# TABLE OF CONTENTS

## I. OVERVIEW OF CLINICAL PRACTICUM
- Clinical Practicum ................................................................. 2
- Objectives of the Clinical Practicum ........................................ 4
- Clinical Clockhours Requirements .......................................... 5
- Clinician Background Sheet ................................................... 6

## II. CLINIC POLICIES AND PROCEDURES
- General Clinic Policies ......................................................... 9
- Guidelines for Observers ....................................................... 10
- Initial Planning Meetings ....................................................... 11
- Therapy .............................................................................. 12
- Supervision ........................................................................ 14
- Record Keeping .................................................................... 15
- Organizing a Client’s File ..................................................... 17
- Use of Materials and Resources ............................................ 18
- Clinician Meetings ............................................................. 19
- Evaluation of Performance in Clinical Practicum .................... 20
- Written Work in Clinical Practicum ...................................... 22
- Mid-Quarter Conference Guidelines ..................................... 23
- End of Quarter Checklist ..................................................... 24
- Final Chart Check ............................................................... 25

## III. CLINIC FORMS
- Client’s Agreement and Release Form ................................... 27
- Authorization for Release of Information ................................. 28
- Permission to Observe & Record/Absence Policy ....................... 29
- Observation-Attendance Record for Work Folder .................... 30
- Intended Therapy Plan .......................................................... 31
- Client Data Sheets: Generic/Task Analysis/Vocabulary ............ 32-34
- Evaluation of Clinical Practicum ........................................... 35-36
- Instruction for Completing Record of Supervised Clinical Experience... 37
- Sample Record of Supervised Clinical Experience ................... 38-39

(continued)
### IV. DOCUMENTATION: REPORTS, INSTRUCTIONS AND EXAMPLES

- Treatment Planning for Initial Conferences Format .............................................. 41
- Instructions for Writing Intended Therapy Plan (ITP) ........................................ 42
- Instructions for Writing a Self Evaluation .......................................................... 43
- Instructions for Writing Therapy Notes ............................................................. 44
- Format of Notes: (SOAP)/Contact ................................................................. 45
- Therapy (SOAP) Note Sample ........................................................................ 46
- Quarterly Therapy Plan (QTP) - Format and Instructions .................................... 47
- Quarterly Therapy Plan (QTP) Evaluation Guidelines ....................................... 49
- Quarterly Therapy Summary (QTS) Explanation of Procedure ....................... 51
- Quarterly Therapy Summary (QTS) - Format and instructions ......................... 52
- Quarterly Therapy Summary (QTS) Evaluation Guidelines .............................. 54
- Home Program Format ................................................................................... 56
- Home Program Evaluation Guidelines/Rubric .................................................. 57

### V. DIAGNOSTIC CLINIC

- Diagnostic Clinic Procedures for Graduate Clinicians ..................................... 59
- Diagnostic Practicum Grade Sheet ................................................................. 61
- Diagnostic Competencies ............................................................................... 62
- Diagnostic Report Grading Rubric ................................................................. 63
- Diagnostic Plan Format and Sample ............................................................... 64
- Diagnostic Evaluation Format ......................................................................... 67
- Speech-Language Re-Evaluation Report Format ............................................. 70
- Selected Guideline for Preparing Diagnostic Reports and Letters ................. 71
- Pathological Writing ....................................................................................... 73
- Technical Writing Style .................................................................................. 79

### VI. INTERNSHIP INFORMATION

- Clinical Internship Requirements ................................................................. 81
- Internship Procedures ................................................................................... 84
- Student Preference Form for Internship ......................................................... 85
- Internship Information and Agreement .......................................................... 86
- Clinical Internship Evaluation form ............................................................... 87-88
- Record of Supervised Clinical Experience (Internship Log) ............................. 89-90

(continued)
<table>
<thead>
<tr>
<th>VII. POLICY STATEMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essential Functions ................................................. 92</td>
</tr>
<tr>
<td>Criminal Background Check ........................................... 94</td>
</tr>
<tr>
<td>Department Policy on Student Literacy ........................... 95</td>
</tr>
<tr>
<td>Confidentiality .................................................................. 96</td>
</tr>
<tr>
<td>Appearance and Identification Badge ............................. 97</td>
</tr>
<tr>
<td>Dress Code ........................................................................ 98</td>
</tr>
<tr>
<td>CPR Training ...................................................................... 99</td>
</tr>
<tr>
<td>How Grades Relate to Satisfactory Progress Toward Graduate Degree Completion ................................. 100</td>
</tr>
<tr>
<td>Expectations and Grading ................................................. 102</td>
</tr>
<tr>
<td>Clinic Policy for Late Written Work ................................. 104</td>
</tr>
<tr>
<td>Required Clinical Activity for Graduate Students ............. 105</td>
</tr>
<tr>
<td>Minimum Academic Requirements Prior to Internship ............ 106</td>
</tr>
<tr>
<td>Internship Certificate of Clearance Requirement ............. 107</td>
</tr>
<tr>
<td>Infection Control .............................................................. 108</td>
</tr>
<tr>
<td>Universal Precautions ...................................................... 109</td>
</tr>
<tr>
<td>Child Abuse Reporting Laws ............................................. 110</td>
</tr>
<tr>
<td>Techniques for the Prevention of Child Abuse and Neglect ... 111</td>
</tr>
<tr>
<td>Emotional Maltreatment ................................................... 112</td>
</tr>
<tr>
<td>Complaint Procedure ....................................................... 113</td>
</tr>
</tbody>
</table>
I. OVERVIEW OF CLINICAL PRACTICUM
Clinical Practicum

As part of the Speech-Language Pathology and Audiology Program, the clinical practicum experience provides student clinicians with a transitional framework for moving from the role of a student toward the role of a professional. Students are exposed to and participate in all phases of the therapeutic process, including observation, diagnostics, treatment, organization, administration and supervision. Student clinicians assume increasing responsibility for the development and implementation of the treatment program as they gain clinical experience. The role of the supervisor also shifts in emphasis from that of guide and mentor to one of a professional colleague.

Levels of Clinical Practicum

Observer Level — SPPA 3856 Observation of Clinical Procedures in Communicative Disorders.
This course provides a practical, preclinical introduction to the nature and components of communication disorders and the therapy process. The course requires at least 12 hours of directed observation in the Speech, Language and Hearing Clinic.

Intermediate, Obs. Level — SPPA 4852/6052 Clinical Methods & Procedures in Comm. Disorders
This course, tiered for undergraduate and graduate student enrollment, provides basic principles of client treatment and management, including structuring the therapy session, designing therapy hierarchies, collecting data, working with families, reinforcing correct behavior and documenting outcomes. Course includes at least 13 hours of supervised clinical observation.

Advanced Observer Level — SPPA 4854/6854 Diagnosis of Speech and Language Disorders.
This course, tiered for undergraduate and graduate student enrollment, provides students with experience in selecting, scoring and interpreting appropriate speech and language diagnostic instruments with individuals presenting a variety of communication disorders. An introduction to interviewing and counseling clients and caregivers is presented. Students will acquire at least 5 hours of directed observation in this course.

Clinician Level — SPPA 6056 Practicum in Speech-Language Pathology: Treatment
In this supervised graduate practicum course, students conduct assessments, including base-lines, develop treatment plans, collect data, implement therapy, provide case management and complete written documentation, over the course of a quarter according to ASHA and departmental standards. (Please refer to syllabi for specific competencies.) Please note that more advanced clinicians may have the opportunity to complete a practicum experience offsite in a school, clinic or medical setting under the close supervision of experienced CA licensed and ASHA certified practitioners.

