.
- Help the student to evaluate existing skills and areas which need improving so that the student becomes a competent professional.
- Receive feedback from students to modify instruction techniques.
- Meet physically with each clinician weekly, either individually or in a group, to ensure continuity of intervention and clinician growth.

Instruction occurs on a continuum, and it is expected that the student will advance along the continuum to become adept at self-instruction. Having a clear understanding of mutual expectations is important for an effective relationship with your Clinical Instructor.

Communications between the student and the Clinical Instructor are necessary so that student's needs and Clinical Instructor's expectations can be addressed. The [ASHA Technical Report on Clinical Instruction](#) which delineates the 13 tasks and 81 associated competencies for effective instruction is contained in the appendix section.

Students are encouraged to analyze and subsequently evaluate themselves. Clinical Instructors will determine which form(s) they want their student to use (see examples in the **appendix**).

EVALUATIONS

At about the midpoint of the semester, each student's clinical performance is evaluated. The Clinical Instructor will arrange to meet with the student for the evaluation. The Clinical Instructor Evaluation of Student Form will be used as the on/off campus evaluation of clinical competencies. Grades for on-campus clinics will be determined using the On-Campus Clinic Grading Rubric. A copy of these evaluation forms will be sent to you at the beginning of each semester. These forms may also be used by the student for self-evaluation. A final conference to discuss the student's progress is typically conducted after the completion of all clinic reports. All on-campus clinical practica are letter graded.

Evaluations of Clinical Instructors are completed by the clinicians at the end of each semester. These forms will be provided by the ASC, and are to be returned to her for placement in the Clinical Instructor's permanent personnel file after the semester is over.

CLINICAL SUPPLIES

Provisions Made by the Clinic

The clinic provides tests, protocols, various acoustic and audiological equipment, and certain therapy materials for students' use. The clinic also provides disposable gloves, tongue depressors, tissues, and disinfectant. Students are encouraged to supply their own stop watches and digital and audio recorders (see below), since these will be necessary for internships. It is the students' responsibility to maintain the materials room/student preparation area (AJH 104) in an organized, clean manner. Each semester, students enrolled in on-campus practicum will be assigned an area to manage. Materials should be put away promptly following therapy, not left out on the table, counter, etc. If a student has a class immediately after therapy, the materials may be left in his/her box, and put away immediately after class when necessary. However, the student should check to see if anyone will need the materials during the next hour and make arrangements with them for access. Clinic materials may be checked out during times posted in the clinic office. Under no circumstances will any clinical materials be removed from the clinic without permission from a Clinical Instructor or ASC. **Materials must be checked out using the designated binder in the clinic office. Materials checked out overnight MUST be returned by 8 AM the next day, as others may need to use them.** Needed supplies and broken equipment should be reported to the Clinical Instructor and to the ASC.

Provisions Made by the Student

Students are encouraged to provide their own digital recorder to record the entire diagnostic or therapy session. Digital recorders are not of sufficient audio quality to use for immediate auditory biofeedback. Therefore, clinicians are encouraged to purchase an audio recorder with output loud and clear enough for clients to hear easily. Many students purchase small speakers to plug into their devices and laptops/iPads for playback. In addition, students are expected to supply their own prizes/stickers, paper, pens/pencils, and any special therapy materials they need.

Clinicians may bring boxes/totes in which to store their clinical supplies and leave them on the shelves in room 104. These must be taken home during the semester and summer breaks.

Off-Campus Internships

This section is designed to provide a brief overview of the internship process. A separate handbook details policies and procedures for student interns and Clinical Internship Instructors.

Off-campus assignments are based on the student's training, schedule, interviews, and placement availability. Prior to graduation, students are required to complete at least 50 hours in each of two distinctive settings, with **at least the first 50 hours accumulated on-campus**. Prior to being placed in an off-campus placement students must complete at least 50 direct supervised clinical education hours, have approval of the faculty and be advanced to candidacy. Off-campus placements include medical (acute, rehab, skilled nursing facilities), private practice, and schools. Off-campus internships can range from 2 to 8 units; however, the majority of internships will be 4 units. The number of hours available at specific sites will vary according to a number of factors (e.g., census) and cannot be predicted with precision. Nonetheless, students are required to be at their internships AT LEAST 3 days a week unless approved by Internship Coordinator. The internship is supervised by a campus supervisor and the on-site Clinical Instructor. Once assignments are made, students contact their site CI and are responsible for completing and submitting internship agreement forms to the ASC in AJH 100.

Students are expected to continue at their placement until the end of the designated time period regardless of their accumulated supervised clinical education hours. Student absences should be reported to their campus supervisor and their onsite clinical instructor.

Summer placements out of the area are possible with ample preparation time. Please contact the Internship Coordinator by December 1st to begin the contract process.

Diagnostic and therapy experiences as well as the amount of direct observation will vary among placements and Clinical Instructors. However, the minimum required direct observation by the master clinician is 25% of all therapy and diagnostics. Record keeping and report writing will also vary, and students should clarify any questions with their on-site master clinician.

A campus supervisor will conduct site-visits each semester. These visits may include observation of therapy, diagnostics, and discussion of hours, experiences, and clientele. The on-site CI will use evaluation forms provided by the CMSD program to evaluate the student's performance. In addition, student interns must monitor their progress toward achieving skills delineated in the KASA and request their Clinical Instructors' signature when a skill would receive a rating of 4 or 5 on the Clinical Instructor Evaluation of Student Form completed by each Clinical Instructor at the end of the semester.

The clinician is responsible for tracking hours obtained at each placement, which must be signed off by the master clinician at the end of the semester and submitted to the ASC for further processing.

REMEDATION PROCEDURES FOR MANAGING UNSATISFACTORY CLINICAL PERFORMANCE

The Code of Ethics of the American Speech-Language-Hearing Association (ASHA) mandates that individuals “hold paramount the welfare of persons they serve professionally.” If clinicians do not have the ability to make appropriate progress along the continuum toward independence, it is the ethical and professional duty of Clinical Instructors to manage this problem. Because of differences in perceptions of clinical competence, evaluation decisions are difficult and are subject to great variability across Clinical Instructors. Thus, it is imperative that Clinical Instructors collect and analyze data throughout a term for all supervisees. Clinical Instructor accountability is demonstrated via documentation of problem areas and supporting action to attempt to develop clinical competence in the supervisee. The Clinical Instructor must be able to demonstrate that she/he has provided specific, direct feedback throughout the term, with opportunities and support for making necessary changes.

If you are not acquiring competencies at an appropriate rate, as judged by the Clinical Instructor, s/he will discuss the problem with the supervisee. For skills that need to be developed, specific behavioral objectives will be set, including time limits for accomplishment. Performance will be reviewed and evaluated at designated intervals. If concerns still exist, the Clinical Instructor will consult with the Clinic Director. If satisfactory outcomes are not attained by the end of the semester, the clinician may be required to repeat target clinical experiences. Off-campus placements will not be made until the clinician has developed adequate skills as judged by the Clinic Director and practicum Clinical Instructors. **Clock hours are earned only for satisfactory completion of clinical activity.**

If after two semesters of on-campus clinic serious concerns remain, a team approach will be implemented. Expectations of the program and of the Clinical Instructor must be clearly defined at the onset of the practicum experience. The Clinic Director, Clinical Instructor and one additional Clinical Instructor will develop a highly structured plan that includes objectives, procedures, criteria, timeline, criteria for performance and specific type and amount of supportive data to be collected during the probationary period. Further, the clinician must be actively involved in data collection and analysis relative to established objectives and must be able to formulate strategies for change during conferences with the team.

POLICY AND PROCEDURES FOR STUDENT COMPLAINTS

Probation Policies and Procedures

Graduate students who fall below a 3.0 GPA will be placed on academic probation, in accordance with university guidelines. Refer to the university catalog for specifications. The faculty can require additional and specific conditions for a student on probation. The CMSD faculty will inform the student of these requirements following notification of probation from the graduate school. Students who do not meet the conditions for the probationary period will be dismissed from the CMSD program.

Student Grievance and Complaint Process

Grievances related to grades, university services, and academic programs on and off campus may be resolved either by an informal or formal process. Every student has the right to use these procedures. For initial consultation, please contact [Chico State Ombuds](#) at (530) 898-3955 or [Student Judicial Affairs](#), Kendall Hall 110, (530) 898-6897, for further information.

The CMSD program has the following policy regarding on- and off-campus practicum: If a problem or conflict arises between a student and Clinical Internship Instructor, the two should meet to resolve the problem, keeping in mind the Clinical Internship Instructor's ultimate responsibility for the treatment plan and welfare of the client. For on-campus practicum, if no resolution is reached at the first level, the Clinic Director will serve as mediator and meet individually, and, if necessary, collectively with the parties to resolve the issue. For off-campus placements, the campus supervisor serves as the initial mediator and the Clinic Director is apprised of the situation. If no solution is found, the Clinic Director becomes actively involved. If still no solution is found, the student may pursue informal or formal grievance procedures as described in the university catalog.

Student issues relative to academic programs are managed in a similar manner. If a problem or conflict arises between a student and instructor, the two will meet to resolve the problem. If no resolution is reached, the Program Director will serve as mediator and meet individually, and, if necessary, collectively with the parties to resolve the issue. If still no solution is found, the student may pursue informal or formal grievance procedures through Student Judicial Affairs, Kendall Hall 110, (530) 898-6897.

Students with complaints about the academic or clinical programs are advised to report their grievance to the Council on Academic Accreditation (CAA) of the American Speech-Language-Hearing Association and are provided the following contact information: CAA Office at American Speech-Language-Hearing Association, 220 Research Blvd, Rockville, MD 20852 or phone ASHA's Action Center at (800) 498-2071. For specific procedures, visit: [CAA Complaint Procedures](#).

APPENDICES

Sample reports

The following ICRs, FCRs, lesson plans and SOAP notes *are examples only*. They primarily follow the medical model, which is the type of report your physician might dictate after a thorough evaluation. The medical model also encompasses the area of SLP for AAC acquisition and differential diagnosis. Your Clinical Instructor may make adaptations to this model; however, it is important that all elements be explored, including family and social history, medical history [including physicians' names and specialties] and medications, client and family expectations, level of intelligibility and comprehensibility, QOL probes, assessment instruments and rationales for administering, dynamic testing (see dx report), results formulated through graphs and clear writing, implications of those results, and goals and rationales. *Your Clinical Instructor may have additional examples of reports to be reviewed in your weekly meetings with your Clinical Instructor.* The ACD and CD also have numerous examples to share during office hours.

These models may be very different from the previous report in the clinic office. This is because the CDD clinic is altering the format to more closely follow the clinical/Medicare model. Again, your Clinical Instructor may make adaptations. Please follow accordingly.

Initial Case Report (Sample)
California State University, Chico
Center for Communication Disorders
Confidential

Name: _____ Date of Report: _____
Address: _____ Telephone: _____
DOB: _____ Age: _____
Date of Initial Session: _____
Clinician: _____
Clinical Instructor: _____

Background

AnonYmous, a x;xx-month-old male, is enrolled for the [] semester at the Center for Communication Disorders (CCD) at California State University, Chico. The [] semester represents Anon’s xxst/th semester of intervention at this clinic. Anon was originally referred to this clinic by [], a speech language pathologist at the []. It was reported that he was diagnosed with autism at [age] at [med center, including physician]. In addition, a Speech and Language Report generated from [] dated [date] states that he has been diagnosed with [condition, a condition that entails xxxx info from Mayo clinic]. He received a diagnostic evaluation at the CSU, Chico, Center for Communication Disorders, on [date]. This evaluation revealed that Anon exhibited a limited expressive vocabulary, consisting primarily of the vowel sounds /~~ai~~/ and /~~au~~/. He demonstrated knowledge of items typical to a child his age, the ability to follow one-step directions, and the use of some American Sign Language including: “please,” “thank you” and “more.” Anon is followed by Dr. [name]. Medications include [meds and side effects and indications]. Anon lives at home with []. His family reports that he is approximately [] intelligible. He conveys wants and needs by [action]. The success of this mode is [report]. The family was interviewed about goals for the semester and reported [].

