Speech-Language Pathology Assistant
Application Checklist

The Board has an open application process. Applications are processed once the application is complete. An application is considered complete when all of the required materials have been received by the Board. Applicants are strongly encouraged to make a copy of their application prior to sending it to the Board. An individual may only begin practicing as a speech-language pathology assistant after receipt of the limited license.

I. All Applicants Must Submit the Following

___ $100.00 Non-Refundable Application Fee
(check or money order payable to the Board of SLP)

___ A recent 2 inch by 2 inch passport size color photo (attached to first page of application)

___ Signed and Notarized Application

___ Proof of graduation from an acceptable program within the last five years

___ Law and Regulation Examination completed and returned with Application

Note: A minimum score of 75 percent is required to pass the Law Examination. The Exam can be downloaded from the Board’s web site at http://www.dhmh.state.md.us/boardsahs/. Use the Forms Link to download a copy of the Exam. To complete the Examination refer to the law and regulations reference numbers included with the question. Use the Law and Regulation Links on the web site to review the appropriate statute or regulation. If you do not have access to a computer, call the Board office at 410-764-4725 and request a copy of the law and regulations. A license will not be issued unless the Law and Regulation Examination is passed.

II. Application for Full License by Waiver

An applicant may qualify for a waiver of the requirements for licensure as a Speech-Language Pathology Assistant if the applicant meets one of the following (A, B or C):

A. Holds a valid ASHA registration as a Speech-Language Pathology Assistant.

In addition to items in Section I, submit with application the following two items:

___ Copy of ASHA SLP Assistant Registration or
Letter from ASHA verifying SLP Assistant Registration

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

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

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

C. Have been working as a Speech-Language Pathology Assistant for at least two years.

In addition to items in Section I, submit with application the following three items:

- Letter from the Supervising Speech-Language Pathologist attesting to the dates the applicant worked as an SLP Assistant
- Delegation Agreement (Form SA6) for each Supervising Speech-Language Pathologist
- Competency Skills Check List (Form SA7) completed by the Supervising Speech-Language Pathologist

III. Application for a Limited License as a Speech-Language Pathology Assistant

In addition to items in Section I, submit the following documentation:

A. Education Requirement

Official transcript from college or university verifying one of the following degrees (applicant must have graduated within 5 years prior to application and transcript must be sent directly to the Board):

- Associate’s Degree from an approved SLP Assistant Program
- Associate’s Degree or higher in an allied health field from an accredited institution with minimum course work that includes at least 3 credit hours in normal speech-language development; speech disorders; anatomy and physiology of speech systems; language disorders; and phonology (Attach Form SA2 describing required minimum coursework as stated on transcript)
- Bachelor’s Degree in Speech-Language Pathology or Communication Disorders
B. Clinical Hours Requirement (not required if applicant attended an approved SLP Assistant program)

Documentation of 25 hours of clinical observation and 75 hours of clinical assistance experience. Submit one of the following (either the Form SA3 or the Form SA4):

_____ Form SA3 Education Institution Verification of Completion of Required Clinical Hours for applicants that completed the minimum of 25 hours of clinical observation and 75 hours of clinical assistance experience in the educational institution

_____ Form SA4 Alternate Plan for Obtaining Required Clinical Hours signed by applicant and Supervising Speech-Language Pathologist. Please note: the required clinical hours must be completed within 60 days of the issuance of the limited license and the Form SA5 must be submitted by the applicant no later than 90 days after issuance of the limited license. Failure to submit the Form SA5 will result in the limited license becoming null and void.

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

The supervising speech-language pathologist must meet either of the following two conditions:

a) be licensed in the State of Maryland; or
b) if exempt from licensure in Maryland hold the Certificate of Clinical Competency from ASHA.

