Alabama A&M UNIVERSITY

Communicative Sciences and Disorders
P. O. Box 357
Normal, Alabama 35762
(256) 372-5534 Office
(256) 372-4055 Fax

Dear Externship Supervisor:

To watch students apply diagnostic and therapeutic theory to practice is one of the most rewarding experiences of my job. It has always been exciting to me to be a part of that cognitive awakening! It is my hope that you too will be caught up in the excitement of your student clinician's practicum "adventure." We want to extend to you a special ***"Thank you"*** for agreeing to take on this additional responsibility into your busy schedule. I personally understand how time consuming supervision can be, and it makes me even more appreciative.

The following paragraphs were developed to help you in the supervision of our students. These summaries answer the most commonly asked questions concerning supervisory responsibilities. Enclosed is an OFF-CAMPUS CLINICAL PRACTICUM AGREEMENT that is to be completed by you and your student during your first visit (see EXTERNSHIP TIME/DATE STIPULATIONS). Please return/fax a completed copy of this agreement to the clinical director at your earliest convenience.

ASHA'S GUIDELINES FOR SUPERVISION OF CLINICAL HOURS:

Enclosed you will find a copy of ASHA's guidelines for supervision of clinical clock hours and a copy of ASHA's Code of Ethics. These guidelines and principles of ethics are to be followed without deviation or revision! **Please remember that you must be currently certified by ASHA to supervise student clinicians**. If you have any questions, please do not hesitate to call. I will be more than happy to explain these regulations to you in detail.

PROFESSIONAL LIABILITY INSURANCE:

All clinical externship students are required to have liability insurance through a blanket policy from Alabama A&M in effect prior to their first day at your site. Our students are presently insured by:

Seabury & Smith - Chicago
332 S. Michigan Avenue
Chicago, IL 60604
1-800-621-3008

This is a $4,000,000.00 per year policy ($2,000,000.00 per claim). The annual premium is paid for by AAMU and is included in the student's clinic fee each fall semester. Please request proof of insurance from me if your company requires that proof prior to providing services.

EXTERNSHIP TIME/DATE STIPULATIONS:

To ensure efficient and ethical supervision of our students, a specific time and day schedule must be arranged for students reporting to your center. This schedule will be established prior to or upon the beginning of the externship. The Director of Clinical Services, the Externship Supervisor, and the student will all be involved in developing this schedule for the student. Schedules are developed according to the supervisor's schedule, student's clinical hour needs, student's clinical schedule on campus and their class schedules. Students may have a maximum of 2 clients on campus during the semesters they are enrolled in an externship. **STUDENTS ARE NOT ALLOWED TO ESTABLISH EXTERNSHIPS ON THEIR OWN WITHOUT CONSULTING WITH THE DIRECTOR OF CLINICAL SERVICES FOR PRIOR APPROVAL**. If a student does make an initial contact with you without consulting me, please contact me immediately before placing that student.

CLINICAL PERFORMANCE/GRADING:

Several forms have been included in this packet for grading clinical performance. There are separate forms for clinical performance on written communication, diagnostic, and treatment sessions. For those of you who have been gracious enough to supervise our students before, we have added the ***Practicum Evaluation Form*** to make your expectations known and for students to live up to their full potential. The grade will be determined from the numbers you have given the student during the goal-setting conference at the beginning of the semester (See page 6 of the ***Practicum Evaluation Form***). We have also included ***Diagnostic Session Evaluation Forms***, ***Treatment Session Evaluation Forms***, and ***Written Communication Evaluation Forms*** to indicate feedback to the student. About 6 to12 of these forms (in total) should be filled out during the practicum experience (averaging one a week). Please fax the feedback forms to me bi-weekly and keep a copy of these to determine numbers for midterm and final grades on the ***Practicum Evaluation Form***. The grades are based on a 5 point scale. You will give a number score for each applicable area on the grading form. There is also a ***Supervision Rating Scale*** that will aid you in giving number grades. When you have completed the applicable areas on the grading form, total the points the student received and divide them by the total number of scores you gave (See attached example). The grading scale is indicated on page 6 of the ***Practicum Evaluation Form***.

Student attendance and promptness is of the utmost importance; thus a CLINICIAN ATTENDANCE RECORD has been supplied to keep track of your student's attendance. Please submit/fax attendance record with midterm and final grades.

To abide by ASHA guidelines and to ensure that our students are well-supervised, you must supervise at least 25% of each diagnostic and therapy sessions. You are not

required to give feedback for each session that you supervise, but these forms do give very important information to our students that they may use to become better speech-language pathologists. Please complete a minimum of 1 feedback form per week.

CLINICAL PRACTICUM REPORTS (CLINICAL CLOCK HOURS):

Instructions for completing clinical practicum hours are enclosed. Student interns should be familiar with this process and can help you. THEY are responsible for completing all of the documentation on this form with the exception of your initials, your signature, and your ASHA certification number. Clinical Practicum Reports should be completed on a daily or weekly basis. You will need to initial each individual or group session. When a sheet is full, or when the externship is completed, please sign, date, and record your ASHA certification number. Mark through any unused portion of the clinic form. (NOTE: Student should add all hours prior to your signature. Please check before signing!)

A CLINICAL TIMELINE has also been enclosed to aid in the "navigation" through a given semester. On this document you will find when midterm/final grades are due and when hours are to be turned in to the AAMU CSD clinical office. Thank you again for your generous offer of sharing your knowledge and time with our students. We are all appreciative! I will be contacting you during this externship to monitor student progress. If I can be of any assistance to you, please do not hesitate to call me at (256)372-4044(office) or 372-4055(fax).

Sincerely,

Esther Phillips-Embden, M.A., CCC-SLP/L
AAMU CSD Director of Clinical Services
Assistant Professor
Alabama A&M University

Student Clinician: _____ Semester: _____

Externship Supervisor Signature Card

Name: _____

Facility: _____

Address: _____

Email: _____

Phone: _____

ASHA #: _____ Exp. Date: _____

Licensure #: _____ State: _____ Exp. Date: _____

Date contract signed: _____

Signature of Supervisor: _____

Please provide copies of your CURRENT ASHA card and license, if applicable.

ALABAMA A&M UNIVERSITY
COMMUNICATION SCIENCES & DISORDERS

OFF-CAMPUS CLINICAL PRACTICUM AGREEMENT

Student Name: _____ **Student Phone:** _____

Supervisor Name: _____ **Supervisor Phone:** _____

Site: _____ **Semester:** _____

Student Schedule: (specify days and hours, all times student is expected to be present, policy for making up missed days due to illness, holiday coverage.)

Student Responsibilities: (state expectations in terms of caseload, lesson plans, report writing, staffing, special projects, etc.)

Supervisory Schedule: (conferences, observations, written evaluations)

Required Orientations/Readings/Other:

_____ _____

Student/date Supervisor/date

If components of this agreement are not met, the supervisor and student should initially attempt to resolve issue by review of stated expectations. The AAMU CSD practicum coordinator will mediate issues that continue to be a problem.

*Form adapted from University of New Hampshire CSD Department

EXTERNSHIP SUPERVISOR/CLINICAN CONFERENCE

MIDTERM:

Comments/Suggestions:

Goals for remainder of semester:

Supervisor's Signature:_____ Date:_____

Clinician's Signature:_____ Date:_____

FINAL:

Comments/Suggestions:

Supervisor's Signature: _____ Date:_____

Clinician's Signature: _____ Date:_____

Supervisor: Please retain copy for your records, give a copy to the student, and submit a copy to AAMU

AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

Clinical Supervision in Speech-Language Pathology

Ad Hoc Committee on Supervision in Speech-Language Pathology

Reference this material as: American Speech-Language-Hearing Association. (2008). *Clinical Supervision in Speech-Language Pathology* [Technical Report]. Available from www.asha.org/policy.

Index terms: supervision

doi:10.1044/policy.TR2008-00296

About This Document

This technical report was developed by the Ad Hoc Committee on Supervision in Speech-Language Pathology of the American Speech-Language-Hearing Association (ASHA). 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.

****

Introduction

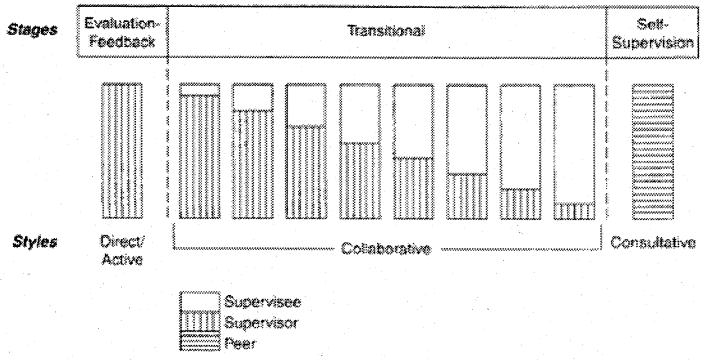
Because of increasing amounts of data from studies on supervision, advances in technology, and a greater understanding of the value of interpersonal factors in the supervisory process, there was a need to update ASHA's 1985 position statement *Clinical Supervision in Speech-Language Pathology and Audiology* (ASHA, 1985b). This 2008 technical report accompanies an updated position statement and knowledge and skills document for the profession of speech-language pathology (ASHA 2008a, 2008b). Although the principles of supervision (also called clinical teaching or clinical education) are common to both professions, the updated documents address only speech-language pathology because of differences in pre-service education and practice between the two professions.

The 1985 position statement identified specified competencies for supervisors, with an emphasis on clinical supervision of students. This 2008 technical report addresses supervision across the spectrum of supervisees, with the exception of speech-language pathology assistants. Professionals looking for guidance in supervising support personnel should refer to the ASHA position statement, guidelines, and knowledge and skills documents on this topic (ASHA, 2002, 2004b, 2004e).

As stated in ASHA's position statement on clinical supervision in speech-language pathology (ASHA, 2008a), "clinical supervision (also called clinical teaching or clinical education) is a distinct area of practice in speech-language pathology and ... is an essential component in the education of students and the continual professional growth of speech-language pathologists" (p. 1). Clinical supervision is also a collaborative process, with shared responsibility for many of the activities throughout the supervisory experience.

At some point in their career, many speech-language pathologists (SLPs) will be involved in a role that involves supervising students, clinical fellows, practicing SLPs, and/or paraprofessionals. Many of these SLPs do not have formal training or preparation in supervision. Recognizing the importance and complexity involved in the supervisory process, it is critical that increased focus be devoted to knowledge of the issues and skills in providing clinical supervision across the spectrum of a professional career in speech-language pathology. The purpose of this technical report is to highlight key principles and issues that reflect the importance and the highly skilled nature of providing exemplary supervision. It is not intended to provide a comprehensive text on how to become a supervisor. The companion document *Knowledge and Skills Needed by Speech-Language*

Figure 1. Continuum of supervision. From *The Supervisory Process in Speech-Language Pathology and Audiology* (p. 25), by E. S. McCrea and J. A. Brasseur, 2003, Boston: Allyn and Bacon. Copyright © 2003 by Pearson Education. Reprinted by permission of the publisher.



Background Information

Pathologists Providing Clinical Supervision (ASHA, 2008b) delineates areas of competence, and the position statement *Clinical Supervision in Speech-Language Pathology* (ASHA, 2008a) affirms the role of supervision within the profession.

In 1978, the ASHA Committee on Supervision indicated that there was little knowledge of the critical factors in supervision methodology (American Speech and Hearing Association, 1978). During the three decades since that report was written, a body of work has been published that has helped to identify some of the critical factors in supervision methodology and their relationship to the effectiveness of supervision.

Jean Anderson's *The Supervisory Process in Speech-Language Pathology and Audiology* (1988) played a significant role in helping professionals understand the critical factors in supervision methodology and their contribution to the effectiveness of supervision. Her continuum of supervision is the most widely recognized supervision model in speech-language pathology (see Figure 1). This model is based on a developmental continuum that spans a professional career.

The continuum mandates a change over time in the amount and type of involvement of both the supervisor and the supervisee in the supervisory process. As the amount of direction by the supervisor decreases, the amount of participation by the supervisee increases across the continuum (J. L. Anderson, 1988). The stages (evaluation-feedback, transitional, self-supervision) should not be viewed as time-bound, as any individual supervisee may be found at any point on the continuum depending on situational variables as well as the knowledge and skill of the supervisee. The model stresses the importance of modifying the supervisor's style in response to the needs, knowledge, and skills of the supervisee at each stage of clinical development. This model also fosters professional growth on the part of both the supervisor and the supervisee.

In addition to the publications from acknowledged experts in the profession, ASHA has provided guidance in the area of supervision through standards, the Code of Ethics, and Issues in Ethics statements. These documents are described below in the sections *Standards, Regulations, and Legal Issues and Ethical Considerations in Supervision.*

Research on Supervision

As the profession of speech-language pathology has advanced, evidence-based knowledge about practice in clinical disorders has developed through experimental and descriptive research. However, there is little empirical evidence in the area of supervision (Spence, Wilson, Kavanagh, Strong, & Worrall, 2001), especially as it relates to client outcomes. Knowledge about supervision in speech-language pathology has primarily come from descriptive studies documented in texts by acknowledged experts, conference proceedings, and personal and shared experience. The results of descriptive studies have led to the identification of some of the behaviors that supervisors need to modify in order to be less directive and to facilitate high levels of critical thinking in supervisees (Dowling, 1995; Strike-Roussos, 1988, 1995, as cited in McCrea and Brasseur, 2003). Another major source of information about supervision comes from the research literature from other professions. McCrea and Brasseur (2003) examined the work of Rogers (1951), Carkhuff (1967, 1969), Leddick and Barnard (1980), and Hart (1982) in psychology; Fiedler (1967) in business management; Kagan (1970) in social work; and Cogan (1973) and Goldhammer (1969; Goldhammer, Anderson, & Kajewski, 1980) in education to show the extent to which other disciplines have contributed to our knowledge of effective supervision, and to emphasize the shared core principles of supervision reagardless of the discipline and/or service delivery setting (Dowling, 2001).

