APPLICATIONS FOR SPEECH-LANGUAGE PATHOLOGY ASSISTANT APPLICATION CHECKLIST

I. ALL APPLICANTS NEED:

____ $100.00 Fee (make check or money order payable: Board of SLP)
____ A recent 2x2 passport size photo
____ Application Signed
____ Application Notarized
____ Law Exam completed and returned with Application

Note: to pass the open book law examination, all applicants must score at least 75. You can download the the examination from the Board's web site at www.mdboardaudhadslp.org. Use the Forms Link to download a copy of the exam. To complete the examination refer to the law and regulations reference numbers included with the question. Use the Law and Regulation Links on the web site to get the correct answer. If you do not have access to a computer, call the Board office at 410-764-4725 and request a copy of the law and regulations. A license will **NOT** be issued unless the law examination is passed.

II. APPLICANT FOR FULL LICENSE BY WAIVER

You may qualify for a waiver of the requirements for licensure as a Speech-Language Pathology Assistant if you meet one of the following.

A. Hold a valid ASHA registration as a SLP Assistant
In addition to items in Section I, submit with application:

____ Copy of ASHA SLP Assistant Registration or
Letter from ASHA verifying SLP Assistant Registration
____ Delegation Agreement (Form SA6) completed by each
Supervising Speech-Language Pathologists

B. Hold a valid license, certification or registration as a Speech-Language Pathology Assistant in another State with requirements equal to or greater than Maryland's.
In addition to items in Section I, submit with application:

____ Verification from the other State of licensure, certification or
registration as a Speech-language Pathology Assistant
(Form SA8) including a copy of other state's law and regulations
governing SLP Assistants.
____ Delegation Agreement (Form SA6) completed by each
Supervising Speech-Language Pathologist.

C. Have practiced as a SLP Assistant for at least two years prior to submitting this application. Application must be received by the Board by March 31, 2004. In addition to items in Section I, submit with application:

____ Letter from the Supervising Speech-Language Pathologist attesting
to the dates you have practiced as a SLP Assistant.
____ Competency Skills Check List (Form SA7) completed by the

Supervising Speech-Language Pathologist.

____ Delegation Agreement (Form SA6) completed by each Supervising Speech-Language Pathologist.

III. Application for a Limited SLP Assistant License
In addition to items in Section I, submit the following documentation:

A. Education Requirement
Have official transcript from college or university verifying one of the following degrees sent directly to the Board:

____ Associate Degree from an approved SLP Assistant Program

____ Associate Degree in an allied health field with 15 hours in required minimum course work (see enclosed regulations)

Attach Form SA2 describing required minimum coursework as stated on transcript.

____ B.A. Degree in Speech-Language Pathology or Communication Disorders

B. Clinical Hours Requirement (Not required if you attended approved SLP Assistant program)

Documentation of 25 hours of clinical observation and 75 hours of clinical assistance experience. Submit either:

Form SA3 Education Institution Verification of Completion of Required Clinical Hours, or

Form SA4 Alternate Plan for Obtaining Required Clinical Hours signed by applicant and Supervising Speech-Language Pathologist.

C. Delegation Agreement (Form SA6) completed by each Supervising Speech-Language Pathologist.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BOARD OF EXAMINERS FOR AUDIOLOGISTS, HEARING AID DISPENSERS AND SPEECH-LANGUAGE PATHOLOGISTS
4201 PATTERSON AVENUE * BALTIMORE, MARYLAND 21215-2299 * PHONE 410-764-4725
FAX 410-358-0273 * TTY FOR DISABLED – MARYLAND RELAY SERVICE 1-800-735-2258

APPLICATION FOR LICENSURE FOR SPEECH-LANGUAGE PATHOLOGY ASSISTANTS

Affix current Photo here

Date_________________

1. Name____
Last First Middle/Maiden

2. Date of Birth ____________________ Social Security # __________________

3. Residence____
Street Apt.

____
City State Zip code

4. Phone #______________Alternate#____________ E-Mail__________________

5. Professional Address ______________________________________
Facility or Company's Name

____
Street Suite #

____
City State Zip Code

Telephone # _______________ Fax__________________ E-mail________________

Beginning Date of Employment ________________________________

6. Have you ever been convicted of a felony or a misdemeanor involving moral turpitude? ____________ Yes ______________ No