To Be Submitted After Initial Limited License Has Been Issued

If a Form SA4 has been submitted to the Board the Form SA5 is due not sooner than 60 days and not more than 90 days after the limited license is issued. The Form SA5 documents the completion of the 25 clinical observation hours and 75 clinical assistance hours. Limited licensees are encouraged to fax the Form SA5 and mail the hardcopy immediately to the Board. Limited licensees are encouraged to call the Board to confirm the Board’s receipt of the Form SA5. If the Board does not receive this form before the date specified in the licensure letter the limited license is null and void; the Board will send a notice of a null and void limited license to the individual. If a limited license is null and void the individual would be required to submit another application for limited licensure.

The Competency Skills Checklist, Form SA7, is due after 9 months of practice under the limited license but no more than 12 months after the limited license has been issued. If the Limited Licensee has more than one supervisor the Limited Licensee must have each supervisor complete a Form SA7. The Limited Licensee is responsible for submitting the Form SA7s to the Board. If the Limited Licensee does not submit the Competency Skills Checklist the Limited License will be null and void.
Notice – Application Processing

An application is considered complete when all supporting documents and fees have been received by the Board. Final processing may take up to 15 business days. **An individual may only begin practicing as a speech-language pathology assistant after receipt of the limited license.**

Renewal of Limited License as a Speech-Language Pathology Assistant

If an individual that holds a limited license as a speech-language pathology assistant is unable to obtain at least 9 months of supervised practice as a full time limited licensee, or obtain the specified months of supervised practice as a part-time limited licensee, and/or is unable to complete the items identified in the Competency Skills Checklist the individual may renew the limited license for an additional year. The renewal form and the $25.00 renewal fee must be submitted at least 30 days prior to the expiration of the limited license. An individual with a renewed limited license is eligible for transfer to a full license provided the minimum number of supervised months has been completed and the Competency Skills Checklist has been submitted to the Board.

If an individual fails to obtain the minimum of 9 months of supervision within the two years of limited licensure the individual must wait an additional year after the expiration of the renewed limited license before the individual can reapply for a limited license as a speech-language pathology assistant.

Transfer of Limited License to Full License

An individual holding a limited license as a speech-language pathologist will be transferred to a full license provided the individual has met all the requirements and the limited licensee has been supervised for at least 9 months. The Form SA7 must be received by the Board no sooner than the 9 months of supervised practice ends and no later than 60 days prior to expiration of the limited license. The limited licensee does not need to fill out another application nor does the limited licensee have to submit another fee.
Application for Licensure for Speech-Language Pathology Assistant

Date ______________________

Na__________me ____________________________

Last    First    Middle/Maiden

Date of Birth _____________________  Social Security # _______________________

Residence _____________________________________________________________

Street         Apt.

City     State    Zip Code

Phone #___________________Alternate#______________ E-Mail_______________________

Professional Address ____________________________________________________________

Facility or Company’s Name

Street                  Suite #

City          State          Zip Code

Telephone # _______________ Fax __________________________ E-mail _______________

Beginning Date of Employment ______________________________

Have you ever been convicted of a felony or a misdemeanor involving moral turpitude? ________ No    ________ Yes     If “Yes” attach full details.

For Office Use Only

Received _____________ CK ( ) MO ( ) Number__________________
Waiver of Requirements

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

B. Do you hold a valid license, certification or registration as a speech-language pathology assistant in another state?  ________ No ________ Yes

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

Has any disciplinary action ever been taken against your license in any other jurisdiction?  
No ______  Yes ______  **If yes, please attach full explanation.**

C. Have you practiced as a SLP Assistant for at least two years prior to submitting this application? 
   __________ No  __________ Yes 
   If yes, attach a letter from your supervising speech-language pathologist attesting to the dates you have practiced as a SLP Assistant. **Also attach** Delegation Agreement (Form SA6) for each supervising Speech-Language Pathologist and completed Competency Skills Check List, (Form SA7).

Education

An applicant must have graduated within 5 years prior to application:

A. School attended: ______________________________________________________________

   Address: _______________________________________________________________________
   ______________________________________________________________________________

   Dates Attended: From _________________________ To: _______________________________

   Degree Granted: __________________________ Date:_____________________

   Have School send official transcript verifying education completed directly to the Maryland Board.