Intervention history:

Anon received speech and language therapy at the California State University, Chico Center for Communication Disorders for the [dates] Previous intervention focused on increasing expressive and receptive language skills as well as expanding Anon’s phonetic inventory. For the [date] semester, Anon demonstrated progress in each targeted area. He successfully identified noun pictures from a field of five. He named over 150 line drawings of high probability objects. His ability to imitate isolated phonemes improved minimally. He was able to imitate the /m/ phoneme in isolation with 91% accuracy and in initial position of words with 85% accuracy. Anon presented difficulty producing the /t/, /d/, and /p/ phonemes. The final report from [] stated that increased awareness on the part of Anon of his oral structures and tongue placement may be necessary in order to achieve the production of these sounds. It should be noted that these phonemes involve high levels of intraoral pressure and would be difficult to produce with velopharyngeal dysfunction.

Anon was administered the *Preschool Language Scale-4* (PLS-4) on [], to investigate language reception and expression. Results revealed minimal production of consonantal sounds. He used gestures more than words to communicate. Anon did not produce different word combinations. A speech sample during play with the clinician documented on [], revealed that Anon possessed a limited vocabulary consisting of words such as *hi, no, and horse*. Additional observations reported that Anon followed one-step directions, produced the phrase “*I want,*” and gestured the signs “*please, thank you, more*” and “*yes.*” He was also observed to distinguish between two items and verbally identify various nouns (i.e. *car, train, ball, puzzle, spoon*), numbers (1-9), and all letters of the alphabet. Other findings report that receptively, Anon followed routines, familiar directions with cues (e.g. Give me the ball), used more than one object in play, and demonstrated appropriate use of objects in play. He was also observed to identify a single familiar object from a group of objects. Further informal assessment from Anon’s Final Case Report for [date] reported that he identified his large body parts, and photographs of familiar objects, understood inhibitory words, and responded accurately to spatial concepts (*in, out*). Therapy was altered mid semester in [date] to focus less on expressive vocabulary and more on eliciting requests. The Picture Exchange Communication System (PECS), which Anon uses at home and at school, was implemented to elicit requests.

Assessment

On [date] the *Rossetti Infant-Toddler Language Scale* was administered. The *Rossetti Infant-Toddler Language Scale* is a criterion-referenced instrument designed to assess the communication skills of children from birth through 36 months of age. It was designed to provide the clinician with a comprehensive and relevant tool to assess the preverbal and verbal aspects of communication and interaction in the young child. It assesses preverbal and verbal areas of communication and interaction using six assessment categories. They are *Interaction-Attachment*, which reflects the reciprocal relationship between the caregiver and child; *Pragmatics*, which assesses the way the child uses language to communicate with and affect others in a social manner; *Gesture*, in regard to the child's use of gesture to express thought and intent prior to the consistent use of spoken language; *Play*, which assesses changes in a child's play behavior, which reflects the development of representational thought; *Language Comprehension*, which reflects the child's understanding of verbal language with and without linguistic cues; and *Language Expression*, to assess the use of preverbal and verbal behaviors to communicate with others.

Results reflect the child’s mastery of skills in each of the areas assessed at three-month intervals. The *Rossetti Infant-Toddler Language Scale* is not norm-referenced; therefore the individual's performance is compared to known developmental parameters as opposed to a group of typically developing children. Results revealed an age performance profile placing Anon in the age range of 27-30 months of age. The *Rossetti Infant-Toddler Language Scale* assesses five areas of language development that are appropriate for children functioning between ages birth and three. These five areas are building blocks for later language and pragmatic development. The skills assessed provide precursors to higher level language development, including turn taking, establishing joint attention and various receptive concepts.

Goals and activities chosen for therapy will be geared toward Anon's developmental age of approximately 30 months. Intervention will be designed to promote the most growth in communication. Therapy objectives include increasing receptive knowledge of concepts such as *in, out, up* and *down*, because these prepositions are typically understood by the age 30-36 months. Other goals are to increase Anon's attention and ability to remain focused, as well as engage in appropriate play and turn taking, because these are play behaviors also expected to emerge in the 30-36 months age range (Paul, 2001).

Based on the *Rossetti Infant-Toddler Language Scale* as a prescriptive assessment tool, Anon demonstrates a need for developmentally appropriate intervention across all levels of communicative performance. Goals will be quantified to match his developmental age.

Goals

Long Term Goal 1: Communicate using one word vocalizations/signs to request or label a desired item or activity.

Rationale: According to Rhea Paul in *Language Disorders from Infancy through Adolescence*, proto-imperatives are used when the child wants an adult to do something for the child. Giving Anon successful experiences when he verbalizes a preference will reinforce his verbal behavior, and encourage more frequent communication attempts. Gestural and verbal demands are early indicators of communicative intent. Anon displays limited communicative intent, which is a precursor to more complex language.

Long Term Goal 2: Anon will attend to a structured activity for 10 minutes, with the clinician, for three consecutive sessions.

Rationale: Increased attention to task is expected to increase the capacity for new learning (Brookshire, 2007). Attending to a structured activity as directed by the clinician will provide support in the school and home setting and is expected to facilitate learning. The goal will include three different structured activities. The clinician-directed activities include classifying big and little objects, using stacking and nesting toys, and naming picture cards or tangible objects presented as drill play with continuous reinforcement schedule.

Long Term Goal 3: Anon will engage in appropriate play and turn taking activities with the clinician.

Rationale: Anon currently demonstrates limited appropriate play responses and turn-taking behaviors. Facilitated play is designed to enhance the expression of communicative intent and the clinician will attempt to structure opportunities within the play to increase vocabulary, express the feelings and intentions of characters, and encourage turn taking (Paul, 2001).

Long Term Goal 4: Anon will produce the sensori-motor movements for the target phonemes /p/, /m/, /t/, and /d/ in initial position consonant vowel and consonant vowel consonant words with 75% accuracy.

Rationale: Anon currently uses primarily vowels with the exception of the consonants.

/h/ and /w/. Targeting the phonemes /p/, /m/, /t/, and /d/ will contribute to an increase in his phonetic inventory and may also contribute to increased intelligibility. Nasals and stop plosives represent some of the earlier developing sounds according to phonological theory (Smit et al, 1990).

Long Term Goal 5: Anon will demonstrate knowledge of specific descriptive words. Anon will match the opposites of *big* and *little*, as well as *soft* and *hard* using tangible items placed in the appropriate categories with 80% accuracy. Anon will also perform tasks in response to the prepositional words *in*, *out*, *up* and *down* with 80% accuracy.

Rationale: Anon has shown improvement in naming nouns but has not demonstrated knowledge of descriptive words. These descriptive words are developmentally appropriate.

Plan of therapy

Therapy during the [date] focused on increasing Anon's receptive and expressive language skills as well as expanding his phonetic inventory. To increase Anon's phonetic inventory, goals included imitation of the /m/, /p/, /t/, and /d/ phonemes in familiar words. Objectives also included identifying common objects from a field of five items, attending to a structured task for 10 minutes, for three consecutive sessions, and matching and naming pictured nouns. The activities and materials used to elicit responses included picture cards, puzzles, coloring books, picture books, and music. A clinician-directed approach to therapy was utilized including positive verbal praise and music.

Therapy for the [] semester will continue to focus on targeting improvement in phonological knowledge and production of the phonemes /m/, /p/, /t/, and /d/ to increase his intelligibility. Continuous reinforcement in the form of music and access to preferred toys and activities will be provided. Developing Anon's requesting behavior will be addressed, using the carrier phrase, "*I want _____.*" The clinician will present a choice of two toys, and Anon will indicate his preference verbally. This will be used as a form of continuous reinforcement, with a "toy break" offered after each completed objective. To increase his receptive language skills, therapy will continue to employ icon and picture matching and target selection exercises. In addition, tangible objects will be used to increase Anon's exposure to descriptive words starting with the adjectives "*big* and *little*" and the prepositions "*in*, *on*, *up* and *down*." Therapy at CSUC Center for Communication Disorders will complement Anon's school Speech and Language objectives. His speech language objectives from [] were obtained with permission from SLP at []. Those goals are:

1. Communicate using one word vocalizations/signs to request or label a desired item or activity ten times in the school day in four of five trial days as observed and recorded by staff.

Anon has achieved this objective in speech and language activities. He labels the words *water* and *Game Boy* with speech approximations using correct vowels and some consonants more than 80% of the time upon request.

2. Cooperate in a variety of teacher-directed activities by sitting quietly during the activity for five minutes without leaving the area eight of 10 trial days.

Anon has achieved this objective in speech and language activities. Anon sits at the table and completes speech and language tasks for 30 minutes without leaving the table for greater than eight of 10 trial days.

3. When shown pictures on a field of two or three pictures, Anon will identify the desired picture response by matching and generating a verbal response at the same time for 100 nouns and 40 descriptive words.

Anon has not attained this objective. While he can match and vocalize in imitation of a model for more than 100 pictured nouns, he does not yet match pictures of descriptive words (adjectives).

4. Anon will produce accurately ten words for each of the target sounds [/p/, /b/, /m/, /t/, /d/] in the initial sound word position with 80% accuracy over six consecutive speech sessions.

Anon has not completed this objective. Speech therapy has been provided following the hierarchy of consonant sounds recommended in Karen Golding Kushner's book, *“Therapy Techniques for Cleft Palate Speech and Related Disorders.”* Anon is pronouncing consonant vowel and some consonant vowel consonant combinations with the phonemes “h, w, m, b, n, d.” Pronunciation of “h” and “w” are 90 % accurate in word initial, consonant-vowel productions. Anon continues to require additional practice with the pronunciation of “m, b, n, d” and the unvoiced consonants “p, t.”

Intervention at the California State University, Chico, Center for Communication Disorders will continue to focus on these objectives employing a variety of methodologies. The clinician will contact parent and school educators to streamline treatment with methodologies currently being delivered. Activities will include matching pictures and icons to objects in play, modeling and imitation of phonemes in consonant vowel and consonant vowel consonant combinations, and activities engaging requesting behavior, such as presenting a desired object paired with a non-desired item to elicit verbal requesting.

These goals have been discussed with Anon’s parents and they agree with the goals.

[] title
Clinical Clinical Instructor

[name, B.A.]
Graduate Clinician

References:

- Brookshire, R.H. (2007). *Introduction to Neurogenic Communication Disorders*, Mosby.
Golding-Kushner, K. J. (2000). *Therapy Techniques for Cleft Palate and Related Disorders*.
Cengage Learning.
Paul, R. (2001). *Language Disorders from Infancy through Adolescence* (2nd ed.). Mosby, Inc.

Smit, A.B., et al. (1990). The Iowa Articulation Norms Project and its Nebraska Replication, *JSHD*, 55, 779-798.

Final Case Report (sample)

California State University, Chico
Center for Communication Disorders
Confidential

Date of Report:

Name:

Address:

Chico, CA

Phone:

Date of Birth:

Age:

Clinician:

Clinical Instructor:

Number of sessions scheduled: 19

Number of sessions attended: 16

Number of hours attended: 17

Summary of progress: Anon Ymous, a xx-year-old female, has completed her fourth semester of therapy at the California State University, Chico, Center for Communication Disorders (CCD). The client presents with reduced receptive and expressive communication following a stroke. See ICR for full medical history.

Mrs. Ymous revealed progress for the [] semester in a number of targeted areas, including reading comprehension accuracy and independence, efficient access to a custom communication book, and accuracy and independence in the completion of functional calculation tasks reflecting tasks performed for instrumental activities of daily living.

