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 Speech-Language Pathology Assistant – Limited License

Affix Current Photo Here

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: _____

Anticipated Beginning Date of Employment: _____

For Office Use Only

Received _____ CK ( ) MO ( ) Number_____

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

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

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. Bachelor's Degree in Speech-Language Pathology or Communication Disorders?
_____Yes _____No

2. Associate Degree from an approved SLP Assistant Program? _____Yes _____No

3. Associate Degree in an allied health field with 15 hours in required minimum course work?
_____Yes _____No

Note: 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.

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 issuance.

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.)

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)

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 observation hours
Applicant
and clinical assistance hours during the time the applicant was a student.

25 Clinical Observation Hours Completed From _____to _____

75 Clinical Assistance Hours Completed From _____ to _____

_____ _____
Signature Title

_____ _____
Print Name Phone

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 Limited License is void and the assistant will need to reapply.

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.**

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

Week	From (mm/dd/yyyy)	To (mm/dd/yyyy)	Observation Hours	Assistance Hours
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
		Grand Total 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 issuance of Limited Licensure*. This form must be submitted to the Board by the end of 90 days of issuance 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: _____ E-Mail: _____

Supervising Speech-Language Pathologist

Name: _____
Last First Middle/Maiden

Address: _____
Facility or Company 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:

Week	From (mm/dd/yyyy)	To (mm/dd/yyyy)	Observation Hours	Assistance Hours
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
		Grand Total 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 Speech-Language Pathology Assistant's Limited License will be null and void. The Speech-Language Pathology Assistant may practice only after reapplying for a new limited license.

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. *Additionally, if there is a change of supervision (adding or removing), a new Delegation Agreement must be filed immediately.*

Speech-Language Pathology Assistant Information:

Applicant's Name: _____

Mailing Address: _____

_____

Telephone: _____ Alternate: _____

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

Supervising Speech-Language Pathologist

Name: _____

Address: _____

_____

Telephone: _____ Alternate: _____

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 Speech-Language Pathologist may not supervise more than the equivalent of two (2) full-time students (SLP assistants and/or SLP clinical fellows and/or clinical interns) per day in off-site placements.

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 60 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 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

	Yes	No
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

	Yes	No
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

	Yes	No
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

	Yes	No
a. Reports any difficulties encountered with screening procedures		
b. Schedules screenings		
c. Organizes screening materials		

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

	Yes	No
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

	Yes	No
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

	Yes	No
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 that, _____,

Speech-Language Pathology Assistant has completed a minimum of 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

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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? No _____ Yes _____

If yes, please explain or attach additional explanation.

_____

_____

_____

Signature _____ Date _____

Title _____

State Board of _____

State of _____

State Seal Here

FORM SA8

Revised January 2020