CALIFORNIA STATE UNIVERSITY, CHICO
COMMUNICATION SCIENCES AND DISORDERS PROGRAM

CENTER FOR COMMUNICATION DISORDERS

GRADUATE ACADEMIC AND CLINIC HANDBOOK

2014-2015

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CSU, Chico
Communication Sciences and Disorders

Graduate Academic and Clinic Handbook

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PROGRAM INFORMATION

COMMUNICATION SCIENCES AND DISORDERS
California State University, Chico
STRATEGIC PLAN

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 exemplary speech-language and hearing services.

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

Objective 4) *Promote life-long learning by supporting professional continuing education for faculty, staff, local SLP professionals.*

Objective 5) *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 Clinical Instructors.*

Objective 6) *Employ a sufficient number of expert faculty and staff in order to meet mission goals.*

Objective 7) *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. Suzanne B. Miller, 898-5751, sbmiller@csuchico.edu.

Accreditation Information
The CMSD program is accredited by the following bodies:

- American Speech-Language-Hearing Association's (ASHA) Council on Academic Accreditation
  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
Five tenure/tenure track faculty and selected 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	209
Number of graduate students	47
Number of graduate applications	267
Number of students accepted/enrolled	29/24

Student information is based on 2013-14 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:

2012 95%
2013 100%
2014 100%

Graduation Rates

The CMSD program is designed to be completed in 2 years. Occasionally, students request to extend the program to 3 years generally 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:

	Full Time Students		Part Time Students
Year Graduated	Completed within 2 years	Completed within 3 years	
2012 – students	21	0	0
2013 – students	16	0	0
2014 – students	22	0	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:

2012 students=100%
2013 students=100%
2014 students=100%

Approximate annual starting salary range was $38,000 to $72,000, depending on setting and location.

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
52	15	52-56	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 typically three internships across a selection of 40 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 all 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

GRADUATE COURSEWORK

Sequence of Classes

Comprehensive examination/thesis/project and practicum (400 supervised clinical education hours) are also required.

FALL SEMESTER 1st year

CMSD	543	(3)	Autism and Behavioral Interventions
CMSD	620	(3)	Neuroanatomy of Speech, Swallowing, and Language
CMSD	632	(2)	EBP and Experimental Design in CMSD
CMSD	640	(3)	Assessment and Management of Auditory Disorders
CMSD	684	(2-4)	Clinical Practicum –*1 client = 2 units, or 2 clients = 4 units*

Total: 13-15 letter graded 1st semester units

SPRING SEMESTER 1st year

CMSD	632	(2)	EBP and Experimental Design in CMSD
CMSD	635	(3)	Disorders of Voice and Resonance
CMSD	642	(3)	Motor Speech and Swallowing Disorders
CMSD	680	(1)	Community and Service Learning *(CR/NC; may be repeated)*
CMSD	684	(2-4)	Clinical Practicum – *1 client = 2 units, or 2 clients = 4 units*
CMSD	698	(2)	Special Topics: Fluency Disorders and Counseling in CMSD

Total: 12-14 letter-graded units and 1 CR/NC unit = 13-15 2nd semester units

Total 1st year: 28 letter-graded units and 1 CR/NC units = 29 units

SUMMER SEMESTER – OPTIONAL

CMSD	689	(4)	Internship – *typically 4 units (CR/NC)*

FALL SEMESTER 2nd year

CMSD	630	(3)	Disorders of Articulation and Phonology
CMSD	652	(3)	Seminar in Language Disorders
CMSD	670	(1)	Methods in Speech-Language Pathology in the Schools *(CR/NC)*
CMSD	675	(1)	Methods in Speech-Language Pathology *(CR/NC)*
CMSD	682	(0-1)	Diagnostic Practicum – *taken once Fall or Spring*
CMSD	689	(4)	Internship – *typically 4 units (CR/NC)*
CMSD	699T/P	(1-6)	Thesis/Project – OPTIONAL

Total: 6-7 letter-graded units and 6 CR/NC unit = 12-13 3rd semester units

SPRING SEMESTER 2nd year

CMSD	633	(3)	Professional Aspects of Speech-Language Pathology
CMSD	645	(3)	Augmentative and Alternative Communication
CMSD	675	(1)	Methods in Speech-Language Pathology *(CR/NC)*
CMSD	680	(0-1)	Community and Service Learning *(CR/NC; OPTIONAL)*
CMSD	682	(0-1)	Diagnostic Practicum – *if not taken Fall*
CMSD	689	(4)	Internship – *typically 4 units*
CMSD	699T/P	(1-6)	Thesis/Project – OPTIONAL

Total: 6-7 letter graded units and 5-6 CR/NC unit = 11-13 4th semester units

Total 2nd year: 13-14 letter-graded units and 11-12 CR/NC units = 24-26 units

TOTAL LETTER GRADED UNITS: 41-42 Plus 12-13 CR/NC units TOTAL UNITS: 53-55

Knowledge and Skills Acquisition (KASA) Summary Form for Certification in Speech-Language Pathology

Knowledge Acquisition

We are accredited by the American Speech-Language-Hearing Association's (ASHA) Council on Academic Accreditation. 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. In the link below, you will find a document that indicates which classes address the knowledge you are required to obtain. 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 form provided in Appendix G. You will need to print this Appendix. 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 should also be included in your portfolio.

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 content of the test, please visit http://www.ets.org/Media/Tests/PRAXIS/pdf/0330.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), and the Department of Consumer Affairs (for state license – 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 November/December. 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: March 25th (1st years); November 15th (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 1: 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 Clinical Instructor evaluations (e.g., Clinical Instructor evals, internship evals)
3. Self-evaluations
4. Clinic reports. Black our 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
8. Pink Hours tracking sheet (up 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.
- Summer/fall internship applications
  - Pick up form and turn in to office personnel - due the Monday after Spring Break
- 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 office personnel and make a copy of your portfolio
    - Input hours on DMS
  - ✓ Evaluations – DMS
    - Clinical Instructor Evaluation of Student (Clinical Instructor completes)
    - Student Evaluation of Internship Site and Clinical Instructor (student completes)

Clinical Population Form

Graduate Trainee Questionnaire
Student Evaluation of Internship
Student Evaluation of Internship Clinical Instructor Form

- Do Not Forget to obtain KASA skills signatures from intern Clinical Instructors
- Renew Student Liability Insurance

Third Semester

- Complete Mid-Program evaluation
- Turn in to office personnel a copy of Liability Insurance policy- renewal
- Turn in Portfolio: Due November 15th 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 600 to apply for licensure/certification/credential)
    - List CSU, Chico; ASHA; CCTC; and CA licensing board as score recipients;
    - print admission ticket
    - Exam offered several times
    - Approximate Fee: $135.00
- Register for comps with your spring courses
- Obtain KASA signatures after practicum and practical classroom experiences
- Internship Log Packets *(Schools)*: 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)

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 & Thur 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 600 to apply for licensure/certification/credential):
    - List CSU, Chico; ASHA; and CA licensing board as score recipients (Codes found in preceding section)
    - Print admission ticket
    - Exam offered several times
    - Approximate Fee: $135.00

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: $71.00
- 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 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 to office personnel and make a copy for your portfolio
        - Input hours to DMS
    - ✓ Evaluations – on Data Management Systems
        - Clinical Instructor Evaluation of Student (Clinical Instructor completes)
- 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 an internship during each semester of their graduate study (summer internships are optional but encouraged).