Reading comprehension increased by 100% and cues were reduced by 91%. Response accuracy for calculation tasks increased by 51% and clinician cues decreased by 67%. Efficient access to a custom communication book revealed 100% accuracy when single pages containing three to 10 items to a field were probed. When the client was required to locate similar items within numerous pages, accuracy decreased. The book initially contained 10 pages and grew to 50 at the close of the semester.

Final Assessment

Boston Diagnostic Aphasia Examination/Short Form-3rd Edition (BDAE-3)

Selected subtests from the BDAE were administered to evaluate expressive and receptive language. Subtests for which the client scored 80% or less at initial testing were re-administered. Results follow:

Word Identification – Picture-Word Matching

For this subtest, a target line drawing is viewed alongside a group of four words that include the name of the target and three structural and semantic foils. The client is instructed to select the single word that most accurately describes the line drawing. Mrs. Ymous revealed 75% accuracy independently for this task. This is a 200% increase in accuracy compared with baseline, which revealed 25% accuracy. The table below documents the client's responses.

Word Identification – Picture-Word Matching (12/4/xx)

Test Item	Client's Response	Accurate/Inaccurate (+/-)
1. Clock	Clock	+
2. Bed	Bed	+
3. Weight	Pounds	-
4. Binocular	Binocular	+
Overall Performance		3/4

Reading Comprehension – Sentences and Paragraphs:

The **Reading of Sentences with Comprehension** subtest instructs the client to read a brief story of approximately four sentences. The client is then instructed to read three questions related to the content of story and select the accurate response from a field of three. The questions require that reader draws inferences from the information provided in the story. Mrs. Ymous revealed 33% accuracy independently for this task. These results reveal no change from baseline. The table below documents the client's responses.

Reading of Sentences with Comprehension (12/4/xx)

Test Item	Client's Response	Accurate/Inaccurate (+/-)
1. The weather was...	Sunny	+
2. Mary and Jim rode in a...	Boat	-
3. The trip took about...	2 hours	-
Overall Performance		1/3

The **Reading Comprehension – Sentences and Paragraphs** subtest assesses an individual's ability to comprehend the stimulus and synthesize and apply meaning to the information presented. For this subtest, the client was presented with an incomplete sentence and four possible choices to complete it (i.e. "Water is... fly, wet, dry, red"). Mrs. Ymous was instructed to silently read the stimulus sentences and point to the response that would most appropriately complete the sentence. The sentences ranged from four to 18 words. Mrs. Ymous provided two accurate responses, revealing 50% accuracy. Baseline response accuracy was 75%. This reflects a 33% decrease in accuracy. It was noted that Mrs. Ymous expressed some difficulty with vision on the date of testing. This could invalidate test results because she could not accurately read the stimulus. Accuracy increased when the clinician orally read the stimulus. The table below documents the client's responses.

Reading Comprehension – Sentences and Paragraphs (12/4/xx)

Test Item	Client's Response	Accurate/Inaccurate (+/-)
1. A dog can...	cat	-
2. Mr. Jones gives haircuts and shampoos. He is a...	Barber	+
3. Schools and roads cost	taxes	+

money. We all pay for them through...

4. Aluminum was once very costly to refine. Now, electricity has solved the refining problem, and aluminum has become...

Very strong

-

Overall Performance **50%**

Burns Left Hemisphere Inventory

The *Burns Left Hemisphere Inventory*, according to the author Martha Burns, is an instrument used to evaluate individuals who have communication or cognitive deficits as a result of a neurological injury. It assists clinicians in selecting appropriate treatment targets and functional treatment goals in adults. Final testing was initiated and completed on December 2, 20xx for subtests on which the client scored less than 80% at initial testing. Results revealed the following:

Reading

Subtest	% accurate	Description
Reading Comprehension of Functional Paragraphs	60% <i>Baseline: 20%</i> Reflects a 40% increase in accuracy from initial testing	The client reads a paragraph of approximately four sentences and responds to yes/no questions presented by the clinician regarding the content of the message

Numerical Reasoning

Subtest	% accurate	Description
Money	90% <i>Baseline: 50%</i> Reflects an 80% increase in accuracy from initial testing	The client is presented with a field of 10 line drawn coin images and is asked to select the images that depict five different monetary values
Calculation	70% <i>Baseline: 40%</i> Reflects an 30% increase in accuracy from initial testing	The client is presented with a menu and is asked five questions regarding the combined prices of several items and the number of hours open

Reading Comprehension Battery for Aphasia-2 (RCBA-2):

The RCBA-2 provides a systematic evaluation of the nature and degree of reading impairment in adults with aphasia. It measures reading comprehension and guides the direction and focus of the therapy. It consists of 20 subtests, beginning with single-word comprehension for visual confusions, auditory confusions, and semantic confusions; functional reading; synonyms; sentence comprehension; short paragraph comprehension; paragraphs; and morpho-syntactic

reading with lexical controls. Subtests I-VI were administered. The results for subtests I-V revealed increases in reading comprehension from initial results. Please see Appendix A for results.

SUMMARY OF TREATMENT

Long Term Goal 1: Increase efficient access to a custom communication book to 100% accuracy by reducing the average amount of time to 40 seconds and number of cues to 0.1 to accurately respond to functional questions.

Rationale: The client's communication book is crucial for effectively communicating everyday needs, wants, feelings, interests, and concerns. Efficient and accurate access is expected to increase Ernestine's everyday independent functioning, such as indicating to her husband where she would like to go for dinner, shopping, or visiting, etc., what she would like to eat, and leisure activities in which she would like to engage.

Intervention:

P1: The clinician gathered information from the client and her husband, specific episodes of communication breakdowns, and semantic categories important for daily life.

P2: The clinician provided opportunities for the client to access the communication book by asking questions and providing the questions in a written format for support and access at home. Responses were scored according to accuracy and number of cues required.

Baseline & Progress: An eight-question probe was administered at the beginning of treatment and again at the end of treatment. Accuracy and number of clinician prompts were recorded. Mrs. Ymous demonstrated 100% accuracy at initial evaluation and 62.5% accuracy at final evaluation. This reflects a 37.5% decrease in accuracy.

The number of clinician cues provided at initial testing was three, compared with six at final testing. This is an average of 0.4 cues per question for initial testing and an average of 0.75 cues per question for final testing. This reflects an 87.5% increase in cues.

It was noted that specific conditions seemed to facilitate accuracy. These included repeated practice with the communication book (i.e., asking the same questions each session) and asking questions with answers located in one section (i.e., asking questions that could all be answered with information under the "Family" section). Again, on the date of final testing, the client was clearly experiencing visually-related difficulties that impacted her performance. Additionally, the number of pages contained within the book increased (i.e. pages increased from approximately 10 to 50), also increasing complexity of the task. However, it should be noted that when probed on single pages only, the client revealed 100% accuracy.

The initial assessment results were recorded October 21, 20xx and the final testing results were recorded December 9, 20xx. Please see Appendix B for charts.

Long Term Goal 2: Client will demonstrate 90% accuracy for reading comprehension of functional paragraphs as measured by responding to five questions related to the body of the paragraph.

Rationale: "Aphasic readers' impaired semantic and syntactic processes may cause them to misinterpret individual text elements and may prevent them from appreciating the overall meaning of printed materials" (Brookshire, 2003). A deficit in reading comprehension

impacts individuals' everyday functioning and can also impact individuals' leisure activities. Targeting functional reading skills by reading functional paragraphs such as those the client may encounter in daily life will aid in increasing comprehension, which is expected to promote independence in every-day functioning.

Intervention:

P1: After the client silently read a brief article or news summary of approximately 100-140 words, she responded to comprehension questions by pointing to the pertinent information within the body of the text. Questions were presented in a written format. Accuracy of responses was scored according to the accuracy of the semantic information provided (i.e., is the response appropriate for the question?) and according to the number and types of cues required. Types of cues included:

1. Client rereads article
2. Clinician or client highlights the sentence
3. Clinician or client reduces text field within response options
4. Clinician orally reads the response
5. Verbal cue

P2: The client and the clinician discussed any questions or difficulties the client may have encountered.

P3: The client was provided with the reading assignment and corresponding comprehension questions to take home. The client read and answered the questions at home.

P4: The client silently reread the article at the following therapy session and responded to the identical corresponding comprehension questions. Results were compared with initial results.

Baseline & Progress: Initial testing required the client to read the article "McCain/Letterman." The article contained 127 words. Five corresponding comprehension questions were presented. The client revealed 40% accuracy with 11 clinician cues for the first reading, and 60% accuracy with 11 clinician cues for the second reading. This is an average of 2.2 cues per question. At final testing, the client read the news summary "Palin 2012," containing approximately 128 words. Five corresponding comprehension questions were presented. The client revealed 80% accuracy with four clinician cues for the first reading and 100% accuracy with one clinician cue on the second reading. This is an average of 0.2 cues per question. This reveals a 100% increase in response accuracy for first readings and a 91% decrease in average number cues per question. These two measures of accuracy and cues reveal that the client's accuracy for reading comprehension has increased.

The initial assessment results were recorded on October 16, 20xx and the final assessment results were recorded on November 20, 20xx. See Appendix C for chart.

Long Term Goal 3: Client will demonstrate 90% accuracy for calculation tasks in the context of daily situations such as monetary calculation, time, and date by selecting the target response from her communication book.

Rationale: This goal will increase the client's daily functioning skills and reduce the client's dependency on her husband for daily life activities. This hones the client's calculation skills for independence in daily living.

Intervention:

P1: The clinician gathered information with respect to the client's preferred dining locales and obtained partial or complete menus from each.

P2: The menus were presented with five corresponding comprehension questions that also featured addition and subtraction tasks.

P3: The client responded by selecting items that fit the calculation criteria (i.e., that did not exceed the monetary limit imposed by the question, such as “You have \$20. What three items can you buy?”).

Baseline & Progress: Initial results revealed 66% accuracy for basic calculation tasks with a total of three clinician cues, averaging one cue per question. Final results revealed 100% accuracy with one cue, averaging 0.33 cues per question. These results show a 51% increase in response accuracy and a 67% reduction in clinician cues.

Initial testing was completed on October 23, 20xx. Final testing was completed December 9, 20xx. See Appendix D for charts.

Summary and Recommendations

Anon Ymous has completed the [] semester of intervention at the California State University, Chico, Center for Communication Disorders. Performance for selected subtests of the *Boston Diagnostic Aphasia Examination, 3rd edition*, *Reading Comprehension Battery for Aphasia, 2nd edition*, and the *Burns Left Hemisphere Inventory* was re-evaluated on December 2, 4, and 9, 200x. Final results revealed that the client continues to present with severely reduced spoken and written output. However, performance for reading comprehension tasks increased for all subtests but one. Results for numerical reasoning tasks, specifically money and calculation, revealed increased accuracy by 80% and 75%, respectively.

Mrs. Ymous’s performance for therapy goals revealed progress for the following: Reading comprehension accuracy increased by 100% and cues decreased by 91%. Efficient access to a custom communication book revealed a 37.5% decrease in accuracy and an 87.5% increase in clinician cues. Response accuracy for calculation tasks increased by 51% and clinician cues decreased by 67%.

It is recommended that Ymous return to the California State University, Chico, CCD for the Spring 2009 semester. Suggested therapy goals include the following:

- 1) Increase efficient access to a custom communication book in functional settings by reducing the amount of time and number of cues required to accurately respond to direct and indirect questions. It is recommended that the clinician and family continue to gather more information to incorporate into the communication book and identify specific settings for communication breakdowns.
- 2) Increase reading comprehension accuracy through continued reading of material of personal interest. Focus in therapy might include comprehension tasks that differ by one word.
- 3) Increase calculation skills for restaurant and shopping exercises, such as compiling a mock shopping list from local grocery advertisements within the confines of a budget.

It is also recommended that Mrs. Ymous receive a complete visual reassessment in light of client complaints of reduced vision for reading and identification tasks. A faculty recommended ophthalmologist’s contact information can be found in Appendix E.