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

   1. Associate Degree from an approved SLP Assistant Program?  ______Yes _____No
2. Associate Degree in an allied health field with 15 hours in required minimum course work?
   ______ Yes ______ No
If you have an Associate Degree in an allied health field, complete Form SA2 describing required minimum coursework as stated on transcript. If the title of the course is not self-explanatory, attach catalog description or syllabus.

3. Bachelor’s Degree in Speech-Language Pathology or Communication Disorders?
   ______ Yes ______ No

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

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

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

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

**Practice Setting Where Limited Licensee Will Practice**

Name of Facility _______________________________________________________________
Address: ____________________________________________________________________
____________________________________________________________________________
Phone Number: ___________________________ Beginning Date: _______________________
Description of Duties: _________________________________________________________
____________________________________________________________________________
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Supervising Speech-Language Pathologist (s):

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**Note:** A Delegation Agreement, Form SA6, must be submitted for each supervising Speech-Language Pathologist.
Please review the regulations and sign the following affirmation:

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

________________________________________________  ___________________
Signature of Applicant       Date

Applicant Must Have This Affidavit Completed by a Notary Public

State of __________________________________________________________

City or County of __________________________________________________

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

_____________________________________ ___________________________________
Signature of Applicant     Signature of Notary

Subscribed and sworn to before this ________ day of _________________________

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

Personal information requested by the Board is necessary in determining your eligibility for licensure. Such personal information is also intended for use as an additional means of verifying the licensee’s identity or to enable the Board to communicate, in a timely manner, with the licensee should the need arise. The licensee has a right to inspect his personal record and to amend or correct the personal data if necessary. Your Social Security Number is needed on the application. It will be used for identification purposes and may be released to the Department of Public Safety and Correctional Services to check for any criminal convictions.
Race/Ethnic Identification

To further its commitment to equal access the Board of Examiners requests applicants to provide, voluntarily, the following information. This information will be used for statistical purposes only by authorized personnel.

Male _______  Female ________

Race/Ethnic Identification – Please Check All That Apply

Are you of Hispanic or Latino origin?   ____ Yes    ____ No   (A person of Cuban, Mexican, Peurto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

Select one or more of the following racial categories:

1. ___ American Indian or Alaska Native (A person having origins in any of the original peoples of North or South America, including Central America, and who maintains tribal affiliations or community attachment.)

2. ___ Asian (A person having origin in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)

3. ___ Black or African American (A person having origins in any of the black racial groups of Africa.)

4. ___ Native Hawaiian or other Pacific Islander (A person having origins in the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)

5. ___ White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

SLP-A
Form SA2

State of Maryland – Department of Health and Mental Hygiene
Board of Examiners for Audiologists,
Hearing Aid Dispensers and Speech-Language Pathologists
4201 Patterson Avenue, Baltimore, Maryland 21215-2299
Phone 410-764-4725        Fax 410-358-0273
TTY/ Maryland Relay Service 1-800-735-2258

Associate Degree in Allied Health Field
Verification of Minimum Required Coursework

Applicant (please type or print)

Name: ______________________________________________________________________
Last      First      Middle/Maiden

Address: ______________________________________________________________________
Street        Apt. #

City      State    Zip Code
Phone #: _____________________________  Alternate #: ___________________________

Educational Institution

Name of Institution: _______________________________________________________________

Address: ______________________________________________________________________
Street___________________________________________________________________________

City                      State    Zip Code

Dates Attended: From _______________ To _________________

Associate Degree in ____________________________________________________________________ granted ________________
(major)      (date – mm/dd/yyyy)
Form SA2