Definition of Supervision

In 1988 Jean Anderson offered the following definition of the supervisory process:

> Supervision is a process that consists of a variety of patterns of behavior, the appropriateness of which depends on the needs, competencies, expectations and philosophies of the supervisor and the supervisee and the specifics of the situation (tasks, client, setting and other variables). The goals of the supervisory process are the professional growth and development of the supervisee and the supervisor, which it is assumed will result ultimately in optimal service to clients. (p. 12)

Anderson's definition is still consistent with the goals of the process but needs some expansion. ASHA's position statement (1985b) noted that "effective clinical teaching" involves the development of self-analysis, self-evaluation, and problem-solving skills on the part of the individual being supervised. Self-analysis and self-evaluation are important activities for the supervisor as well. Therefore, Anderson's definition may be expanded to include the following:

> Professional growth and development of the supervisee and the supervisor are enhanced when supervision or clinical teaching involves self-analysis and self-evaluation. Effective clinical teaching also promotes the use of critical thinking and problem-solving skills on the part of the individual being supervised.

Critical thinking is based on building hypotheses, collecting data, and analyzing outcomes. A supervisor can facilitate the critical thinking abilities of supervisees through collecting data and facilitating problem solving. Engaging in this process will also help supervisees assess the quality of their service delivery. The *Data Collection in Supervision* section that follows provides further information on this topic.

The following sections discuss key issues that affect supervision or influence the supervisory process.

Supervision Across Settings

Professional, clinical, and operational demands across practice settings vary; however, the supervisory process can be viewed as basically the same wherever speech-language pathology services are delivered. Client populations as well as equipment, tools, and techniques used to provide clinical services can differ across the practice settings. Nevertheless, the dynamics of the supervisory relationship and the components of the supervisory process are similar regardless of work setting.

Often the supervisor is also responsible for day-to-day operations and program management. These supervisors with management responsibilities are accountable to multiple stakeholders (e.g., administrators, regulatory agencies, consumers, employees, and payers). These supervisors also have an obligation to provide clinical teaching to supervisees at all levels of their career. Clinical education may be managed directly by the supervisor, facilitated as a collaborative activity by the supervisor, or delivered in peer training formats (e.g., through literature review and discussion, or continuing education). Methods may vary according to the needs of the clinical population, developmental level of the supervisee, supervisor and supervisee teaching/learning styles and preferences, economics, and practice setting. The basic objective of professional growth and development for both the supervisor and supervisee remains at the core of the supervisory process.

Technology in Supervision

Although technology is not a new concept in supervision, the ways in which technology may be used have changed immensely. It can allow one message to be received by many at one time (through an e-mail list) or it can provide support to just one supervisee through the use of two-way videoconferencing (i.e., "e-supervision"). Through the use of technology, information can be delivered at a distance in real time or be archived for users to retrieve at their convenience. Many forms of technology can be used to support communication and clinical teaching, particularly the Internet, which facilitates the use of e-mail, e-mail lists, instant messaging, Web sites/pages, videoconferencing, video software, Weblogs (or "blogs"), and podcasting. The Appendix provides examples of current uses of technology for supervision. When one uses technology in supervision (e.g., videoconferencing) it is important to be aware of and follow regulatory guidelines involving confidentiality.

The Influence of Power in Supervision

Power has been defined as the ability of one party to change or control the behavior, attitudes, opinions, objectives, needs, and values of another party (Rahim, 1989). Although different models and descriptions of power are described in the literature, some researchers have acknowledged the importance of modifying supervisees' behavior using social and interpersonal influence processes. One form of social

influence is power (Wagner & Hess, 1999). According to Robyak, Goodyear, and Prange (1987), supervisors' power influences trainees to change their clinical behaviors. Other disciplines have extensively investigated social power because of the influence that power has on subordinates' compliance, motivation, satisfaction, task commitment, job performance, and interpersonal conflicts (Wagner & Hess, 1999).

Understanding the influence of social power on the supervisory relationship is important. Supervisors hold the power of grading, signing off on clinical hours, conducting performance evaluations, and making promotion decisions. Lack of awareness of the influence of power can result in intimidation and a reluctance on the part of the supervisee to participate actively in the supervisory experience.

Individuals from diverse cultural and/or linguistic backgrounds may respond differently to the power dynamic (e.g., to people they perceive to be in roles of authority). They may behave in ways that may be interpreted as inappropriate by those who are unfamiliar with their culture and/or background (Coleman, 2000). Therefore, it is important for supervisors to know when to consult someone who can serve as a cultural mediator or advisor concerning effective strategies for culturally appropriate interactions with individuals (clients and supervisees) from specific backgrounds.

Mentoring in Supervision

The terms *mentoring* and *supervision* are not synonymous but are often used interchangeably (Urish, 2004). Mentoring is typically defined as a relationship between two people in which one person (the mentor) is dedicated to the personal and professional growth of the other (the mentee) (Robertson, 1992). While this definition may sound similar to the relationship of the supervisor and the supervisee, the primary focus of supervision is accountability for the supervisee's performance (e.g., providing grades or conducting performance evaluations; documenting professional behavior and clinical performance). In contrast, mentoring focuses on creating effective ways to build skills, influence attitudes, and cultivate aspirations. Mentors advise, tutor, sponsor, and instill a professional identity in mentees. Mentoring is an intense interaction between two people, where the mentor has authority and power based on experience. To highlight the importance of the mentoring role, the 2005 ASHA Standards for Clinical Certification references mentoring. In some sections the terminology has been changed from *supervision* to *mentoring* and from *clinical fellowship supervisor* to *clinical fellowship mentor* (Council for Clinical Certification in Audiology and Speech-Language Pathology [CFCC], 2005).

Some aspect of mentoring should be involved in all supervisory relationships, the degree being dependent on supervisory style, the amount of experience and skill level of the supervisee, and factors associated with the practice setting. Supervisors who maintain a "direct-active" style of supervision as described by J. L. Anderson (1988) are less likely to address the mentoring aspect of supervision. The "direct-active" style focuses mainly on growth in performance rather than on the personal growth of the supervisee. "Collaborative" or "consultative" styles, as described by J. L. Anderson (1988), better facilitate the ability to address the mentoring aspect of supervision. Mentoring is most appropriate when supervisees have moved into the advanced level of the "transitional stage" and/or the self-supervision stage on the Anderson continuum.

Training in Supervision

Many professionals are thrust into the role of supervisor or clinical educator without adequate preparation or training (J. L. Anderson, 1988; Dowling, 2001; McCrea & Brasseur, 2003; Spence et al., 2001). They become "overnight supervisors" and are forced to draw on their own past experiences as supervisees, positive or negative, as a source for their own techniques and methodologies. Supervisors in all practice settings may also have unrealistic expectations concerning the academic and clinical preparation of supervisees, particularly students.

Dowling (2001) and McCrea and Brasseur (2003) discussed research in speech-language pathology by Culatta and Seltzer (1976), Irwin (1975, 1976), McCrea (1980), Roberts and Smith (1982), and Strike-Roussos (1988, 1995) indicating that supervisors who engage in supervisory conferences/meetings without formal supervisory training tend to dominate talk time, problem solving, and strategy development. These supervisors tend to use the same direct style of supervision with all supervisees regardless of their knowledge or skill levels, and without regard for the supervisee's learning style, which can lead to passive supervisee involvement and dependence on the supervisor (J. L. Anderson, 1988). Further, a direct style of supervision diminishes the need for the supervisee to use critical thinking and problem-solving skills. Supervisors should seek training on the supervisory process so that they can learn about differing supervisory styles and develop competence in supervision. This will help ensure the use of strategies and behaviors that promote supervisee learning and development. ASHA's *Knowledge and Skills Needed by Speech-Language Pathologists Providing Clinical Supervision* (ASHA, 2008b) lists competencies for effective supervision. Training in supervision can be obtained through course work, continuing education programs, self-study, peer mentoring, and resources from ASHA (e.g., products and/or continuing education offerings) and from Special Interest Division 11, Administration and Supervision.

Supervisor Accountability

Quite often, the effectiveness of a supervisor is determined by asking the supervisee to evaluate the clinical instructor. While such evaluations do have some importance, few supervisees have sufficient understanding of the supervisory process to know what to expect of a supervisor. Further, unless complete anonymity is ensured, the likelihood of receiving honest feedback may be questioned. Therefore, supervisors should also evaluate their own behaviors relative to the supervisory process. Given the lack of validated guidelines for accomplishing such self-evaluation, supervisors must devise their own methods of data collection (McCrea & Brasseur, 2003) or turn to resources from other fields. Casey (1985) and colleagues (Casey, Smith, & Ulrich, 1988) developed a self-assessment guide to assist supervisors in determining their effectiveness in acquiring the 13 tasks and 81 associated competencies contained in the 1985 position statement (ASHA, 1985b). Analyzing the results allows the supervisor to identify supervisory objectives, decide on certain procedures, and determine whether goals were accomplished.

Studying the supervisory process in relation to one's own behavior is an opportunity for the supervisor to develop a personalized quality assurance mechanism, and a way to ensure accountability. Making a decision to improve as a supervisor also promotes job satisfaction, self-fulfillment, and ethical behavior, and prevents burnout (Dowling, 2001).

Data Collection in Supervision

Objective data about the supervisee's performance adds credibility and facilitates the supervisory process (J. L. Anderson, 1988; Shapiro, 1994). According to J. L. Anderson (1988) and Shapiro (1994), data collection methods can include rating scales, tallying behaviors, verbatim recording, interaction analysis, and individually designed methods. A number of tools have also been developed for analysis of behaviors and self-assessment (J. L. Anderson, 1988; Casey et al., 1988; Dowling, 2001; McCrea & Brasseur, 2003; Shapiro, 1994). Results from the analysis of this data can be applied both to the supervisee's clinical interactions with clients as well as to behaviors of the supervisor and supervisee during supervisory conferences. Analysis of both the supervisee and supervisor's behaviors during supervisory conferences can yield valuable insights to improve the interactions and outcomes of the supervisory experience for both individuals.

To be effective at their job, supervisors must be concerned about their own learning and development. Studying one's own behavior in supervisory process not only facilitates accountability in clinical teaching, but also is an opportunity for supervisors to examine their own behavior in order to improve their effectiveness in supervision.

Communication Skills in Supervision

Although supervisors may collect data and analyze the behaviors of supervisees, success in facilitating a supervisee's development may ultimately rest on the supervisor's skill in communicating effectively about these behaviors. While there are many resources that discuss interpersonal communication, McCrea and Brasseur (2003) briefly reviewed the literature in speech-language pathology on the interpersonal aspects of the supervisory process, citing Pickering (1979, 1984, 1987, 1990), Caracciolo and colleagues (1978), Crago (1987), Hagler, Casey, and DesRochers (1989), McCrea (1980), McCready and colleagues (1987, 1996), and Ghitter (1987). All of these researchers found a relationship between the interpersonal skills of supervisors and the clinical effectiveness of the supervisees. In their review of the literature, McCrea and Brasseur noted the importance of a supervisor's skill in communication. Adopting an effective communication style for each supervisee was shown to affect the supervisees' willingness to participate in conferences, share ideas and feelings, and positively change clinical behaviors. Ghitter (1987, as cited in McCrea & Brasseur, 2003) reported that when supervisees perceive high levels of unconditional positive regard, genuineness, empathic understanding, and concreteness, their clinical behaviors change in positive directions.

The ability to communicate effectively is viewed by many as an aptitude or an innate skill that people possess without any training. However, many professionals operate at a level of effectiveness far below their potential (Adler, Rosenfeld, & Proctor, 2001). There are also potential barriers to clear and accurate communication (e.g., age, gender, social and economic status, and cultural/

linguistic background). Further information addressing such barriers is included in the sections *Generational Differences* and *Cultural and Linguistic Considerations in Supervision*). Training in interpersonal communication is an important component of supervisory training. Growth in the interpersonal domain will enhance supervisors' proficiencies in interacting with clinicians in a helpful manner.

Standards, Regulations, and Legal Issues

Various external groups provide guidance for or regulation of supervision in speech-language pathology, particularly with respect to students and clinical fellows. ASHA's standards for certification and accreditation, state licensure laws, and federal/state reimbursement programs set minimum standards for the amount of supervision provided to individuals who are not certified SLPs.

At the preprofessional level, the *Standards for Accreditation of Graduate Education Programs in Audiology and Speech-Language Pathology* (Council on Academic Accreditation in Audiology and Speech-Language Pathology [CAA], 2004) require competent and ethical conduct of faculty, including on-site and off-site faculty. The standards also require programs to demonstrate that "Clinical supervision is commensurate with the clinical knowledge and skills of each student..." (Standard 3.5B; CAA, 2004).