Clinician Level — SPPA 6057 Practicum in Speech-Language Pathology: Assessment
In this supervised practicum which includes both on and offsite assessment experiences, students review client records, develop diagnostic plans, administer, score and interpret appropriate assessments for individuals presenting a variety of communication disorders. As part of the assessment process students also interview and counsel clients or caregivers. The students are responsible for all written documentation, including narrative reports, home programs, letters to the clients or caregivers and offsite agency forms (e.g., Individual Educational Plans), etc. (Please refer to syllabi for specific competencies.)
Clinician Level — SPPA 6156 Practicum in Audiologic Assessment
In this supervised practicum students conduct screening procedures (i.e., otoscopy, OAE, tympanography & pure tone), and if necessary, adapt them to meet the needs of preschool to elderly clientele, in a variety of community settings. Students work collaboratively with other graduate clinicians, supervisors, and agency representatives to provide efficient and effective services to the community and contract agencies. Student clinicians are responsible for tracking results in screenings and reporting these to appropriate parties, including the SLP supervisor. (Please refer to syllabi for specific competencies.)

Clinician Level — SPPA 6066 Clinical Internship in Speech-Language Pathology
Graduate students complete two 12 or 13-week fieldwork assignments which occur in a variety of community-based settings including public schools, hospitals, clinics, and private practice settings. Within each clinical internship, the intern is expected to observe the mentor clinician (site supervisor) for 2-3 weeks before the intern gradually assumes the caseload management with continuing supervisory input. Each intern is expected to obtain a minimum of 150 client contact hours for each assignment, reflecting a breadth of experience in assessment and treatment with a variety of speech, language, and communication disorders and differences, including dysphagia and aural rehabilitation, as available in the setting. Interns are expected to show competency with diverse populations across the lifespan, as well as in the specific skills needed to perform effectively in their designated internship setting. (Please refer to syllabi for specific competencies.)
Objectives of the Clinical Practicum Program

Students will show evidence of meeting the following objectives at the end of their graduate program:

1. Select, administer, score, and interpret at least 15 standardized and non-standardized assessment procedures, which assess an array of speech and language impairments.

2. Prepare an appropriate treatment program based on assessment findings and clinical observations for at least 25 cases, which represent a variety of speech and language impairments.

3. Present information about at least 12 cases, both orally and in writing, to professionals and other students-in-training (e.g., CSUEB Clinic planning meetings and clinical rounds, internship staffings, or conference presentations).

4. Prepare critical comments and present them, orally and in writing, in a professional manner to a clinical supervisor, academic instructor, case management team, or a group of peers in clinical rounds, for at least three diagnostic sessions conducted by another clinician, at least three diagnostic sessions conducted personally, at least ten treatment sessions conducted by another clinician, and at least ten treatment sessions conducted personally.

5. Conduct at least 20 conferences, each a minimum of 15 minutes, with individuals and/or their family members, in which there is an appropriate exchange of information regarding a client’s assessment or treatment plan. Such exchanges may include, but are not limited to, diagnostic intake and exit interviews, I.E.P. meetings, family training sessions, or group support treatment sessions.

6. Prepare all required documentation in a professional manner that is, well-edited, accurate and concise, and submit the documentation in a timely manner.

7. State at least five ways in which a client’s privacy and confidentiality might be compromised, and at least two ways of avoiding each compromise in accordance with HIPAA regulations.
ASHA Certification, CA License & CA Credential Clinical Clock Hours Requirements

Upon completion of the Master of Science Degree Program, students will be eligible to obtain the following:

- ASHA’s Certificate of Clinical Competence –CCC (after completion of “mentored professional experience — Clinical Fellowship — CF)
- Speech- Language Pathology and Audiology Board - License to Practice Speech-Language Pathology in California after 9 month Required Professional Experience (RPE)
- California Commission on Teacher Credentialing (CTC) – Speech-Language Pathology Services Credential

ASHA CCC Requirements
- Total of 400 clock hours, including 25 hours of observation hours.
- 375 clinical contact hours attained through practicum and internships
- 325 of the 375 must be during the graduate training program

CA Speech-Language Pathology License Requirements
- Minimum of 300 hours of supervised clinical practice in three different clinical settings (i.e., CSUEB onsite clinic, two internships and/or offsite placements) across a wide spectrum of ages and communication disorders.

CA Speech-Language Pathology Services Credential Requirements
- Total of 400 clock hours, including 25 hours of observation hours completed prior to earning contact hours.
- Minimum of 100 of the required 375 clinical contact hours of practicum in a school setting — school internship(s), offsite clinic placement and/or offsite assessments in a school setting(s).

CSUEB Dept. of CSD Minimums
To meet ASHA Standards for Certification (breadth across disorders and the lifespan), the department requires that students shall gain experience with both children and adult clients imposing minimal clockhours distribution, including hours from internships, as well as onsite and offsite clinical experiences as follows:

- Minimum of 50 contact hours with adults, broken down as follows: (a) 40 contact hours in treatment, including a minimum of 10 each in speech vs. language disorders; and (b) 10 contact hours in assessment, including a minimum of 3 each in speech vs. language disorders.

- For students completing two pediatric internships, to ensure a breadth with children, the two placements must provide sufficiently different clinical experiences in regards to one or more of the following: setting (e.g., clinic, hospital vs. school, including classroom vs. itinerant, etc.); ages (preschool, elementary, middle school, high school); and/or populations (e.g., regular education, vs. special needs, vs. AAC exclusively, etc.)

- Minimum of 20 contact hours in the minor area of audiology with a minimum of 5 in treatment with the hearing impaired population a (e.g., conduction or sensorineural losses, with or without assistive devices, cochlear implants) and 5 in hearing screenings.

Note:
1) Clinical Contact Hours means direct client contact, including consulting with family members, but not paperwork, staffing or preparation
2) The clinical contact hours reported for an individual or group session may be divided to represent the activities (Dx or Tx) and category (speech or language) that occurred during the session.
CALIFORNIA STATE UNIVERSITY, EAST BAY  
DEPARTMENT OF COMMUNICATIVE SCIENCES AND DISORDERS  
NORMA S. AND RAY R. REES SPEECH, LANGUAGE AND HEARING CLINIC  
Clinical Practicum in Speech Pathology and Audiology  
Clinician Background Sheet and Schedule  
Quarter/Year: [ ]

 Clinician Name: [ ]  
 Net ID: [ ]

 Complete Address: [ ]  
 Email: [ ]  
 Phone No.: [ ]

 Clinical practicum course are you registering for:  
 ☐ SPPA 6056 (Grad.)  
 ☐ SPPA 6057 (Grad. DX Clinic)  
 (# of onsite leads completed [ ], assists [ ], offsite DX [ ])

 Number of previous quarters at CSUEB? [ ]  
 Other universities? (specify) [ ]

 If this will be your first quarter of clinic, have you met with your academic advisor to confirm eligibility to start clinical practicum?  
 ☐ Yes  ☐ No

 Do you sign?  
 ☐ No  ☐ Yes  
 If yes, what level?  
 ☐ Beginner  ☐ Intermediate  ☐ Advanced

 Other languages spoken [ ]  
 Fluent?  
 ☐ Yes  ☐ No

 Place a “D” (for Done) next to the courses you have taken prior to this quarter of clinic.  
 Place an X next to the courses you will take during this quarter of clinic.