The Board’s regulations require that an applicant with an Associate’s Degree in an allied health field from an accredited institution has completed at least 3 credit hours in each of the areas listed below. Please indicate the name of the course on the transcript that fulfills each requirement and attach an official transcript showing the Associate Degree. If the title of the course is not self-explanatory, attach catalog description or syllabus. A minimum of 3 credit hours is required in each of the following areas:

**Normal Speech-Language Development**

Name of Course ________________________________________________________________
Semester Taken ________________________________________________________________
Additional Courses in this area: __________________________________________________
______________________________________________________________________________

**Speech Disorders**

Name of Course ________________________________________________________________
Semester Taken ________________________________________________________________
Additional Courses in this area: __________________________________________________
______________________________________________________________________________

**Anatomy and Physiology of Speech Systems**

Name of Course ________________________________________________________________
Semester Taken ________________________________________________________________
Additional Courses in this area: __________________________________________________
______________________________________________________________________________

**Language Disorders**

Name of Course ________________________________________________________________
Semester Taken ________________________________________________________________
Additional Courses in this area: __________________________________________________
______________________________________________________________________________

**Phonology**

Name of Course ________________________________________________________________
Semester Taken ________________________________________________________________
Additional Courses in this area: __________________________________________________
______________________________________________________________________________
Form SA3

State of Maryland – Department of Health and Mental Hygiene
Board of Examiners for Audiologists, Hearing Aid Dispensers
and Speech-Language Pathologists
4201 Patterson Avenue, Baltimore, Maryland 21215-2299
Phone 410-764-4725 * Fax 410-358-0273 * TTY/ Maryland Relay Service 1-800-735-2258

Educational Institution Verification of Completion of Required Clinical Hours

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

Applicant (Please Type or Print)

Name: ______________________________________________________________________
Last       First     Middle/Maiden

Address: ______________________________________________________________________
Street          Apt. #

City         State     Zip Code

Phone: ________________________  Alternate Phone: ______________________

Name of Educational Institution: _______________________________________________

Address: ______________________________________________________________________
Street

City         State     Zip Code

Dates Attended (mm/yy): From ___________________ to _________________

Verification

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

25 Clinical Observation Hours Completed From _____________ to _____________

75 Clinical Assistance Hours Completed From ______________ to _____________

______________________________________________  ______________________
Signature       Title

______________________________________________  ______________________
Print Name        Phone

Revised 5/2011
### Alternative Plan for Obtaining Required Clinical Hours

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

**Applicant (Please Type or Print)**

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**Supervising Speech-Language Pathologist**

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This Plan must be approved by the Board and a Limited License issued before any clinical observation or clinical assisting experience is obtained. Experienced gained in violation of the laws and regulations will not be accepted as having met the licensure requirements.

The Alternative Plan must ensure that the applicant will obtain the required 25 clinical observation hours and 75 clinical assisting hours within 60 days of the applicant’s receipt of a limited License. The plan shall be designed and signed by the supervising speech-language pathologist. If the Board does not receive proof of successful completion of the hours by the end of 90 days, the assistant’s Temporary License is void and the assistant will need to reapply.
FORM SA4

The 75 hours of clinical assistance shall include 100% direct supervision by the supervising speech-language pathologist of the speech-language pathologist assistant during any client contact hours. The first month of clinical hours must start after the Board approves the Form SA4.

Pursuant to COMAR 10.41.11.08(B) “a licensed full-time (35 hours or more a week) speech-language pathologist may not supervise more than the equivalent of two full-time (35 hours or more a week) speech-language pathology assistants.” Pursuant to COMAR 10.41.11.08(C) “a licensed part-time (35 hours or more a week) speech-language pathologist may not supervise more than the equivalent of one full-time (35 hours or more a week) speech-language pathology assistant.” The Board will not issue a full SLP-A license or limited SLP-A license to an applicant until it is satisfied that the supervisor noted on the Form SA4 is in compliance with the foregoing regulations.