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**.

The following criteria for supervised clinical education hours 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. To help ensure confidentiality, **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 room (AJH 104), to the lab (AJH 112F), or to the Clinical Instructor's office. Photocopying of any information in the file is not allowed. Further, 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.) 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 Student Health Service adheres to the regulations of the California Medical Information Act (CMIA) and the Health Insurance Portability and Accountability Act (HIPAA). As an employee, volunteer or business associate of the above named facility, I agree that use and/or disclosure of PHI \and patient identifiable information is against federal and California state law. I further understand that California Medical Information Act (CMIA) and Health Insurance Portability and Accountability Act (HIPAA) regulations are adhered to by the CSUC Student Health Service.

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 these standards (see **Appendix**). 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 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."

[1] Health Insurance Portability and Accountability Act

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; s**horts (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:

- 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 a 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. 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 8 to 5. 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. Please note that beginning Fall 2011, reports will be generated in a more Medicare-based format, so please follow the style of the reports included in the **Student Handbook appendices** rather than copy the previous clinic report style verbatim. Once previous reports have been reviewed, it is the clinician's responsibility (with the approval of the Clinical Instructor) to ensure that valid assessment instruments be administered, rather than solely relying on "informal" observation. Informal observations alone often miss variables of interest. It is the clinician's responsibility to:

1. **Review** and discuss with his/her Clinical Instructor the administration of at least **two new assessment instruments** to measure behaviors of interest. These assessment instruments do not need to be administered in their entirety; depending on the behaviors(s) of interest, selected subtests may be administered in isolation. Discuss with your Clinical Instructor. Also, ensure that you write the **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? Brookshire (p 171) notes that items in the last one third to one half of most vocabulary tests rarely occur in everyday communicative interactions! However, Saxton, et al. (2000) report normative education and age values for BNT results. Be thoughtful when you administer evaluations; this is why we write rationales. Rationales are easy to find. Just look in any textbook related to the disorder or look in the examiner's manual. Also see the Burns rationales on BBL CMSD 632.

2. Administer a quality of life instrument (QOL). QOL instruments emerged from a widespread need within the profession of SLP for a valid and reliable instrument that could be used to determine the **impact** of a communication disorder on an adult's **relationships and life interactions**. A valid adult QOL instrument at the clinic is ASHA's Quality of Communication Life Scale. For clients presenting with dysfluency, clinicians might administer the Erikson Scale of Communication Attitudes. This is found in most good fluency texts, including Guitar's. The clinician with the child client would need to identify an appropriate child intake QOL instrument. It is the responsibility of the Clinical Instructor and the clinician to identify and administer an appropriate QOL instrument. The rationale for these instruments is multifold, but primarily the purpose is to assist with treatment planning, prioritization of goals, counseling and documentation of outcomes. For more information, see ASHA website on QOL and Brookshire.

3. Administer the ASHA FACS, Communication Pages, Biographical Questionnaire or another age-appropriate tool to investigate the communication strengths and needs of the client. For instruments and score sheets, see the CD or ACD, or locate in the materials room. For children,

the Participation Inventory is especially important. This is available as a PDF and on BBL CMSD 632.

4. P**erform 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.

5. 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.

Beginning Fall 2012, student clinicians are encouraged to incorporate audio biofeedback in their sessions. 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 (asha.org/Members/ebp/intro/) 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 (sheets are colored according to the type of disorder). See the appendices for an example of a therapy log sheet. Only direct contact with the client or the client's family in assessment, management, and/or counseling can be counted toward practicum.

Reports
Each semester, the student will generate two clinical reports: the Initial Case Report (ICR) and the Final Case Report (FCR). 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 take to the materials room, 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 24 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 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 Position Statement 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 instrument (see appendix). 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 digitized recorder/player for audio biofeedback and 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 audio 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.

REMEDIATION 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.

Off Campus Assignments/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 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 three 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. Students must complete the appropriate applications for requesting placements, and must complete a clinician schedule card. Students will be assigned two Clinical Instructors: 1) On-site master clinician and 2) campus Clinical Instructor. Once assignments are made, sign an agreement form, students are expected to contact their master clinician to arrange their schedule. Once a schedule is agreed upon by the student and master clinician, it is the clinician's responsibility to notify both the campus Clinical Instructor and the master clinician PRIOR to an absence. Students are expected to continue at their placement until the end of the designated time period regardless of their accumulated supervised clinical education hours. Internship agreements must be signed by all parties and submitted to the internship coordinator. Agreement forms are available on the Data Management System.

Summer placements out of the area are possible with ample. Please contact the Internship Coordinator by January 30th 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 Clinical Instructor will conduct site-visits each semester. These visits may include observation of therapy, diagnostics, and discussion of hours, experiences, and clientele. The on-site master clinician 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 (Jackie) for further processing. See appendices for a sample of hours log.

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

The CMSD program has the following policy regarding on and off-campus practicum:
If a problem or conflict arises between a student clinician and Clinical Instructor, the two should meet to try to resolve the problem, keeping in mind the Clinical 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. In off-campus placements, the university Clinical Instructor 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 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 no solution is found, the student will be referred to the Department Chair. 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.

Complaints that cannot be satisfactorily resolved within the program, department or university levels should be submitted to the Council on Academic Accreditation (CAA) of the American Speech-Language-Hearing Association. Contact the CAA Office at: American Speech-Language-Hearing Association, 220 Research Blvd, Rockville, MD 20852 or phone ASHA's Action Center at (800) 498-
2071; http://www.asha.org/academic/accreditation/accredmanual/section8.htm

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 Clinical Instructory meetings*. 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 /I / and /ς/. 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 senori-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   [name, B.A.]
Clinical Clinical Instructor   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 money. We all pay for them through…	taxes	+
4. Aluminum was once very costly to refine. Now,	Very strong	-

electricity has solved the refining problem, and aluminum has become…		
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% *Baseline: 20%* 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% *Baseline: 50%* 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% *Baseline: 40%* 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, in 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.