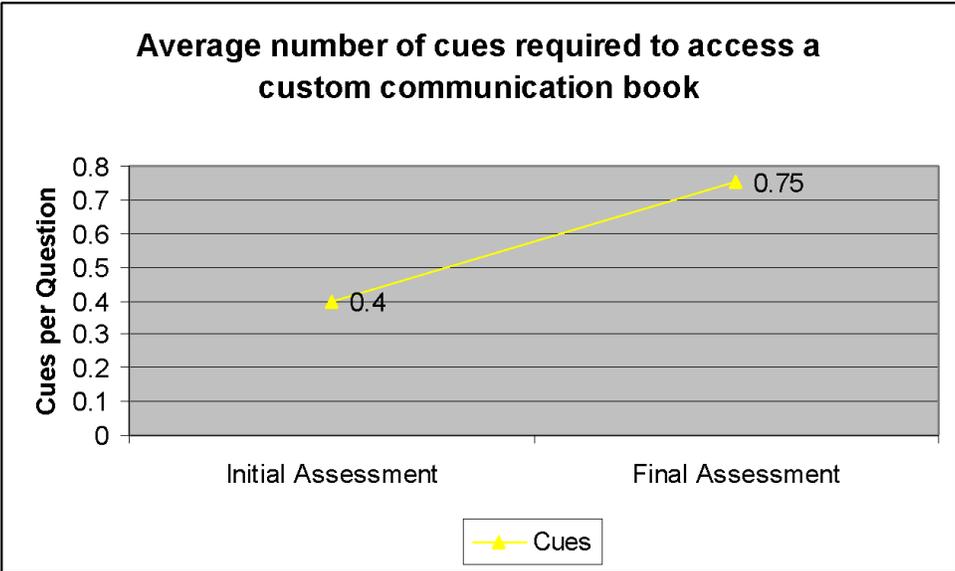
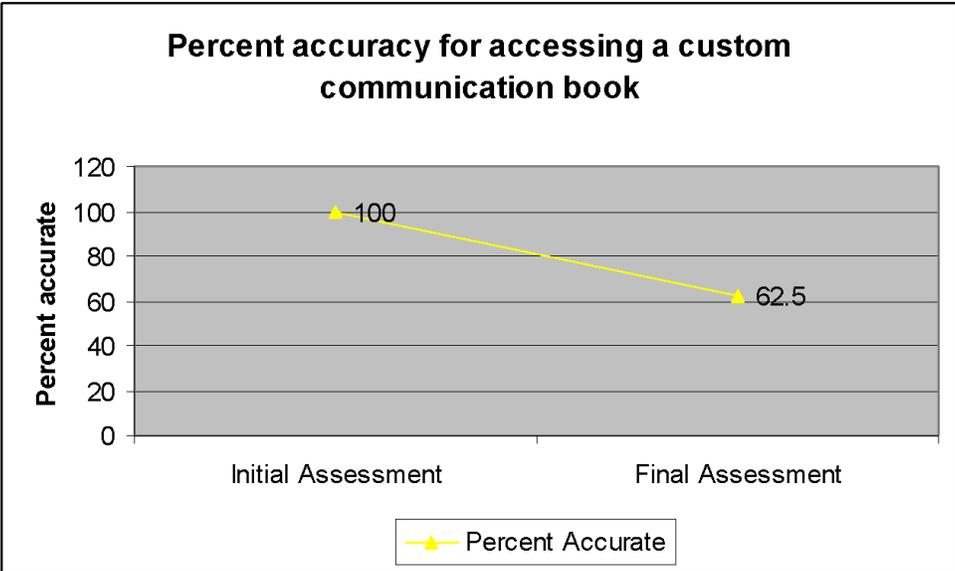
Ms. Ymous has stated that she would like to return to the CCD clinic for further intervention in the [date.] She says best days and times for intervention are MW mid mornings.

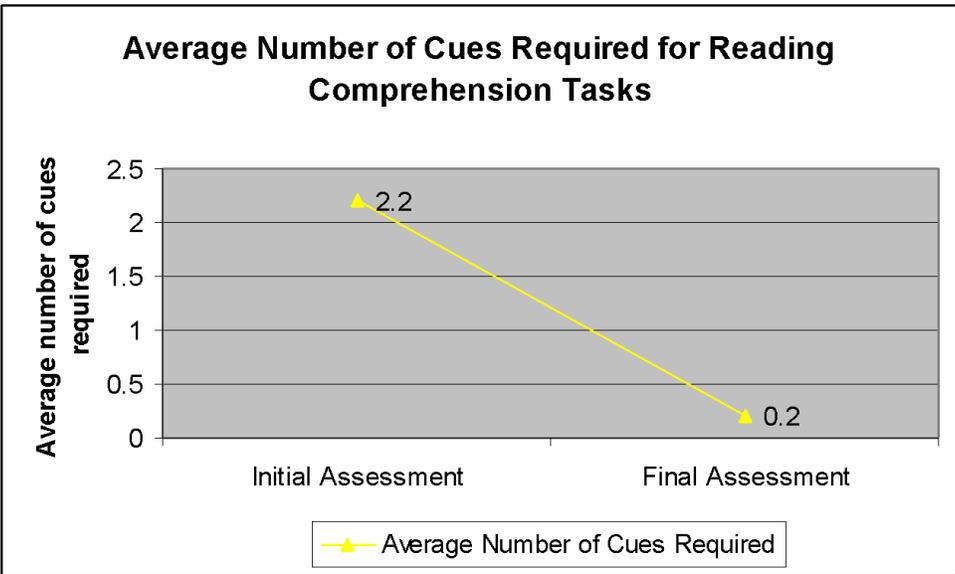
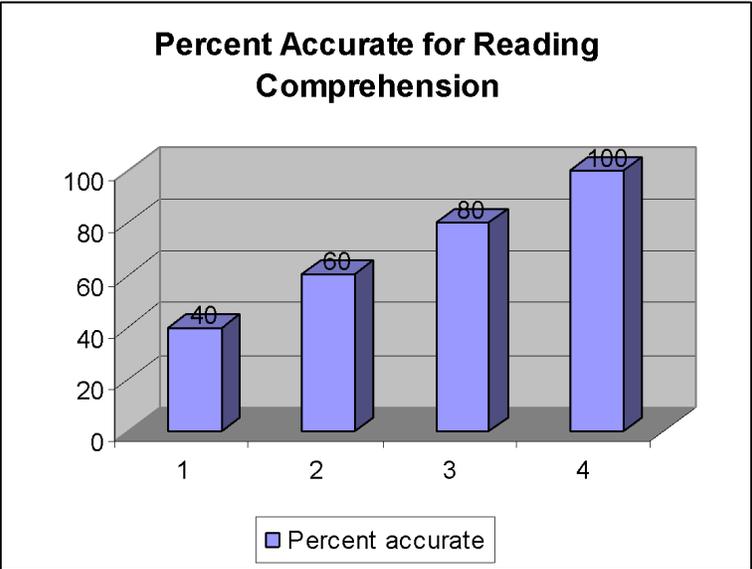
Selected assessment results

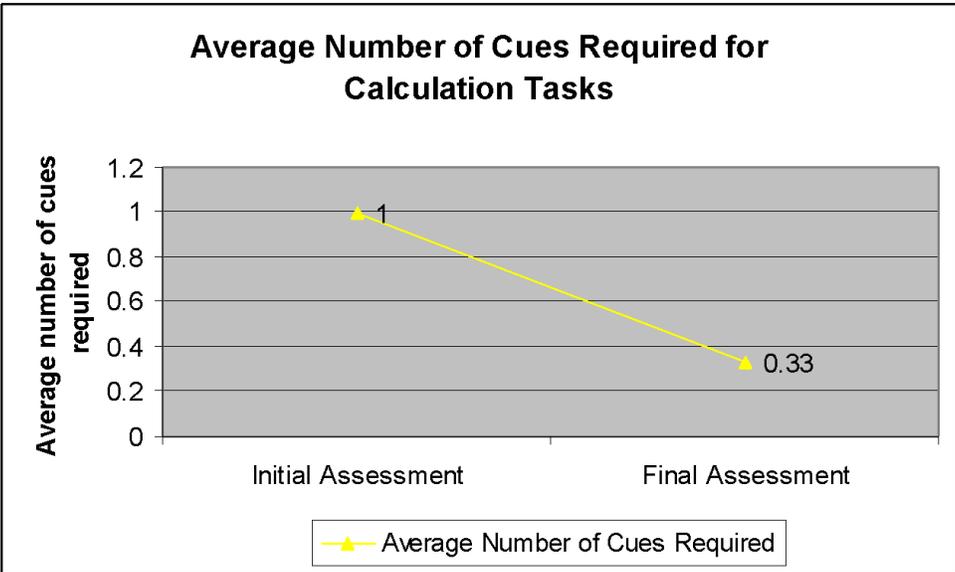
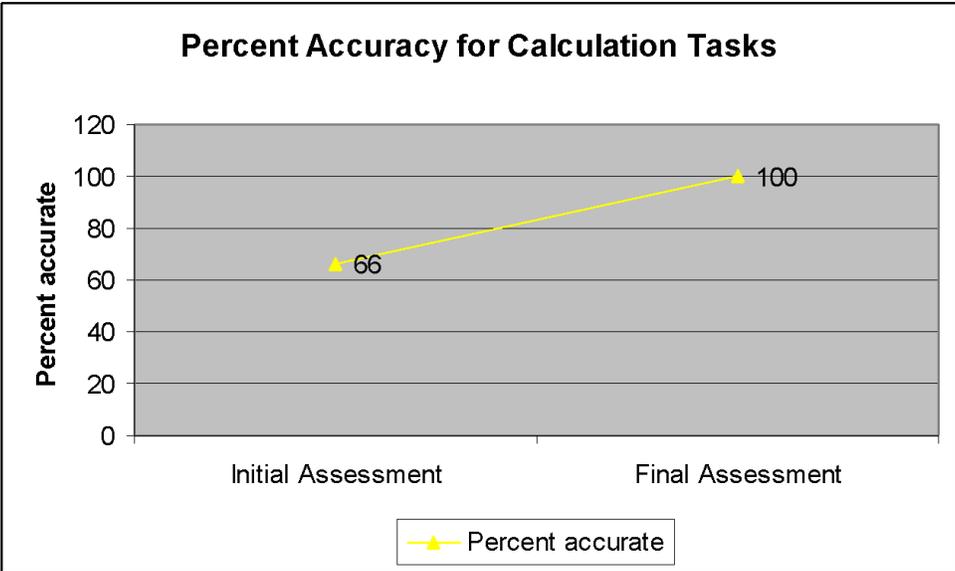
Final results for the RCBA-2 (12/2/08 and 12/4/xx)

Subtest	% accurate	Description
I. Word-Visual (WV)	70% <i>Baseline: 60%</i> Reflects an 16% increase in accuracy from initial testing	Client views a line drawing and selects the accurate single-word response from a field of three visually related choices.
II. Word-Auditory (WA)	90% <i>Baseline: 70%</i> Reflects an 28.5% increase in accuracy from initial testing	Client views a line drawing and selects the accurate single-word response from a field of three auditorally related choices.
III. Word-Semantic (WS)	100% <i>Baseline: 70%</i> Reflects an 42.8% increase in accuracy from initial testing	Client views a line drawing and selects the accurate single-word response from a field of three semantically related choices.
IV. Functional Reading (FR)	60% <i>Baseline: 40%</i> Reflects an 50% increase in accuracy from initial testing	Client views three line drawings or a text excerpt. Client then reads a question selects the accurate response from within the first presentation (drawing or text excerpt).
V. Synonyms (SY)	50% <i>Baseline: 40%</i> Reflects an 25% increase in accuracy from initial testing	Client views a word and then selects the synonym from a field of three
VI. Sentence-Picture (SP)	40% <i>Baseline: 70%</i> Reflects an 42.8% <i>decrease</i> in accuracy from initial testing*	Client reads a sentence and then selects the corresponding response from a field of three line drawings.