IF "YES" ATTACH FULL DETAILS

For Office Use

Received **CH( )** **MO( )** **Number___________________**

Revised 11/07

7. **Waiver of Requirements**

A. Do you hold a valid American Speech-Language-Hearing Association Registration as a speech-language pathology assistant?
______ Yes ______ No If yes, Date originally granted ________________
Attach copy of ASHA SLP Assistant Registration or letter from ASHA verifying registration as an SLP Assistant. **Also attach** Delegation Agreement (Form SA6) completed by each supervising speech-language pathologist.

B. Do you hold a valid license, certification or registration as a speech-language pathology assistant in another state? _____ Yes _____ No
If yes, list State (s) _____ ______ _______ _______
Has any disciplinary action ever been taken against your license in any other jurisdiction? Yes ______ No ______

If yes, please attach full explanation.
Attach copy of SLP Assistant license, certification or registration from the State. **Send** affidavit (Form SA8 – last page of application) verifying license, certification, or registration to the State(s) and ask that it be returned to the Maryland Board. **Also attach** Delegation Agreement (Form SA6) completed by each supervising speech-language pathologist.

C. Have you practiced as a SLP Assistant for at least two years prior to submitting this application? __________Yes _________No.

If yes, attach a letter from your supervising speech-language pathologist attesting to the dates you have practiced as a SLP Assistant. **Also attach** Delegation Agreement (Form SA6) for each supervising Speech-Language Pathologist **and** completed Competency Skills Check List, (Form SA7)

8. **Education**
A. School attended: ____
Address: ____
____
Dates Attended: From _________________ To: ______________________
Degree Granted: _______________________________ Date:________________
Have School send official transcript verifying education completed directly to the Maryland Board.

B. Please indicate whether you have one of the following degrees:

1. Associate Degree from an approved SLP Assistant Program _______Yes _____No

2. Associate Degree in an allied health field with 15 hours in required minimum course work _________Yes _________No

If you have an Associate Degree in an allied health field, complete Form SA2 describing required minimum coursework as stated on transcript. If the title of the course is not self-explanatory, attach catalog description or syllabus.

3. B. A. Degree in Speech-Language Pathology or Communication Disorders
_______Yes _______No

C. Did your educational program include the following required clinical hours as a Speech-Language Pathology Assistant?

25 hours of clinical observation _________Yes ________ No
75 hours of clinical assistance _________ Yes ________ No

If you did not attend an approved SLP Assistant Program, **attach Form SA3** signed by the Department Chair or Clinic Director documenting the required clinical hours.

If your educational program did not include the required clinical hours, complete Form SA4 documenting the Plan that you and the supervising speech-language pathologist have developed to complete the clinical hours within the first 60 days of limited licensure.

9. Practice Setting

Name of Facility ____
Address: ____
____
Phone Number:________________________ Beginning Date:___________________
Description of Duties:____
____
____
Supervising Speech-Language Pathologist (s):

____
Name Title

____
Name Title

____
Name Title

Note: A Delegation Agreement, Form SA6, must be submitted for each supervising Speech-Language Pathologist.

Please review the regulations and sign the following affirmation:

I affirm that I have read the Speech-Language Pathology Assistant regulations, including the sections specifying activities that are within the scope of practice of SLP Assistants and activities that are not with the scope of practice of SLP Assistants.

____ _____________________
Signature of Applicant Date

10. Have this Affidavit completed by a Notary Public

STATE OF ____

CITY OR COUNTY OF ____

The undersigned, being duly sworn deposes and says that he/she is the person who executed this application, that the statements herein contained are true to the best of his/her knowledge, that he/she has not suppressed any information that might affect this application and that he/she has read and understands this affidavit.

____

Signature of Applicant Signature of Notary

Subscribed and sworn to before this __________ day of _________________________

- -

In accordance with Executive Order 01.01.1093-18, the Board is required to advise you as follows regarding the collection of personal information:

Personal information requested by the Board is necessary in determining your eligibility for licensure. Such personal information is also intended for use as an additional means of verifying the licensee's identity or to enable the Board to communicate, in a timely manner, with the licensee should the need arise. The licensee has a right to inspect his personal record and to amend or correct the personal data if necessary.