____________________________ ____________________________

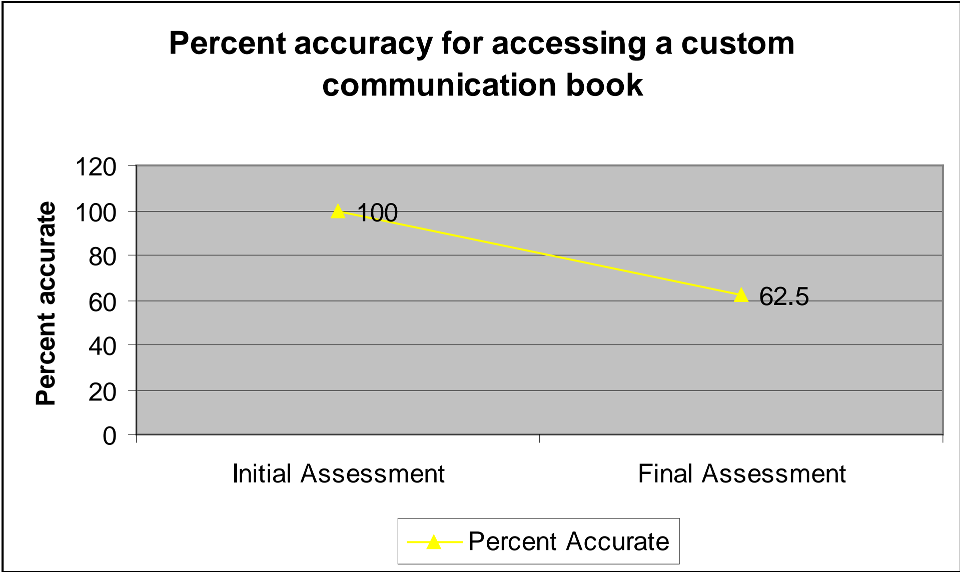
Clinical Instructor Graduate Student Clinician

Selected assessment results

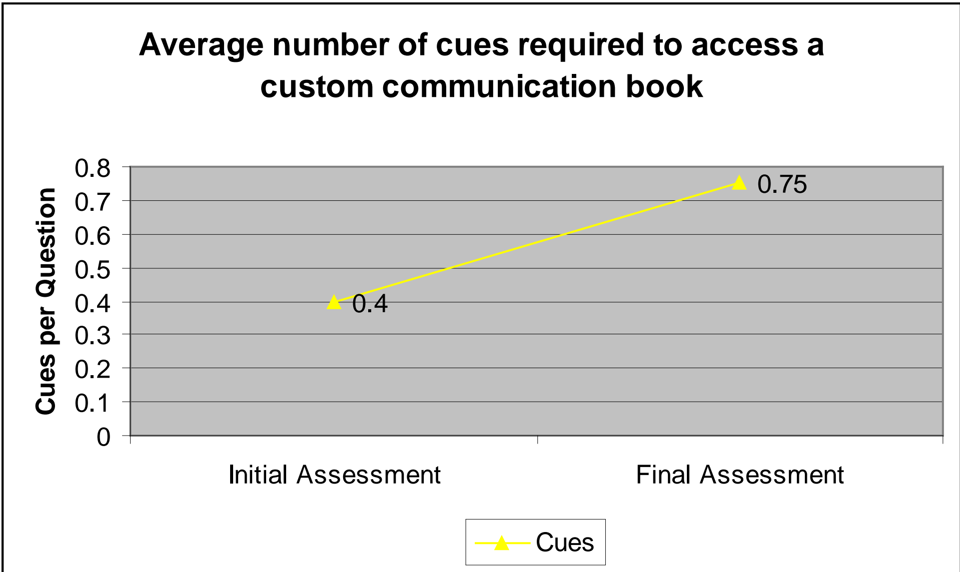
Final results for the RCBA-2 **(12/2/08 and 12/4/xx)**

Subtest	% accurate	Description
I. Word-Visual (WV)	70% *Baseline: 60%* 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% *Baseline: 70%* 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% *Baseline: 70%* 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% *Baseline: 40%* 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% *Baseline: 40%* 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% *Baseline: 70%* Reflects an 42.8% *decrease* in accuracy from initial testing*	Client reads a sentence and then selects the corresponding response from a field of three line drawings.

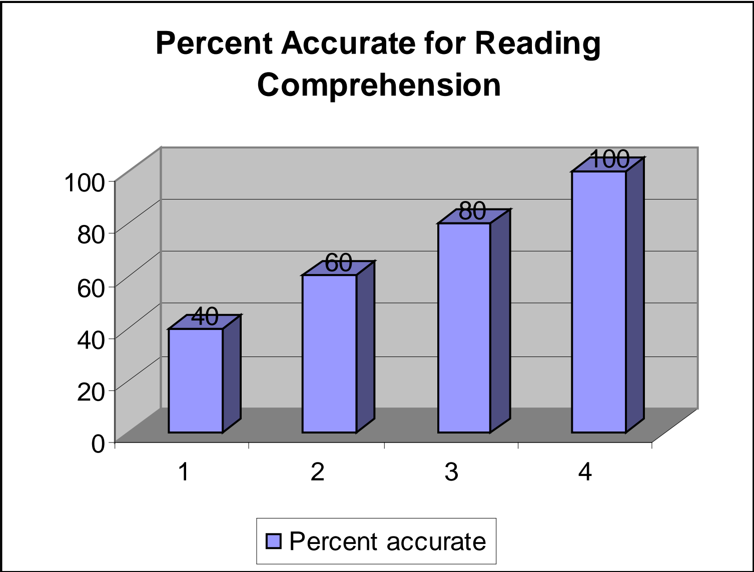
* It was noted that Mrs. Ymous expressed some difficulty with vision on the date of testing. This could invalidate test results because she could not accurately read the stimulus. Accuracy increased when the clinician orally read the stimulus and reduced the field of possible responses to two.