Alternative Plan for Clinical Hours

First Month: Week One from ______________ to ______________
Estimated Observation Hours ________ Estimated Assistance Hours _________

First Month: Week Two from ______________ to ______________
Estimated Observation Hours ________ Estimated Assistance Hours _________

First Month: Week Three from ______________ to ______________
Estimated Observation Hours ________ Estimated Assistance Hours _________

First Month: Week Four from ______________ to ______________
Estimated Observation Hours ________ Estimated Assistance Hours _________

Second Month: Week Five from ______________ to ______________
Estimated Observation Hours ________ Estimated Assistance Hours _________

Second Month: Week Six from ______________ to ______________
Estimated Observation Hours ________ Estimated Assistance Hours _________

Second Month: Week Seven from ______________ to ______________
Estimated Observation Hours ________ Estimated Assistance Hours _________

Second Month: Week Eight from ______________ to ______________
Estimated Observation Hours ________ Estimated Assistance Hours _________

Signature of Applicant ___________________________ Date ________________

Signature of Supervisor ___________________________ Date ________________

Supervisor: (select one of the following)

( ) Holds MD License in Speech-Language Pathology
( ) Holds ASHA CCC-SLP
( ) Holds Licensure in SLP in State of ________________________________
Verification of Completion of Required Clinical Hours

The limited licensee must submit the Form SA5 to the Board when the assistant has completed the required 25 clinical observation hours and 75 clinical assistance hours. The required hours must be completed within the first 60 days of Limited Licensure. This form must be submitted to the Board by the end of 90 days of receipt of a Limited License as specified in the letter received with the limited license. If this form is not submitted by the date specified in the letter enclosed with the limited licensee the limited license becomes null and void per COMAR 10.41.11.03(B)(2)(e).

Applicant (Please Type or print)

Name: ____________________________________________

Last       First     Middle/Maiden

Address: ____________________________________________

Street Apt. #

City State Zip Code

Phone: ______________________________

Supervising Speech-Language Pathologist

Name: ____________________________________________

Last       First     Middle/Maiden

Professional Address: __________________________________

Facility or Company’s Name

Street Suite #

City State Zip Code

Phone # ______________________________ E-Mail _____________________________
FORM SA5

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

First Month: Week One from _____________ to ________________
Observation Hours _______ Assistance Hours _________

First Month: Week Two from ______________ to ______________
Observation Hours _______ Assistance Hours _________

First Month: Week Three from ______________ to ______________
Observation Hours _______ Assistance Hours _________

First Month: Week Four from ______________ to ______________
Observation Hours _______ Assistance Hours _________

Second Month: Week Five from ______________ to ______________
Observation Hours _______ Assistance Hours _________

Second Month: Week Six from ______________ to ______________
Observation Hours _______ Assistance Hours _________

Second Month: Week Seven from ______________ to ______________
Observation Hours _______ Assistance Hours _________

Second Month: Week Eight from ______________ to ______________
Observation Hours _______ Assistance Hours _________

Signature of Supervisor _______________________________ Date ________________

Supervisor: (check one of the following)
( ) Holds MD License in Speech-Language Pathology, License # _____________________
( ) Holds ASHA CCC-SLP, Certificate # _____________________
( ) Holds Licensure in SLP in State of ____________________, License # ________________

If the Board does not receive proof of successful completion of the clinical hours by the end of 90 days, the assistant’s Limited License is void and the assistant will need to reapply.

FORM SA5
Delegation Agreement

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

Speech-Language Pathology Assistant Information:

Applicant’s Name: ________________________________________________________________

Mailing Address: __________________________________________________________________

Day Phone: _____________________________ Evening Phone: ____________________________

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

Supervising Speech-Language Pathologist

Name: __________________________________________________________________________

Address: _________________________________________________________________________

Day Phone: _____________________________ Evening Phone: ____________________________

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

Facility Information (where the SLP Assistant Limited Licensee will be practicing)

Facility Name: ___________________________________________________________________

Facility Address: __________________________________________________________________

Contact Person: ___________________________ Phone: _________________________________
FORM SA6

Will the supervising Speech-Language Pathologist be responsible for the practice of the SLP Assistant at additional facilities? _____ Yes _____ No

If yes, please indicate the additional facilities and their addresses here:
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Delegation Agreement
The Speech-Language Pathology Assistant named in this Delegation Agreement is authorized to assist the supervising Speech-Language Pathologist named in this agreement in the implementation of speech-language pathology treatment goals and related activities as outlined in the SLP Assistant Regulations (COMAR 10.41.11) under the direction of the supervising SLP at the above named facility(ies).