* It was noted that Mrs. Ymous expressed some difficulty with vision on the date of testing. This could invalidate test results because she could not accurately read the stimulus. Accuracy increased when the clinician orally read the stimulus and reduced the field of possible responses to two.







Lesson Plan (sample)
Communication Sciences and Disorders
California State University, Chico
Center for Communication Disorders
*** note Lesson Plan for *beginning* of semester

Client	Session: 2 & 3
Age:	Date: 2/23 & 2/25/20xx
Diagnosis:	Time: 10:00 – 11:15
Individual Session	Room: 102C
Clinical Instructor:	Clinician:

Goals and Objectives

1: *Reading Comprehension Battery for Aphasia-2 (RCBA)* by LaPointe & Horner

Rationale: The RCBA-2 evaluates the nature and degree of reading impairment in adults with aphasia, including oral-reading comprehension” in a way that “guides the direction and focus of the therapy. Prior to the stroke, Ms. Ymous was an avid reader. Now, she reports that she has difficulty retaining the information she reads. The RCBA-2 will show the degree of the client’s reading strengths and impairment, which will provide a direction for therapy.

2: *Correct Information Unit (CIU) Analysis* by Nicholas and Brookshire

Rationale: CIU analysis is used to “evaluate the informativeness and efficiency of the connected speech” of adults with brain damage or aphasia (Nicholas & Brookshire, 1993, p. 338). CIU analysis is standardized, thus providing a way to quantify changes in the “informativeness of connected speech elicited with a variety of stimuli” (Nicholas & Brookshire, 1993, p. 339). Increasing Ms. Ymous’s informativeness of connected speech will serve to improve the quality of her communication efforts. Therefore, findings will guide the focus of therapy this semester.

3: *Assessment of Language-Related Functional Activities (ALFA)* by Baines, Heeringa, and Martin

Rationale: The ALFA has 10 subtests that evaluate the client’s ability to tell time, count money, address an envelope, solve daily math problems, write a check/balance a check book, read medicine labels, use a calendar, read instructions, use a telephone, and write a phone message. The client’s expressive and receptive language abilities, as well as her reading and writing skills will be used to perform these tasks. The following subtests will be used: telling time, counting money, addressing an envelope, solving daily math problems, and writing a check/balancing a check book. Any difficulty the client may have with these tasks will be addressed in therapy, as they are important in the independent functioning of the client on a daily basis.

4: The client will write 10 words based on ACRT with maximum cueing and 90% accuracy.

Rationale: According to previous reports, Ms. Y presents with a significant impairment in spelling that interferes with her ability to communicate effectively through this modality. Ms. Y indicated that she would like to improve her writing and spelling abilities this semester in order to improve her communication efforts. According to Ms. Y, she often knows that a word is spelled incorrectly; however, she cannot identify how to correct her spelling. She also indicates that her spelling is so poor, that most people do not know what she is trying to convey. She uses Facebook, but must copy what other people have written in order to network with other Facebook users. ACRT is used to “close the gap between the poor ability to spell and the need or wish to improve spelling abilities” (Beeson, 1999). Ms. Y presents with a word finding difficulty; however, she often uses her finger to trace the letters of the word she would like to say. For this reason, ACRT will be a means of transferring her strategy of tracing to writing for communication. This is consistent with the operational framework for ACRT in that it “closes the gap between the inability to express oneself verbally and the need to communicate needs and ideas” (Beeson, 1999).

See Dr. Pelagie Beeson at beeson.web.arizona.edu/. This site features scientific-based intervention published in peer-reviewed journals.

Diagnostic Evaluation Report (sample)

California State University, Chico
Center for Communication Disorders
Confidential

Diagnostic Evaluation Report (sections to be incorporated)

Name:	Date of evaluation:
Address:	Phone:
Referral source:	
DOB:	Age:
Examiners:	Clinical Instructor

Background:

Generate here the name and age of the client and where and when he/she was evaluated (i.e., Joe Doe, a 4 year 5 month old boy, was seen for a speech and language evaluation at...). Also report the referral source and the concern.

Provide all relevant history information. This will be derived from the case history and/or the interview. This section can include information regarding:

family living situation (who live with, family members, language spoken)
medical history, surgeries, medications, physicians that follow the client
pregnancy/birth history
speech and language developmental history
motor developmental history
social/emotional history
education history
previous services
family history
information from other referral sources and other reports

Assessment:

This section will have numerous subsections. Each subsection should contain information about test procedures used, basic purpose/goal of procedures (1-2 sentences), findings, concrete examples of client responses, any relevant behavioral observations that may explain the results obtained. All areas tested should be reported, even if within normal limits (WNL). The subsections will include:

Behavior

- how behavior was during diagnostic session
- any information that will indicate reliability of testing

Receptive Language (for adults: Auditory Comprehension)

- name of each test - what it does and how it assesses
- results of tests
- criterion-referenced testing and results

- dynamic testing procedures
- include information about results that were within normal limits
- concrete examples

Expressive Language (for adults: Verbal Expression)

- name of each test - what it does and how it assesses
- results of tests
- criterion-referenced testing and results
 - include information about results that were within normal limits
 - concrete examples

Reading/Writing

Same as above

Articulation/Phonology (for adults: Speech)

- name of each test - what it does and how it assesses
- results of tests
- sound errors
- consistency
- phonological processes
- intelligibility
- stimulability

Oral Mechanism

Administer the Clinical Evaluation of Motor Speech or similar assessment

Voice (if necessary)

- describe any testing -
- description of voice - quality, pitch, resonance
- breath support, type of breathing
- muscular tension
- vocal abuses
- stimulability of improved voice

Fluency (if necessary)

- types and frequencies of dysfluencies
- associated secondary behaviors
- avoidance behaviors
- speech rates with and without dysfluencies
- stimulability of fluent speech

Hearing

- hearing screening or more sophisticated auditory assessment

Summary of clinical impressions:

This is a summary of your impressions of the individual's communication impairment. You are synthesizing and analyzing the assessment results. Starts with: Joe Doe, a 4 year 5 month old, was seen at this clinic for an evaluation of speech and language. . . Include information such as:

- speech or language irregularities and clinical characteristics of the irregularities
- severity
- operational definitions and quantification of the clinical behaviors
- how the speech and language reductions impact client/family, school, everyday functioning

Recommendations:

This is a summary of your recommendations. This indicates what would be the best course of action. This section should include:

- type and extent of treatment plan
- referral for additional testing
- suggestions for what family/client can or should do in the near future

Also, include EB references to support your recommendations

(This section is often presented in a list.)

(Type Name)
Clinical Instructor

(Type Name)
Clinician

(Type Name)
Clinician

cc: Mr. and Mrs. "NAME" (No address needed if listed on 1st page of report)
Any physicians or other professionals

Diagnostic Evaluation Report (sample)
California State University, Chico
Center for Communication Disorders
Confidential

Name: Anon Ymous	Date of evaluation:
Address: Chico, CA	Telephone: (530)
DOB:	Age:
Referred by:	
Examiners:	Clinical Instructor

Background Information:

Anon Ymous, an eight-year, 10-month old male was referred to the California State University, Chico, Center for Communication Disorders, by xxx, for a speech and language evaluation on [date]. Anon was accompanied by his mother, Mrs. Ymous. Mrs. Ymous reports that Anon presents with high-functioning autism. Anon currently attends third grade at Elementary School. He receives speech therapy services once a week, from the school's speech pathologist, xxx, CCC-SLP. Copies of Anon's most recent individualized education plan (IEP), dated xxx, were provided by Mrs. Ymous .

According to the CCD clinic questionnaire, Mrs. Ymous reported concerns regarding Anon 's expressive and receptive language, and reading comprehension skills. She noted that Anon presents with a limited vocabulary, and at times it is difficult for other adults and children to understand Anon . Mrs. Ymous and Anon 's father often use visual aids with him. According to the IEP report, speech therapy at school targets the following annual goal and subsequent short term goals:

1. By [date], when presented with a story Anon will answer who, what, when, where, and why questions about the story and paraphrase information presented in the story with 90% accuracy on 5 trials as measured by the specialist.
 - a. By [date], when presented with a picture and one or more questions asking who, what, when, where, and why, Anon will tell whether the picture answers a specific question with 90% accuracy in 5 trials as measured by the specialist.
 - b. By [date], when presented with pictures and wh-questions Anon will answer the questions and retell the story from the questions with 90% accuracy on 5 trials as measured by the specialist.

The provided IEP report revealed that in the classroom Anon presents age appropriate self-help skills, has a positive attitude, is well-liked by peers, is appropriate and helpful, and desires to be liked by his teachers. Needs were documented in reading, making inferences, and understanding instruction during whole class teaching. The report states, "Anon has many friends and appropriately interacts and plays with them...Anon is easy-going and can solve minor conflicts

with peers independently. He, occasionally, has difficulty reading inferred social cues.” Results from the psycho-educational study conducted on [date], by the school psychologist, [name] reveal Anon earned a standard score of 75 (5th percentile) on the Verbal Comprehension Scale of the *Wechsler Intelligence Scale for Children-Fourth Edition*. Mrs. Ymous’s report and observations during the evaluation revealed similar findings.

Medical history states Anon reached developmental milestones at “age-appropriate times,” as reported by Mrs. Ymous . He was diagnosed with autism in [date] by Dr. [name]. Anon demonstrated many high-level academic skills during the evaluation; he frequently answered questions that were intended for children 2-3 years older than his chronological age. According to the IEP and Mrs. Ymous ’s report, hearing and vision tests [date] revealed results within normal limits. Mrs. Ymous also reported that Anon experiences seasonal allergies, but has no other significant medical history.

Anon lives at home with [family]. According to Mrs. Ymous , Anon is an easy-going boy who enjoys swimming at the local gym, watching television, and playing [games]. Anon interacts well with other children and accepts discipline. He presents normal sleep patterns and only eats foods that are “round, brown, and crunchy.” Mrs. Ymous reported no other family history of communication disorders.

During the two-hour assessment, Anon completed ten subtests of the *Comprehensive Assessment of Spoken Language Test* (CASL). However, further testing of reading comprehension was not completed due to time constraints. Therefore, Anon was dismissed and asked to return on [date], to complete the reading comprehension portion of the assessment. Results at that time will be provided in an addendum to this report.

Assessment

Expressive and Receptive Language

Expressive and receptive language skills were assessed employing the CASL. Expressive language skills refer to what is verbally conveyed by an individual and receptive language skills refer to how language is understood by the individual.