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<tr>
<th>DISORDER</th>
<th>Pediatric Hours/Client Initials</th>
<th>Adult Hours/Client Initials, ATP or Aphasia Group (AG)</th>
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<tr>
<td>Language</td>
<td>E.g., 6/JT</td>
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<td>AAC</td>
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 Have you completed 25 observation hours?  
 ☐ Yes  ☐ No

 Have you fulfilled the University Writing Skills Requirement (UWSR)?  
 ☐ Yes  ☐ No  ☐ Unknown

 Please indicate/approximate the number of hours (and their relative distribution) for each of your clients, to date. Follow this number with the client(s) initials, or ATP or Aphasia Group, as appropriate.

 Type of client you followed in SPPA 4852/6052? (client initials & disorder) [ ]
Please indicate the program (e.g., ATP, Aphasia Gp., offsite), types of clients (disorders/etiologies and/or age
group-preschool, school age, adult) you would like to work with this quarter and why?

1. 
2. 
3. 

Is this your final clinic experience at CSUEB? (check one)  □ Yes   □ No 

Indicate with an √ ALL your FREE times on this time schedule, including Friday availability. **Please show class
times and work schedules, although we are not obligated to accommodate for the latter.** Scheduling will be
facilitated if you provide as much free time as possible. Clinic Director may be unable to meet your needs if
minimal times are indicated.

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Scheduling preferences/notes to Clinic Director: __________________________________________________________

**SOME NOTES ON FILLING OUT CLINICIAN BACKGROUND SHEET CORRECTLY & COMPLETELY!**

1. Enter all your ASHA contact clock hours in appropriate boxes. These can be approximations.
2. Correctly identify all SPPA classes taken previously as well as courses which will be taken concurrently in the same
   quarter as the upcoming clinic.
3. Read instructions on filling out schedule carefully using **X’s to indicate available times for clinic**.
4. Please indicate ALL times you are available to see clients. A minimum of 6-8 available hours is necessary.
5. Clinic is scheduled on a Monday/Wednesday or Tuesday/Thursday schedule. On a limited basis, off-site practicum
   experiences are available which may vary from the listed schedule above.
6. Clearly write in both your class and work schedules on this form as it helps Clinic Director visualize your schedule.
7. Note clinic schedule preferences below schedule grid (e.g., Tu/Th, afternoon schedule preferred, etc.).
8. Please note that work schedules, childcare and other situations affecting your availability will be considered.
   However, given that this is a clinical program you may need to adjust existing schedules, to ensure an appropriate
   clinical assignment.
II. CLINIC POLICIES AND PROCEDURES
General Clinic Policies

1. The clinic is generally open from 9:00 a.m. to 5:00 p.m. Monday through Friday. Clinic after 5:00 p.m. is scheduled on a limited basis.

2. Appointment cancellations, whether by the client or by the clinician, must be reported by calling the Clinic at 510-885-3241 and also by contacting the supervisor.

3. All information regarding clients is confidential, and may not be discussed in halls or anywhere where a client's privacy might be violated, even unintentionally. Goals, activities, progress, and other pertinent information should be conveyed through parent or caregiver conferences and homework assignments at the conclusion of every therapy session. These communications must be completed within therapy rooms and not in the corridors or waiting room area.

4. All client charts are to remain in the clinic at all times!!!

5. Recording of sessions is for instructional and clinical training purposes only. It is not for client use. If parents or caregivers have a question about this policy, please refer them to the Clinic Director, the Director of Special Programs or the supervisor of the case.

6. All resource materials, including tests, remain in the clinic! Clinicians may request permission to make copies of specific pages in test manuals in accordance with copyright law, but the manuals are not to be taken home or out of the clinic. An exception to this policy is made for graduate diagnostic clinicians.

7. The Assessment Room is to be locked when no one is in it. The key may be obtained from the Department Administrative Support Coordinator. Protocols are available in the locked filing cabinet in the Assessment Room. Please do not use the last one as the office staff will need to restock and/or re-order forms. Only one protocol per client is allowed. Please use pencil and then finalize in pen.

8. All students participating in Clinic Practicum must be covered for professional liability insurance. This insurance is currently provided through the University as part of registration in clinical practicum courses.
Guidelines For Observers

WHO MAY OBSERVE

Adult family members of clients may observe therapy sessions when invited to do so by the student clinician or the Clinical Supervisor. Siblings should remain in the waiting room and parents should bring something to keep them occupied. Young children should not be left alone in the waiting room without adult supervision (i.e., a family friend or relative, an available student clinician). Student clinicians should make prior arrangements for child care when inviting a parent who has a young child to observe the session. Family members must sign in at the front desk and obtain an identification badge.

Students in Speech Pathology and Audiology classes may observe any diagnostic or treatment session under the following constraints: a) the student has signed a CSD privacy form; b) the client or parent has given approval for observation; c) the number of student observers does not interfere with clinic activities or exceed available space; and d) student observers follow observation protocol in the clinic, observation room and waiting room. A schedule of therapy is maintained on the board on the wall to the right of the front desk which indicates times and room assignments by age and type of disorder. Students must sign in and out at the front desk and obtain an identification badge.

Visitors and students in other CSUEB classes who have been invited by our Departmental staff members or who have made prior arrangements through another program on campus may observe. They must sign in at the front desk and obtain an identification badge.

IDENTIFICATION BADGES

All observers must sign in at the front desk. Observers will be given an appropriate identification badge to wear while observing. The student observer badge entitles the user to observe any therapy session. The caregiver observer badge restricts the user to observe only their family member’s room.

CLINIC AREA, OBSERVATION ROOMS AND OBSERVATION HALLWAYS

a. No eating or drinking is permitted in the clinic area, observation rooms, or observation hallways.

b. Supervisors and family members are to be given priority in using chairs. Sitting on the counters is not permitted.

c. Professional discussions may be carried out quietly; however a client’s confidentiality must be preserved. Do not discuss a particular client while other parents, students, observers, or visitors are present in the observation hallway. Under no circumstances should a client be discussed in the corridor or clinic waiting area. Specific questions should be directed to the clinician or supervisor after the session in a quiet, private area as time and space permit.

NO SMOKING IS PERMITTED IN ANY BUILDING ON THE CSUEB CAMPUS!
Initial Planning Meetings

Planning Meetings are the first opportunity for the clinician to present themselves and pertinent information about their clinical assignment in a professional, organized, well researched and coherent manner. (Please refer to SPPA 6056 syllabi.)

Each clinician is assigned a 30-minute time period for each client (typically, this time coincides with the time of their therapy session). If a clinician has both of their clinical assignments with the same supervisor, two consecutive 30-minute planning meetings are scheduled. In preparation for the meeting, the clinician must prepare Treatment Planning for Initial Conferences according to the format in the Documentation section of the Clinic Manual.

Before this meeting, the Supervisor will:
- Review the client’s file, paying particular attention to the last QTS (Quarterly Therapy Summary), previous DX report and SOAP notes.
- Consider need for any standardized testing (typically not routinely done within therapy, unless recommendation for testing is clearly justified in previous QTS and based on need to obtain additional information).

During this meeting, the Clinician should:
- Briefly summarize pertinent information about their client (age, relevant medical/developmental hx, communication diagnosis, relevant info from recent testing, etc.)
- Summarize relevant information from last quarter of therapy (e.g., goals, progress, barriers, recommendations, etc.)
- Discuss areas for initial baselining/probing in first 1-2 sessions (e.g., rationale for decision, functionality of goal area, types/delivery of cues)
- Describe facilitating techniques, activities, probes and materials to be used in first 1-2 sessions
- Discuss initial meeting with client (within first 2 sessions) in order to discuss previous therapy, changes to status, progress with Home Program, areas of interest, client/caregiver concerns and therapy priorities.
- Indicate time frame for Hearing and Oral Mechanism screenings

During this meeting, the Supervisor will:
- Provide verbal feedback as to the appropriateness of your plan.
- Discuss their expectations, office hours, format for feedback, methods of instruction, etc.
Therapy

1. Therapy planning and evaluation is an ongoing process. Therapy objectives are set at the beginning of each quarter using the Quarterly Therapy Plan (QTP) format and are based on the results of testing and clinical observations. Objectives are set for each session on the Intended Therapy Plan (ITP) and revised each week depending on the results of the previous week.