Your Social Security Number is needed on the application. It will be used for identification purposes and may be released to the Department of Public Safety and correctional Services to check for any criminal convictions.

BOARD OF EXAMINERS FOR AUDIOLOGISTS, HEARING AID DISPENSERS AND SPEECH-LANGUAGE PATHOLOGISTS

4201 PATTERSON AVENUE * BALTIMORE, MARYLAND 21215-2299 * PHONE 410-764-4725
FAX 410-358-0273 * TTY FOR DISABLED – MARYLAND RELAY SERVICE 1-800-735-2258

ASSOCIATE DEGREE IN ALLIED HEALTH FIELD
VERIFICATION OF MINIMUM REQUIRED COURSEWORK

Applicant (Please type or print)

Name: ____

Last First Middle/Maiden

Address: ____

Street Apt. #

____

City State Zip Code

Phone: ________________ Alternate #________________

Educational Institution

Name of Institution: ____

Address: ____

Street____

____

City State Zip Code

Dates Attended: From _______________ To _________________

Associate Degree in _____________________granted _______________

(major) (date)

The Board's regulations require that an applicant with an Associate's Degree in an alliedhealth field from an accredited institution has completed at least 3 credit hours in each of the areas listed below.

FORM SA2

FORM SA2

Please indicate the name of the course on the transcript that fulfills each requirement and **attach an official transcript showing the Associate Degree.** If the title of the course is not self-explanatory, attach catalog description or syllabus. A minimum of 3 credit hours is required in each of the following areas:

1. Normal Speech-Language Development
Name of Course ____
Semester Taken ____
Additional Courses in this area: ___________________________________
____

2. Speech Disorders
Name of Course ____
Semester Taken ____
Additional Courses in this area: ___________________________________
____

3. Anatomy and Physiology of Speech Systems
Name of Course ____
Semester Taken ____
Additional Courses in this area:___________________________________
____

4. Language Disorders
Name of Course ____
Semester Taken ____
Additional Courses in this area: ___________________________________
____

5. Phonology
Name of Course ____
Semester Taken ____
Additional Courses in this area:___________________________________
____

FORM SA3

BOARD OF EXAMINERS FOR AUDIOLOGISTS, HEARING AID DISPENSERS AND SPEECH-LANGUAGE PATHOLOGISTS

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FAX 410-358-0273 * TTY FOR DISABLED – MARYLAND RELAY SERVICE 1-800-735-2258

EDUCATIONAL INSTITUTION VERIFICATION OF COMPLETION OF REQUIRED CLINICAL HOURS

The Board's regulations require that the speech-language pathology assistant shall demonstrate completion of at least 25 hours of clinical observation and 75 hours of clinical assistance experience obtained within an educational institution or in one of the educational institution's cooperating programs.

Applicant (Please Type or print)

Name: ____
Last First Middle/Maiden

Address: ____
Street Apt. #

____
City State Zip Code

Phone: __________________

2. Educational Institution

Name of Institution: ____

Address: ____
Street

____
City State Zip Code

Dates Attended: From ________________ To __________________

3. Verification

I verify that ____ completed the
Applicant
following clinical observation hours and clinical assistance hours during the time he/she was a student at ______________________________________
educational institution

25 Clinical Observation Hours completed From ____________to __________

75 Clinical Assistance Hours completed From ___________to ____________

_______________________________________ ________________________
Signature Title

_____________________________________ ________________________
Print Name Phone

FORM SA4

BOARD OF EXAMINERS FOR AUDIOLOGISTS, HEARING AID DISPENSERS AND SPEECH-LANGUAGE PATHOLOGISTS

4201 PATTERSON AVENUE * BALTIMORE, MARYLAND 21215-2299 * PHONE 410-764-4725
FAX 410-358-0273 * TTY FOR DISABLED – MARYLAND RELAY SERVICE 1-800-735-2258

ALTERNATIVE PLAN FOR OBTAINING REQUIRED CLINICAL HOURS

This form must be completed if you have not obtained the required 25 clinical observation hours and 75 clinical assistance hours from your educational institution.