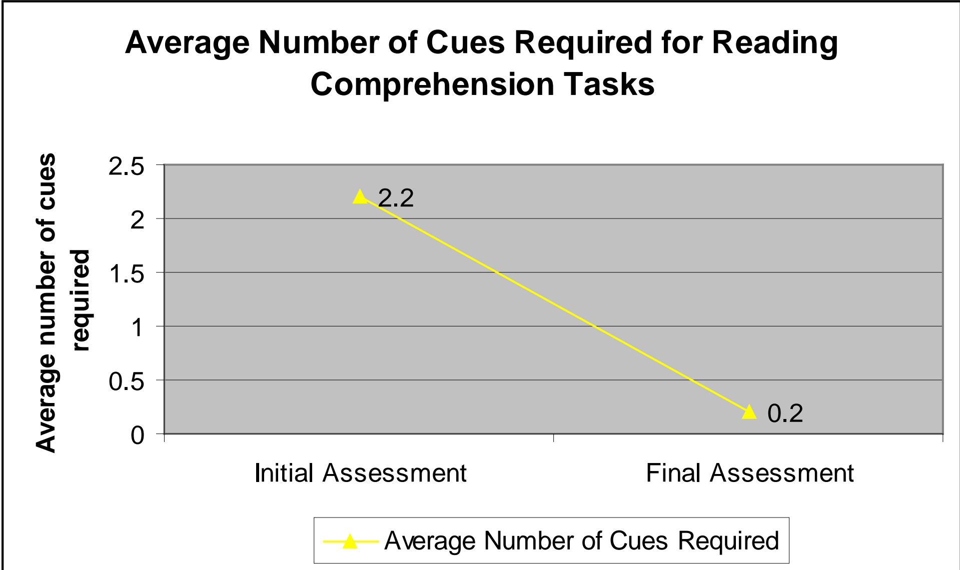


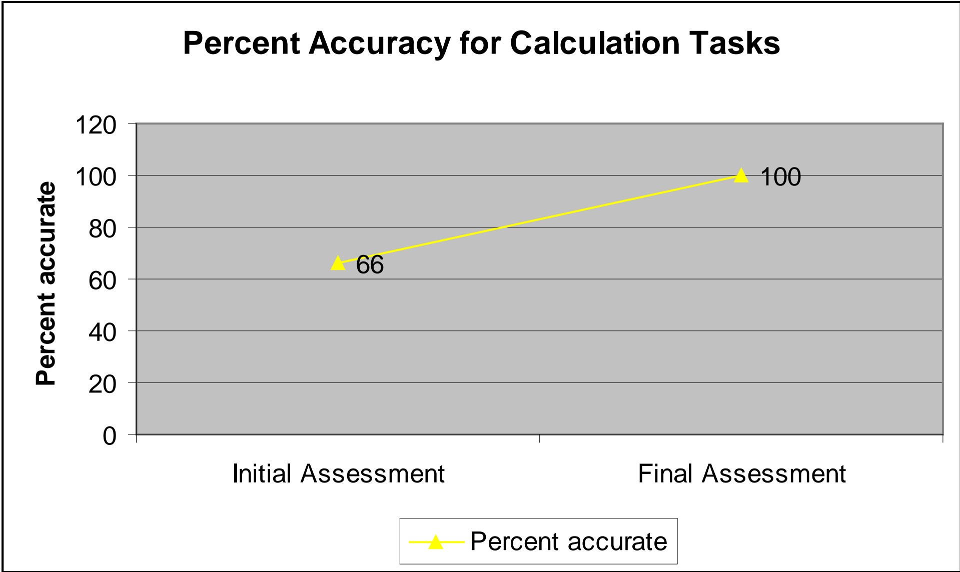
Percent accuracy for accessing a custom communication book
Percent accurate
120
100
80
60
40
20
0
100
62.5
Initial Assessment
Final Assessment
Percent Accurate

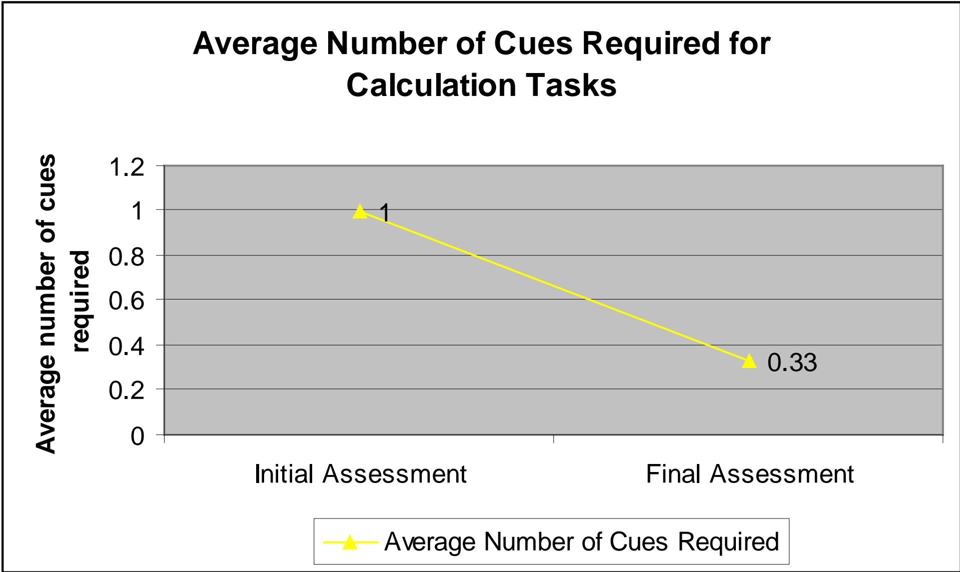


Average number of cues required to access a custom communication book
Cues per Question
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0
0.75
0.4
Initial Assessment
Final Assessment
Cues


Percent Accurate for Reading Comprehension
100
80
60
40
20
0
40
60
80
100
1
2
3
4
Percent accurate


Average Number of Cues Required for Reading Comprehension Tasks
Average number of cues required
2.5
2
1.5
1
0.5
0
2.2
0.2
Initial Assessment
Final Assessment
Average Number of Cues Required


Percent Accuracy for Calculation Tasks
Percent accurate
120
100
80
60
40
20
0
66
100
Initial Assessment
Final Assessment
Percent accurate


Average Number of Cues Required for Calculation Tasks
Average number of cues required
1.2
1
0.8
0.6
0.4
0.2
0
1
0.33
Initial Assessment
Final Assessment
Average Number of Cues Required

<u>**Lesson Plan (sample)**</u>

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 stoke, 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.

<u>Diagnostic Evaluation Report (sample)</u>

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 <u>all</u> 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	Dare of evaluation:
Address:	Telephone: (530)
Chico, CA	
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., *up:* <u>*down*</u>)	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., *home: tree, flower, picture,* <u>*house*</u>*)*	86*
Sentence Completion	The initial segment of a sentence was read and Anon was instructed to complete the sentence with a logical word of	60

	phrase. For example, *When Jim jumped off the diving board into the water, he made a big splash.*	
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 won't go to the party unless _______ (you take me,* or *I have to* would be acceptable responses).	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., *See is to seeing as play is to playing*).	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, *The dog was run after the squirrel.* Anon accurately identified the sentence as incorrect and changed it to: *The dog ran after the squirrel.*	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, *The teacher told the class that he wanted all eyes on the board. What did he mean?* 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, *Sarah wanted a glass of milk. However, after looking in the refrigerator, she had a glass of orange juice instead. Why?* 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, *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?* 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 combing 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 story 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 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
<u>Target Response Form</u>

Target
Response:

Student:

Schedule:
(Day/Time)

% Correct															
100%															
95%															
90%															
85%															
80%															
75%															
70%															
65%															
60%															
55%															
50%															
45%															
40%															
35%															
30%															
25%															
20%															
15%															
10%															
5%															
0%															

Date																	
Total Responses																	
Number Correct																	
% Correct																	

CLINICAL INSTRUCTOR EVALUATION OF STUDENT
Center for Communication Disorders

Mid Eval ___
Final Eval ___
Self Eval ___

Clinician: ______________________________ **Semester/Year:** ______________
Supervisor: ______________________________ **Site:** ______________
(Please Print)

KEY:
Level 5 = Demonstrates independence by taking initiative; displays superior competencies and evaluates self accurately.
Level 4 = Demonstrates independence, but needs general direction to perform competently and evaluate self and/or client accurately.
Level 3 = Needs general and some specific direction from supervisor to perform competently and evaluate self and/or client accurately.
Level 2 = Needs repeated specific direction and/or demonstration from supervisor to perform competently and evaluate self and/or client accurately.
Level 1 = Specific direction from supervisor does not alter unsatisfactory performance/evaluation skills. Inability to make change.