2. Prior to the first therapy session, the student clinician should verify that the client file has current required release forms on file (Authorization for Release of Information, Client’s Agreement and Release, and Permission to Observe and Record), and that the Contact Summary Date Sheet includes up-to-date contact information.

3. At the first therapy session, it is the student clinician’s responsibility to greet the client at the appointed time in the waiting room, and introduce himself/herself to the client (and parent, accompanying family member or caregiver). The clinician should ask that the client, parent or family member pay clinic fees at that time or arrange a fee reduction payment schedule with the Clinic. The clinician will then direct the parent or family member to the observation area and accompany the client to the therapy room. If the client is new to the clinic, the clinician should instruct the caregiver on how to operate audio equipment and the observation rules outlined earlier in this section. Escort the client back to the waiting room at the conclusion of the session.

4. No “method” of therapy is prescribed, although clinicians will be encouraged to implement specific approaches based on current research. (ITP requires rationales or evidence-based practice citations.) Clinicians are encouraged to try various approaches and determine what works best for them and their client.

5. A sound rationale for any treatment technique employed is expected. When feasible, an effort is made to structure therapy so that clients achieve an accuracy rate of at least 70% to 90% and have an opportunity to produce the desired responses consistently during each session. When a therapy task yields a response rate above 90% consistently, the clinician should upgrade the task to a more difficult level. When a client responds below 60-70% accuracy, the clinician should either decrease the difficulty of the activity or switch to a less demanding task.

6. Discussing therapy progress with other student clinicians and with observers is often helpful in planning future sessions and is encouraged.

7. Homework is assigned after each therapy session, as appropriate, and should be included on the ITP for the session. A copy of the assignment should be kept in the work folder. The clinician should first demonstrate the activity while the parent or family member is present. That person should then demonstrate the activity while the clinician observes, and finally, the client is encouraged to do the activity at home.
8. A mid-term conference with the parent, family member, caregiver or client is required so they may know the results of the baseline assessment and the therapy objectives for the quarter.

9. A final conference with the parent, family member, caregiver or client is required so they know what has been achieved in therapy during the quarter and what they should be doing during the quarter break, as described in the Home Program.

10. Plans for discharge should be discussed with the supervisor several weeks prior to the end of the quarter. A counseling session with the client, parent, family member or caregiver may be conducted jointly by the clinician and the supervisor.

11. If a make-up time is schedule for a missed therapy session, verify that a speech-language pathologist who holds the ASHA CCC and California license to practice speech-language pathology will be onsite.
**Supervision**

1. Primary onsite supervision is provided by the clinic supervisors and faculty members.

2. Supervision is highly individualized in terms of content and style, depending on the skills and needs of each student clinician.

3. Verbal feedback is given both formally and informally. Three scheduled supervisor-clinician conferences are required each quarter: an initial planning meeting, a mid-quarter conference and a final conference held during finals week. Each clinician is encouraged to view/analyze a recording of one session prior to the mid-quarter meeting with their supervisor. Clinicians are encouraged to meet with their supervisors on an as-needed basis.

4. Written feedback is given for written documentation as well as for the portions of therapy sessions which are observed. All therapy notes and reports are reviewed and cosigned by the supervisor. Test protocols are also reviewed.

5. Clinicians are encouraged to record themselves whenever possible and to view their therapy sessions.

6. Voluntary clinical roundtable discussions will be held periodically throughout the quarter, in which the therapy programs for one or two clients are discussed. These conferences will serve as problem-solving examples for therapy programs, behavior management, or other relevant issues or specific client concerns. Frequently, solutions to problems emerge from a supportive group setting.

7. Demonstration testing, therapy, and counseling by clinic supervisors is highly encouraged to as a clinical training strategy.
Record Keeping

WORK FOLDER

1. Each quarter, the clinician prepares a work folder for each client enrolled in therapy. The work folder is to be kept in the clinician’s mailbox near the conference room.

2. All therapy notes, ITPs, self-evaluations, and observation comments are to be kept in this folder at all times.

3. Each clinician has a private mailbox labeled with his/her name. All work folders are to be kept in this space – they are not to be taken home. Individual forms may be taken home to prepare for the next day’s session or to write up the previous day’s therapy notes.

4. Each folder has 2 pockets. All clinical documentation is kept in the RIGHT pocket, including ITPs, Therapy Notes, Self-Evaluations and any written supervisor feedback. Dividers should be placed between each section. Documentation should be organized so that the most recent document is on top.

5. Observation and Attendance Record is kept in the LEFT pocket. The supervisor will indicate in the appropriate space if he/she has observed the session and read a therapy note, ITP and self-evaluation, and will indicate whether or not revisions are necessary. The supervisor will take the folder only while he/she is observing a therapy session, or when evaluating written work.

6. Clinical hours reported on this form are easily transferred to the Record of Observation and Clockhours form at the end of each quarter.

CLIENT CHART

1. Client files are considered CONFIDENTIAL! Active folders are located in the file drawers in the reception area outside the Administrative Support Coordinator’s office and may be signed out by a clinician for use in the clinic area only. Complete an “out” card for each file when borrowing and returning folders.

2. When the file is full and a second file must be started see the Clinic Receptionist. Remember to add a new Therapy Notes page beneath the Client Summary Data Sheet. Label the second client file as the previous one, except add the notation 2 of 2 (or 3 of 3.).

3. All telephone communications, therapy sessions, conferences, cancellations and other pertinent contacts must be documented in the client’s chart. All notations made in client charts must be made in ink, dated with the month, day and year, and signed by the person making the entry, with the first and last name clearly written out.
4. Test protocols must include the client’s name, date of testing, and the examiner’s name. All scoring sections of test protocols should be completed or a notation should be made on the test protocol indicating why a section is incomplete.

5. Rough drafts of reports are to be typed, double or triple spaced. Final copies are to be typed single spaced, with double spacing between paragraphs. See section on Report Forms and Clinic Forms.

6. Release of Information
   a. When information is required from medical, educational, or allied health professionals, the student clinician provides the client or his/her designate with the Authorization for Release of Information form. After this form has been completed, it is given to the Clinic Receptionist for mailing.

   b. If the client wants copies of a report sent to other individuals, the client or designate must sign the Request for Information form. A form must be completed for each person or agency to whom the reports are to be sent. Notation should be made in the client’s file form indicating what reports were sent and to whom. All diagnostic clients or their designate receive a copy of their assessment report for their personal records to distribute as they choose.