The CASL is a formal examination that assesses several different components of language. Individual core subtests that were administered to Anon are described in the following table (examples of accurate responses are underlined). *Subtest standard scores between 85 and 115 are considered to be within the range of normal for children Anon ’s age and are identified by an asterisk (*). Scores below 77 demonstrate areas of difficulty.*

Subtest	Description	Standard Score
Antonyms	Anon was presented with a word and asked to provide a word that means the opposite (e.g., <u>up</u> : <i>down</i>)	90*
Synonyms	Anon was presented with a word and asked to choose a word from a field of four that means the same (e.g., <i>home</i> : <u>tree</u> , <i>flower</i> , <i>picture</i> , <i>house</i>)	86*

Sentence Completion	The initial segment of a sentence was read and Anon was instructed to complete the sentence with a logical word or phrase. For example, <i>When Jim jumped off the diving board into the water, he made a big splash.</i>	60
Syntax Construction	Anon was asked to create a number of different syntactic (word order) constructions, such as forming questions, answering questions with a sentence, and combining two sentences. For example, <i>I won't go to the party unless _____ (you take me, or I have to would be acceptable responses).</i>	79*
Paragraph Comprehension	A paragraph was read aloud to Anon and he was asked to answer questions regarding the passage by pointing to an appropriate picture from a field of four.	86*
Grammatical Morphemes	Anon was asked to provide the correct grammatical morpheme in an analog format (e.g., <i>See is to seeing as play is to playing</i>).	93*
Grammaticality Judgment	Anon was presented with a sentence and asked to decide if the sentence was grammatically correct or incorrect. If it was incorrect, Anon was required to repair the erroneous sentence. For example, <i>The dog was run after the squirrel.</i> Anon accurately identified the sentence as incorrect and changed it to: <i>The dog ran after the squirrel.</i>	68
Non-literal Language	Anon was presented with a variety of non-literal references (idioms, figures of speech) and was asked to explain what they meant. For example, <i>The teacher told the class that he wanted all eyes on the board. What did he mean?</i> Anon accurately responded that the teacher wanted to the class to pay attention.	75
Inference	Brief passages containing abstract references were read to Anon and he was asked to explain something about the passage that required inferencing (processing information based on more than simple recall). For example, <i>Sarah wanted a glass of milk. However, after looking in the refrigerator, she had a glass of orange juice instead. Why?</i> Anon's accurate response was, "Because there was no milk."	77
Pragmatic Judgment	Various scenarios were read and Anon was asked to discuss the type of language that should/should not have been used to solve the problems that arose in the scenarios. This task requires pragmatic skills, which as skills for using language in social situations. For example, <i>There is a new boy at school. Jenny wants to find out if he is in the third grade also. What does Jenny say to the new boy?</i> Anon accurately responded "Are you in third grade?"	70

Results from the CASL reveal age-appropriate understanding of *antonyms, synonyms, syntax construction, paragraph comprehension, and grammatical morphemes*. Areas of difficulty were

sentence completion, grammaticality judgment, non-literal language, inference, and pragmatic judgment.

Antonyms: This subtest assesses word knowledge: the ability to identify words that are opposite in meaning. It also assesses an aspect of language expression: the ability to retrieve, generate, and produce a single word when its opposite is given as a stimulus.

Synonyms: The Synonyms subtest assesses word knowledge by looking at a client's ability to identify a synonym for a given word. Synonyms are words that have the same meaning or that are sufficiently alike in meaning to be substituted for one another. To recognize that words are synonymous, a language user must have a clear understanding of the specific feature or features of meaning in one word that correspond with the features of meaning in the other word, those features that make the two words "mean" the same thing.

Sentence Completion: This skill requires the listener to perceive and process initial information from a sentence and then hold this information constant while generating an appropriate conclusion to the sentence. Difficulties were characterized by a reduced ability to interpret and retain the initial segment, which resulted in Anon responding with "I don't know that one" or providing an inappropriate answer. Anon experienced greater success when he was presented with pictures to aid him with visual cues.

Anon's performance on the Antonyms and the Synonyms Subtests indicate that his word knowledge abilities are within normal limits when compared with same-age peers. As previously mentioned, both of these subtests assess word knowledge. The Sentence Completion subtest is also a measure of word knowledge, as well as retrieval and expression, but within a linguistic context. To succeed in the sentence completion task, the client must comprehend the vocabulary and syntactic structure of the stimulus sentence as well as have sufficient world knowledge (i.e., having an awareness and understanding of concepts regarding one's surroundings and humanities in general) to use its content and grammatical structure to generate an acceptable completion using a single word. Analyzing the results of these three subtests reveals that word knowledge is one of Anon's linguistic strengths. According to the authors of the CASL, the difficulty Anon experienced with the Sentence Completion subtest may indicate deficits in syntax comprehension (the accurate grammatical order of a sentence) or world knowledge (semantic comprehension of the sentence) (Carrow-Woolfolk, p. 42). Anon did not present evidence of a deficit in world knowledge throughout the evaluation, thus it was likely the difficulties on this subtest were related to grammar skills.

Syntax Construction: This subtest requires the performance of different tasks (e.g., finishing a sentence, answering questions with phrases, repeating a sentence and combining to sentences). It was noted that Anon presented difficulty transitioning from task to task. In order for Anon to demonstrate an understanding of the required task, instructions were rephrased or repeated. For example, Anon was directed "*Finish what I say with more than one word. Here the girl goes into the school. Here the girl comes ____.*" The directions were repeated before Anon accurately responded with more than one word. Once Anon demonstrated comprehension of the task, he completed the tasks at an age-appropriate level. Further observations revealed two of Anon's

responses did not include the appropriate verb tense. (For example, when Anon was asked “*What happened then?*” He responded, “*They were in a fight*”).

Paragraph Comprehension: Auditory comprehension of syntax, word meaning, word sequences, and grammar is important for understanding connected discourse. In a situation in which connected speech is used, such as a classroom or home, it is important that an individual decode and synthesize the information accurately to comprehend and act appropriately. A few difficulties were revealed in the area of perceiving and processing conversational syntax and content. For example, Anon demonstrated difficulty identifying the main character of a story when characters from previous stories were also included.

Grammatical Morphemes: A morpheme is a meaningful unit of speech that can be attached to words to provide detail and specificity about that word. For example, the morpheme “-ed” distinguishes the verb “walk” from its past tense form “walked.” Grammatical morphemes are used throughout language and speech. It is imperative to have an understanding of grammatical morphemes and how words differ when in combination with such morphemes. This subtest assessed Anon’s ability to recognize relationships (grammatical morphemes) among words and apply that relationship to new sets of words. For example, “*Tall is to Taller, as Big is to _____,*” Anon accurately responded “*bigger.*” Results reveal that this is an area of strength for Anon. Having the skill to recognize grammatical relationships and apply them to novel forms is necessary for successful language comprehension and use, in addition to reading comprehension.

Grammaticality Judgment: According to Shapiro (1997), “Our knowledge of language allows us to make judgments regarding the sentences that are acceptable and those that are not” (p. 255). If such judgments cannot be made by the examinee (Anon), the hypothesis is that language knowledge is deficient. The ability to judge grammatical errors in the spoken language of others will lead to the ability to judge one’s own errors, a skill that, although important in spoken language, is critical for accurate *written* language. Inaccuracies were observed in irregular past tense (e.g., *went* vs. *goes*), correct placement of modifiers in a sentence (e.g., *the pretty girl is dancing*, rather than *the girl is dancing pretty*, which was Anon’s response), and accurate use of the verb *is/are* (e.g., Anon did not recognize the error in the statement *Are any of the cake left?*). During the evaluation, errors were observed for use of pronouns (e.g., *he, she, them, they*) and prepositions (e.g., Anon stated “*she’s on the jump rope*” to describe a picture of a girl jumping rope). Modifiers and prepositions are an integral aspect of grammar and language because they provide specific information regarding the message, and provide distinction among subjects. Correct verb usage is also imperative to language because it carries significant meaning to the message; it informs the listener what happened and when.

Non-literal Language: A literal interpretation of language is one in which the lexical and syntactic forms in the sentences are understood according to their ordinary meaning, that is, according to the actual denotation of words. Non-literal language, on the other hand, is language that cannot be comprehended by decoding the lexical and syntactic forms of sentences in a word-by-word fashion. Non-literal language requires the listener to recognize environmental situations or linguistic conditions and apply them to find the meaning. It requires the ability to transition from the here-and-now events and concrete interpretations to future or past events and

abstract concepts. Non-literal language also requires the ability to suspend meaning until a relationship is found between the events and what the speaker is attempting to communicate. Deficits in spoken and written communication can occur if an individual has difficulties in this area. Furthermore, non-literal references in the forms of idioms (e.g., *as sharp as a tack*) and words with multiple meanings (e.g., *bat = mammal*, and *bat = baseball hitter*) frequently are found in children's literature and conversations. If one does not understand non-literal language, he or she may miss out on the intended meanings of conversation, written language and humor. It was observed that inaccuracies on this subtest consisted of repeating the stimulus statement, rather than interpreting them and providing an explanation (e.g., when provided a scenario in which a dog enters a yard and eats hidden Easter eggs, it was stated "...*only the dog entered the yard. What do you think happened?*" Anon's response was "*dog just entered the yard*". With assistance and rephrasing, Anon demonstrated appropriate understandings of the non-literal language. For example, the examiner stated, "*The sky began to cry. Large tears began to drop down. What was happening?*" Anon's response was "*The sky is crying.*" However, when the examiner prompted, "*What else could we say about the sky, what does that mean if water is coming out of the sky?*" Anon accurately responded "*It's raining.*" The significance of rephrasing is an important indicator of useful strategies to incorporate in therapy.

Inference: Inference skills are crucial for understanding abstract language. For children to glean the maximum amount of information from their conversations and from reading assignments, they need to be able to infer. This requires that they process information that cannot simply entail the recall of facts. To infer, one must be able to extend from the context deeper and more abstract meanings. This is an important skill because much of the reading comprehension work that children do in school requires inferencing on various levels. During the evaluation, Anon required assistance to make appropriate inferences. For example, the following statement was given: "*When Joe last visited his grandmother, she proudly pointed out that her cat was 15 years old. The next time Joe visited, the cat was gone. What happened?*" Anon responded that he didn't know what happened. However, when the statement was rephrased to, "*Joe's grandmother had a very old cat. When Joe went to visit, the cat was gone. What do you think happened to the cat?*" Anon was able to infer "*Oh yeah! He died.*" Thus, inference skills can also be strengthened through repetition and rephrasing strategies.

Pragmatic Judgment: Pragmatic skills are those skills used for the appropriate language use in a variety of social-communicative situations. In order to have "good" pragmatic skills, one must provide relevant and cohesive information, use the appropriate register when speaking to different people (e.g., teachers versus friends), take conversational turns well, and remain on topic. Difficulties demonstrated on this subtest included: a lack of forming requests in hypothetical situations that required a request be made by Anon (e.g., being lost in a department store and asking for help), misunderstanding the material, and conversational turn-taking. For example, Anon was provided the following statement: "*Carole is in a large store with her mother. She suddenly realizes that she has lost her mother. What should Carole do and what should she say?*" Anon's response was "*That she should have to find her.*" However, when Anon was further prompted with "*She's trying to find her mother in this very big store what should she do? Who should she tell?*" he appropriately responded with "*Oh yeah, she's lost!*" Again, using strategies, such as rewording, were effective in increasing understanding and

judgment of various situations. Another example was noted during the evaluation, in which Anon was asked “*When were you born?*” He demonstrated confusion of the question until the question was restated to “*When is your birthday? When do you have a birthday party?*” Anon then provided the accurate response. By breaking down the question and rephrasing it, it enabled Anon to understand the question. Informal observations also revealed further errors in conversational turn-taking. For example, Anon has many meaningful and important statements to contribute to a topic of conversation, but does not pause to allow others to contribute. His expressive output tends to be rapid with little time for execution of phrases and pauses (e.g., in 30 seconds of conversation about pets, Anon provided 8 pieces of information without pausing between statements; when others tried to comment he continued to speak).

Summary

Anon Ymous, an 8-year 10-month old male, was seen for an evaluation of speech and language at the California State University, Chico, Center for Communication Disorders clinic on [date]. According to Mrs. Ymous, Anon presents with high-functioning autism. She is concerned he presents with deficits in expressive and receptive language, and reading comprehension. The primary findings of this evaluation indicate that Anon is a friendly and hard-working boy. Assessment results reveal his linguistic strengths are in understanding and using antonyms, synonyms, syntax construction, paragraph comprehension, and grammatical morphemes. Results also reveal Anon performs below normative values for children his age in the areas of sentence completion, grammaticality judgment, non-literal language, inference, and pragmatic judgment. Although Anon’s scores on the CASL subtests are in the borderline/mild range, the difficulties with recognition and synthesis of inferential language and deficits in receptive and expressive cohesiveness are cause for concern. The ability to accurately use irregular verbs, prepositions, and modifiers is an integral aspect of thematic language and successful reading comprehension.