1. Applicant (Please Type or print)

Name:____
Last First Middle/Maiden

Address:____

____
Street Apt. #

____
City State Zip Code

Phone: ____________________________ E-mail______________________

2. Supervising Speech-Language Pathologist

Name:____
Last First Middle/Maiden

Professional Address:____
Facility or Company's Name

____
Street Suite #

____
City State Zip Code

Telephone # ________________________________

This Plan must be approved by the Board and a Limited License issued BEFORE any clinical observation or clinical assisting experience is obtained

The Alternative Plan must ensure that the applicant will obtain the required 25 clinical observation hours and 75 clinical assisting hours **within 60 days** of the applicant's receipt of a limited License. The plan shall be designed and signed by the supervising speech-language pathologist. If the Board does not receive proof of successful completion of the hours by the end of 90 days, the assistant's Temporary License is void and the assistant will need to reapply.

FORM SA4

The 75 hours of clinical assistance shall include 100% direct supervision by the supervising speech-language pathologist of the speech-language pathologist assistant during any client contact hours.

3. Alternative Plan for Clinical Hours

First Month

Week One from _______________ to _________________

Estimated Observation Hours ________ Estimated Assistance Hours _________

Week Two from ________________to ________________

Estimated Observation Hours _______ Estimated Assistance Hours __________

Week Three from _______________to ________________

Estimated Observation Hours _______ Estimated Assistance Hours _________

Week Four from ________________to ________________

Estimated Observation Hours _______ Estimated Assistance Hours _________

Second Month

Week Five from ________________ to ________________

Estimated Observation Hours _______ Estimated Assistance Hours _________

Week Six from ________________ to _______________

Estimated Observation Hours _______ Estimated Assistance Hours ________

Week Seven from _______________ to _______________

Estimated Observation Hours _______ Estimated Assistance Hours ________

Week Eight from _______________ to _______________

Estimated Observation Hours _______ Estimated Assistance Hours _______

Signature of Applicant _______________________________ Date ______________

Signature of Supervisor _______________________________Date_______________

Supervisor: ( ) Holds MD License in Speech-Language Pathology

( ) Holds ASHA CCC-SLP ( ) Holds Licensure in SLP in State of ___________

FORM SA5

BOARD OF EXAMINERS FOR AUDIOLOGISTS, HEARING AID DISPENSERS AND SPEECH-LANGUAGE PATHOLOGISTS

4201 PATTERSON AVENUE * BALTIMORE, MARYLAND 21215-2299 * PHONE 410-764-4725
FAX 410-358-0273 * TTY FOR DISABLED – MARYLAND RELAY SERVICE 1-800-735-2258

VERIFICATION OF COMPLETION OF REQUIRED CLINICAL HOURS

This form is to be submitted to the Board when the assistant has completed the required 25 clinical observation hours and 75 clinical assistance hours. The required hours must be completed within the first 60 days of Limited Licensure. This form must be submitted to the Board by the end of 90 days of receipt of a Limited License

1. Applicant (Please Type or print)

Name:____
Last First Middle/Maiden

Address:____
Street Apt. #

____
City State Zip Code

Phone: ________________________

2. Supervising Speech-Language Pathologist

Name:____
Last First Middle/Maiden

Professional Address:__________________________________
Facility or Company's Name

____
Street Suite #

____
City State Zip Code

Telephone # ________________________

3. I verify that___________________________________ , a Speech-Language
Applicant
Pathology Assistant under my supervision, has completed 25 hours of clinical observation and 75 hours of clinical assisting experience as indicated below:

First Month

Week One from ______________ to ________________
Observation Hours ________ Assistance Hours _________

Week Two from _______________to _______________
Observation Hours _______ Assistance Hours __________

Week Three from ______________to _______________
Observation Hours _______ Assistance Hours _________

Week Four from _______________to _______________
Observation Hours _______ Assistance Hours _________

Second Month

Week Five from _______________ to _______________
Observation Hours _______ Assistance Hours _________