7. Client charts are maintained in the following order:
   a. Chronological with most recent item on top.

   b. Left side used for items not directly related to therapy at CSUEB, and contact notes.

   c. Right side contains CSUEB documentation, e.g., evaluation and therapy reports, letters, notes, test forms, and the original application for services.

   d. Test forms are to be placed immediately underneath the report that describes results.
**ORGANIZING A CLIENT’S FILE**

<table>
<thead>
<tr>
<th>LEFT SIDE</th>
<th>RIGHT SIDE</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>(top)</em> Client Summary Data Sheet</td>
<td><em>(top)</em> QTS Report</td>
</tr>
<tr>
<td><em>(next)</em> Contact Notes</td>
<td><em>(next)</em> Home Program</td>
</tr>
<tr>
<td>CSUEB permission forms</td>
<td>Tx protocols</td>
</tr>
<tr>
<td>Authorization to Release Info</td>
<td>Dx notes</td>
</tr>
<tr>
<td>Client’s Agreement and Release</td>
<td>Dx report</td>
</tr>
<tr>
<td>Permission to Observe/Record</td>
<td>Dx letter</td>
</tr>
<tr>
<td>All reports outside of CSUEB *</td>
<td>Dx notes</td>
</tr>
<tr>
<td>IEP/IFSP</td>
<td>Dx protocols</td>
</tr>
<tr>
<td>Medical Reports</td>
<td>Clinic Application</td>
</tr>
<tr>
<td>Speech &amp; Language Reports</td>
<td>Intake Form</td>
</tr>
<tr>
<td>Discharge Summaries</td>
<td></td>
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</tbody>
</table>

* All reports outside of CSUEB should be organized in chronological order starting with the most recent report on top.
Use of Materials and Resources

1. Clinic therapy and diagnostic materials are located in two locations. Tests and their protocols are in the Assessment Room, MB 1095 and therapy materials are in the student workroom, MB1593.

2. These resources exist for the use of students and staff. Since we do not have attendants to monitor their use, it is imperative that everyone be responsible and cooperative about the care of materials:
   a) All clinic materials are provided for CSUEB clinical use on the “honor system.”
   b) All therapy materials must be returned as soon as possible following completion of the therapy session. They must be returned to their correct places on shelves in their respective storage locations in the clinic.
   c) Check materials out in SETS/KITS so that the items remain complete. For example, take the entire deck of articulation cards even though only a few may be used; check out the entire PLS-4 even if you are only using the teddy bear. A kit is useless to the next person if parts of it are missing or if they are disordered or misplaced!
   d) When using test or therapy forms, check to see how many forms are left. If there is just one left, notify the Clinic Receptionist in writing so she can replenish the supply. DO NOT TAKE THE LAST ONE! (Make copies and return last one to folder).
   e) The maintenance of materials and equipment is always difficult in the Clinic. Therapy materials are expensive. Wear and tear is inevitable. Loss of materials because clinicians do not return them promptly and carefully is unnecessary. It is also inconsiderate because it deprives everyone of the use of these materials and could result in a situation where no materials are provided. Please consider the seriousness of irresponsible use of materials and equipment.
   f) Due to increased loss of diagnostic materials, test kits, manuals, etc are to be checked out by DX clinicians only. Any clinicians in need of DX materials should request this from their Supervisor.

3. Supplementary sources for materials are located in the Arts and Education Building on campus in the Reading Center AE 143, Ext. 53058. The Reading Center allows our students to borrow materials such as those used for Early Childhood Education and perceptual training. Materials are to be signed out and returned intact, observing whatever conditions are set by the teacher education programs.

4. Students are encouraged to develop their own therapy materials and begin to develop a library of professional books and materials. Current catalogs are available from the Clinic Director. Local school districts will often give student clinicians old workbooks which may form the basis for a good collection of therapy materials.

5. Clinical forms are kept in lateral file drawers beneath the clinician’s mailboxes. You may also check on-line, at http://www20.csueastbay.edu/class/departments/commsci/students/forms.html

6. Lockers are available in MB1593 for storage of therapy materials. The Clinic Receptionist coordinates the locker rental and a $10.00 cash deposit is required for use. Lockers may be renewed Winter, Spring, and Summer only. Deposits are refunded when the locker is cleaned at the end of use. Deposits are not refunded if students leave the Clinic without renewing or cleaning out their locker.

7. Notify the Clinic Director of any malfunctioning equipment, incomplete activity sets or damaged materials.
Clinician Meetings

1. First quarter clinicians meet once weekly as shown in the schedule of classes. Professional exchanges of opinion at these meetings serve to integrate the theoretical base acquired in the classroom with the clinical application needed for implementation of therapy plans.

2. A topic syllabus is distributed at the beginning of each quarter. Topics covered may include the following:
   a. clinic policy
   b. report writing
   c. therapy procedures development based on outcome measures and clinical observations
   d. techniques for shifting to a new task, upgrading task difficulty or simplifying therapy activities
   e. reinforcement procedure
   f. interaction analysis
   g. discussion of issues such as motivation, behavior control, or termination of therapy
   h. mini-seminars on diagnostics and/or therapy procedures associated with specific communicative disorders
   i. ethics
   j. scope of practice

3. Continuing clinicians (second quarter and beyond) are required to complete a group assignment, designed to supplement previous and current coursework. Prior topics include remediation of specific articulation disorders, narrative discourse, and bilingualism; topics for each quarter will be posted on BlackBoard by the 3rd week of each quarter.

4. Continuing clinicians will present their projects at the end of the quarter during a mandatory Internship Meeting (days and times to be announced).

5. The CSUEB chapter of the National Student Speech-Language and Hearing Association (NSSLHA) schedules guest speakers each quarter to discuss current trends in the field. Speakers are often practicing clinicians with information about the realities of working in clinical and school settings. Meetings are well publicized and all students are encouraged to attend.
Evaluation of Performance in Clinical Practicum

Two evaluation conferences take place during the quarter: one midway through the quarter and one during the finals week. The purpose of these meetings is for the student clinician and the supervisor to give one another feedback on their performance. An Evaluation of Clinical Practicum is completed separately by both the supervisor and the clinician, then reviewed with the student clinician at the mid-term and final conferences. Goals for the remainder of the quarter or for the next quarter are also discussed.

The grade for onsite clinical practicum, with the exception of Aphasia Group, is weighted as follows:

- Therapy sessions, including Therapy Notes, ITPs and Self-evaluations= 60%
- Written Documentation (The average of grades for QTP, QTS, HP)= 40%

Aphasia Group and Offsite Evaluation of Clinical Practicum are different in that written documentation is one of 14 equally weighted competencies.

A student is graded separately for each client or group. (Please refer to Policy Statement-How Grades Relate to Satisfactory Progress Toward Graduate Degree Completion in Section VII.)

Criteria for assigning grades are as follows:

I. Therapy sessions (60%) components (see Evaluation of Clinical Practicum for specific skills assessed) include:
   - Diagnosis in Therapy
   - Development and Preparation for Therapy,
   - Therapy Implementation,
   - Written Documentation for work folder (see below)
   - Interpersonal Skills and Personal and Professional Qualities

Written Documentation (work folder ITP, SOAP, SE)
   (1) All written work is due on time, as dictated by the supervisor’s schedule. Extensions must be approved in advance by the student’s supervisor in clinic. Work not submitted by the due date or extension date will be reduced by one full letter grade for each day late. The final copy of the Quarterly Therapy Summary (QTS) is due no later than the last day of the quarter. Students failing to meet this deadline will earn an Incomplete for the quarter.