Standards and Implementation Procedures for the Certificate of Clinical Competence address the requirements for direct and indirect supervision of students (CFCC, 2005). The standards require that student supervision be provided by a certified SLP, and that at least 25% of a student's total contact with each client be directly observed. The amount of supervision "should be adjusted upward if the student's level of knowledge, experience, and competence warrants" (CFCC, 2005). Standards for clinical fellows require 36 mentoring activities, including 18 hours of on-site direct client contact observation. Both sets of standards may be updated periodically.

Regulation by state licensure boards is separate from ASHA requirements; therefore, all students, clinical fellows, and certified clinical practitioners must be aware of and adhere to ASHA certification requirements as well as their state's requirements. Licensure laws regulate the provision of SLP services within the state; for SLPs practicing in schools, different or additional standards may also be required. States' requirements for student supervision may in some cases exceed ASHA's requirements.

Supervisors also must be aware of regulations for student supervision issued by payers such as the Centers for Medicare and Medicaid Services (CMS). For services delivered to Medicare beneficiaries under Part B, Medicare guidance explicitly states that the qualified SLP must be in the room at all times and be actively engaged in directing the treatment provided by the student (CMS, 2003, chapter 15, section 230B.1). There is an exception for services to Part A beneficiaries residing in a skilled nursing facility where "line of sight" supervision of the student by the qualified SLP is required instead of "in the room."

The nature of the supervisory relationship includes a vicarious liability for the actions of the supervisee. Supervisors hold full responsibility for the behavior, clinical services, and documentation of the student clinician. For their own protection as well as to foster the growth of students and protect the welfare of clients, supervisors must be fully involved and aware of the performance of the student and address any issues that could affect patient outcomes or satisfaction.

Ethical Considerations in Supervision

ASHA's Code of Ethics (2003) provides a framework for ethical behavior of supervisors across supervisory responsibilities. Principle of Ethics I states that client welfare must always be held paramount. Accordingly, the supervisor must provide appropriate supervision and adjust the amount and type of supervision based on the supervisee's performance. The supervisor ensures that the supervisee fulfills professional responsibilities such as maintaining confidentiality of client information, documenting client records in an accurate and timely manner, and completing other professional activities. In addition, the supervisor has an obligation to inform the client of the name and credentials of individuals (such as students) involved in their treatment.

Principle of Ethics II addresses issues of professional competence, and its rules state that professionals should only engage in those aspects of the profession that are within their scope of competence. Accordingly, supervisors should seek training in the area of effective supervisory practices to develop their competence in this area. Supervisors also have the responsibility to ensure that client services are provided competently by supervisees whether they are students, clinical fellows, or practicing clinicians. In addition, the rules state that treatment delegated to clinical fellows, students, and other nonprofessionals must be supervised by a certified speech-language pathologist.

Principle of Ethics IV addresses the ethical responsibility to maintain "harmonious interprofessional and intraprofessional relationships" and not abuse their authority over students (ASHA, 2003). See the section *The Influence of Power in Supervision* for further discussion of this issue.

Issues in Ethics statements are developed by ASHA's Board of Ethics to provide guidance on specific issues of ethical conduct. Statements related to supervision include *Fees for Clinical Service Provided by Students and Clinical Fellows* (ASHA, 2004a), *Supervision of Student Clinicians* (ASHA, 2004d), and *Responsibilities of Individuals Who Mentor Clinical Fellows* (2007).

Supervisors should also be cognizant of the problems that may arise from developing a social relationship with a supervisee in addition to their supervisory relationship. Although working together may provide opportunities for socialization beyond professional activities, supervisors must be comfortable in addressing a supervisee's performance without being influenced by their relationship outside the work setting.

King (2003) identified situations where ethical misconduct in the area of supervision may occur. Although King's comments were directed to the supervision of students, these concerns can be applied to all supervisory relationships. According to King, situations of potential misconduct can include,

but are not limited to, failure to provide a sufficient amount of supervision based on the performance of the supervisee, failure to educate and monitor the supervisee's protection of patient confidentiality, failure to verify appropriate competencies before delegating tasks to supervisees, failure to demonstrate benefit to the patient based on outcomes, and failure to provide self-assessment tools and opportunities to supervisees.

Supervision by Other Professionals

Increasingly, ASHA-certified SLPs and clinical fellows may work in settings where their direct supervisor may be an administrator or an individual from another profession. Evaluation of clinical skills by that individual is not appropriate, according to ASHA's position statement on *Professional Performance Appraisal by Individuals Outside the Professions of Speech-Language Pathology and Audiology* (ASHA, 1993). Peer appraisal and/or self-evaluation are recommended as alternatives. In addition, guidelines on the *Professional Performance Review Process for the School-Based Speech-Language Pathologist* (ASHA, 2006) were recently developed to help address this frequently occurring situation in schools.

Access to Clinical Externships

Practicing SLPs participate in the training and development of those who are entering the profession. However, pressures within the workplace have created challenges to students gaining access to externship sites (McAllister, 2005). Students are considered by some clinicians and administrators to be a drain on existing resources. The pace of the work, productivity demands, complexity of clients, and program specialization can limit an organization's willingness to embrace the task of student training (McAllister, 2005). In some cases, an externship supervisor's expectations of a student's knowledge and skills may be unrealistic and/or not met. Requirements for specified levels of supervision imposed by regulatory agencies (e.g., CMS) have also been identified as barriers to accepting students.

Staffing shortages can also limit student placement opportunities. Student training is often one of the casualties of inadequate staffing in the workplace. Veteran SLPs have much to offer students and other supervisees, but these individuals may work on a part-time or as-needed basis. Organizations that implement flexible work schedules to retain seasoned employees may refuse student placements because they believe they cannot accommodate the students' scheduling needs (McAllister, 2005). An unfortunate irony exists because sites that do not offer student externship placements are less likely to successfully recruit qualified SLPs.

McAllister (2005) posited the need for innovative solutions in the following areas. A shift in training models may be necessary in some cases to provide more opportunities for student placements. Ingenuity and collaboration between universities and work sites can ultimately produce innovative scheduling, supervisory incentives, and exploration of new supervisory models that may allow for excellent training opportunities. Cooperative partnerships between the universities, work sites, and clinicians are needed to develop collaborative training models appropriate to work site demands and pressures. Universities can play a key role in assisting work sites in experimenting with and evaluating innovative training models and in educating potential and existing supervisors on best practices in clinical education.

Cultural and Linguistic Considerations in Supervision

The population of the United States is becoming increasingly diverse. Supervisors will interact more frequently with individuals from backgrounds that are different from their own. As they interact with others, supervisors will have to take into account culturally based behaviors, values, and belief systems to be successful in their interactions. No universal communication, learning, or behavioral style is used by all people. Many cultural values have a significant impact on how and when individuals choose to communicate, how they behave in various settings, and how they prefer to learn. Differences in cultural values have an impact on the nature and effectiveness of all aspects of clinical interactions, including supervisor-supervisee relationships. Supervisors must take into consideration culturally based behaviors and learning styles of supervisees if their interactions with them are to be successful (Coleman, 2000).

Shapiro, Ogletree, and Brotherton (2002) reported research findings that most faculty were viewed as not being prepared for engaging in the supervisory process even with students from mainstream backgrounds. This problem is even more widespread in view of previous findings that most SLPs do not believe they are prepared to work effectively with clients from culturally and linguistically diverse backgrounds (ASHA, 1985a; Carey, 1992; Coleman & Lieberman, 1995; Keough, 1990). The lack of understanding and/or appreciation for culturally and linguistically diverse clients could also have a significant impact on the nature of interactions these professionals have with other nontraditional students, such as older students or returning students (McAllister, 2005).

Supervisors who supervise individuals from culturally and linguistically diverse backgrounds should develop competencies that will help them engage in appropriate clinical education practices (ASHA, 1998a, 1998b, 2004c, 2005). Many researchers across disciplines have addressed the issue of culturally appropriate clinical intervention strategies (Adler, 1993; N. B. Anderson, 1992, Battle, 1993, Cheng, 1987, Langdon & Cheng, 1992). One of the first suggestions in most of these sources is that the service provider conduct a self-inventory of his or her cultural awareness and sensitivity. Resources for cultural competence awareness assessment may be obtained through ASHA and/or literature review. Recognizing that behavior may be influenced by culture allows supervisors to develop a better understanding of variations among people.

Generational Differences

The coexistence of multiple generations in the workforce presents unique challenges in supervision. Differences in values and expectations of one generation versus another can result in misinterpretations and misunderstandings during supervisor–supervisee interactions. McCready (2007) noted that various authors (Kersten, 2002; Lancaster & Stillman, 2002; and Raines, 2002, 2003) have mentioned that the disparities among generations today are deeper and more complex than in the past. According to Lancaster and Stillman (2002), there are four separate and distinct generations working together today: the Traditionalists (born between 1900 and 1945), the Baby Boomers (born 1946–1964), the Generation Xers (born 1965–1980), and the Millennials (1981–1999). People, places, events, and symbols not only define each of these generational cohorts but

profoundly influence their values and expectations. Supervisors therefore need to be prepared to understand and accommodate attitudes and behaviors that may differ from their own.

McCready (2007) described ways in which supervisors across work settings can bridge the generation gap and facilitate improved communication. One suggestion is to form study groups to investigate the research in this area; the group could then present their findings to a larger group within the work setting (McCready, 2007). The supervisor can also engage in discussions about the generations represented in the work setting and how generational characteristics may and may not apply to specific individuals (McCready, 2007). Such discussion might include generational characteristics that can lead to miscommunication and misunderstandings in interactions with clients and supervisors.

Supervising Challenging Supervisees

Students who are admitted to graduate programs in communication sciences and disorders have successfully passed through a very competitive screening process using a variety of selection criteria such as Graduate Record Examination scores, undergraduate grade point averages, and letters of recommendation. Most of these students perform well in their academic courses and clinical assignments. However, most training programs periodically encounter students who present special challenges during the supervisory process (Shapiro et al., 2002) and are often referred to as "marginal" students. Dowling (1985, as cited in Dowling, 2001) described marginal students as individuals who "cannot work independently, are unable to formulate goals and procedures, have basic gaps in conceptual understanding, and cannot follow through with suggestions" (p. 162). Given the impact on students, programs, clients, and the professions, working effectively with marginal students deserves serious and systematic consideration (Shapiro et al., 2002). These same issues may apply to supervisees of varying experience levels and in all practice settings.

One characteristic that is frequently reported about these challenging supervisees is their lack of ability to accurately evaluate their skill level (Kruger & Dunning, 1999, as cited in McCrea & Brasseur, 2003). Using the supervisory conference/ meeting can be critically important in assisting them in evaluating their own performance (Dowling, 2001). During these meetings, supervisors need to give specific feedback based on data collected about the supervisee's performance and provide concrete assistance in planning and strategy development (Dowling, 2001). Eventually, however, the supervisee must learn to engage in self-analysis and self-evaluation to develop an understanding of his or her own performance.

Summary

This document defines supervision and highlights key issues that reflect the complexity of providing exemplary supervision. Acquiring competency as a supervisor is essential to developing supervisory behaviors and activities that are critical to the training of professionals. Such supervisory training may not be provided as part of graduate education programs; therefore, SLPs must look to continuing education opportunities, peer learning and mentoring, and self-study using literature that focuses on the supervisory process (J. L. Anderson, 1988; Casey et al., 1988; Dowling, 2001; McCrea & Brasseur, 2003; Shapiro, 1994; Shapiro & Anderson, 1989). Although there may be opportunities to learn from other disciplines that also use supervisory practices, preparation in the supervisory

process specific to speech-language pathology is critically important. McCrea and Brasseur (2003) and Dowling (2001) discussed ways in which preparation in the supervisory process can be implemented. The models discussed in these texts range from inclusion of information in early clinical management courses to doctoral level preparation. Training that is included as part of academic and clinical training of professionals and extended to supervisors at off-campus practicum sites will enhance the supervisors' effectiveness (Dowling, 1992; and Dowling, 1993, 1994, as cited in McCrea & Brasseur, 2003). ASHA's *Knowledge and Skills Needed by Speech-Language Pathologists Providing Clinical Supervision* (ASHA, 2008b) delineates specific areas of competence deemed necessary to the provision of effective supervision.

Research Directions

Systematic study and investigation of the supervisory process is necessary to expand the evidence base from which increased knowledge about supervision and the supervisory process will emerge. Topics for further research may include the following:

- exploring different supervisory approaches that promote problem solving, self-analysis, and self-evaluation to develop clinical effectiveness;
- identifying essential components of training effective supervisors;
- examining the efficacy of supervisory training on supervisor/supervisee satisfaction and competence;
- identifying the basic behaviors/skills that supervisors should use in their interactions with supervisees that are essential to an effective working relationship;
- examining how supervisory style affects the development of clinical competence;
- examining different methods to develop more efficient models of supervision;
- examining supervisor behaviors that enhance supervisee growth (e.g., examining the process for negotiating and mutually agreeing on targets for change and measuring the impact that supervisor change has on the supervisee's professional growth) or training supervisors to use specific interpersonal skills (e.g, empathy, active listening) and then measuring how such skills enhance supervisee growth (McCrea & Brasseur, 2003);
- examining the effectiveness and efficiency of technology in delivering supervision;
- examining the impact of supervision on client outcomes;
- examining supervisory approaches and communication styles with supervisees in consideration of gender, age, cultural, and linguistic diversity;
- examining aspects of the supervisory process (i.e., understanding, planning, observing, analyzing, and integrating) and the relationship of each to the success of the supervisory experience (McCrea & Brasseur, 2003).