SKILLS	PERFORMANCE LEVEL					
	Level 1	Level 2	Level 3	Level 4	Level 5	Does Not Apply
Prevention 1. Recognizes and assesses for concomitant disorders that may accompany the primary speech/language deficit (e.g. vision, hearing, and irregular motor movements). (CTC SLP 5, 7; PS 7; NCP6)						
2. Interviews and investigates indications and side effects for all medications taken by the client.						
3. Collaborates during prevention activities. (SLP 7; PS 7; NCP 6)						
Evaluation (All NCP 4) 4. Conducts screening procedures, including hearing and acoustic and oral motor. (SLP 4)						
5. Collects case history information and integrates information from clients/patients, family, teachers and other professionals. Re-administers appropriate adult, adolescent or adult intake form, QOL instrument or biographical intake form. (SLP 4, 7; PS 5, 7; NCP 6; NDP 4)						
6. (1) Selects, (2) provides rationale for, (3) administers and (4) scores diagnostic evaluations appropriately. (Includes behavioral observations, use of standardized and non-standardized tests.) (SLP 3, 4; PS 3, 5; NCP 3)						
7. Adapts evaluation procedures to meet client/patient needs. This includes administering diagnostic instruments in practice format first, and understanding rationale for dynamic testing. (SLP 3; PS 3, 5; NCP 3).						
8. Interprets, integrates, and synthesizes in writing all information to develop operational definitions for the behaviors to be targeted and generates appropriate and measurable recommendations for intervention. (SLP 4; PS 5)						
9. Completes administrative and reporting functions necessary to support evaluation.						
10. Refers clients/patients for appropriate additional services; DSS, vocational rehab., Handy-Riders, etc. (SLP 4; PS 4).						
11. Proficient in use of interpreters/translators in assessing English language. (SLP 4)						
12. Knowledge of required statewide assessments, and local state and federal accountability systems. (PS 5)						

SKILLS	PERFORMANCE LEVEL					
	Level 1	Level 2	Level 3	Level 4	Level 5	Does Not Apply
13. Proficient in assessment for and selection of appropriate AAC systems. (SLP 4; PS 6)						
Intervention 14. Develops appropriate intervention plans with measurable and achievable goals that meet client/patient needs. Documents collaboration with client/patient and relevant others in the planning process designed to support IEP, IFSP, ITP, and access to core curriculum, following all legal requirements. (SLP 3, 5, 7; PS 3, 4, 7, NCP 5, 6; NDP 4)						
15. Implements intervention plans (involve client/patient and relevant others in the intervention process). (SLP 5; PS 4; NCP 6; NDP 4, 5)						
16. Generates appropriate materials and instrumentation for intervention based on evidence based practices appropriate for all learners. (SLP 5; PS 2, 3; NCP 3, 4)						
17. Plans strategies for maintaining on-task behavior, including structuring the teaching environment and setting behavioral limits. (SLP 5; NDP 5)						
18. Presents feedback (verbal, visual, written, audio-visual) and/or reinforcement that are consistent, discriminating and meaningful to client. (SLP 5)						
19. Measures and evaluates client/patient performance on-line and off-line. Maintains an audio record of each session should the supervisor wish to review off-line. (SLP 5)						
20. Uses data for clinical decision-making. (NCP 4)						
21. Proficient in training of students, family/caregivers, teachers and other professionals in use of AAC devices. (SLP 5; PS 6)						
22. Able to work in variety of service models. (SLP 5)						
23. Facilitation of second language/dialect acquisition. (SLP 5)						
24. Appropriate use of interpreter/translators. (SLP 5)						
Interpersonal Skills 25. Accepts, empathizes, shows genuine concern for the client as a person and understands the client's problems, needs, and stresses. Conveys to the client in a non-threatening manner what the standards of behavior and performance are. Creates an atmosphere based on honesty and trust; enables client to express his/her feelings and concerns. (NCP 1, 3, 5; NDP1, 5)						
26. Perceives verbal and nonverbal cues which indicate the client is not understanding the task; is unable to perform all or part of the task; or when emotional stress interferes with performance of the task. (NDP 5)						
27. Develops understanding of teaching goals and procedures with client. Is clear and concise. (NDP 5)						
28. Listens, asks questions, participates with supervisor in therapy and/or client related discussions; is not defensive. Requests assistance from supervisor and/or other professionals when appropriate. (NCP 5; NDP 3)						
29. Communicates with other disciplines on a professional and culturally appropriate level and collaborates as needed. (PS 2, 3, 5; NCP 6; NDP 1, 4)						

SKILLS	PERFORMANCE LEVEL					
	Level 1	Level 2	Level 3	Level 4	Level 5	Does Not Apply
30. Responsive to the needs of all learners. (NDP 1, 2)						
Reporting 31. Generates reports, lesson plans and SOAPs that are thorough and reflective of the medical/clinical model. This model is integral to qualification for services and for operationally defining and quantifying clinical observations.						
32. Attends all meetings with supervisor to ensure quality of reporting; shares significant discoveries with peers during those meetings.						
33. Generates accurate client contact information, date of reports, name spelling, etc. (SLP 4)						
34. Generates SOAP notes and FCRs that contain summaries of intervention and clear charts and graphs that demonstrate changes in behaviors targeted (similar to SS design). (SLP 5)						
35. Generates ICRs and FCRs and lesson plans that contain references (including ref list) to EB literature that support the approaches taken.						
36. Writes in an organized, concise, clear and grammatically correct style. Spelling is accurate.						
37. Completes all necessary documentation in a **timely manner**, e.g. reports, lesson plans, SOAP notes.						
Professional Behavior and Responsibilities 38. Respects confidentiality of all professional activities.						
39. Appears to recognize own professional limitations. (NCP 5)						
40. Follows appropriate dress code guidelines for setting.						
41. Demonstrates ethical behaviors (PS 2)						
42. Is reflective and desires to improve. (NCP 5; NDP 3)						
43. Plays a leader role in advocating; promotes civic engagement. (NCP 7)						
44. Utilizes appropriate knowledge of SLP 1, 2, 3 when diagnosing and treating clients. (SLP 1, 2, 3, PS 5)						
45. Modifies DX/TX appropriate to diverse clients. (PS 3; NCP 3)						

Comments

Please calculate the totals

#5s____ x 5 =_____
#4s____ x 4 =_____
#3s____ x 3 =_____
#2s____ x 2 =_____
#1s____ x 1 =_____
Sum of total_______(divided by) # scored DNA excluded

Supervisor's Signature ____ Date ______________________________

Clinician's Signature ____ Date ______________________________

08/26/14 updated JM student0814.docx

California State University, Chico
Communication Sciences and Disorders

INTERNSHIP (Circle One): School Private Practice Medical

CLIENT AGE (Circle One): **Adult** **Child**

COURSE/ACTIVITY: CMSD - 682 (DX) 684 (TX) 689 (Internship) 680 (S&HF) K-Roundup Other: ______________________ (Specify)

NAME: ____________________ **SEM:** __________ **YR:** __________

SUPERVISOR: ____________________
(Please PRINT)
SIGNATURE: ____________________

SITE: ____

DAY/WEEK* OF SERVICE	SPEECH								LANGUAGE								AURAL REHAB		SUPERVISOR INITIALS
	ARTIC		DYSPH		VOICE		FLUENCY		Language		Com Modalities		Cog Aspects		Soc Aspects				
	DX	TX	DX	TX	DX	TX	DX	TX	DX	TX	DX	TX	DX	TX	DX	TX	DX	TX	
TOTAL																			

*Week of service only applies for internship settings

TOTAL LANGUAGE DX		TOTAL LANGUAGE TX		TOTAL HRS =

REMINDER: All hours are to be entered in 15 minute increments. (Ex. .25, .50, .75, 1.0)

DIVERSITY: R = Racial Ethnic; S = Socio-Economic Status; L = Language

# of Hours																

12/2013 SM

SAMPLES OF STUDENT EVALUATION FORMS

It is the Clinical Instructor's decision as to which forms are used. The videotape observation report is mandatory.