Week Six from _______________ to ______________
Observation Hours _______ Assistance Hours ________

Week Seven from ______________ to ______________
Observation Hours _______ Assistance Hours ________

Week Eight from ______________ to ______________
Observation Hours _______ Assistance Hours _______

Signature of Supervisor______________________________Date______________

Supervisor: ( ) Holds MD License in Speech-Language Pathology
( ) Holds ASHA CCC-SLP ( ) Holds Licensure in SLP in State of ________________
<u>If the Board does not receive proof of successful completion of the hours by the end of 90 days, the assistant's Limited License is void and the assistant will need to reapply.</u>

FORM SA5

FORM SA6

MARYLAND BOARD OF EXAMINERS FOR AUDIOLOGISTS, HEARING AID DISPENSERS, AND SPEECH-LANGUAGE PATHOLOGISTS

4201 Patterson Avenue
Baltimore, Maryland 21215

SPEECH-LANGUAGE PATHOLOGY ASSISTANT/ SUPERVISING SPEECH-LANGUAGE PATHOLOGIST DELEGATION AGREEMENT

A Speech-Language Pathology Assistant or an applicant for licensure as a Speech-LanguagePathology Assistant must file a Delegation Agreement with the Board. A separate agreement must be filed for **each** supervising Speech-Language Pathologist under whom the SLP Assistant will be working. **Each Delegation Agreement must be re-filed at the time of license renewal.**

1. **SPEECH-LANGUAGE PATHOLOGY ASSISTANT INFORMATION:**

Applicant's Name:____

Mailing Address:____

____

Day Phone:______________________ Evening Phone:_______________________

If licensed as an assistant, Maryland SLP Assistant License Number:_______________

2. SUPERVISING SPEECH-LANGUAGE PATHOLOGIST

Name:____

Address:____

____

Day Phone:_______________________ Evening Phone:______________________

Maryland SLP License Number:__________ and/or ASHA Number:______________

3. **FACILITY INFORMATION** (where the SLP Assistant will be practicing)

Facility Name:____

Facility Address:____

____

Contact Person:___________________________ Phone:________________________

FORM SA6

Will the supervising Speech-Language Pathologist be responsible for the practice of the SLP Assistant at additional facilities? ______yes ______no
If yes, please indicate the additional facilities and their addresses here:

____
____
____
____

4. AGREEMENT

The Speech-Language Pathology Assistant named in this **Delegation Agreement** is authorized to assist the supervising Speech-Language Pathologist named in this agreement in the implementation of speech-language pathology treatment goals and related activities as outlined in the **SLPA Regulations** (COMAR 10.41.11**) under the direction of the supervising SLP at the above named facility(ies).**
The Supervising Speech-Language Pathologist agrees to supervise the SLP Assistant according to the standards outlined in the COMAR regulations.
The SLP Assistant agrees to perform only those activities authorized in the COMAR regulations.
The SLP Assistant agrees to notify the Board if this Delegation Agreement is no longer valid.

______________________________________ ____________________
Signature of SLPA Date

______________________________________ ______________________
Signature of Supervising SLP Date

FORM SA7

BOARD OF EXAMINERS FOR AUDIOLOGISTS, HEARING AID DISPENSERS AND SPEECH-LANGUAGE PATHOLOGISTS

4201 PATTERSON AVENUE * BALTIMORE, MARYLAND 21215-2299 * PHONE 410-764-4725
FAX 410-358-0273 * TTY FOR DISABLED – MARYLAND RELAY SERVICE 1-800-735-2258

SPEECH-LANGUAGE PATHOLOGY ASSISTANT COMPETENCY SKILLS CHECKLIST

At the beginning of the Assistant's Limited Licensure:

The Supervising Speech-Language Pathologist and the Speech-Language Pathology Assistant should review the competency skills check list **at the beginning** of the period of limited licensure and periodically thereafter. Discussion of the skills required and review of the Assistant's progress towards acquiring these skills can prove useful throughout the limited licensure period. Using the checklist as a learning tool will provide clear goals for the Assistant and lead to the successful completion of the Check List at the end of the nine months of supervised practice.