References

Adler, S. (1993). *Nonstandard language: Its assessment in multicultural communication skills in the classroom.* Boston: Allyn & Bacon.

Adler, S., Rosenfeld, L. B., & Proctor, R. F. (2001). *Interplay: The process of interpersonal communication.* New York: Harcourt.

American Speech and Hearing Association. (1978). Current status of supervision of speech-language pathology and audiology [Special Report]. *Asha, 20,* 478–486.

American Speech-Language-Hearing Association. (1985a). *Clinical management of communicatively handicapped minority language populations* [Position Statement]. Available from www.asha.org/policy.

American Speech-Language-Hearing Association. (1985b). *Clinical supervision in speech-language pathology and audiology* [Position Statement]. Available from www.asha.org/policy.

American Speech-Language-Hearing Association. (1993). *Professional performance appraisal by individuals outside the professions of speech-language pathology and audiology* [Position Statement]. Available from www.asha.org/policy.

American Speech-Language-Hearing Association. (1998a). *Students and professionals who speak English with accents and nonstandard dialects: Issues and recommendations* [Position Statement]. Available from www.asha.org/policy.

American Speech-Language-Hearing Association. (1998b). *Students and professionals who speak English with accents and nonstandard dialects: Issues and recommendations* [Technical Report]. Available from www.asha.org/policy.

American Speech-Language-Hearing Association. (2002). *Knowledge and skills for supervisors of speech-language pathology assistants.* Available from www.asha.org/policy.

American Speech-Language-Hearing Association. (2003). *Code of ethics* (Revised). Available from www.asha.org/policy.

American Speech-Language-Hearing Association. (2004a). *Fees for clinical service provided by students and clinical fellows* [Issues in Ethics]. Available from www.asha.org/policy.

American Speech-Language-Hearing Association. (2004b). *Guidelines for the training, use, and supervision of speech-language pathology assistants.* Available from www.asha.org/policy.

American Speech-Language-Hearing Association. (2004c). *Knowledge and skills needed by speech-language pathologists and audiologists to provide culturally and linguistically appropriate services* [Knowledge and Skills]. Available from www.asha.org/policy.

American Speech-Language-Hearing Association. (2004d). *Supervision of student clinicians* [Issues in Ethics]. Available from www.asha.org/policy.

American Speech-Language-Hearing Association. (2004e). *Training, use, and supervision of support personnel in speech-language pathology* [Position Statement]. Available from www.asha.org/policy.

American Speech-Language-Hearing Association. (2005). *Cultural competence* [Issues in Ethics]. Available from www.asha.org/policy.

American Speech-Language-Hearing Association. (2006). *Professional performance review process for the school-based speech-language pathologist* [Guidelines]. Available from www.asha.org/policy.

American Speech-Language-Hearing Association. (2007). *Responsibilities of individuals who mentor clinical fellows* [Issues in Ethics]. Available from www.asha.org/policy.

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

American Speech-Language-Hearing Association. (2008b). *Knowledge and skills needed by speech-language pathologists providing clinical supervision.* Available from www.asha.org/policy.

Anderson, J. L. (1988). *The supervisory process in speech language pathology and audiology.* Austin, TX: Pro-Ed.

Anderson, N. B. (1992). Understanding cultural diversity. *American Journal of Speech-Language Pathology, 1*, 11–12.

Battle, D. (1993). *Communication disorders in multicultural populations.* Boston: Butterworth-Heinemann.

Carey, A. I. (1992). Get involved: Multiculturally. *Asha, 34*, 3–4.

Casey, P. (1985). *Supervisory skills self-assessment.* Whitewater: University of Wisconsin.

Casey, P., Smith, K., & Ulrich, S. (1988). *Self supervision: A career tool for audiologists and speech-language pathologists (Clinical Series No. 10).* Rockville, MD: National Student Speech Language Hearing Association.

Centers for Medicare and Medicaid Services *Medicare benefit policy manual.* 2003 Retrieved December 13, 2008, from http://www.cms.hhs.gov/manuals/downloads/bp102c15.pdf

Cheng, L. (1987). *Assessing Asian language performance.* Gaithersburg, MD: Aspen Publishers.

Coleman, T. J. (2000). *Clinical management of communication disorders in culturally diverse children.* Needham Heights, MA: Allyn & Bacon.

Coleman, T. J., & Lieberman, R. J. (1995, November). *Preparing speech-language pathologists for work with diverse populations: A survey* . Paper presented at the Annual Convention of the American Speech-Language-Hearing Association, Anaheim, CA.

Council for Clinical Certification in Audiology and Speech-Language Pathology. (2005). *Membership and certification handbook of the American Speech-Language-Hearing Association.* Retrieved December 28, 2007, from www.asha.org/about/membership-certification/handbooks/slp/slp_standards.htm

Council on Academic Accreditation in Audiology and Speech-Language Pathology. (2004). *Standards for accreditation of graduate education programs in audiology and speech-language pathology programs.* Available from www.asha.org/policy.

Dowling, S. (1992). *Implementing the supervisory process: Theory and practice.* Englewood Cliffs, NJ: Prentice-Hall.

Dowling, S. (1995). Conference question usage: Impact of supervisory training. In R. Gillam (Ed.), *The supervisors' forum* (Vol. 2, pp. 11–14). Nashville, TN: Council of Supervisors in Speech-Language Pathology and Audiology.

Dowling, S. (2001). *Supervision: Strategies for successful outcomes and productivity.* Needham Heights, MA: Allyn & Bacon.

Dudding, C., & Justice, L. (2004). An e-supervision model: Videoconferencing as a clinical training tool. *Communication Disorders Quarterly, 25*(3), 145–151.

Keough, K. (1990). Emerging issues for the professions in the 1990s. *Asha, 32*, 55–58.

King, D. (2003, May 27). Supervision of student clinicians: Modeling ethical practice for future professionals. *The ASHA Leader, 8*, 26.

Lancaster, L., & Stillman, D. (2002). *When generations collide.* New York: Harper Business.

Langdon, H. W., & Cheng, L. (1992). *Hispanic children and adults with communication disorders.* Gaithersburg, MD: Aspen Publishers.

McAllister, L. (2005). Issues and innovations in clinical education. *Advances in Speech-Language Pathology, 7*(3), 138–148.

McCrea, E. S., & Brasseur, J. A. (2003). *The supervisory process in speech-language pathology and audiology.* Boston: Allyn & Bacon.

McCready, V. (2007). Generational differences: Do they make a difference in supervisory and administrative relationships? *Perspectives in Administration and Supervision, 17* (3), 6–9.

Rahim, M. A. (1989). Relationships of leader power to compliance and satisfaction with supervision: Evidence from a national sample of managers. *Journal of Management, 15*, 495–516.

Robertson, S. C. (1992). *Find a mentor or be one.* Bethesda, MD: American Occupational Therapy Association.

Robyak, J. E., Goodyear, R. K., & Prange, M. (1987). Effects of supervisors' sex, focus and experience on preferences for interpersonal power bases. *Counselor Education and Supervision, 26*, 299–309.

Shapiro, D. A. (1994). Interaction analysis and self-study: A single-case comparison of four methods of analyzing supervisory conferences. *Language, Speech, and Hearing Services in Schools, 25*, 67–75.

Shapiro, D. A., & Anderson, J. L. (1989). One measure of supervisory effectiveness in speech-language pathology and audiology. *Journal of Speech and Hearing Disorders, 54*, 549–557.

Shapiro, D. A., Ogletree, B. T., & Brotherton, W. D. (2002). Graduate students with marginal abilities in communication sciences and disorders: Prevalence, profiles, and solutions. *Journal of Communication Disorders, 35*, 421–451.

Spence, S., Wilson, J., Kavanagh, D., Strong, J., & Worrall, L. (2001). Clinical supervision in four mental health professions: A review of the evidence. *Behavior Change, 18*, 135–155.

Strauss, W., & Howe, N. (1992). *Generations: The history of America's future 1584 to 2069*. New York: Morrow.

Urish, C. (2004). *Ongoing competence through mentoring*. Bethesda, MD: American Occupational Therapy Association.

Wagner, B. T., & Hess, C. H. (1999). Supervisors' use of social power with graduate supervisees in speech-language pathology. *Journal of Communication Disorders, 32*, 361–368.

Appendix

Uses of Current Technology for Supervision

E-mail with attachments: The primary benefit of using electronic mail is the speed of delivery versus traditional mail. If contacting the supervisor by phone is difficult, an e-mail message may be sent instead. With e-mail, the supervisor has the option of responding at his or her convenience rather than trying to schedule a phone call or a face-to-face meeting with the supervisee when only a short response may be required. Lesson plans, sample individualized education program goals, diagnostic reports, and so on may be attached and submitted to the supervisor for his or her review and comment.

E-mail lists: Sending messages via e-mail to a closed list of supervisees. Each supervisee has the opportunity to ask questions, pose problems, or ask for suggested resources from peers. This can be extremely powerful in learning from each other's experiences and sharing innovative ideas or tried-and-true therapy techniques.

Instant messaging: The individual can see which other individuals are available at their computer through "buddy" icons and contact them through instant messaging. A group can communicate in an instant messaging conference, or the SLP can converse with his or her supervisor instantly rather than waiting for the supervisor to check e-mail.

Web sites/Web pages: Information pertinent to supervisees (such as frequently asked questions on licensure renewal, guidelines on service delivery options, or frequently used forms) is placed on the supervisor's Web site. The supervisees can access the information when needed. Supervisees can suggest what materials, links, or resources they would find helpful to have uploaded to the supervisor's site.

E-supervision: Using two-way videoconferencing to supervise graduate students in a public school setting is one example of electronic supervision according to Dudding and Justice (2004). The equipment costs of videoconferencing are offset by the productivity in clinical instruction. Dudding and Justice reported that electronic supervision allows for more flexibility in scheduling and a reduction in travel costs while also increasing the student's knowledge and appreciation for technology.

Video software: Embedding a visual message within an e-mail or on a Web site provides access to information when it is needed, and the message can be archived for later reference as well. With the use of video software, the supervisor can easily video record a message while also embedding photos or graphics into the message. The software requires a simple mounted camera on the computer to video record the supervisor's message. The message can be an update on therapy techniques or a short training on the use of new forms, for example. Once recorded, it can be embedded into an e-mail and sent out to all of the supervisees or archived on a Web site to be accessed when needed. This expedites the training process by only recording and delivering the message one time and makes the information available when the supervisee has time to retrieve the information, which can differ for all involved.

Weblogs: Journal entries displayed in reverse chronological order. The supervisor and others can leave comments or statements of support for the supervisee in this interactive format.

AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

Code of Ethics

Reference this material as: American Speech-Language-Hearing Association. (2010). *Code of Ethics* [Ethics]. Available from www.asha.org/policy.

Index terms: ethics

doi:10.1044/policy.ET2010-00309

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

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

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

Principle of Ethics II

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

Rules of Ethics

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

Principle of Ethics III

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

Rules of Ethics

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

Principle of Ethics IV

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

Rules of Ethics

A. Individuals shall uphold the dignity and autonomy of the professions, maintain harmonious interprofessional and intraprofessional relationships, and accept the professions' self-imposed standards.
B. Individuals shall prohibit anyone under their supervision from engaging in any practice that violates the Code of Ethics.
C. Individuals shall not engage in dishonesty, fraud, deceit, or misrepresentation.
D. Individuals shall not engage in any form of unlawful harassment, including sexual harassment or power abuse.
E. Individuals shall not engage in any other form of conduct that adversely reflects on the professions or on the individual's fitness to serve persons professionally.
F. Individuals shall not engage in sexual activities with clients, students, or research participants over whom they exercise professional authority or power.
G. Individuals shall assign credit only to those who have contributed to a publication, presentation, or product. Credit shall be assigned in proportion to the contribution and only with the contributor's consent.
H. Individuals shall reference the source when using other persons' ideas, research, presentations, or products in written, oral, or any other media presentation or summary.
I. Individuals' statements to colleagues about professional services, research results, and products shall adhere to prevailing professional standards and shall contain no misrepresentations.
J. Individuals shall not provide professional services without exercising independent professional judgment, regardless of referral source or prescription.
K. Individuals shall not discriminate in their relationships with colleagues, students, and members of other professions and disciplines on the basis of race or ethnicity, gender, gender identity/gender expression, age, religion, national origin, sexual orientation, or disability.
L. Individuals shall not file or encourage others to file complaints that disregard or ignore facts that would disprove the allegation, nor should the Code of Ethics be used for personal reprisal, as a means of addressing personal animosity, or as a vehicle for retaliation.
M. Individuals who have reason to believe that the Code of Ethics has been violated shall inform the Board of Ethics.
N. Individuals shall comply fully with the policies of the Board of Ethics in its consideration and adjudication of complaints of violations of the Code of Ethics.

ASHA PRACTICUM STANDARDS THAT CURRENTLY EXIST

Educational Standards Board

4.6 Clinical education obtained outside the jurisdiction of the program must be coordinated and monitored by a member of the program's instructional staff holding the ASHA CCC.

4.8 The program must ensure that the first 25 hours of each student's supervised clinical education provided by that program are supervised directly by a member of the program's instructional staff.