   (2) Intended Therapy Plans (ITP)
      Categories considered in evaluating:
      - Objectives stated in measurable terms
      - Performance, conditions, criteria and rationale clearly stated for each objective
      - Objectives set which are reasonable to attain in a single session
      - Activity and rationale appropriate for attaining stated objectives

   (3) Chart/soap Notes (See instructions for Writing TX Notes – Section IV)
      Categories considered in evaluating:
      - Results and impressions reflect facts and clinical impressions, respectively
      - Behavior described in measurable and professional terms
      - Progress in therapy documented throughout the quarter
      - Notes are well-edited
      - Notes placed in work folder following each session, clearly dated and signed, with client info on bottom
(4) Self Evaluations (SE)
Categories considered when evaluating:
• Clinician strengths and weaknesses of each session are outlined
• Progressive improvement into recognition of strengths and weaknesses
• Plans for improvement of weak areas are sound

II. **Written Documentation (40%) components include:** (QTP, HP, QTS)

1. Quarterly Therapy Plan (See QTP Rubric in Section IV for details)
Parameters considered when grading:
• Findings and behavior reported accurately, concisely and using professional terminology
• Facts and opinions clearly separated
• Logical interpretation of findings provided
• Appropriate objectives developed from evaluation results
• Therapy techniques stated clearly and appropriate for attaining objectives
• Rationales documented from current literature and relevant to client’s level of functioning
• Adherence to General Elements in QTP Rubric
• Specific Elements are stated clearly and accurately

2. Home Program (See HP Rubric in Section IV for details.)
Parameters considered when grading:
• Program is logical and addresses goals from therapy.
• Plan is well organized and clear to the reader.
• Activities are clearly stated as to the skills they address.
• Includes all materials necessary for successful implementation.
• Instruction for cueing, reinforcement and correction are clearly detailed.
• Time required is reasonable, and program is simple to administer during the client’s daily activities.

3. Quarterly Therapy Summary (QTS) (See QTS Rubric in Section IV.)
Categories considered when grading:
• Behavior described objectively, concise using professional terminology
• Results, impressions and progress toward objectives stated in measurable terms
• Logical rationale given for recommendation
• Recommendations stated specifically

III. Expectations and Grading Memo – See VII. Policy Statements

IV. Evaluation of Clinical Practicum Form – See III. Clinic Forms

V. Quarterly Therapy Plan Rubric — See IV. Documentation: Reports, Instructions and Examples

VI. Home Program Rubric — See IV Documentation: Reports, Instructions and Examples

VII. Quarterly Therapy Summary Rubric — See IV. Documentation: Reports, Instructions and Examples
<table>
<thead>
<tr>
<th>TYPE</th>
<th>PURPOSE</th>
<th>WHEN DUE</th>
<th>WHERE</th>
<th>LENGTH</th>
<th>FORM</th>
<th>FEEDBACK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intended Therapy Plan (ITP)</td>
<td>provides a detailed plan for weekly therapy sessions – one per week</td>
<td>at least 1 hour before each session</td>
<td>work folder in mailbox</td>
<td>1 – 2 pages</td>
<td>typed on ITP template</td>
<td>written on ITP in work folder or on separate supervisor notes</td>
</tr>
<tr>
<td>Self-Evaluation</td>
<td>analyzes your impressions of your performance in a session and your clinical skills</td>
<td>immediately after each session</td>
<td>work folder in mailbox</td>
<td>1 page</td>
<td>separate sheet of paper</td>
<td>written in work folder</td>
</tr>
<tr>
<td>SOAP Notes</td>
<td>objectively describes results and impressions of therapy sessions as well as brief plan for next session</td>
<td>at least 1 hour before next session</td>
<td>work folder in mailbox</td>
<td>½ to 1 page</td>
<td>Typed on Therapy Notes template</td>
<td>co-signature if approved or comments in work folder</td>
</tr>
<tr>
<td>Quarter Therapy Plan (QTP)</td>
<td>reports statement of problem, initial status, quarter objectives, task sequences and therapy rationales</td>
<td>rough draft one week after 3rd therapy session with client</td>
<td>work folder in mailbox</td>
<td>2 – 5 pages</td>
<td>rough draft typed, double spaced</td>
<td>graded with supervisor feedback; returned to clinician's mailbox</td>
</tr>
<tr>
<td>Quarter Therapy Summary Report (QTS)</td>
<td>documents progress during quarter and current status; makes recommendations for further therapy or discharge</td>
<td>rough draft by Monday of last week of clinic; final copy due during finals week</td>
<td>work folder in mailbox</td>
<td>3 – 4 pages</td>
<td>rough draft typed, double spaced, incorporating Part I of QTP. Final copy typed, single spaced. Part II omits task sequence and rationale from QTP</td>
<td>graded with supervisor feedback; returned to clinician's mailbox</td>
</tr>
<tr>
<td>Home Program</td>
<td>Generalizes skills achieved in therapy</td>
<td>Approximately week 7</td>
<td>work folder in mailbox</td>
<td>1-2 pages</td>
<td>Rough draft typed/double spaced</td>
<td>Graded with supervisor feedback</td>
</tr>
</tbody>
</table>
Mid-Quarter Conference Guidelines

In addition to reviewing the profile of skills on the Evaluation of Clinical Practicum, these topics are offered to help clinicians assess their clinical skills at mid-quarter. Ask these questions for each assigned client and try to identify areas for improvement, so that as a clinician you are prepared to actively participate in your mid-quarter conference.

1. Do I have a good grasp of the client’s speech and language behaviors?
2. Do I evaluate the client’s achievements regularly and incorporate the new information (data) into his/her therapy plan?
3. Do I utilize the client’s conversational output to evaluate change and to modify therapy objectives?
4. Have I planned the most appropriate therapy program for the client’s needs?
5. Do I know when it is appropriate to move the client from one step to the next? Do I know when it is appropriate to change a therapy objective? Modify cueing?
6. Do I have a sense of the overall direction in which I am trying to help the client move? Do I have a sense of movement in the work I am doing?
7. Do I communicate objectives to the client? Do I respect the client’s right to participate actively in his/her program?
8. Do I give directions clearly, concisely and in language that is meaningful to the client?
9. Are my discrimination skills (listening; judgment) adequate?
10. Do I encourage the client to use her/his new skills in communication? Do I find ways to try to make new skills functional, even at early stages?
11. Do I close the therapy session with a review of the achievements that took place within the session?
12. Do I interact with the client’s family in a way that is beneficial to the client and the family?
13. Do I demonstrate consistently appropriate interpersonal skills and professional demeanor?
14. Do I have a sense that I am growing in my ability to manage this case independently and effectively?
15. Am I able to manage the demands of a clinical caseload with professionalism and flexibility?
16. What behaviors can I select to modify in myself that will be most effective in improving my clinical skills?
17. Do I use available supervision in a way that is maximally beneficial to me?
18. Do I understand and effectively implement my supervisor’s suggestions?
19. Do I adequately prepare for conferences?
**End Of Quarter Checklist**

Check the space to the left upon the completion of each of the following.  
**BRING THIS CHECKLIST TO THE FINAL CONFERENCE!**

<table>
<thead>
<tr>
<th>Client #1</th>
<th>Client #2</th>
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<tr>
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</tbody>
</table>

- Discussed client continuation or discharge with supervisor.
- Completed & submitted *Clinician Background Sheet* to Clinic Director.  
  Signed up for clinic on board if planning to enroll in next quarter practicum.  
  Be sure to continue to check Black Board and CSUEB Horizon email for  
  information regarding next quarter’s clinic!
- Completed final conference with client, parent, family member or caregiver to  
  discuss what was accomplished in therapy and reviewed Home Program.
- Returned completed yellow client schedule sheets to Clinic Director.
- Cleared out clinician mailboxes, leaving blue work folder containing all  
  original copies of notes, drafts, self-evals, etc. with supervisor feedback.  
  Signed Treatment notes, reports, etc. filed in client files.  Bring *Observation*  
  and *Attendance* record to final conferences for your supervisor’s use!
- Completed FINAL CHART CHECK, bringing file to final conference for  
  supervisor’s review and any missing signatures.  Filed signed QTS, *Home Program*  
  & treatment notes in client’s file.  Place discharged client files in  
  Clinic Director’s mailbox for archiving.
- Noted contacts in client’s folder, e.g. letters to other agencies, record of  
  reports sent, etc.  (A signed *Request for Information* form is necessary to  
  release QTS or DX report to client, family member or any other  
  agent/agency.  CSUEB does not release any other information such as  
  treatment notes, test protocols or recordings.)
- Updated client *Summary Data Sheet* on inside front cover of folder.
- Completed two *Record of Supervised Clinical Experience in Speech Pathology* hours sheets (1st quarter clinicians start new form while continuing clinicians use forms from previous quarter[s].)
- Completed *Onsite Supervisor and Clinic Assignment Review*
- Completed *Clinical Profile* as self-evaluation of work in therapy in preparation  
  for final conference with supervisor.
- Returned all borrowed materials to appropriate clinic areas or to supervisors.
- Returned locker key and notified clerical for deposit refund (if applicable)
**Final Chart Check**

Check the client(s)' charts before the final conference with the supervisor to be sure documentation is ordered according to procedure (see Organizing a Client Chart). Bring clients’ folders to the final conference. As noted in the Student Handbook and Clinical Training Manual the clinical practicum grade will be posted only when all written work is in a client’s chart in final form.