After 9 months of supervised practice:

The Competency Skills Check List is to be completed by the supervising Speech-Language Pathologist after the Speech-Language Pathology Assistant has completed a minimum of nine (9) months of supervised practice under a limited license. Completion of the checklist verifies that the Assistant has acquired the skills and knowledge needed to receive a full license as a Speech-Language Pathology Assistant. The Speech-Language Pathology Assistant shall submit the completed Competency Skills Check List to the Board **at least 60 days before** the limited license expiration date.

FORM SA7

BOARD OF EXAMINERS FOR AUDIOLOGISTS, HEARING AID DISPENSERS AND SPEECH-LANGUAGE PATHOLOGISTS

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FAX 410-358-0273 * TTY FOR DISABLED – MARYLAND RELAY SERVICE 1-800-735-2258

SPEECH-LANGUAGE PATHOLOGY ASSISTANT COMPETENCY SKILLS CHECKLIST

Speech-Language Pathology Assistant:____
Supervising Speech-Language Pathologist:_____________________________________

DIRECTIONS:
The supervising speech-language pathologist marks yes or no to indicate that the assistant is competent and meets the following criteria.

I. INTERPERSONAL SKILLS:

Standard: The speech-language pathology assistant actively demonstrates cooperation, adaptability, and effective communication.

1. Criteria: Deals effectively with the attitudes and behaviors of the patients/clients **Yes No**
   - a. Maintains appropriate patient/client relationships ___ ___
   - b. Communicates effectively and with sensitivity the needs of the patient/client, family and caregivers ___ ___
   - c. Addresses/considers patient/client and significant others cultural needs and values ___ ___
   - d. Demonstrates insight into patient/client and caregivers attitudes and behaviors ___ ___
   - e. Refers patient/client/caregivers/other professionals to the supervising speech-language pathologist when appropriate ___ ___
   - f. Other:____ ___ ___

2. Criteria: Communicates and interacts effectively with supervisor Yes No
   - a. Accepts and responds appropriately to constructive criticism ___ ___
   - b. Requests assistance from supervisor appropriately ___ ___
   - c. Actively participates in interactions with supervisor ___ ___
   - d. Other:____ ___ ___

II. PERSONAL QUALITIES:

Standard: The speech-language pathology assistant demonstrates professional behavior and confidentiality.

1. Criteria: Demonstrates behaviors of a dependable team member, which may include: Yes No
   - a. Arrives punctually to appointments with prepared assignments ___ ___
   - b. Submits documentation on time ___ ___
   - c. Completes assigned tasks within designated treatment session ___ ___

2. Criteria: Demonstrates appropriate conduct in the work environment,
which may include:
a. Maintains confidentiality of client information at all times ___ ___
b. Maintains professional appearance for work environment ___ ___
c. Recognizes own professional limitations and performs ___ ___
within the boundaries of training and job responsibilities

III. TECHNICAL-ASSISTANT SKILLS
Standard: The speech-language pathology assistant assists the therapist in providing adequate treatment
1. Criteria: Maintains a facilitating environment for all tasks Yes No
a. Adjusts environment to facilitate learning ___ ___
(i.e. Lights, noise, etc)
b. Organizes treatment space appropriately ___ ___
c. Other ____ ___ ___
2. Criteria: Selects prepares and presents materials effectively
a. Selects and prepares appropriate treatment materials ___ ___
b. Selects treatment materials based on clients age, needs, ___ ___
culture and motivation
3. Criteria: Complies with documentation standards
a. Documents treatment plans and protocols accurately, ___ ___
completely and concisely for the supervising speechlanguage
pathologist
b. Documents client progress and performance to supervisor ___ ___
c. Signs documents and assures cosignature when required ___ ___
d. Prepares and maintains client records, charts, graphs, ___ ___
objective data as directed by the supervisor
4. Criteria: Provides assistance to the supervising speech-language pathologist
a. Assists the supervisor as directed during assessments by ___ ___
the speech-language pathologist
b. Assist with informal documentation ___ ___
c. Schedules activities appropriately ___ ___
d. Participates with the supervisor in research projects ___ ___
e. Participates in inservices training ___ ___
f. Participates in public relations programs ___ ___
g. Performs checks and maintenance of equipment ___ ___