4.9 The program must ensure that the nature and amount of clinical supervision are adjusted to the experience and ability of the student and that appropriate guidance and feedback are provided to the student.

* At least 50% of each diagnostic evaluation, including screening and identification, in speech-language pathology and audiology must be observed directly by a supervisor.

* At least 25% of each student's total contact time in clinical treatment with each client must be observed directly by the supervisor. Observation of clinical treatment be scheduled appropriately throughout the treatment period.

4.10 The program must ensure that all major decisions by students regarding evaluation and treatment of a client are implemented or communicated only after approval by the supervisor.

4.11 The program must ensure that the welfare of each client served by its students is protected. A person holding the appropriate ASHA CCC must be available on site for consultation at all times when a student is providing clinical services as part of the student's clinical education, both on and off campus.

Professional Services Board

6.2.2 Non-certified staff who provide clinical services in audiology and speech-language pathology are supervised by individuals holding a current ASHA Certificate of Clinical Competence for each profession in which services are provided.

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

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

Implementation:

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

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

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

Implementation:

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

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

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

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

Implementation:

A minimum of 325 clock hours of clinical practicum must be completed at the graduate level. The remaining required hours may have been completed at the undergraduate level, at the discretion of the graduate program.

Standard IV-E: Supervision must be provided by individuals who hold the Certificate of Clinical Competence in the appropriate area of practice. The amount of supervision must be appropriate to the student's level of knowledge, experience, and competence. Supervision must be sufficient to ensure the welfare of the client/patient.

Implementation:

Direct supervision must be in real time and must never be less than 25% of the student's total contact with each client/patient and must take place periodically throughout the practicum. These are minimum requirements and should be adjusted upward if the student's level of knowledge, experience, and competence warrants. A supervisor must be available to consult as appropriate for the client's/patient's disorder with a student providing clinical services as part of the student's clinical education. Supervision of clinical practicum must include direct observation, guidance, and feedback to permit the student to monitor, evaluate, and

improve performance and to develop clinical competence.

All observation and clinical practicum hours used to meet Standard IV-C must be supervised by individuals who hold a current CCC in the professional area in which the observation and practicum hours are being obtained. Only the supervisor who actually observes the student in a clinical session is permitted to verify the credit given to the student for the clinical practicum hours.

Standard IV-F: Supervised practicum must include experience with client/patient populations across the life span and from culturally/linguistically diverse backgrounds. Practicum must include experience with client/patient populations with various types and severities of communication and/or related disorders, differences, and disabilities.

Implementation:

The applicant must demonstrate direct client/patient clinical experiences in both diagnosis and treatment with both children and adults from the range of disorders and differences named in Standard III-C.

Standard IV-G: The applicant for certification must complete a program of study that includes supervised clinical experiences sufficient in breadth and depth to achieve the following skills outcomes:

1. Evaluation

   a. Conduct screening and prevention procedures (including prevention activities).
   b. Collect case history information and integrate information from clients/patients, family, caregivers, teachers, relevant others, and other professionals.
   c. Select and administer appropriate evaluation procedures, such as behavioral observations, non-standardized and standardized tests, and instrumental procedures.
   d. Adapt evaluation procedures to meet client/patient needs.
   e. Interpret, integrate, and synthesize all information to develop diagnoses and make appropriate recommendations for intervention.
   f. Complete administrative and reporting functions necessary to support evaluation.
   g. Refer clients/patients for appropriate services.

2. Intervention

   a. Develop setting-appropriate intervention plans with measurable and achievable goals that meet

clients'/patients' needs. Collaborate with clients/patients and relevant others in the planning process.

b. Implement intervention plans (involve clients/patients and relevant others in the intervention process).

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

d. Measure and evaluate clients'/patients' performance and progress.

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

f. Complete administrative and reporting functions necessary to support intervention.

g. Identify and refer clients/patients for services as appropriate.

3. Interaction and Personal Qualities

a. Communicate effectively, recognizing the needs, values, preferred mode of communication, and cultural/linguistic background of the client/patient, family, caregivers, and relevant others.

b. Collaborate with other professionals in case management.

c. Provide counseling regarding communication and swallowing disorders to clients/patients, family, caregivers, and relevant others.

d. Adhere to the ASHA Code of Ethics and behave professionally.

Implementation:

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

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

SAMPLE

Alabama A & M University

Speech-Language-Hearing Clinic
EXTERNSHIP
CLINICIAN ATTENDANCE RECORD

Semester: Summer Year: 2004 Midterm or Final (circle one)

Supervisors: Please check the dates that your student clinician was present and absent from his/her practicum. Mark this form weekly. A copy of this form should be submitted to the Mrs. Embden at **midterm** with the *Formative Assessment Rubric* **and another one prior to final exams** (also with the Formative Assessment). Enter the clinician's last name in the column on the left. Enter each date of practicum in the small boxes on the top row. Fill in the correct code in the box below the date that the student clinician was scheduled for practicum.

Use the following key: Present - √
Cancelled – C
Late– L

DATES

STUDENT CLINICIAN	7/1	7/2	7/3	7/4	7/7	7/8	7/9	7/10	7/11	7/14	7/15	7/16	7/17
Joe Speech	√	√	√	√	L	√	√	√	√	√	C	√	√

7/18	7/21	7/22	7/23	7/24	7/25	7/28						
√	√	√	√	√	√	√						

COMMENTS: 7/7 Mr. Speech was 30 minuets late. Student did not call supervisor informing her that he would be late. 7/15 Mr. Speech cancelled stating he was ill.

Alabama A & M University

Speech-Language-Hearing Clinic
EXTERNSHIP
CLINICIAN ATTENDANCE RECORD

Semester: _____ Year: _____ Midterm or Final (circle one)

Supervisors: Please check the dates that your student clinician was present and absent from his/her practicum. Mark this form weekly. A copy of this form should be submitted to the Mrs. Embden at **midterm** with the *Formative Assessment Rubric* **and another one prior to final exams** (also with the Formative Assessment). Enter the clinician's last name in the column on the left. Enter each date of practicum in the small boxes on the top row. Fill in the correct code in the box below the date that the student clinician was scheduled for practicum.

Use the following key: Present - √
Cancelled – C
Late– L

DATES

STUDENT CLINICIAN													

COMMENTS:

SEMESTER SUMMARY GRADING LOG

Clinician: _____ Supervisor: _____ Semester: _____

DATE																							
GRADE																							

DATE																							
GRADE																							

Total of all grades/Total number of grades obtained = Midterm Grade = Letter Grade

_____ divided by _____ = _____ = _____

DATE																							
GRADE																							

DATE																							
GRADE																							

Total of all grades/Total number of grades obtained = Final Grade = Letter Grade

_____ divided by _____ = _____ = _____

Student _____ Supervisor(s) _____ Semester: _____

Alabama A&M University
Communicative Sciences & Disorders
Speech & Hearing Clinic

Practicum Evaluation

(CSD 321, 406, 516) L1, L2, L3

Client Disorder / Difference	Client Cultural /Linguistic Diversity	Client Age Group

The following evaluation of clinical practicum will be completed by student self-evaluation and by supervisor evaluation of student performance at beginning, midterm and the end of the semester. Knowledge or skills will be rated according to the descriptors on the *Supervision Rating Scale/Supervision Continuum*:

5 = Consistent 4 = Adequate 3 = Present 2 = Emerging 1 = Not Evident NO = Not Observed

KNOWLEDGE / SKILL	BEHAVIORAL DESCRIPTORS	GOAL	MT	FINAL
A. ORAL COMMUNICATION				
1. Demonstrates effective speaking and listening skills	Demonstrates speaking and listening ability for effective clinical and professional interaction with clients and their relevant others.			
2. Demonstrates effective modeling and targets	Demonstrates speech and language skills in English so that modeling of the target phoneme, grammatical feature, or other aspect of speech and language that characterizes the client's problem is correct.			
	ORAL COMMUNICATION TOTAL	**0**	**0**	**0**
B. WRITTEN COMMUNICATION				
ORGANIZATION				
1. Follows appropriate format for type of document	Follows standard format as stated in clinic procedures.			
2. Presents information in organized and concise manner	Uses a logical order and appropriate transition statements.			
CONTENT/STYLE				
3. Writes thorough, objective reports that synthesize various data sources	Includes supporting data and relevant information in diagnostic reports, initial tx plans, lesson plans, SOAP notes, summary reports, professional correspondence, or other assigned reports; information is integrated and synthesized for appropriate analysis of information and support for conclusions.			
4. Includes appropriate recommendations	Includes specific ideas for tx, including measurable goals, procedures, cues, reinforcement, and materials, as indicated.			
5. Writes clearly and concisely	Excludes insignificant or irrelevant information, does not include new information in summary.			
6. Writes appropriate behavioral objectives	Plans/writes behavioral objectives and goals that consider functional needs of clients and are prioritized, measurable, achievable.			

Student _____ Supervisor(s) _____ Semester: _____

KNOWLEDGE / SKILL	BEHAVIORAL DESCRIPTORS	GOAL	MT	FINAL
7. Uses professional language and terminology	Uses formal, professional, objective language that is grammatically correct. Explains jargon and terminology as appropriate. Avoids emotional language. Uses approved abbreviations in daily documentation. No abbreviations not on approved list.			
8. Edits and proofreads all documentation	Carefully edits and proofreads written documentation and reports before submission.			
	WRITTEN COMMUNICATION TOTAL	**0**	**0**	**0**
C. INTERACTION AND PERSONAL/PROFESSIONAL QUALITIES				
PROFESSIONAL RESPONSIBILITY				
1. Is punctual for meetings with supervisor and for client sessions	Arrives before session to set up clinic room, begins work promptly at scheduled diagnostic/therapy time, is on time for meetings.			
2. Attends scheduled meetings, classes, client sessions	Attends all scheduled meetings/classes/seminars. If unable to attend meeting, informs supervisor well in advance. Reschedules therapy sessions when absent (following supervisor approval).			
3. Submits work on time and as specified according to procedures	Submits written reports/lesson plans by due dates; work is complete when submitted.			
4. Demonstrates organization/preparation	Is prepared for sessions, has practiced test administration and techniques, session is well sequenced and organized; brings appropriate or required materials/documents to sessions and meetings			
5. Demonstrates initiative in clinical management	Attends to case management issues and seeks information and resources; recognizes case management needs; provides client with optimal level of service.			
6. Demonstrates knowledge of clinic safety, confidentiality, ethical procedures, clinic procedures	Demonstrates adherence to universal/standard precautions/infection control procedures, emergency and safety procedures, ASHA Code of Ethics, confidentiality procedures. Follows checkout procedures for materials, tests, and client files; does not remove client records from the clinic.			
7. Keeps compete, accurate, and timely records	Accurately completes practicum hours, places and secures all information appropriately in client file, following clinic procedures. Completes all sections of client folder in a timely manner and submits for processing. Sends reports as indicated to client, caregivers, physicians, etc. ensures appropriate release of information and fee payment contract are in file.			
8. Maintains a professional appearance	Dresses appropriately for clinic assignments, following dress code guidelines; conducts self in professional manner.			
PROFESSIONAL INTERACTIONS				
9. Is approachable and responsive to clients, parents, and other professionals. Demonstrates poise and maturity in professional interactions	Appropriately interacts with clients and caregivers in the clinical setting: demonstrates active listening skills and appropriate nonverbal communication. Addresses client's concerns in a positive and confident manner, is receptive to clients and caregiver's questions, utilizes effective counseling techniques. Provides organized information during conferences that are appropriate for educational level of client or caregiver.			
10. Is approachable and responsive to supervisor	Consults with the supervisor in appropriate setting and manner, respects supervisory relationship, seeks information and or clarifies information in an open, non-defensive manner. Seeks input; accepts supervisors comments/suggestions, integrates supervisor's suggestions. Responds to and incorporates supervisor's feedback on written documentation, as appropriate.			
11. Displays acceptance of the client's disability and differences; treats all clients with positive regard. Respects cultural differences	Adapts to client's age, cognitive level, language level, and cultural/ethic differences with appropriate communication strategies and modifications to the therapy setting. Demonstrates acceptance and tolerance for cultural differences; varies interaction style as needed for clinical interactions.			
12. Collaborates with other professionals	Consults with other professionals as appropriate for case management; secures consent and maintains confidentiality.			