**Left Side** of the folder

1. *Client Summary Data Sheet* is complete for the current quarter. Place on the top left.

2. Left side of chart contains only information from other sources, in chronological order, with the most recent on top.

3. Note any letters or reports sent on the Summary of Contacts Sheet located under the *Client Summary Data Sheet*.

**Right Side**

1. The Therapy Notes should be placed on top of last quarter’s final summary in chronological order, most recent on top.

2. Be sure all notes are signed by the clinician as well as by the supervisor. Check to be sure the bottom line with identifying information is complete on each sheet. Tests done throughout the quarter should be documented with notes on appropriate date.

3. Make sure all absences or cancellations are entered in the Therapy Notes.

4. Place a copy of the Home Program in order.

5. The current Quarterly Therapy Summary (QTS) and any final test forms should go on top.
III. CLINIC FORMS
Instructions: The next three forms must be either completed or verified current in the client file at the first meeting before any interviewing or testing is begun.

CALIFORNIA STATE UNIVERSITY, EAST BAY
DEPARTMENT OF COMMUNICATIVE SCIENCES AND DISORDERS
NORMA S. AND RAY R. REES SPEECH, LANGUAGE, AND HEARING CLINIC

CLIENT'S AGREEMENT AND RELEASE FORM

I hereby authorize the Speech Pathology and Audiology Program, California State University, East Bay, to provide speech, language and/or audiology services to:
______________________________ (Client's Name)

I understand that the services indicated above may be provided by student clinicians as part of their pre-professional and professional clinical training. Such services will be supervised by a certified or licensed Speech Pathologist or Audiologist. I understand, further, that the assignment of student clinicians is at the discretion of the supervisory staff and that services may be interrupted or terminated according to the training requirements of the clinical training program and/or the availability of clinical personnel. I understand that every effort will be made to refer clients for appropriate services when those services cannot be provided by this program. I understand that, due to the design of the observation facilities, services delivered could be observed by other individuals. I am aware that special arrangements for privacy can be made upon request.

I agree that the State of California, the Trustees of the California State University and Colleges, California State University, East Bay, and each and every officer, agent and employee of them (hereafter collectively referred to as the State) shall not be responsible for any injury, damage, or loss which occurs from any cause beyond the control of the State or which does not occur from the sole negligence of the State. I further agree to hold harmless, defend and indemnify the State from any and all claims, injuries, damages, losses, causes of action and demand and all costs and expenses incurred in connection therewith (hereafter collectively referred to as liability) resulting from or in any manner arising out of or in connection with any negligence on the part of the Speech Pathology and Audiology Program, its agents or employees, in the performance of the services, irrespective of whether such liability is also due to any negligence on the part of the State but not if such liability is due to the sole negligence of the State.

I understand that no client information can be released to any person or agency without my specific written authorization.

Date: ___________________ 20____  __________________________________________

Month   Day   Client's Signature

______________________________
Relationship to Client
(If signing for dependent child or disabled adult)
Authorization for Release of Information

I authorize the Speech, Language and Hearing Clinic, Cal State East Bay to release SPEECH-LANGUAGE-AUDIOLOGY records and information pertaining to

Name of client: ___________________________ Date of Birth: ________________

______________________________________________________________________________

Address      City  State   Zip Code      Telephone

to the following:  □ the client, or

Name: ___________________________ Facility, if applicable ___________________________

______________________________________________________________________________

Address      City  State   Zip Code      Telephone

AUTHORIZATION - You must have legal authority to request information. If you are acting as a legal representative to another individual, you must describe the legal relationship to act for the individual.

DURATION - This authorization shall become effective immediately and remain in effect for one year from the date of signature, unless otherwise indicated below.

REVOCATION - You may revoke this authorization, in writing, at any time. The written revocation will be effective upon receipt, but will not be effective to the extent that the person requesting information or others have acted in reliance upon this authorization.

REDISCLOSURE - You may not lawfully further use or disclose the health information to another unless another authorization is obtained or unless such disclosure is specifically required or permitted by law.

COPIES - You have a right to receive a copy of this release authorization form.

FEES - A fee of $1.00 per page will be charged for each page in excess of ten.

USE OF INFORMATION: The information will be used for the following purposes:

______________________________________________________________________________

______________________________________________________________________________

Printed Name of Person Signing Release  Signature  Date

Legal Relationship to Client, or  □ self  Expiration Date for Authorization
PERMISSION TO OBSERVE AND RECORD

The Speech, Language and Hearing Clinic at California State University, East Bay, is both a teaching and clinical service facility. It serves the training needs of students preparing for careers in Speech-Language Pathology and Audiology. It also provides diagnostic and remedial services to individuals with speech, language or hearing disorders.

Diagnostic evaluations and therapy done by student clinicians must be observed by the professional staff of the department. In addition, students enrolled in courses in the department are often required to observe diagnostic and therapy sessions. Audio and video recordings of evaluations and therapy sessions are frequently made for supervisory and training purposes.

With this information in mind, I agree to permit observation of my diagnostic and/or therapy sessions by staff supervisors and others in the professional training programs of the Clinic. I also agree to the audio or video recording of my diagnostic/therapy sessions to be used for educational purposes. I understand that these recordings will not be used outside of the Speech Pathology and Audiology Program without my express permission and that everything will be done to protect my privacy.

____________________________________   __________________
Client's Signature      Date
(Parent or Guardian, if a minor)

ABSENCE POLICY

In order to complete their course requirements, student clinicians are required to complete a minimum of 15 hours of therapy with each assigned client each quarter. Regular attendance is therefore very important. When clients do not keep their appointments, it is difficult or impossible for students to complete their requirements. In addition, it makes it very difficult for clients to meet their therapy goals.

Please notify the clinician or the clinic office (510-885-3241) if you will be unavoidably detained or absent. After two absences, the clinician or supervisor will discuss attendance with the client and issue a warning. After three absences within one quarter, we reserve the right to terminate therapy. I understand the attendance policy as stated and agree to these terms.

