Maryland Department of Health
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

Application for Licensure for Speech-Language Pathology Assistant

Date__________________

Please Read The Application Checklist Before Completing Application Below:

Name____
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.

Pactice Setting Where Limited Licensee Will Practice

Name of Facility ____

Address: ____

____

Phone Number:____________________________ Beginning Date:_______________________

Description of Duties:____

____

____

Supervising Speech-Language Pathologist (s):

____
Name Title

____
Name Title

____
Name Title

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

Please review the regulations and sign the following affirmation:

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

_______________________________________ ____________________
Signature of Applicant Date

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

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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

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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
Applicant
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 April, 2020

FORM SA4

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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)

Name:____
Last First Middle/Maiden

Address:____
Street Apt. #

____
City State Zip Code

Phone: _____________________________ E-mail_______________________________

Supervising Speech-Language Pathologist

Name:____
Last First Middle/Maiden

Professional Address:____
Facility or Company's Name

____
Street Suite #

____
City State Zip Code

Telephone # ______________________________

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

FORM SA5

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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 within 90 days, proof of successful completion of the clinical hours within 60 days, the assistant's Limited License is void and the assistant will need to reapply.

FORM SA5

FORM SA6

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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

FORM SA7

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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 30 days before the limited license expiration date.

FORM SA7

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

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

II. Personal Qualities:

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

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

2. Criteria: Demonstrates appropriate conduct in the work environment, which may include:

	Yes	No
a. Maintains confidentiality of client information at all times	_____	_____
b. Maintains professional appearance for work environment	_____	_____
c. Recognizes own professional limitations and performs within the boundaries of training and job responsibilities	_____	_____

III. Technical-Assistant Skills

Standard: The speech-language pathology assistant assists the therapist in providing adequate treatment.

1. Criteria: Maintains a facilitating environment for all tasks	**Yes**	**No**
a. Adjusts environment to facilitate learning (i.e. lights, noise, etc)	_____	_____
b. Organizes treatment space appropriately	_____	_____
c. Other ____	_____	_____
2. Criteria: Selects prepares and presents materials effectively		
a. Selects and prepares appropriate treatment materials	_____	_____
b. Selects treatment materials based on clients age, needs, culture and motivation	_____	_____
3. Criteria: Complies with documentation standards		
a. Documents treatment plans and protocols accurately, completely and concisely for the supervising 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:	**Yes**	**No**
a. Differentiates correct vs. incorrect responses	_____	_____
b. Completes screening protocol form accurately	_____	_____
2. Criteria: Manages screening		
a. Reports any difficulties encountered with screening procedures	_____	_____
b. Schedules Screenings	_____	_____
c. Organizes screening materials	_____	_____

3. Criteria: Communicates results to supervising speech-language pathologist

a. Seeks guidance when appropriate	_____	_____
b. Provides descriptive behavioral observations that contribute to results	_____	_____

V. Treatment

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

1. Criteria: Performs treatment tasks as outlined by the supervisor	**Yes**	**No**
a. Accurately and efficiently follows treatment plans developed by the speech-language pathologist	_____	_____
b. Incorporates feedback from speech-language pathologist for modifying own behavior with the client, caregivers and other professional staff	_____	_____
2. Criteria: Manages client behavior and provides appropriate treatment		
a. Maintains on-task behavior	_____	_____
b. Provides appropriate feedback to the client as to the accuracy of the response	_____	_____
c. Uses feedback and reinforcement that are consistent, discriminating and meaningful	_____	_____
d. Gives direction and instructions that are age, education and culturally appropriate	_____	_____
e. Implements treatment objectives/goals in specified sequence	_____	_____
f. Applies behavior modification and other reinforcement behavior appropriately as designated by the speech language pathologist	_____	_____

3. Criteria: Demonstrates knowledge of treatment objectives and plan

a. Demonstrates understanding of client disorder and needs	_____	_____
b. Identifies correct vs. incorrect responses	_____	_____
c. Identifies client behaviors which demonstrate an improvement in function	_____	_____
d. Accurately reports completion of tasks	_____	_____

I verify ____

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

____ ______________________

Supervising Speech-Language Pathologist Date

FORM SA8

Department of Health

Board of Examiners for Audiologists, Hearing Aid Dispensers and Speech-Language Pathologists

4201 Patterson Avenue, Baltimore, Maryland 21215-2299

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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 ____

State Seal Here

FORM SA8