Student _____ Supervisor(s) _____ Semester: _____

KNOWLEDGE / SKILL	BEHAVIORAL DESCRIPTORS	GOAL	MT	FINAL
PROFESSIONAL ATTITUDE				
13. Demonstrates pride in profession	Shows enthusiasm in professional interactions about speech-language pathology as a profession and career choice; is a positive role model for others as a clinician.			
14. Displays emotional control, stability, and maturity	Maintains a neutral emotional display when appropriate or needed. Demonstrates emotional maturity and self-confidence.			
15. Demonstrates interest and involvement in clinic	Views each clinical assignment as a learning opportunity, recognizes personal needs for clinical and professional growth and experiences, displays a positive attitude about all cases and assignments. Demonstrates effort and enthusiasm for the clinical assignments.			
16. Demonstrates ability to self-evaluate professional growth	Comes prepared to conferences for discussing clinical performance; sets goals for own clinical and professional development. Provides constructive feedback to the supervisor regarding the supervisory process and developmental needs.			
	INTERACTION/PROFESSIONAL SKILLS TOTAL	**0**	**0**	**0**
D. PREVENTION				
1. Demonstrates ability to screen hearing	Performs puretone air conduction hearing screening accurately. Correctly interprets findings and makes appropriate referrals.			
2. Demonstrates ability to screen for middle ear pathology	Performs screening tympanometry accurately under supervision of audiologist. Correctly interprets findings and makes appropriate referrals.			
3. Demonstrates ability to screen speech-language and swallowing skills	Performs speech-language and swallowing screenings accurately. Correctly interprets findings and makes appropriate referrals.			
4. Participates in prevention activities that eliminate, inhibit, or delay the onset and development of a communication or swallowing disorder by minimizing susceptibility or reducing exposure	Participates in identification of target groups at risk for communication disorders and prevention activities to identify and eliminate risk factors for the onset, development, or maintenance of a communication disorder; or to improve ability to cope with communication disorders (such as clinic and community screenings, health fairs, inservices, parent/client education, support groups, etc.).			
	PREVENTION TOTAL	**0**	**0**	**0**
E. ASSESSMENT				
PLANNING				
1. Demonstrates understanding of referral questions and diagnostic issues	Thoroughly reviews client history/reason for referral, and plans appropriately; secures necessary information from client/caregiver, if indicated.			
2. Applies theory, research, and knowledge from academic courses in formulating a diagnostic hypothesis	Demonstrates ability to integrate knowledge from academic courses and research to formulate a diagnostic hypothesis.			
3. Selects and administers appropriate evaluation measures	Investigates validity and reliability data and chooses appropriate diagnostic tools. Selects appropriate behavioral observations, non-standardized/standardized tests, and instrumental procedures. Demonstrates understanding of cultural factors.			
EXECUTION: DIAGNOSTIC/SCREENING				
4. Conducts appropriate client interview	Talks to client, caregivers, spouse, as appropriate and generates investigative questions.			
5. Manages client behavior	Uses appropriate techniques to manage client behavior that facilitates best performance.			
6. Administers formal and informal tests accurately	Demonstrates preparation and appropriate amount of practice; administers test efficiently according to standardized procedures; shows ability to correctly establish basal and ceiling.			
7. Organizes/manages session	Organizes session appropriately, manages materials and modifies environment as needed, uses time			

Student _____ Supervisor(s) _____ Semester: _____

KNOWLEDGE / SKILL	BEHAVIORAL DESCRIPTORS	GOAL	MT	FINAL
DATA COLLECTION AND SCORING				
8. Records responses accurately	Records client's responses during test administration and informal observations; observes performance of the client with insight; collects a communication sample. Ensures backup data retrieval system available (i.e., audio and/or videotape, second tape recorder). Accurately discriminates sound productions.			
9. Scores accurately	Scores formal and informal tests accurately.			
ANALYSIS AND INTERPRETATION				
10. Accurately analyzes, interprets, and integrates data; applies academic and clinical knowledge	Analyzes and interprets data accurately; integrates results from case history, observation, formal testing and informal procedures to make accurate impressions and assessment/diagnosis. Integrates knowledge form academic courses into assessment interpretation.			
11. Makes recommendations based on integration of information	Makes accurate recommendations for intervention or referrals to other professionals or services, as needed. Is aware when full evaluation is needed after screenings.			
	ASSESSMENT TOTAL	**0**	**0**	**0**
F. INTERVENTION				
PLANNING				
1. Investigates client file for pertinent background information	Identify client's needs, case management issues, relevant factors, previous treatment, outcomes and recommendations; makes contacts as appropriate to secure necessary information.			
2. Develops an individualized intervention plan that considers client and caregiver needs	Establishes treatment plans with objectives and goals that meet the individual client's needs. Collaborates with clients and relevant others in the planning process; plans projected progress considering length of planned therapy. Sequences and organizes short-term objectives and long-term goals appropriately considers future planning and carryover needs.			
3. Plans specific, effective and appropriate therapy procedures, including cues and reinforcement	Uses procedures appropriate for client's needs, strengths, developmental level, learning style, cultural and linguistic factors. Plans for modifications needed in the physical environment to meet the client's needs. Follows hierarchies to transition clients to next level.			
4. Applies theory, research, and knowledge from academic courses in formulating an intervention plan	Demonstrates ability to integrate knowledge from academic courses and best practices into clinical practice.			
5. Develops/plans treatment to ensure generalization	Develops objectives and strategies to address generalization needs. Collects data on generalization skills and plans accordingly.			
6. Follows intervention plans; modifies strategies, materials, or instrumentation as appropriate	Follows plan and modifies as appropriate to meet client needs. Uses branching strategies. Involves clients and relevant other in the intervention process.			
7. Selects or develops a variety of materials, strategies, and instrumentation	Uses a variety of strategies to gain client cooperation. Considers functional needs of client. Demonstrates ability to facilitate attention, concentration, cooperation, and learning in clients of all ages; uses age-appropriate strategies for client management. Deals with problem behaviors appropriately. Identifies and reacts appropriately to client's verbal/nonverbal responses.			
8. Uses session time efficiently	Paces session well, obtains an optimal number of client responses. Conducts efficient and effective			
9. Measures and evaluates client's performance and progress	Collects data accurately and efficiently without interrupting the flow of therapy.			
10. Monitors verbal and nonverbal interactions	Provides appropriate and effective verbal directions and reinforcement; monitors verbal and nonverbal behaviors.			

Student _____ Supervisor(s) _____ Semester: _____

KNOWLEDGE / SKILL	BEHAVIORAL DESCRIPTORS	GOAL	MT	FINAL
11. Communicates effectively with the client	Gives information clearly, concisely, and at a language level that is meaningful to the client. Gives clear and consistent instructions, modifies instructions when the client is not understanding. Communicates rational for therapy techniques, as appropriate for age and cognitive level.			
12. Provides home program instructions	Trains client and caregivers in home program, ensures that client/caregiver understands instructions. Provides home program materials, as appropriate, and documents training in client file.			
13. Demonstrates problem-solving skills	Uses resources from the clinic, class, supervision, library, journals, Internet, etc. to effectively address clinical needs and concerns; does not depend on supervisor for problem identification, evaluation, and generation of solution. Conducts self-evaluation of the session to improve own clinical skills.			
REPORTING				
14. Accurately records and evaluates clients performance	Accurately completes required documentation of intervention results.			
15. Provides organized presentation of information to client, caregivers, supervisor, etc.	Is prepared, practiced, well-sequenced, and well-organized with material and presentation that is free of jargon.			
16. Provides feedback to client and/or caregiver effectively	Discusses treatment plans and gives therapy feedback in a clear and practical manner, ensuring confidentiality. Summarizes session objectives and results at the conclusion of the session. Communicates effectively, recognizing the needs, values, preferred mode of communication, and cultural/linguistic background of the client, and caregivers.			
	INTERVENTION TOTAL	**0**	**0**	**0**

Student:_____ Supervisor(s):_____ Semester:_____ 20___

PRACTICUM EVALUATION RATING SUMMARY

GOAL SETTING CONFERENCE

Clinical Supervisor(s) Signature Date

Student Signature Date

MIDTERM RATING

Area	Student Area Total Rating	Total Score For Each Area	%
A. Oral	0.00	0.00	0
B. Written	0.00	0.00	0
C. Interaction/Professional	0.00	0.00	0
D. Prevention	0.00	0.00	0
E. Assessment	0.00	0.00	0
F. Intervention	0.00	0.00	0
Total	**0.00**	**0.00**	**#DIV/0!**
		GRADE	**#DIV/0!**

Clinical Supervisor(s) Signature Date

Student Signature Date

FINAL RATING

Area	Student Area Total Rating	Total Score For Each Area	%
A. Oral	0.00	0.00	0
B. Written	0.00	0.00	0
C. Interaction/Professional	0.00	0.00	0
D. Prevention	0.00	0.00	0
E. Assessment	0.00	0.00	0
F. Intervention	0.00	0.00	0
Total	**0.00**	**0.00**	**#DIV/0!**
		GRADE	**#DIV/0!**

Clinical Supervisor(s) Signature Date

Student Signature Date

Grading Scale: 90 - 100 = A; 80 - 89 = B; 70 - 79 = C; 60 - 69 = D; below 60 = F

ADDITIONAL COMMENTS ON PERFORMANCE, STUDENT CLINICAL/PROFESSIONAL GOALS, DATE (attach additional sheet, if needed)

☐ Student is recommended to continue in clinic practicum in the AAMU Clinic/AAMU sites.

☐ Student is recommended to continue in clinic practicum in off-campus placements (requires a minimum rating of 4.0).

☐ Student needs continued development of skill or competency areas. A Competency Remediation Plan may be needed.

☐ Student does not demonstrate required skills to continue placement in clinical practicum.

Adapted from: Clinical Evaluation Form, The University of Texas, Speech and Hearing Center, Austin, Texas

Adapted from: CF 405 (Revised 07-09-02) Practicum Evaluation UGA Speech and Hearing Clinic

Alabama A&M University
Communicative Sciences & Disorders
Speech & Hearing Clinic

SUPERVISION RATING SCALE / SUPERVISION CONTINUUM

Student Behaviors	Not Evident	Emerging	Present	Adequate	Consistent
	• Skill is not evident most of the time. • Student needs direct instruction to modify behavior. • Student is often unaware of need to change. (Skill present <25%)	• Skill is emerging; is inconsistent or inadequate. • Student shows awareness of need to change behavior with supervisor input. (Skill present 26-50%)	• Skill is present and needs further development, refinement, or consistency. • Student is aware of need to modify behavior, but does not modify behavior independently. (Skill present 51-75%)	• Skill is developed / implemented most of the time and needs continued refinement or consistency. • Student is aware and can modify behavior in session; can self-evaluate. • Problem solving is independent. (Skill present 76-90%)	• Skill is consistent and well developed or mastered. • Student is able to modify own behavior and client treatment as needed. • Independent problem solving is frequent. • Student generalizes skills to other clients, as appropriate. • Student takes initiative with skill development. (Skill present > 90%)
RATING	**1**	**2**	**3**	**4**	**5**
Supervisor Behaviors	• Supervisor must model behavior and implement the skill required for client to receive optimal care. • Supervisor provides numerous instructions and frequent modeling.	Supervisor frequently provides instructions and support for all aspects of case management and services.	Supervisor provides ongoing monitoring and feedback; focuses on increasing student awareness of how/when to improve skill.	Supervisor collaborates with the student to plan and suggest possible alternatives.	Supervisor serves as consultant in areas where student has less experience. Provides guidance on ideas initiated by student.
Supervisor Styles	**Modeling/Intervention**	**Frequent Intervention**	**Frequent Monitoring**	**Infrequent Monitoring**	**Guidance**

Supervisors use the rating scale/continuum to evaluate student performance on the Practicum Evaluation form and the Clinical Competency and Formative Assessment Record. Students are rated according to the level of skill or competency demonstrated and degree of supervision required.

Adapted from:
- Anderson, J. L. (1988). The supervisory process in speech-language pathology and Audiology. Boston: College-Hill Press.
- CSD Network Practicum Grade Determination, Communication & Sciences Department, University of Pittsburgh.
- Student Performance Review, Department of Hearing and Speech Sciences, Vanderbilt University.
- Supervision Rating Scale/Supervision Continuum, Department of Communication and Speech Disorders, University of Georgia.

Student Susie Speech Supervisor(s) ESTHER EMBDEN Semester: SPRING 2009

Alabama A&M University
Communicative Sciences & Disorders
Speech & Hearing Clinic

Practicum Evaluation

(CSD 321, 406, 516) L1, L2, L3

Client Disorder / Difference	Client Cultural /Linguistic Diversity	Client Age Group
Language	African American	Tottler
Pragmatic Language/Autism	Anglo-American	Child
Speech and Language Screenings	Variety	Child

The following evaluation of clinical practicum will be completed by student self-evaluation and by supervisor evaluation of student performance at beginning, midterm and the end of the semester. Knowledge or skills will be rated according to the descriptors on the *Supervision Rating Scale/Supervision Continuum*

5 = Consistent 4 = Adequate 3 = Present 2 = Emerging 1 = Not Evident NO = Not Observed

KNOWLEDGE / SKILL	BEHAVIORAL DESCRIPTORS	GOAL	MT	FINAL
A. ORAL COMMUNICATION				
1. Demonstrates effective speaking and listening skills	Demonstrates speaking and listening ability for effective clinical and professional interaction with clients and their relevant others.	5	5	5
2. Demonstrates effective modeling and targets	Demonstrates speech and language skills in English so that modeling of the target phoneme, grammatical feature, or other aspect of speech and language that characterizes the client's problem is correct.	5	5	5
	ORAL COMMUNICATION TOTAL	**10**	**10**	**10**
B. WRITTEN COMMUNICATION				
ORGANIZATION				
1. Follows appropriate format for type of document	Follows standard format as stated in clinic procedures.	5	3	4
2. Presents information in organized and concise manner	Uses a logical order and appropriate transition statements.	5	3	4
CONTENT/STYLE				
3. Writes thorough, objective reports that synthesize various data sources	Includes supporting data and relevant information in diagnostic reports, initial tx plans, lesson plans, SOAP notes, summary reports, professional correspondence, or other assigned reports; information is integrated and synthesized for appropriate analysis of information and support for conclusions.	5	3	4
4. Includes appropriate recommendations	Includes specific ideas for tx, including measurable goals, procedures, cues, reinforcement, and materials, as indicated.	5	3	4
5. Writes clearly and concisely	Excludes insignificant or irrelevant information, does not include new information in summary.	5	3	4
6. Writes appropriate behavioral objectives	Plans/writes behavioral objectives and goals that consider functional needs of clients and are prioritized, measurable, achievable.	5	3	4