Anon presents with receptive and expressive difficulties synthesizing and summarizing language that requires inference, non-literal interpretation, and pragmatic skills. Difficulty in these areas may place Anon at risk in the academic setting due to a reduced understanding of abstract references that are frequently encountered in school. He also presents with difficulty receiving and processing multi-unit auditory information, as evidenced by frequent statements such as “I don’t understand.” Difficulty in the area of auditory comprehension for syntactically and semantically complex information could lead to reduced ability to process and act upon instructions for class activities and homework (as was noted in the IEP report).

It was observed that Anon frequently defaults to “I forgot” if he is unsure of an answer. However, when questions were repeated and/or rephrased, he provided appropriate answers. Anon uses ancillary self-strategies such as repeating unfamiliar words aloud, and stating “I don’t understand that.” Such strategies are imperative to meaningful communication, and can be capitalized on in therapy. Inferential strategies can also be used in therapy, such as “filling-in” missing information with the context of the message. It is crucial for Anon to have access to such strategies, because he will be entering fourth grade next year and will be expected to use inferential comprehension, and understand decontextualized language. In addition, successful reading comprehension is dependent on the above skills to allow an individual to use thematic processing (finding central themes) and understand the overall messages.

Anon was cooperative and focused throughout the evaluation. He demonstrated successful use of help-strategies, indicating that future speech therapy would be effective. However, after two hours of assessment, there was not enough time to complete further reading comprehension testing. It was decided that Anon return in two weeks for further assessment of reading comprehension skills. The results of testing at that time will be added to this report in an addendum.

Recommendations:

Research suggests that understanding syntax and manipulating it is becoming more and more important to the treatment of language disorders. Based on the information revealed during observation and dynamic testing (as discussed in this report) and supported by evidence-based research, the following is recommended:

1. It is recommended Anon return for further assessment of reading comprehension.
2. It is recommended Anon return to the CSUC Center for Communication Disorders

for further speech therapy services, to focus on the following skills:

- a. Increase eye contact when expressing a misunderstanding or requesting clarification (i.e., making eye contact when stating “I don’t understand” to ask for clarification or rephrasing.)
- b. Increase comprehension of non-literal language and inferential comprehension by engaging Anon in short stories and proverbs that contain idioms, similes, words with multiple meanings, and metaphors. Have him explain in full sentences the meaning of the passages and use the non-literal expressions in conversation, thus requiring him to draw conclusions about the information. (Popular comic strips and children’s books are excellent sources of non-literal language.)
- c. Increase multi-unit auditory information processing (e.g., understanding and following directions, comprehending paragraphs, completing sentences). This can be initiated by having Anon explain main ideas of short stories or films, using full sentences. This requires Anon to isolate and process pertinent information and generate appropriate responses using that information. Such activities will support thematic identification skills as well. (Resources for activities include: *The Source; Listen, Think, and Remember: Activities for Attention, Memory and Comprehension Skills; Language Exercises for Auditory Processing (LEAP); and Memory Stretch Following Direction Tapes*).
- d. Increase conversational turn-taking skills and pragmatic judgment skills (e.g., allowing others to exchange ideas during conversation, and analyzing social situations and making appropriate judgments about them). Role-playing via videotape can be used to demonstrate such skills.
- e. Incorporate ancillary self-strategies into expressive and receptive language skills (e.g., repeating new words and phrases to himself, and asking for a statement to be reworded rather than saying “I forgot”).

The above recommendations coincide with Anon 's IEP goal of answering who, what, when, where, and why questions about stories, and paraphrasing information presented in the story, by targeting skills related to recalling details of orally presented materials and stories, and listening and organizing information. The above recommendations also support goals set-forth in his IEP by his inclusion support teacher, including: a.) Anon will work cooperatively with other students, by offering pertinent ideas, listening to other's ideas, b.) Anon will, independently, remain on topic and ask, or answer questions accordingly.

Clinical Instructor

Graduate Clinician

Graduate Clinician

cc: Mr. and Mrs. Ymous

Sources Cited: Carrow-Woolfolk, E. (1999). *Comprehensive Assessment of Spoken Language*. MN: American Guidance Service, Inc.; Shapiro, L. (1997). Tutorial: An introduction to syntax. *Journal of Speech, Language, and Hearing Research, 40*, 254-272.

Sample Charting Form

CALIFORNIA STATE UNIVERSITY, CHICO
Communication Sciences and Disorders

Target Response Form

Target
Response: % Correct
100
%

95%

90%

85%

80%

Student:

75%

70%

65%

60%

55%

50%

Schedule:

45%

(Day/Time)

40%

35%

30%

25%

20%

15%

10%

5%

0%

Date

Total Responses

Number Correct

% Correct

A video observation is mandatory. It is the Clinical Instructor's decision on the format.
CALIFORNIA STATE UNIVERSITY, CHICO
Center for Communication Disorders
VIDEOTAPE OBSERVATION REPORT

CLINICIAN _____ Client's Initials _____ Date _____

- After you have viewed your videotape, answer each of the questions below by placing a check in the appropriate column to the right.
- Keep in mind that there is no right or wrong answer. What may be acceptable in one situation, may not be in another.
- As you complete the form, circle the number of the items that you identify as a possible problem area in your therapy delivery.

YES	SOME TIMES/ MAYBE	NO
-----	-------------------------	----

- Do my goals meet my client's therapy needs?
- Does the client understand what is expected of him?
- Does the client interrupt the therapy by asking questions, looking away, getting down from the table, throwing things, etc.?
- Am I using a reinforcer?
- Is the client working to get the reinforcer?
- Do I reinforce correct responses on a fixed ratio schedule?
- Do I reinforce correct responses in a random manner?
- Do I reinforce a response as soon as it is given?
- Do I ever positively reinforce an incorrect response?
- Do I model the correct response?
- Do I provide a cue to help the client give the correct response?
- Do I vary my social praise?
- Does the client talk enough?
- Do I change activities before the client loses interest?
- Am I counting accurately?
- Are my materials out and ready?
- Do I fumble around looking for or selecting materials during therapy?
- Are my material appropriate for the response I want?
- Do I look like I know what I am doing?
- Do I look at the client's face when he is making a response?
- Does my client watch my lips when I am modeling?
- Am I getting a good number of responses?

Does my client say multiple (i.e., 3, 4, or 10 for example) responses at one time?

Do I control the session

Am I satisfied with my session?

Analyze a five-minute segment of therapy. What percentage of time are you talking? (Count the total number of utterances of your therapy. Divide your number of utterances to get a percentage of your talk time. If it's more than your client's justify why.)

A. List the items you identified as being problem areas with your therapy delivery.

B. State, in the form of a behavioral objective, what you intend to do to improve your therapy delivery in each of the problem areas.

END OF TERM EVALUATION

A. State the areas where improvement has been made.

B. Identify areas where additional change needs to occur.

(Adapted from R. Harris, CSU Northridge Language, Speech Hearing Center)

Knowledge And Skills Acquisition (KASA) Tracking form

Student Name: _____

California State University, Chico
Communication Sciences and Disorders Program

EVALUATION

(A) = Adult (C) = Child

- | | | | | |
|--|--|--|---|--|
| a. Conduct screening & prevention procedures | b. Collect Case History info. & integrate info. from clients, family, teachers & other professionals | c. Select & administer appropriate evaluation procedures (beh. observations, standardized, non-standardized tests & instrumental procedures) | d. Adapt evaluation procedures to meet client/patient needs | e. Interpret, integrate, & synthesize all info. to develop diagnoses & make appropriate recommendations for TX |
|--|--|--|---|--|

ARTICULATION

(A)

(C)

(A)

FLUENCY

(C)

(A)

VOICE & RESONANCE

(including respiration & phonation)

(C)

(A)

RECEPTIVE/EXPRESSIVE LANGUAGE

(phonology, morphology, syntax, semantics & pragmatics in speaking, listening, reading, writing & manual modalities)

(C)

(A)

HEARING

(including the impact on speech & language)

(C)

KASA Tracking Form Pg. 2

EVALUATION

- | | | | | |
|--|--|---|---|--|
| a. Conduct screening & prevention procedures | b. Collect Case History info. & integrate info. from clients, family, teachers & other professionals | c. Select & administer appropriate evaluation procedures (beh. observations, standardized, non-standardized tests & | d. Adapt evaluation procedures to meet client/patient needs | e. Interpret, integrate, & synthesize all info. to develop diagnoses & make appropriate recommendations for TX |
|--|--|---|---|--|

instrumental
procedures)

(A)

SWALLOWING

(e. g. oral, pharyngeal, esophageal & related functions, including oral function for feeding; oral facial myofunction)

(C)

(A)

COGNITIVE ASPECTS

(e. g. attention, memory, sequencing, problem solving, executive functioning)

(C)

(A)

SOCIAL ASPECTS

(e.g. behavioral & social skills affecting communication)

(C)

(A)

COMMUNICATION MODALITIES

(e.g. oral, manual & augmentative & alternative communication techniques & assistive technologies)

(C)

(A) = Adult (C) = Child

KASA Tracking Form Pg. 3

INTERVENTION

(A) = Adult (C) = Child

a. Develop/set appropriate TX plans with measurable & achievable goals that meet clients needs. Collaborate with clients & relevant others planning process

(A)

b. Implement TX plans (involve clients & relevant others in the intervention process)

c. Select or develop & use appropriate materials & instrumentation for prevention & intervention

d. Measure & evaluate clients performance and progress

e. Modify intervention plans, strategies, materials, or instrumentation as appropriate to meet the needs of clients

ARTICULATION

(C)

(A)

FLUENCY

(C)

(A)

VOICE & RESONANCE
(including respiration & phonation)

(C)

RECEPTIVE/EXPRESSIVE LANGUAGE
(phonology, morphology, syntax, semantics & pragmatics in speaking, listening, reading, writing & manual modalities)

(A)

(C)

HEARING
(including the impact on speech & language)

(A)

(C)

KASA Tracking Form Pg. 4

INTERVENTION

- a. Develop/set appropriate TX plans with measurable & achievable goals that meet clients needs. Collaborate with clients & relevant others planning process
- b. Implement TX plans (involve clients & relevant others in the intervention process)
- c. Select or develop & use appropriate materials & instrumentation for prevention & intervention
- d. Measure & evaluate clients performance and progress
- e. Modify intervention plans, strategies, materials, instrumentation as appropriate to meet the needs of client

(A)

SWALLOWING
(e. g. oral, pharyngeal, esophageal & related functions, including oral function for feeding; oral facial myofunction)

(C)

(A)

COGNITIVE ASPECTS
(e. g. attention, memory, sequencing, problem solving, executive functioning)

(C)

(A)

SOCIAL ASPECTS
(e.g. behavioral & social skills affecting communication)

(C)

(A)

COMMUNICATION MODALITIES
(e.g. oral, manual & augmentative & alternative communication techniques & assistive technologies)

(C)

(A) = Adult (C) = Child
10/1/12-LS:jl (New forms)

Code of Ethics
CODE OF ETHICS EFFECTIVE MARCH 1, 2016

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Preamble

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

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

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

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

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

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

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

Terminology

ASHA Standards and Ethics

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

advertising

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

conflict of interest

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

crime

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

diminished decision-making ability

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

fraud

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

impaired practitioner

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

individuals

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

informed consent

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

jurisdiction

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

know, known, or knowingly

Having or reflecting knowledge.

may vs. shall

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

misrepresentation

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

negligence

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

nolo contendere

No contest.

plagiarism

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

publicly sanctioned

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

reasonable or reasonably

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

self-report

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

shall vs. may

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

support personnel

Those providing support to audiologists, speech-language pathologists, or speech, language, and hearing scientists (e.g., technician, paraprofessional, aide, or

assistant in audiology, speech-language pathology, or communication sciences and disorders). For more information, read the Issues in Ethics Statements on [Audiology Assistants](#) and/or [Speech-Language Pathology Assistants](#).

telepractice, teletherapy

Application of telecommunications technology to the delivery of audiology and speech-language pathology professional services at a distance by linking clinician to client/patient or clinician to clinician for assessment, intervention, and/or consultation. The quality of the service should be equivalent to in-person service. For more information, [see the telepractice section](#) on the ASHA Practice Portal.

written

Encompasses both electronic and hard-copy writings or communications.