SEQUENCE COUNTS

Sequence	# of Events
C/PV	
C/NVP	
C/T	
C/E	
C/PV/NVP	
C/PV/NVP/PT/T	
Etc.	

SELF-ASSESSMENT: CORRECTIVE FEEDBACK

Clinician______________
Date_________________

Corrective feedback is defined as the type of corrective measures the clinician will utilize after the client has made as incorrect response. Beginning clinicians have historically demonstrated difficulty in this area by (1) using ambiguous feedback resulting in confusion for the client as to whether the response was correct or incorrect and (2) using feedback lacing descriptive qualities such as modeling, phonetic placement and motokinesthetic techniques. This critique form looks at types and sequences of corrective feedback used, then asks the clinician to review the percentage of correct responses to determine if the corrective feedback techniques utilized resulted in maximum gain by the client.

Utilizing the coding system below, tally the type of corrective feedback given the client after an incorrect or approximated response. Place the code for each event in one box of the matrix working left to right.

RESPONSE CODE
I= incorrect response
A= approximated response
C= correct response

FEEDBACK CODE
NR= no response from clinician
VN= verbal negative, e.g. "No, try again."
M= model
VC= visual clue
PP= phonetic placement e.g. "Put your tongue up and back."
MC= motokinesthetic cue, i.e. giving tactile cues.

Total number of responses (I + A + C) = ___________

Percentage of correct responses $\frac{C}{I + A + C}$ = ____________

Examine the matrix and circle the sequences of corrective feedback. In the space below list the sequences and the number of times each sequence occurred in the session. The slash indicates "followed by" in sequence counts.

SEQUENCE COUNTS

Sequence	# of Events
I/NR	
I/VN	
I/VN/PP/M	
I/MC/PP/M	

SELF-ASSESSMENT: GROUP MANAGEMENT ROTATION RATES

Clinician___________

Date_____________

Group management is not the norm in most practicum sites for speech-language pathology. Therefore, when the beginning student is faced with teaching two or more children at the same time, he often does not understand how to rotate from child to child quickly in order to keep all children as involved as possible and behavior problems at a minimum. With this self-assessment form student clinicians can assess, in minutes and seconds, the amount of time spent with each child in a group management session. This not only given information regarding how quickly the SLP rotates from child to child, but this count will also yield a total amount of time spent with each individual child so the clinician can note if more time is being spent with one client than the others.

Below write out the session task for each child. This will help in the analysis since, for example, in articulation management more time may appropriately be spent with a client at the level of concentration versus a client at the word level of remediation.

Task for Child A ________________________

Task for Child B ________________________

Task for Child C ________________________

Task for Child D ________________________

Using the matrix below, figure in minutes and seconds the time spent with each child for "his turn" during the speech session. Compute the total amount of time spent with each child.

TURN

	1	2	3	4	5	6	7	8	9	10	11	12
Child A												
Child B												
Child C												
Child D												

Total time spent with Child A _______________
Child B _______________
Child C _______________
Child D _______________

$\frac{\text{Total time with all children}}{\text{Total number of turns}}$ = Mean length of each turn = ____________

SELF-ASSESSMENT: RESPONSE RATE

Clinician___________________
Date_______________________

The response rate form was developed so the clinician can self-assess how many responses per minute are being elicited from the client. When a Clinical Instructor says that the pace of the session is too slow, the supervisee can count responses to see if this is an area which needs to be improved. The clinician can accumulate baseline data and attempt to improve number of responses per minute until the Clinical Instructor and supervisee agree the number of responses per session appropriate.

To figure response rate, add together correct and incorrect responses and divide by number of minutes of direct management. For example, if in an individual management session the client had 37 correct and 24 incorrect responses, add these scores together for a total of 61. Then divide by the time involved in direct drill, e.g. 20 minutes. The response rate for the session would be:

$$\frac{\text{61 total responses}}{\text{20 min. direct drill}} = \text{3.05 responses per minute}$$

An example of figuring group response rates would be:

Child A has 12 correct and 43 incorrect for a total of 55
Child B has 29 correct and 12 incorrect for a total of 41
Child C has 42 correct and 9 incorrect for a total of 51

Add these totals together to find a total number of responses for the session. In this example the total equals 147. Next divide total number of responses in the session by the time involved in direct drill, 23 minutes.

$$\frac{147 \text{ responses}}{23 \text{ min. direct drill}} = 6.4 \text{ responses per minute}$$

Client	Task	# Correct	# Incorrect	Minutes of Drill	Responses per Minute

Comments:

SELF-ASSESSMENT: CLINICIAN RESPONSE TO CLIENT SOCIAL COMMENTS

Clinician____

Task____

Date____

As you listen to the audio- or videotape, after each social comment from the client note the category of the clinician's next remark by placing a checkmark in the appropriate space. Next note the effect your behavior had on the child in the column marked "Consequence." Indicate the topic of the "Client Social" by paraphrasing the comment in a few words, i.e., "recess fight."

Client Social (Comment)	Clinician			Consequences
	Social	Bad Evaluation	Return to Task	
Example 1. "Mary hit Tom" – recess fight				Client returned
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

Comments regarding the data: ____
____
____
____
____
____
____
____

SELF-ASSESSMENT: CLINICIAN VS. CLIENT TALK –TIME

Clinician____
Task____
Date____

For this self-analysis, you will need to have two stopwatches. As you listen to the audio-or videotape, measure the clinician's talk-time with one stopwatch and the client's talk-time with the other.

Talk-time of the clinician ______________________

Talk-time of the client ______________________

Total talk-time for session ______________________

Percentage of the clinician talk-time ___________________

(Clinician talk-time / total talk = % clinician talk-time)

Comments regarding the data: ____
____
____
____
____
____
____

Reprinted with permission from: Mawdsley, B. (1987). Kansas inventory of self-instruction. In Farmer, S. (Ed.) (1987). *Clinical instruction: A coming of age.* Proceedings of a conference held at Jekyll Island, GA: Las Cruces, N. M., New Mexico State University.