Student Susie Speech Supervisor(s) ESTHER EMBDEN Semester: SPRING 2009

KNOWLEDGE / SKILL	BEHAVIORAL DESCRIPTORS	GOAL	MT	FINAL
7. Uses professional language and terminology	Uses formal, professional, objective language that is grammatically correct. Explains jargon and terminology as appropriate. Avoids emotional language. Uses approved abbreviations in daily documentation. No abbreviations not on approved list.	5	3	5
8. Edits and proofreads all documentation	Carefully edits and proofreads written documentation and reports before submission.	5	3	5
	WRITTEN COMMUNICATION TOTAL	**40**	**24**	**34**
C. INTERACTION AND PERSONAL/PROFESSIONAL QUALITIES				
PROFESSIONAL RESPONSIBILITY				
1. Is punctual for meetings with supervisor and for client sessions	Arrives before session to set up clinic room, begins work promptly at scheduled diagnostic/therapy time, is on time for meetings.	5	2	4
2. Attends scheduled meetings, classes, client sessions	Attends all scheduled meetings/classes/seminars. If unable to attend meeting, informs supervisor well in advance. Reschedules therapy sessions when absent (following supervisor approval).	5	2	5
3. Submits work on time and as specified according to procedures	Submits written reports/lesson plans by due dates; work is complete when submitted.	5	2	5
4. Demonstrates organization/preparation	Is prepared for sessions, has practiced test administration and techniques, session is well sequenced and organized; brings appropriate or required materials/documents to sessions and meetings	5	3	4
5. Demonstrates initiative in clinical management	Attends to case management issues and seeks information and resources; recognizes case management needs; provides client with optimal level of service.	5	3	5
6. Demonstrates knowledge of clinic safety, confidentiality, ethical procedures, clinic procedures	Demonstrates adherence to universal/standard precautions/infection control procedures, emergency and safety procedures, ASHA Code of Ethics, confidentiality procedures. Follows checkout procedures for materials, tests, and client files; does not remove client records from the clinic.	5	3	5
7. Keeps compete, accurate, and timely records	Accurately completes practicum hours, places and secures all information appropriately in client file, following clinic procedures. Completes all sections of client folder in a timely manner and submits for processing. Sends reports as indicated to client, caregivers, physicians, etc. ensures appropriate release of information and fee payment contract are in file.	5	3	4
8. Maintains a professional appearance	Dresses appropriately for clinic assignments, following dress code guidelines; conducts self in professional manner.	5	3	5
PROFESSIONAL INTERACTIONS				
9. Is approachable and responsive to clients, parents, and other professionals. Demonstrates poise and maturity in professional interactions	Appropriately interacts with clients and caregivers in the clinical setting: demonstrates active listening skills and appropriate nonverbal communication. Addresses client's concerns in a positive and confident manner, is receptive to clients and caregiver's questions, utilizes effective counseling techniques. Provides organized information during conferences that are appropriate for educational level of client or caregiver.	5	3	5
10. Is approachable and responsive to supervisor	Consults with the supervisor in appropriate setting and manner, respects supervisory relationship, seeks information and or clarifies information in an open, non-defensive manner. Seeks input; accepts supervisors comments/suggestions, integrates supervisor's suggestions. Responds to and incorporates supervisor's feedback on written documentation, as appropriate.	5	3	5
11. Displays acceptance of the client's disability and differences; treats all clients with positive regard. Respects cultural differences	Adapts to client's age, cognitive level, language level, and cultural/ethic differences with appropriate communication strategies and modifications to the therapy setting. Demonstrates acceptance and tolerance for cultural differences; varies interaction style as needed for clinical interactions.	5	3	5
12. Collaborates with other professionals	Consults with other professionals as appropriate for case management; secures consent and maintains confidentiality.	5	3	5

Student Susie Speech Supervisor(s) ESTHER EMBDEN Semester: SPRING 2009

KNOWLEDGE / SKILL	BEHAVIORAL DESCRIPTORS	GOAL	MT	FINAL
PROFESSIONAL ATTITUDE				
13. Demonstrates pride in profession	Shows enthusiasm in professional interactions about speech-language pathology as a profession and career choice; is a positive role model for others as a clinician.	5	3	5
14. Displays emotional control, stability, and maturity	Maintains a neutral emotional display when appropriate or needed. Demonstrates emotional maturity and self-confidence.	5	3	5
15. Demonstrates interest and involvement in clinic	Views each clinical assignment as a learning opportunity, recognizes personal needs for clinical and professional growth and experiences, displays a positive attitude about all cases and assignments. Demonstrates effort and enthusiasm for the clinical assignments.	5	3	5
16. Demonstrates ability to self-evaluate professional growth	Comes prepared to conferences for discussing clinical performance; sets goals for own clinical and professional development. Provides constructive feedback to the supervisor regarding the supervisory process and developmental needs.	5	3	5
	INTERACTION/PROFESSIONAL SKILLS TOTAL	**80**	**45**	**77**
D. PREVENTION				
1. Demonstrates ability to screen hearing	Performs puretone air conduction hearing screening accurately. Correctly interprets findings and makes appropriate referrals.	5	3	5
2. Demonstrates ability to screen for middle ear pathology	Performs screening tympanometry accurately under supervision of audiologist. Correctly interprets findings and makes appropriate referrals.	NA	NA	NA
3. Demonstrates ability to screen speech-language and swallowing skills	Performs speech-language and swallowing screenings accurately. Correctly interprets findings and makes appropriate referrals.	5	3	5
4. Participates in prevention activities that eliminate, inhibit, or delay the onset and development of a communication or swallowing disorder by minimizing susceptibility or reducing exposure	Participates in identification of target groups at risk for communication disorders and prevention activities to identify and eliminate risk factors for the onset, development, or maintenance of a communication disorder; or to improve ability to cope with communication disorders (such as clinic and community screenings, health fairs, inservices, parent/client education, support groups, etc.).	5	3	5
	PREVENTION TOTAL	**15**	**9**	**15**
E. ASSESSMENT				
PLANNING				
1. Demonstrates understanding of referral questions and diagnostic issues	Thoroughly reviews client history/reason for referral, and plans appropriately; secures necessary information from client/caregiver, if indicated.	5	3	4
2. Applies theory, research, and knowledge from academic courses in formulating a diagnostic hypothesis	Demonstrates ability to integrate knowledge from academic courses and research to formulate a diagnostic hypothesis.	5	3	4
3. Selects and administers appropriate evaluation measures	Investigates validity and reliability data and chooses appropriate diagnostic tools. Selects appropriate behavioral observations, non-standardized/standardized tests, and instrumental procedures. Demonstrates understanding of cultural factors.	5	3	4
EXECUTION: DIAGNOSTIC/SCREENING				
4. Conducts appropriate client interview	Talks to client, caregivers, spouse, as appropriate and generates investigative questions.	5	3	4
5. Manages client behavior	Uses appropriate techniques to manage client behavior that facilitates best performance.	5	3	4
6. Administers formal and informal tests accurately	Demonstrates preparation and appropriate amount of practice; administers test efficiently according to standardized procedures; shows ability to correctly establish basal and ceiling.	5	3	4
7. Organizes/manages session	Organizes session appropriately, manages materials and modifies environment as needed, uses time	5	3	4

Student Susie Speech Supervisor(s) ESTHER EMBDEN Semester: SPRING 2009

KNOWLEDGE / SKILL	BEHAVIORAL DESCRIPTORS	GOAL	MT	FINAL
DATA COLLECTION AND SCORING				
8. Records responses accurately	Records client's responses during test administration and informal observations; observes performance of the client with insight; collects a communication sample. Ensures backup data retrieval system available (i.e., audio and/or videotape, second tape recorder). Accurately discriminates sound productions.	5	3	5
9. Scores accurately	Scores formal and informal tests accurately.	5	3	5
ANALYSIS AND INTERPRETATION				
10. Accurately analyzes, interprets, and integrates data; applies academic and clinical knowledge	Analyzes and interprets data accurately; integrates results from case history, observation, formal testing and informal procedures to make accurate impressions and assessment/diagnosis. Integrates knowledge form academic courses into assessment interpretation.	4	3	4
11. Makes recommendations based on integration of information	Makes accurate recommendations for intervention or referrals to other professionals or services, as needed. Is aware when full evaluation is needed after screenings.	4	3	4
	ASSESSMENT TOTAL	**53**	**33**	**46**
F. INTERVENTION				
PLANNING				
1. Investigates client file for pertinent background information	Identify client's needs, case management issues, relevant factors, previous treatment, outcomes and recommendations; makes contacts as appropriate to secure necessary information.	5	3	5
2. Develops an individualized intervention plan that considers client and caregiver needs	Establishes treatment plans with objectives and goals that meet the individual client's needs. Collaborates with clients and relevant others in the planning process; plans projected progress considering length of planned therapy. Sequences and organizes short-term objectives and long-term goals appropriately considers future planning and carryover needs.	5	3	5
3. Plans specific, effective and appropriate therapy procedures, including cues and reinforcement	Uses procedures appropriate for client's needs, strengths, developmental level, learning style, cultural and linguistic factors. Plans for modifications needed in the physical environment to meet the client's needs. Follows hierarchies to transition clients to next level.	5	3	5
4. Applies theory, research, and knowledge from academic courses in formulating an intervention plan	Demonstrates ability to integrate knowledge from academic courses and best practices into clinical practice.	5	2.5	4
5. Develops/plans treatment to ensure generalization	Develops objectives and strategies to address generalization needs. Collects data on generalization skills and plans accordingly.	5	3	4
6. Follows intervention plans; modifies strategies, materials, or instrumentation as appropriate	Follows plan and modifies as appropriate to meet client needs. Uses branching strategies. Involves clients and relevant other in the intervention process.	5	3	4
7. Selects or develops a variety of materials, strategies, and instrumentation	Uses a variety of strategies to gain client cooperation. Considers functional needs of client. Demonstrates ability to facilitate attention, concentration, cooperation, and learning in clients of all ages; uses age-appropriate strategies for client management. Deals with problem behaviors appropriately. Identifies and reacts appropriately to client's verbal/nonverbal responses.	5	3	4
8. Uses session time efficiently	Paces session well, obtains an optimal number of client responses. Conducts efficient and effective	5	3	4
9. Measures and evaluates client's performance and progress	Collects data accurately and efficiently without interrupting the flow of therapy.	5	3	4
10. Monitors verbal and nonverbal interactions	Provides appropriate and effective verbal directions and reinforcement; monitors verbal and nonverbal behaviors.	5	3	4

Student Susie Speech Supervisor(s) ESTHER EMBDEN Semester: SPRING 2009

KNOWLEDGE / SKILL	BEHAVIORAL DESCRIPTORS	GOAL	MT	FINAL
11. Communicates effectively with the client	Gives information clearly, concisely, and at a language level that is meaningful to the client. Gives clear and consistent instructions, modifies instructions when the client is not understanding. Communicates rational for therapy techniques, as appropriate for age and cognitive level.	5	3	4
12. Provides home program instructions	Trains client and caregivers in home program, ensures that client/caregiver understands instructions. Provides home program materials, as appropriate, and documents training in client file.	4	3	4
13. Demonstrates problem-solving skills	Uses resources from the clinic, class, supervision, library, journals, Internet, etc. to effectively address clinical needs and concerns; does not depend on supervisor for problem identification, evaluation, and generation of solution. Conducts self-evaluation of the session to improve own clinical skills.	4	3	4
REPORTING				
14. Accurately records and evaluates clients performance	Accurately completes required documentation of intervention results.	5	3	4
15. Provides organized presentation of information to client, caregivers, supervisor, etc.	Is prepared, practiced, well-sequenced, and well-organized with material and presentation that is free of jargon.	5	3	5
16. Provides feedback to client and/or caregiver effectively	Discusses treatment plans and gives therapy feedback in a clear and practical manner, ensuring confidentiality. Summarizes session objectives and results at the conclusion of the session. Communicates effectively, recognizing the needs, values, preferred mode of communication, and cultural/linguistic background of the client, and caregivers.	5	3	5
	INTERVENTION TOTAL	**78**	**47.5**	**69**

Student: JANE DOE Supervisor(s): ESTHER EMBDEN Semester: SPRING 20 04

PRACTICUM EVALUATION RATING SUMMARY

GOAL SETTING CONFERENCE

1. Student will learn how to adequately administer the Rosetti test with 90% acc.

Esther J. Embden, MA, CCC-SLP/L	06/01/09
Clinical Supervisor(s) Signature	Date
Susie Speech BA, graduate clinician	06/01/09
Student Signature	Date

MIDTERM RATING

Area	Student Area Total Rating	Total Score For Each Area	%
A. Oral	10.00	10.00	100
B. Written	24.00	40.00	60
C. Interaction/Professional	45.00	80.00	56.25
D. Prevention	9.00	15.00	60
E. Assessment	33.00	53.00	62.264
F. Intervention	47.50	78.00	60.897
Total	**168.50**	**276.00**	**61**
		GRADE	**D**

Esther J. Embden, MA, CCC-SLP/L	06/15/09
Clinical Supervisor(s) Signature	Date
Susie Speech BA, graduate clinician	06/15/09
Student Signature	Date

FINAL RATING

Area	Student Area Total Rating	Total Score For Each Area	%
A. Oral	10.00	10.00	100
B. Written	34.00	40.00	85
C. Interaction/Professional	77.00	80.00	96.25
D. Prevention	15.00	15.00	100
E. Assessment	46.00	53.00	86.792
F. Intervention	69.00	78.00	88.462
Total	**251.00**	**276.00**	**91**
		GRADE	**A**

Esther J. Embden, MA, CCC-SLP/L	07/25/09
Clinical Supervisor(s) Signature	Date
Susie Speech BA, graduate clinician	07/24/09
Student Signature	Date

Grading Scale: 90 - 100 = A; 80 - 89 = B; 70 - 79 = C; 60 - 69 = D; below 60 = F

ADDITIONAL COMMENTS ON PERFORMANCE, STUDENT CLINICAL/PROFESSIONAL GOALS, DATE (attach additional sheet, if needed)

- [x] Student is recommended to continue in clinic practicum in the AAMU Clinic/AAMU sites.
- [x] Student is recommended to continue in clinic practicum in off-campus placements (requires a minimum rating of 4.0).
- [ ] Student needs continued development of skill or competency areas. A Competency Remediation Plan may be needed.
- [ ] Student does not demonstrate required skills to continue placement in clinical practicum.