The Supervising Speech-Language Pathologist agrees to supervise the SLP Assistant according to the standards outlined in the COMAR regulations.

The SLP Assistant agrees to perform only those activities authorized in the COMAR regulations.

The SLP Assistant agrees to notify the Board if this Delegation Agreement is no longer valid.

______________________________________________   ________________________
Signature of SLP Assistant       Date

______________________________________________   ________________________
Signature of Supervising SLP      Date
Competency Skills Checklist

At the beginning of the Assistant’s Limited Licensure:
The Supervising Speech-Language Pathologist and the Speech-Language Pathology Assistant should review the Competency Skills Checklist at the beginning of the period of limited licensure and periodically thereafter. Discussion of the skills required and review of the Assistant’s progress towards acquiring these skills can prove useful throughout the limited licensure period. Using the Checklist as a learning tool will provide clear goals for the Assistant and lead to the successful completion of the Checklist at the end of the nine months of supervised practice.

After 9 months of supervised practice:
The Competency Skills Checklist is to be completed by the supervising Speech-Language Pathologist after the Speech-Language Pathology Assistant has completed a minimum of nine (9) months of supervised practice under a limited license. Completion of the Checklist verifies that the Assistant has acquired the skills and knowledge needed to receive a full license as a Speech-Language Pathology Assistant.

The Speech-Language Pathology Assistant shall submit the completed Competency Skills Checklist to the Board at least 60 days before the limited license expiration date.
Competency Skills Checklist

Speech-Language Pathology Assistant: ____________________________________________

Supervising Speech-Language Pathologist: _______________________________________

**Directions:** The supervising speech-language pathologist marks Yes or No to indicate that the assistant is competent and meets the following criteria. If the supervisor marks “not applicable” (N/A), the supervisor must include an explanation.

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

1. Criteria: Deals effectively with the attitudes and behaviors of the patients/clients
   a. Maintains appropriate patient/client relationships
   b. Communicates effectively and with sensitivity the needs
      of the patient/client, family and caregivers
   c. Addresses/considers patient/client and significant others
      cultural needs and values
   d. Demonstrates insight into patient/client and caregivers
      attitudes and behaviors
   e. Refers patient/client/caregivers/other professionals to the
      supervising speech-language pathologist when appropriate
   f. Other: ________________________________________

2. Criteria: Communicates and interacts effectively with supervisor
   a. Accepts and responds appropriately to constructive criticism
   b. Requests assistance from supervisor appropriately
   c. Actively participates in interactions with supervisor
   d. Other: ________________________________________

**II. Personal Qualities:**
Standard: The speech-language pathology assistant demonstrates professional behavior and confidentiality.

1. Criteria: Demonstrates behaviors of a dependable team member, which may include:
   a. Arrives punctually to appointments with prepared assignments
   b. Submits documentation on time
   c. Completes assigned tasks within designated treatment session

Revised 5/2011
2. Criteria: Demonstrates appropriate conduct in the work environment, which may include:
   a. Maintains confidentiality of client information at all times
   b. Maintains professional appearance for work environment
   c. Recognizes own professional limitations and performs within the boundaries of training and job responsibilities

III. Technical-Assistant Skills
Standard: The speech-language pathology assistant assists the therapist in providing adequate treatment.
1. Criteria: Maintains a facilitating environment for all tasks
   a. Adjusts environment to facilitate learning (i.e. lights, noise, etc)
   b. Organizes treatment space appropriately
   c. Other