IV SCREENINGS
Standard: The speech-language pathology assistant will provide appropriate screening procedures
1. Criteria: Administers screening tools appropriately as directed Yes No
by the supervisor for communication and/or swallowing disorders which may include:
a. Differentiates correct vs. incorrect responses ___ ___
b. Completes screening protocol form accurately ___ ___
2. Criteria: Manages screening
a. Reports any difficulties encountered with screening ___ ___

procedures
b. Schedules Screenings ___ ___
c. Organizes screening materials ___ ___
3. Criteria: Communicates results to supervising speech-language pathologist
a. Seeks guidance when appropriate ___ ___
b. Provides descriptive behavioral observations that ___ ___
contribute to results

V. TREATMENT

Standard: The speech-language pathology assistant provides appropriate treatment resulting in optimal client improvement.

1. Criteria: Performs treatment tasks as outlined by the supervisor Yes No
a. Accurately and efficiently follows treatment plans ___ ___
developed by the speech-language pathologist
b. Incorporates feedback from speech-language pathologist ___ ___
for modifying own behavior with the client, caregivers
and other professional staff
2. Criteria: Manages client behavior and provides appropriate treatment
a. Maintains on-task behavior ___ ___
b. Provides appropriate feedback to the client as to the ___ ___
accuracy of the response
c. Uses feedback and reinforcement that are consistent, ___ ___
discriminating and meaningful
d. Gives direction and instructions that are age, education ___ ___
and culturally appropriate
e. Implements treatment objectives/goals in specified ___ ___
sequence
f. Applies behavior modification and other reinforcement ___ ___
behavior appropriately as designated by the speech language pathologist
3. Criteria: Demonstrates knowledge of treatment objectives and plan
a. Demonstrates understanding of client disorder and needs ___ ___
b. Identifies correct vs. incorrect responses ___ ___
c. Identifies client behaviors which demonstrate an ___ ___
improvement in function
d. Accurately reports completion of tasks ___ ___

I verify ____
Speech-Language Pathology Assistant
has completed nine (9) months of supervised practice as a Speech-Language Pathology Assistant under my supervision and has obtained the knowledge and skills needed to obtain a full license as a Speech-Language Assistant.

______________________________________ ____________________
Supervising Speech-Language Pathologist Date
.

FORM SA8

BOARD OF EXAMINERS FOR AUDIOLOGISTS, HEARING AID DISPENSERS AND SPEECH-LANGUAGE PATHOLOGISTS

4201 PATTERSON AVENUE * BALTIMORE, MARYLAND 21215-2299 * PHONE 410-764-4725
FAX 410-358-0273 * TTY FOR DISABLED – MARYLAND RELAY SERVICE 1-800-735-2258

AFFIDAVIT TO BE COMPLETED BY LICENSURE BOARD

This portion of the form is to be completed by the Speech-Language Pathology Assistant
Would you please verify___licensure ___certification or ___registration as a Speech-Language Pathology Assistant in your State for:

____

First Name Middle Last Name

Date of Birth____________________ Social Security Number _____________________

License/Certificate/Registration Number: _____________________

This portion of the affidavit is to be completed by the Board:

License/Certificate /Registration Number _____________ Date Issued_______________

Is License/Certificate/Registration in good standing?____________________

Expiration Date ____________________________

Please provide basis for qualifying for license/certificate/registration as a Speech-Language Pathology Assistant in your state that this person met (e.g. educational requirements, practice requirements, examination, etc.) _________________________
____
____

Please attach law and regulations governing Speech-Language Pathology Assistants for your state.

Has License/Certificate/Registration ever been suspended or revoked? _______________
If yes, please explain why or attach additional explanation.
____
____

Has License/Certificate/Registration been reinstated? _____________________________

Has disciplinary action ever been taken against this person? __________ If yes, please explain why or attach additional explanation.
____
____

Is there any derogatory information on file concerning this person? __________ If yes, please explain or attach additional explanation.

____

____

Signature _______________________________________ Date ________________________

Title ____

State Board of ____

State of ____

State Seal Here

FORM SA8