Adapted from: Clinical Evaluation Form, The University of Texas, Speech and Hearing Center, Austin, Texas

Adapted from: CF 405 (Revised 07-09-02) Practicum Evaluation UGA Speech and Hearing Clinic

INSTRUCTIONS FOR FILLING OUT
GRADUATE CLINICAL PRACTICUM REPORTS
Example Attached
(Students are responsible for completing these correctly and turning in per Clinical Timeline)

1. SEMESTER: write the semester and the year. Example: Spring 2007.
2. NAME: write your name in this space
3. NAME: client initials may be used or "group one," etc.
4. DATE: record actual date you worked with (observed, etc.) the client.
5. TYPE OF PROBLEM: record disorder/problem the client exhibits or is tested for. Example: Language. If the client has language and artic problems, divide the time per problem on separate lines. **NOTE**: Only use language, artic, voice, fluency, dysphagia, or aural rehab (audiology) in this column. DO NOT write Aphasia, Foreign Accent, Phonology, Dysarthria, Oral Motor, etc.
6. AGE: this column should have "C" for child or "A" for adults. Actual age of client is not necessary.
7. GROUP: if you have more than one client at the time of therapy. Record time in minutes. Example: 75 minutes (not necessary to put the word minutes, see example)
8. DIAGNOSTIC: this column is to record the times when evaluating and testing the client. Record time in minutes. Example: 120 minutes (not necessary to put the word minutes, see example)
9. OTHER: this column is for parent/client conferences, hearing screenings, and observations. Record time in minutes.
10. LOCATION: the location that therapy, etc. is taking place. USE A SEPARATE SHEET FOR EACH LOCIATION AND A SEPARATE SHEET FOR EACH SUPERVISOR EVEN IF THE SUPERVISORS ARE AT THE SAME LOCATION.
11. SUPERVISOR INITIALS: the supervisor MUST initial all the filled in rows in order to verify the information recorded in that row.
12. Cross out any unused rows of documentation.
13. THERAPY: place the total number of minutes per problem and per adult or child in the appropriate places. Use a pencil for these totals for easier error correction.
14. TOTAL MINUTES: list total number of minutes on the page. Use a pencil for these totals for easier error correction (not necessary to put the word minutes, see example).
15. TOTAL HOURS: list total number of hours on this page, divide total minutes by 60. Example: 615 minutes ÷ 60 = 10.25 hours (not necessary to put the word hours, see example). Use a pencil for these totals for easier error correction.
16. SUPERVISOR'S SIGNATURE: This is to be obtained either when sheet is full or before turn in date per Clinical Timeline. Sheet will not be accepted if signature is obtained 30 or more days after treatment date.
17. CCC: list supervisor's certification area: Example: SLP, SLP/A, or A.
18. ASHA #: ASHA number of supervisor is required for the hours to be tabulated.
19. DATE: list the date the supervisor signed the form (date must agree with the last session documented).

In order to make it easier to track your hours, please put only one location per page and one supervisor per page.

IT IS YOUR RESPONSIBILITY TO MAKE SURE YOUR PAPERWORK IS CORRECT, NEAT, AND COMPLETED PROMPTLY AND PROPERLY.

Ethics Statement:
All acts of dishonesty in any work constitute academic misconduct. This includes, but is not limited to: cheating, plagiarism/stealing, fabrication of information, misrepresentation and abetting any of the above.

Academic misconduct represents unethical behavior unbecoming to the teaching and CSD profession and is against the principles outlined in the American Speech-Language-Hearing Association's *Code of Ethics* document. There is no tolerance of such behavior. Academic misconduct may result in a failing grade for the course.

Form updated 5/07

GRADUATE CLINICAL PRACTICUM REPORT
SPEECH-LANGUAGE-HEARING
ALABAMA A&M UNIVERSITY

NOTE: One supervisor and one location per page. (1)

SEMESTER: Spring 2007

(2) NAME: Jane Doe

* Age = Adult, Child

(3) NAME	(4) DATE	(5) TYPE OF PROBLEM Language, artic, voice, fluency dysphagia, aural rehab	THERAPY INDIV. (6) AGE A / C	THERAPY INDIV. CLOCK MIN.	THERAPY (7) GROUP AGE A / C	THERAPY GROUP CLOCK MIN.	DIAGNOSTIC (8) (Evals, Test) AGE A / C	DIAGNOSTIC CLOCK MIN.	OTHER: (9) Conference, hrg screenings, observations TYPE	OTHER CLOCK MIN.	(10) LOCATION	(11) SUPERVISOR INTIALS
JH	1/4/07	Language	C	30							AAMU Speech Clinic	KW
FA, SB, PT	1/4/07	Artic			C	25					"	KW
		Language			C	20					"	KW
TF	1/5/07	Fluency					A	60			"	KW
SB	1/6/07	Language	C						Parent Conference	60	"	KW
PY	1/6/07	Language	C						Observation	30	"	KW
MT	1/7/07		A						Hearing Screen	15	"	KW
JH	1/9/07	Language	C	30							"	KW
PD	1/9/07	Fluency					A	120			"	KW
TF	1/9/07	Fluency	A	75							"	KW
SC	1/10/07	Voice	C	45							"	KW
FF	1/11/07	Aural Rehab	A	30							"	KW
SS	1/11/07	Audiology					A	75			"	KW

(13)

Therapy	A / C	Diagnostic	A / C
Language	/ 80		/
Artic	/ 25		/
Voice	/ 45		/
Fluency	75 /		180 /
Dysphagia	/		/
Audiology	30 /		75 /

	A / C
Staffing Hrs.	160
Observation	30
Hearing Screening	15 /

(14) TOTAL MIN 615

(15) TOTAL HRS 10.25

(16) SUPERVISOR'S SIGNATURE: Kerry Walker

Kerry Walker

(17) CCC- SLP/A

(18) ASHA #: 00211123

(19) DATE: 1-11-07

Form updated 5/07

GRADUATE CLINICAL PRACTICUM REPORT
SPEECH-LANGUAGE-HEARING
ALABAMA A&M UNIVERSITY

NOTE: One supervisor and one location per page.

SEMESTER: _____ NAME: _____

*** Age = Adult, Child**

NAME	DATE	TYPE OF PROBLEM (Language, artic, voice, fluency dysphagia, aural rehab)	THERAPY INDIV. AGE A / C	THERAPY INDIV. CLOCK MIN.	THERAPY GROUP AGE A / C	THERAPY GROUP CLOCK MIN.	DIAGNOSTIC (Evals, Test) AGE A / C	DIAGNOSTIC (Evals, Test) CLOCK MIN.	OTHER: Conference, hrg screenings, observations TYPE	OTHER: Conference, hrg screenings, observations CLOCK MIN.	LOCATION	SUPERVISOR INTIALS

Therapy	A / C	**Diagnostic**	A / C		A / C
Language	/		/	Staffing Hrs.	/
Artic	/		/	Observation	
Voice	/		/	Hearing Screening	/
Fluency	/		/		
Dysphagia	/		/		
Audiology	/		/		

TOTAL MIN _____

TOTAL HRS _____

SUPERVISOR'S SIGNATURE: _____ CCC-_____ ASHA #: _____ DATE: _____

Alabama A&M University
Communicative Sciences and Disorders
DIAGNOSTIC SESSION EVALUATION
Supervised Clinical Practicum (CSD 321, 406, and 516)

_____ **Client's Initials** _____ **Date** _____ **Supervisor** _____

Planning:	☐ Clinician is thoroughly familiar with ct's history ☐ Explains rationale for tests and procedures selected	☐ Takes initiative to plan all aspects of evaluation ☐ Selects appropriate procedures based on information available
Structure:	☐ Session is organized ☐ Appropriate language used considering client's MA and CA ☐ Client has sufficient time to respond	☐ Instructions are clear and easy to understand ☐ Cln effectively manipulates materials to enhance ct's attention and participation
Formal Test Administration:	☐ Administers test according to standardized procedures ☐ Demonstrates flexibility by modifying procedures during session	☐ Provides appropriate feedback or reinforcement consistent with testing procedures ☐ Records responses efficiently and accurately
Informal Procedures:	☐ Executes procedure(s) appropriately ☐ Elicits a representative sample of behavior	☐ Demonstrates flexibility by modifying procedures during session
Behavior Management:	☐ Appropriate behavior is established and client's attention is maintained during session	☐ Reinforcement is used effectively ☐ Undesired behavior is recognized and minimized
Professionalism:	☐ Shows respect to the client ☐ Displays appropriate demeanor, dress and language ☐ Punctual ☐ Adheres to Code of Ethics	☐ When appropriate, tone of session is positive ☐ Establishes a "safe" environment for client to express feeling
Other/Comments:		

Session time observed _____ minutes
Actual length of session _____ minutes
Percentage observed _____ %

Alabama A&M University
Communicative Sciences and Disorders
WRITTEN COMMUNICATION EVALUATION
Supervised Clinical Practicum (CSD 321, 406, and 516)

Clinician _____ **Client's Initials** _____ **Date** _____ **Supervisor** _____

Professional Language/Error Correction:

- ☐ Use of first person
- ☐ Use of contractions
- ☐ Use of unapproved abbreviations
- ☐ Use of white out
- ☐ Use of ink color other than black.
- ☐ More than a single line with initials through errors.

Grammar/Punctuation/Spelling:

- ☐ Significant/frequent G/P/S errors
- ☐ Illegible

Writing Style:

- ☐ Overly personal or judgmental; emotional tone
- ☐ Too wordy, stiff or awkward

SOAP Note, Dx Report, Initial Therapy Plan, Semester Summary– Format, Quality, Description, Data:

- ☐ Information under the wrong heading
- ☐ Not all areas are addressed.
- ☐ Minimal elaboration regarding facts of the session
- ☐ Omits data or percentages from targeted objectives – no cues or error examples
- ☐ Statements are disjointed or confusing
- ☐ Concerns and recommendations not supported by the observations (and vice versa)

Lesson Plan – Consistency, Completeness, Clarity:

- ☐ Significant departure from Initial Therapy Plan or updated SOAP plan or plan discussed with supervisor
- ☐ Activities are too repetitive or drill-oriented
- ☐ Not all fields are completed.
- ☐ Confusing or contradictory goals or procedures

Other:

Alabama A&M University
Communicative Sciences and Disorders
TREATMENT SESSION EVALUATION
Supervised Clinical Practicum (CSD 321, 406, and 516)

Clinician _____ **Client's Initials** _____ **Date** _____ **Supervisor** _____

Objectives:	☐ Objectives evident in treatment session ☐ Procedures congruent with written objectives ☐ Maximizes responses	☐ Target stimuli are appropriate for client's abilities and stated objectives ☐ Clinician modifies procedures when indicated
Structure:	☐ Transition from activity to activity is smooth ☐ Effectively manipulates materials to enhance client's attention and participation	☐ Instructions are clear and enable client to understand ☐ Activities and materials are appropriate to client and objectives
Cueing/Modeling Strategies:	☐ Appropriate elicitation techniques are used ☐ Cueing strategy is effective ☐ Client's errors are correctly discriminated	☐ Cueing is increased or decreased as needed ☐ Target behavior is modeled correctly
Feedback/Correction Techniques:	☐ Consistent, concrete, concise feedback provided ☐ Client is encouraged to self-evaluate	☐ Appropriate correction techniques ☐ Target responses are effectively reinforced
Behavior Management:	☐ Environment is arranged to facilitate optimal behavior ☐ Desired behavior is effectively reinforced ☐ Employs effective reinforcement system	☐ Appropriate behavior is established and maintained during the session ☐ Undesired behavior is recognized and minimized
Professionalism:	☐ Shows respect to the client ☐ Displays appropriate demeanor, dress and language ☐ Punctual ☐ Adheres to Code of Ethics	☐ When appropriate, tone of session is positive ☐ Establishes a "safe" environment for client to express feeling
Other:		

Session time observed _____ minutes
Actual length of session _____ minutes
Percentage observed _____ %