2. Criteria: Selects prepares and presents materials effectively
   a. Selects and prepares appropriate treatment materials
   b. Selects treatment materials based on clients age, needs, culture and motivation

3. Criteria: Complies with documentation standards
   a. Documents treatment plans and protocols accurately, completely and concisely for the supervising speech-language pathologist
   b. Documents client progress and performance to supervisor
   c. Signs documents and assures co-signature when required
   d. Prepares and maintains client records, charts, graphs, objective data as directed by the supervisor

4. Criteria: Provides assistance to the supervising speech-language pathologist
   a. Assists the supervisor as directed during assessments by the speech-language pathologist
   b. Assist with informal documentation
   c. Schedules activities appropriately
   d. Participates with the supervisor in research projects
   e. Participates in in-services training
   f. Participates in public relations programs
   g. Performs checks and maintenance of equipment

IV. Screenings
Standard: The speech-language pathology assistant will provide appropriate screening procedures.
1. Criteria: Administers screening tools appropriately as directed by the supervisor for communication and/or swallowing disorders which may include:
   a. Differentiates correct vs. incorrect responses
   b. Completes screening protocol form accurately

2. Criteria: Manages screening
   a. Reports any difficulties encountered with screening procedures
   b. Schedules Screenings
   c. Organizes screening materials
3. Criteria: Communicates results to supervising speech-language pathologist
   a. Seeks guidance when appropriate
   b. Provides descriptive behavioral observations that contribute to results

V. Treatment
Standard: The speech-language pathology assistant provides appropriate treatment resulting in optimal client improvement.
1. Criteria: Performs treatment tasks as outlined by the supervisor
   a. Accurately and efficiently follows treatment plans developed by the speech-language pathologist
   b. Incorporates feedback from speech-language pathologist for modifying own behavior with the client, caregivers and other professional staff
2. Criteria: Manages client behavior and provides appropriate treatment
   a. Maintains on-task behavior
   b. Provides appropriate feedback to the client as to the accuracy of the response
   c. Uses feedback and reinforcement that are consistent, discriminating and meaningful
   d. Gives direction and instructions that are age, education and culturally appropriate
   e. Implements treatment objectives/goals in specified sequence
   f. Applies behavior modification and other reinforcement behavior appropriately as designated by the speech language pathologist

3. Criteria: Demonstrates knowledge of treatment objectives and plan
   a. Demonstrates understanding of client disorder and needs
   b. Identifies correct vs. incorrect responses
   c. Identifies client behaviors which demonstrate an improvement in function
   d. Accurately reports completion of tasks

I verify

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

_________________________________________________ _____________________
Supervising Speech-Language Pathologist    Date
Affidavit To Be Completed By Licensure Board

This portion of the form is to be completed by the Speech-Language Pathology Assistant:

Please verify _________ licensure _________ certification or _________ registration as a Speech-Language Pathology Assistant in your State for:

________________________________________________________________________________

First Name       Middle      Last Name

Date of Birth _______________________  Social Security Number ________________________

License/Certificate/Registration Number: __________________________

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

License/Certificate /Registration Number: _________________  Date Issued: _______________

Is License/Certificate/Registration in good standing?  _______________________

Expiration Date: ____________________________

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

______________________________________________________________________________

______________________________________________________________________________

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

Has License/Certificate/Registration ever been suspended or revoked?   No _____  Yes _____

If yes, please explain why or attach additional explanation.

______________________________________________________________________________

______________________________________________________________________________
Has License/Certificate/Registration been reinstated? _____________________________

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

________________________________________________________________________
________________________________________________________________________

Is there any derogatory information on file concerning this person? Yes _____ No _____

If yes, please explain or attach additional explanation.

________________________________________________________________________
________________________________________________________________________

Signature __________________________ Date ______________________

Title _______________________________________

State Board of __________________________________________

State of __________________________________________

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