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 TIME/ MAYBE	NO
1. Do my goals meet my client's therapy needs?			
2. Does the client understand what is expected of him?			
3. Does the client interrupt the therapy by asking questions, looking away, getting down from the table, throwing things, etc.?			
4. Am I using a reinforcer?			
5. Is the client working to get the reinforcer?			
6. Do I reinforce correct responses on a fixed ratio schedule?			
7. Do I reinforce correct responses in a random manner?			
8. Do I reinforce a response as soon as it is given?			
9. Do I ever positively reinforce an incorrect response?			
10. Do I model the correct response?			
11. Do I provide a cue to help the client give the correct response?			
12. Do I vary my social praise?			
13. Does the client talk enough?			
14. Do I change activities before the client loses interest?			
15. Am I counting accurately?			
16. Are my materials out and ready?			
17. Do I fumble around looking for or selecting materials during therapy?			
18. Are my materials appropriate for the response I want?			
19. Do I look like I know what I am doing?			
20. Do I look at the client's face when he is making a response?			
21. Does my client watch my lips when I am modeling?			
22. Am I getting a good number of responses?			

23. Does my client say multiple (i.e., 3, 5, or 10 for example) responses at one time?
24. Do I control the session?
25. 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 <u>your</u> 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.

<u>END OF TERM EVALUATION</u>

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

Kansas Inventory of Self-Instruction
(KISS)
Brenda L. Mawdsley

SELF-ASSESSMENT: OVERUSE OF "OK"

Clinician____
Date_______________

When supervising beginning students in speech-language pathology, it becomes apparent that many tend to say "OK" an excessive number of times during the management session. Four main types of "OK" responses seem to be the ones overused. They are "OK" used as (1) a filler, (2) a positive reinforcer, (3) corrective feedback and (4) tag question. The definitions are as follows:

"OK" as a filler- This happens when the clinician says "OK" for no reason throughout the session. For example "OK, now let's turn to the back page."

"OK" as a positive reinforcer – This is used after the client has given a correct response. Used in this manner, it can often appear as if clinicians are really not committing themselves to the client's production.

"OK" as corrective feedback- This often occurs when beginning clinicians are afraid to commit as to the correctness or incorrectness of a response. After an error the clinician would say "OK" instead of giving a rich descriptive feedback.

"OK" as a tag question- An example of this is "Pull your tongue up and back, OK?" or "Let's get out our speech books, OK?" The addition of "OK" makes a statement into a nonassertive request.

During a 20-minute session, count the number of times each of the following types of "OK" are spoken by the clinician.

TYPE	DATA
"OK" used a filler	
"OK" as positive reinforcer	
"OK" as corrective feedback	
"OK" as a tag question	
Total number of "OK"s ______________________________	

After listening to the tape, set a realistic goal for reducing the incidence of "OK." Audio or video sessions weekly until the goal is met up.

SELF-ASSESSMENT: POSITIVE REINFORCEMENT

Clinician____________
Date_______________

Positive reinforcement is a tool which is utilized daily by speech-language pathologists. This form assists the beginning clinician in categorizing the various types of positive reinforcement used, and in examining sequences of positive reinforcement. For example, the clinician might say, "Good talking," then smile at the client, then give him a token. Three types of positive reinforcement have been utilized and now can be

categorized and counted. The clinician can analyze the type and amount of reinforcement being used, examine the amount of progress the client is making and adjust the reinforcement sequences accordingly.

Utilizing the coding system below, tally the type of positive reinforcement given the client after a correct response in the blank matrix, placing only one code per box. (Note: For a young client who needs maximum reinforcement, one may chart type of positive reinforcement used after any responses.)

RESPONSE CODE
C= correct response
I= incorrect response

FEEDBACK CODE
PV= positive verbal
NVP= non-verbal positive
(smiling, nodding, leaning)
PT= positive touch
T= token reinforcement
E= edible reinforcement

Total number of responses (C+I) = ________________

Percentage of correct responses $\frac{C}{C + I}$ = __________

Examine the matrix and circle the sequences of positive reinforcement used. For example, a correct response followed by a smile, positive touch and a token would have a sequence code of C/NVP/PT/T. (Slashes indicate "followed by" in sequence counts). List the sequences and the number of times that sequences is used during the session.

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	f. Complete administrative & reporting functions necessary to support evaluation	g. refer clients/patients for appropriate services
(A) **ARTICULATION** (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) = 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	f. Complete administrative & reporting functions necessary to support evaluation	g. refer clients/patients for appropriate services
(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)							

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	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	f. Complete administrative & reporting functions necessary to support intervention	g. Identify & refer clients for services as appropriate
(A) **ARTICULATION** (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. 4

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	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	f. Complete administrative & reporting functions necessary to support intervention	g. Identify & refer clients for services as appropriate
(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)							

10/1/12-LS:jl (New forms)

CODE OF ETHICS

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Preamble

The preservation of the highest standards of integrity and ethical principles is vital to the responsible discharge of obligations by speech-language pathologists, audiologists, and speech, language, and hearing scientists. This Code of Ethics sets forth the fundamental principles and rules considered essential to this purpose.
Every individual who is (a) a member of the American Speech-Language-Hearing Association, whether certified or not, (b) a nonmember holding the Certificate of Clinical Competence from the Association, (c) an applicant for membership or certification, or (d) a Clinical Fellow seeking to fulfill standards for certification shall abide by this Code of Ethics.
Any violation of the spirit and purpose of this Code shall be considered unethical. Failure to specify any particular responsibility or practice in this Code of Ethics shall not be construed as denial of the existence of such responsibilities or practices.
The fundamentals of ethical conduct are described by Principles of Ethics and by Rules of Ethics as they relate to the responsibility to persons served, the public, speech-language pathologists, audiologists, and speech, language, and hearing scientists, and to the conduct of research and scholarly activities.
Principles of Ethics, aspirational and inspirational in nature, form the underlying moral basis for the Code of Ethics. Individuals shall observe these principles as affirmative obligations under all conditions of professional activity.
Rules of Ethics are specific statements of minimally acceptable professional conduct or of prohibitions and are applicable to all individuals.

Principle of Ethics I

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

Rules of Ethics

1. Individuals shall provide all services competently.
2. Individuals shall use every resource, including referral when appropriate, to ensure that high-quality service is provided.
3. Individuals shall not discriminate in the delivery of professional services or the conduct of research and scholarly activities on the basis of race or ethnicity, gender, gender identity/gender expression, age, religion, national origin, sexual orientation, or disability.
4. Individuals shall not misrepresent the credentials of assistants, technicians, support personnel, students, Clinical Fellows, or any others under their supervision, and they shall inform those they serve professionally of the name and professional credentials of persons providing services.
5. Individuals who hold the Certificate of Clinical Competence shall not delegate tasks that require the unique skills, knowledge, and judgment that are within the scope of their profession to assistants, technicians, support personnel, or any nonprofessionals over whom they have supervisory responsibility.