Principle of Ethics I

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

Rules of Ethics

- A. Individuals shall provide all clinical services and scientific activities competently.
- B. Individuals shall use every resource, including referral and/or interprofessional collaboration when appropriate, to ensure that quality service is provided.
- C. Individuals shall not discriminate in the delivery of professional services or in the conduct of research and scholarly activities on the basis of race, ethnicity, sex, gender identity/gender expression, sexual orientation, age, religion, national origin, disability, culture, language, or dialect.
- D. Individuals shall not misrepresent the credentials of aides, assistants, technicians, support personnel, students, research interns, Clinical Fellows, or any others under their supervision, and they shall inform those they serve professionally of the name, role, and professional credentials of persons providing services.
- E. Individuals who hold the Certificate of Clinical Competence may delegate tasks related to the provision of clinical services to aides, assistants, technicians, support personnel, or any other persons only if those persons are adequately prepared and are appropriately supervised. The responsibility for the welfare of those being served remains with the certified individual.
- F. Individuals who hold the Certificate of Clinical Competence shall not delegate tasks that require the unique skills, knowledge, judgment, or credentials that are within the scope of their profession to aides, assistants, technicians, support personnel, or any nonprofessionals over whom they have supervisory responsibility.
- G. Individuals who hold the Certificate of Clinical Competence may delegate to students tasks related to the provision of clinical services that require the unique skills, knowledge, and judgment that are within the scope of practice of their profession only if those students are adequately prepared and are appropriately supervised. The responsibility for the welfare of those being served remains with the certified individual.
- H. Individuals shall obtain informed consent from the persons they serve about the nature and possible risks and effects of services provided, technology employed, and products dispensed. This obligation also includes informing persons served about possible effects of not engaging in treatment or not following clinical recommendations. If diminished decision-making ability of persons served is

suspected, individuals should seek appropriate authorization for services, such as authorization from a spouse, other family member, or legally authorized/appointed representative.

- I. Individuals shall enroll and include persons as participants in research or teaching demonstrations only if participation is voluntary, without coercion, and with informed consent.
- J. Individuals shall accurately represent the intended purpose of a service, product, or research endeavor and shall abide by established guidelines for clinical practice and the responsible conduct of research.
- K. Individuals who hold the Certificate of Clinical Competence shall evaluate the effectiveness of services provided, technology employed, and products dispensed, and they shall provide services or dispense products only when benefit can reasonably be expected.
- L. Individuals may make a reasonable statement of prognosis, but they shall not guarantee—directly or by implication—the results of any treatment or procedure.
- M. Individuals who hold the Certificate of Clinical Competence shall use independent and evidence-based clinical judgment, keeping paramount the best interests of those being served.
- N. Individuals who hold the Certificate of Clinical Competence shall not provide clinical services solely by correspondence, but may provide services via telepractice consistent with professional standards and state and federal regulations.
- O. Individuals shall protect the confidentiality and security of records of professional services provided, research and scholarly activities conducted, and products dispensed. Access to these records shall be allowed only when doing so is necessary to protect the welfare of the person or of the community, is legally authorized, or is otherwise required by law.
- P. Individuals shall protect the confidentiality of any professional or personal information about persons served professionally or participants involved in research and scholarly activities and may disclose confidential information only when doing so is necessary to protect the welfare of the person or of the community, is legally authorized, or is otherwise required by law.
- Q. Individuals shall maintain timely records and accurately record and bill for services provided and products dispensed and shall not misrepresent services provided, products dispensed, or research and scholarly activities conducted.
- R. Individuals whose professional practice is adversely affected by substance abuse, addiction, or other health-related conditions are impaired practitioners and shall seek professional assistance and, where appropriate, withdraw from the affected areas of practice.
- S. Individuals who have knowledge that a colleague is unable to provide professional services with reasonable skill and safety shall report this information to the appropriate authority, internally if a mechanism exists and, otherwise, externally.
- T. Individuals shall provide reasonable notice and information about alternatives for obtaining care in the event that they can no longer provide professional services.

Principle of Ethics II

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

Rules of Ethics

- A. Individuals who hold the Certificate of Clinical Competence shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their certification status, education, training, and experience.
- B. Members who do not hold the Certificate of Clinical Competence may not engage in the provision of clinical services; however, individuals who are in the certification application process may engage in the provision of clinical services consistent with current local and state laws and regulations and with ASHA certification requirements.
- C. Individuals who engage in research shall comply with all institutional, state, and federal regulations that address any aspects of research, including those that involve human participants and animals.
- D. Individuals shall enhance and refine their professional competence and expertise through engagement in lifelong learning applicable to their professional activities and skills.
- E. Individuals in administrative or supervisory roles shall not require or permit their professional staff to provide services or conduct research activities that exceed the staff member's certification status, competence, education, training, and experience.
- F. Individuals in administrative or supervisory roles shall not require or permit their professional staff to provide services or conduct clinical activities that compromise the staff member's independent and objective professional judgment.
- G. Individuals shall make use of technology and instrumentation consistent with accepted professional guidelines in their areas of practice. When such technology is not available, an appropriate referral may be made.
- H. Individuals shall ensure that all technology and instrumentation used to provide services or to conduct research and scholarly activities are in proper working order and are properly calibrated.

Principle of Ethics III

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

Rules of Ethics

- A. Individuals shall not misrepresent their credentials, competence, education, training, experience, and scholarly contributions.
- B. Individuals shall avoid engaging in conflicts of interest whereby personal, financial, or other considerations have the potential to influence or compromise professional judgment and objectivity.
- C. Individuals shall not misrepresent research and scholarly activities, diagnostic information, services provided, results of services provided, products dispensed, or the effects of products dispensed.
- D. Individuals shall not defraud through intent, ignorance, or negligence or engage in any scheme to defraud in connection with obtaining payment, reimbursement, or grants and contracts for services provided, research conducted, or products dispensed.

- E. Individuals' statements to the public shall provide accurate and complete information about the nature and management of communication disorders, about the professions, about professional services, about products for sale, and about research and scholarly activities.
- F. Individuals' statements to the public shall adhere to prevailing professional norms and shall not contain misrepresentations when advertising, announcing, and promoting their professional services and products and when reporting research results.
- G. Individuals shall not knowingly make false financial or nonfinancial statements and shall complete all materials honestly and without omission.

Principle of Ethics IV

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

Rules of Ethics

- A. Individuals shall work collaboratively, when appropriate, with members of one's own profession and/or members of other professions to deliver the highest quality of care.
- B. Individuals shall exercise independent professional judgment in recommending and providing professional services when an administrative mandate, referral source, or prescription prevents keeping the welfare of persons served paramount.
- C. Individuals' statements to colleagues about professional services, research results, and products shall adhere to prevailing professional standards and shall contain no misrepresentations.
- D. Individuals shall not engage in any form of conduct that adversely reflects on the professions or on the individual's fitness to serve persons professionally.
- E. Individuals shall not engage in dishonesty, negligence, fraud, deceit, or misrepresentation.
- F. Applicants for certification or membership, and individuals making disclosures, shall not knowingly make false statements and shall complete all application and disclosure materials honestly and without omission.
- G. Individuals shall not engage in any form of harassment, power abuse, or sexual harassment.
- H. Individuals shall not engage in sexual activities with individuals (other than a spouse or other individual with whom a prior consensual relationship exists) over whom they exercise professional authority or power, including persons receiving services, assistants, students, or research participants.
- I. Individuals shall not knowingly allow anyone under their supervision to engage in any practice that violates the Code of Ethics.
- J. Individuals shall assign credit only to those who have contributed to a publication, presentation, process, or product. Credit shall be assigned in proportion to the contribution and only with the contributor's consent.
- K. Individuals shall reference the source when using other persons' ideas, research, presentations, results, or products in written, oral, or any other media presentation or summary. To do otherwise constitutes plagiarism.
- L. Individuals shall not discriminate in their relationships with colleagues, assistants, students, support personnel, and members of other professions and disciplines on

the basis of race, ethnicity, sex, gender identity/gender expression, sexual orientation, age, religion, national origin, disability, culture, language, dialect, or socioeconomic status.

- M. Individuals with evidence that the Code of Ethics may have been violated have the responsibility to work collaboratively to resolve the situation where possible or to inform the Board of Ethics through its established procedures.
- N. Individuals shall report members of other professions who they know have violated standards of care to the appropriate professional licensing authority or board, other professional regulatory body, or professional association when such violation compromises the welfare of persons served and/or research participants.
- O. Individuals shall not file or encourage others to file complaints that disregard or ignore facts that would disprove the allegation; the Code of Ethics shall not be used for personal reprisal, as a means of addressing personal animosity, or as a vehicle for retaliation.
- P. Individuals making and responding to complaints shall comply fully with the policies of the Board of Ethics in its consideration, adjudication, and resolution of complaints of alleged violations of the Code of Ethics.
- Q. Individuals involved in ethics complaints shall not knowingly make false statements of fact or withhold relevant facts necessary to fairly adjudicate the complaints.
- R. Individuals shall comply with local, state, and federal laws and regulations applicable to professional practice, research ethics, and the responsible conduct of research.
- S. Individuals who have been convicted; been found guilty; or entered a plea of guilty or nolo contendere to (1) any misdemeanor involving dishonesty, physical harm—or the threat of physical harm—to the person or property of another, or (2) any felony, shall self-report by notifying ASHA Standards and Ethics (see Terminology for mailing address) in writing within 30 days of the conviction, plea, or finding of guilt. Individuals shall also provide a certified copy of the conviction, plea, nolo contendere record, or docket entry to ASHA Standards and Ethics within 30 days of self-reporting.
- T. Individuals who have been publicly sanctioned or denied a license or a professional credential by any professional association, professional licensing authority or board, or other professional regulatory body shall self-report by notifying ASHA Standards and Ethics (see Terminology for mailing address) in writing within 30 days of the final action or disposition. Individuals shall also provide a certified copy of the final action, sanction, or disposition to ASHA Standards and Ethics within 30 days of self-reporting.

CONFIRMATION OF ESSENTIAL FUNCTIONS

The following list of abilities has been identified as essential functions for work as a speech-language pathologist in all settings. Please read and check all those you are able to perform, sign at the bottom, and return with your application materials to Dr. Steffani.

Physical Abilities

- Able to maintain attention and concentration for sufficient time to complete academic/clinical activities, typically 2-4 hours with 1-2 breaks
- Able to physically be in a classroom or clinic room for 2-4 hour blocks of time with 1 or 2 breaks
- Able to move independently to, from and in academic/clinical facilities
- Able to manipulate therapeutic/diagnostic materials, including setting out test items, turning pages, etc.
- Able to make accurate auditory judgments about speech and/or acoustic signals
- Able to read the dials on instruments and to visually monitor a client's response
- Able to respond quickly enough to provide a safe environment for clients in emergency situations.
- Able to provide for one's own personal hygiene

Professional Competency

- Able to independently analyze, synthesize, interpret ideas and concepts in academic and diagnostic/clinic settings
- Able to comprehend and read professional literature/reports and write university level papers and clinical reports in Standard English
- Able to speak Standard English intelligibly, including the ability to give live-voice test items to clients
- Able to make appropriate decisions, including the ability to evaluate and generalize appropriately without immediate supervision
- Able to maintain appropriate work ethics, including punctuality and regular attendance
- Able to submit required academic and clinical paperwork within deadlines
- Able to understand, respect, and comply with Clinical Instructor authority
- Able to engage in and embrace cultural and linguistic diversity in clinical and educational opportunities
- Able to interact effectively and courteously with people in person, on the telephone, and through emails, texts, or social media
- Able to maintain appropriate behavior, including appropriate interpersonal skills both one-on-one and in group settings
- Able to work cooperatively in a group

Name (Printed)

Signature

Date