6. Individuals who hold the Certificate of Clinical Competence may delegate tasks related to provision of clinical services to assistants, technicians, support personnel, or any other persons only if those services are appropriately supervised, realizing that the responsibility for client welfare remains with the certified individual.
7. Individuals who hold the Certificate of Clinical Competence may delegate tasks related to provision of clinical services that require the unique skills, knowledge, and judgment that are within the scope of practice of their profession to students only if those services are appropriately supervised. The responsibility for client welfare remains with the certified individual.
8. Individuals shall fully inform the persons they serve of the nature and possible effects of services rendered and products dispensed, and they shall inform participants in research about the possible effects of their participation in research conducted.
9. Individuals shall evaluate the effectiveness of services rendered and of products dispensed, and they shall provide services or dispense products only when benefit can reasonably be expected.
10. Individuals shall not guarantee the results of any treatment or procedure, directly or by implication; however, they may make a reasonable statement of prognosis.
11. Individuals shall not provide clinical services solely by correspondence.
12. Individuals may practice by telecommunication (e.g., telehealth/e-health), where not prohibited by law.
13. Individuals shall adequately maintain and appropriately secure records of professional services rendered, research and scholarly activities conducted, and products dispensed, and they shall allow access to these records only when authorized or when required by law.
14. Individuals shall not reveal, without authorization, any professional or personal information about identified persons served professionally or identified participants involved in research and scholarly activities unless doing so is necessary to protect the welfare of the person or of the community or is otherwise required by law.
15. Individuals shall not charge for services not rendered, nor shall they misrepresent services rendered, products dispensed, or research and scholarly activities conducted.
16. Individuals shall enroll and include persons as participants in research or teaching demonstrations only if their participation is voluntary, without coercion, and with their informed consent.
17. Individuals whose professional services are adversely affected by substance abuse or other health-related conditions shall seek professional assistance and, where appropriate, withdraw from the affected areas of practice.
18. Individuals shall not discontinue service to those they are serving without providing reasonable notice.

Principle of Ethics II

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

Rules of Ethics

1. [Deleted effective June 1, 2014] ~~Individuals shall engage in the provision of clinical services only when they hold the appropriate Certificate of Clinical Competence or when they are in the certification process and are supervised by an individual who holds the appropriate Certificate of Clinical Competence.~~
2. Individuals shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their level of education, training, and experience.
3. Individuals shall engage in lifelong learning to maintain and enhance professional competence and performance.
4. Individuals shall not require or permit their professional staff to provide services or conduct research activities that exceed the staff member's competence, level of education, training, and experience.
5. Individuals shall ensure that all equipment used to provide services or to conduct research and scholarly activities is in proper working order and is properly calibrated.

Principle of Ethics III

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

Rules of Ethics

1. Individuals shall not misrepresent their credentials, competence, education, training, experience, or scholarly or research contributions.
2. Individuals shall not participate in professional activities that constitute a conflict of interest.
3. Individuals shall refer those served professionally solely on the basis of the interest of those being referred and not on any personal interest, financial or otherwise.
4. Individuals shall not misrepresent research, diagnostic information, services rendered, results of services rendered, products dispensed, or the effects of products dispensed.
5. Individuals shall not defraud or engage in any scheme to defraud in connection with obtaining payment, reimbursement, or grants for services rendered, research conducted, or products dispensed.
6. Individuals' statements to the public shall provide accurate information about the nature and management of communication disorders, about the professions, about professional services, about products for sale, and about research and scholarly activities.
7. Individuals' statements to the public when advertising, announcing, and marketing their professional services; reporting research results; and promoting products shall adhere to professional standards and shall not contain misrepresentations.

Principle of Ethics IV

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

Rules of Ethics

1. Individuals shall uphold the dignity and autonomy of the professions, maintain harmonious interprofessional and intraprofessional relationships, and accept the professions' self-imposed standards.
2. Individuals shall prohibit anyone under their supervision from engaging in any practice that violates the Code of Ethics.
3. Individuals shall not engage in dishonesty, fraud, deceit, or misrepresentation.
4. Individuals shall not engage in any form of unlawful harassment, including sexual harassment or power abuse.
5. Individuals shall not engage in any other form of conduct that adversely reflects on the professions or on the individual's fitness to serve persons professionally.
6. Individuals shall not engage in sexual activities with clients, students, or research participants over whom they exercise professional authority or power.
7. Individuals shall assign credit only to those who have contributed to a publication, presentation, or product. Credit shall be assigned in proportion to the contribution and only with the contributor's consent.
8. Individuals shall reference the source when using other persons' ideas, research, presentations, or products in written, oral, or any other media presentation or summary.
9. Individuals' statements to colleagues about professional services, research results, and products shall adhere to prevailing professional standards and shall contain no misrepresentations.
10. Individuals shall not provide professional services without exercising independent professional judgment, regardless of referral source or prescription.
11. Individuals shall not discriminate in their relationships with colleagues, students, and members of other professions and disciplines on the basis of race or ethnicity, gender, gender identity/gender expression, age, religion, national origin, sexual orientation, or disability.

12. Individuals shall not file or encourage others to file complaints that disregard or ignore facts that would disprove the allegation, nor should the Code of Ethics be used for personal reprisal, as a means of addressing personal animosity, or as a vehicle for retaliation.
13. Individuals who have reason to believe that the Code of Ethics has been violated shall inform the Board of Ethics.
14. Individuals shall comply fully with the policies of the Board of Ethics in its consideration and adjudication of complaints of violations of the Code of Ethics.

Index terms: ethics
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POSITION STATEMENT:
CLINICAL SUPERVISION IN SPEECH-LANGUAGE PATHOLOGY

Ad Hoc Committee on Supervision in Speech-Language Pathology

About this Document

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

Position Statement

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

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

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Index terms: supervision

Reference this material as: American Speech-Language-Hearing Association. (2008). *Clinical supervision in speech-language pathology* [Position Statement]. Available from www.asha.org/policy.

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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 do, sign at the bottom, and return with your application materials.

Physical Abilities

- Able to participate in classroom or clinical activities 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 provide for one's own personal hygiene
- Able to manipulate therapeutic/diagnostic materials, including setting out test items, turning pages, etc.
- Able to respond quickly enough to provide a safe environment for clients in emergency situations.
- Able to read the dials on instruments and to visually monitor a client's response
- Able to make accurate auditory judgments about speech and/or acoustic signals

Affective Abilities

- Able to interact effectively and courteously with people in person, on the telephone, and through emails, texts, or social media
- Able to make appropriate decisions, including the ability to evaluate and generalize appropriately without immediate instruction
- Able to understand, respect, and comply with Clinical Instructory authority
- Able to maintain appropriate work ethics, including punctuality and regular attendance
- Able to maintain appropriate behavior, including appropriate interpersonal skills both one-on-one and in group settings, and appropriate professional attire

Cognitive Abilities

- Able to comprehend and read professional literature/reports and write university level papers and clinical reports in Standard English
- Able to submit required academic and clinical paperwork within deadlines
- Able to work and operate in a group
- Able to speak Standard English intelligibly, including the ability to give live-voice test items to clients
- Able to independently analyze, synthesize, interpret ideas and concepts in academic and diagnostic/clinic settings
- Able to maintain attention and concentration for sufficient time to complete academic/clinical activities, typically 2-4 hours with 1-2 breaks.

I have read, understand and agree to comply with the functions above.
____ (student signature and date).