____________________________________   __________________
Client or Guardian's Signature     Date
**OBSERVATION-ATTENDANCE RECORD FOR WORK FOLDER**

Clinician __________________________  Qtr/Yr ____________  Client(s) Initials ________

* Attendance:  NS = No show  C = Cancelled  SC = Clinician Cancelled  * Only mark unattended sessions

** Disorder Area:  L = Language  A = Articulation  V = Voice  F = Fluency  AR = Aural Rehabilitation

<table>
<thead>
<tr>
<th>DATE</th>
<th>Attendance NS/CS/C*</th>
<th>TX or DX</th>
<th>OBS or N/O</th>
<th>WRITTEN OR VERBAL FEEDBACK</th>
<th>DISORDER AREAS**</th>
<th>ITP</th>
<th>SELF-EVAL</th>
<th>THERAPY NOTES</th>
<th>OBS/ TX MINS</th>
<th>SUP. INITIALS</th>
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Total Number of Minutes Observed ÷ Total Minutes of Therapy = Percentage of Observation

Supervisor Signature  CA License  ASHA
Intended Therapy Plan for ________________________________  Date: ____________

<table>
<thead>
<tr>
<th>Performance</th>
<th>Conditions</th>
<th>Criterion</th>
<th>Rationale</th>
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</thead>
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Clinician : ____________________________________

31
Client Data - Generic

Client
Clinician
Goal/Objective:

Materials needed:

<table>
<thead>
<tr>
<th>PROCEDURE</th>
<th>Date</th>
<th>Staff</th>
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<th>Setting</th>
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Sample Form
## Client Data - Task Analysis

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<tr>
<th>Client</th>
<th>Goal</th>
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</table>

### PROCEDURE

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### TASK ANALYSIS

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### PROMPT CODES

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33
## Client Data - Vocabulary

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<tr>
<td>clinician</td>
<td>date</td>
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<tr>
<td>TARGET</td>
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### PROCEDURE

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### PROMPT CODES

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### CSUEB DEPT. OF COMMUNICATIVE SCIENCES AND DISORDERS
Evaluation of Clinical Practicum

**Clinician:**

**Quarter/Year:**

**Quarter of clinic:**

**Supervisor:**

**% Supervision:**

**Client Type:**

**Client Initials:**

**Disorder Types:**

**Add'l Disorder Types:**

**Clinical Contact Minutes:**

**Supervision Minutes:**

**Clock Hours Total:**

### GRADING RUBRIC

<table>
<thead>
<tr>
<th>Clear/Convincing evidence (can work independently)</th>
<th>A+</th>
<th>A-</th>
<th>B+</th>
<th>B-</th>
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<td>10-12</td>
<td>12</td>
<td>11</td>
<td>10</td>
<td>9</td>
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<tr>
<td>7-9 Clear evidence (needs only general direction)</td>
<td>8</td>
<td>7</td>
<td>6</td>
<td>5</td>
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<tr>
<td>4-6 Partial evidence (need specific direction/demonstration)</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
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<td>1-3 Little or minimal (no evidence of specified skill/ineffective)</td>
<td>0</td>
<td>0</td>
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<tr>
<td>NA Not applicable</td>
<td>0</td>
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### Profile of Clinical Skills

#### I. Diagnosis in Therapy Setting

A. Familiarity with, and choice of, appropriate diagnostic tools, ensuring use of least biased testing techniques

B. Demonstrates effective use of translators/interpreters for assessment of English Language Learners (ELLs) when appropriate.

C. Administers and scores according to established procedures

D. Observes and identifies relevant behaviors

E. Interprets and analyzes diagnostic information accurately

F. Establishes appropriate short and long term objectives

G. Collects and uses baseline data as appropriate

#### II. Development & Preparation for Therapy

A. Applies theory and research knowledge in treatment

B. Demonstrates creative selection/preparation of treatment techniques and materials, and, if applicable, ensuring appropriate accommodations and modifications to support client access to academic curriculum

C. Plans and organizes lessons to meet individual & group goals

#### III. Therapy Implementation

A. Uses materials and/or equipment proficiently

B. Provides clear, concise instruction in a manner appropriate to the age, attention, and functional level of the client/patient

C. Uses appropriate cues and task modifications, as needed, to maintain attention while eliciting/facilitating therapy objectives

D. Demonstrates appropriate reinforcement/behavior management

E. Responds to/modifies treatment based on changes in client/patient performance

F. Uses time in therapy session effectively to maximize learning

G. Demonstrates ability to lead and collaborate in group activities

#### IV. Written Documentation

A. Includes information that is relevant, accurate and appropriate

B. Writes in a style that is clear, well-balanced and complete

#### V. Interpersonal Skills

A. Demonstrates sensitivity and responsiveness to the emotional as well as the behavioral needs of clients/patients

B. Interacts appropriately with family members/other professionals

#### VI. Personal & Professional Qualities

A. Professionalism: Oral communication model, dependability, appearance, level of involvement, seeks help when needed

B. Manages time, documentation & clinic demands with flexibility

C. Responds to supervisor’s suggestions appropriately

D. Takes initiative and works in a self-directed manner

E. Trains family/caregivers to enhance therapy, as appropriate, and if applicable, plans, implements, and evaluates transitional life experiences for clients and families

### Grades

- **60% of grade**
  - CLINICAL SKILLS
  - Written Ave.

- **40% of grade**
  - WRITTEN DOCUMENTS
  - QTP
  - HP
  - QTS
  - Written Ave.

**Final Ave.**

**Mid Qtr**

**Final**

**Grades round up at .7 to next grade**

**MIDQUARTER CLINICAL SKILLS AVE**

**FINAL CLINICAL SKILLS AVE**

**MIDQUARTER LETTER GRADE**

**FINAL LETTER GRADE**

35
# MIDQUARTER EVALUATION OF CLINICAL PRACTICUM

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<th>Clinician:</th>
<th>Supervisor:</th>
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<tr>
<td>ASHA #:</td>
<td>CA License</td>
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**List Strengths Here …**

**List Areas to Improve here …**

The following have been chosen as targets for improvement for the rest of the quarter:

1. 
2. 
3. 

I acknowledge having reviewed this profile.

Student Signature Date

Supervisor Signature Date

# FINAL EVALUATION OF CLINICAL PRACTICUM

**List Strengths Here …**

**List Areas to Improve Here …**

**Progress towards selected goals**

1. 
2. 
3. 

**Final Comments:**

I acknowledge having reviewed this profile.

Student Signature Date

Supervisor Signature Date

☐ Additional MidQtr comments by attachment

☐ Additional Final Evaluation comments by attachment
Instructions for Completing
Record of Supervised Clinical Experience

1. Use the pink sheets for clinical hours obtained in the CSUEB Clinic or in other sites that are off campus but are NOT Internship sites.
2. Use one sheet for all practicum at CSUEB. Complete a new section each quarter.
3. Hours for clients with mixed disorders should be divided appropriately among disorders.
4. When updating the department clock hours each quarter with your supervisor, always bring your personal copy of clinical hours to update at the same time.
5. The copy in the grad folder must never be taken out of the folder. Supervisors may check out department graduate student files for the purpose of entering hours and filing any pertinent clinician documents.
6. For offsite therapy assignments, not internships, those clinicians will follow specific directions in regards to entering clockhours in department folders and filing appropriate documentation, including Record of Observations and Evaluation of Clinical Practicum.
### Record of Observation and Clinic Hours

**Communicative Sciences and Disorders**

**Clinician:**

<table>
<thead>
<tr>
<th>Observation</th>
<th>No. of Hours</th>
<th>Course Prefix/es &amp; Number/s</th>
<th>Term/s &amp; Year/s</th>
<th>IF NOT COMPLETED AT CSUEB</th>
<th>Instructor Name</th>
<th>DEPT USE ONLY</th>
<th>ASHA #</th>
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Program Director's signature and stamp verifies that observation hours required have been completed by clinician either at CSUEB or another institution.

Program Director Signature

ASHA # & CA SLP License #

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<th>CLINIC</th>
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<th>SPEECH HOURS</th>
<th>DYSPHAGIA HOURS</th>
<th>AUDIO HRS</th>
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<td>Voice/Prosody</td>
<td>Fluency</td>
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<td>Adult</td>
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<td>School</td>
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Course Prefix & No. Quarter & Year (e.g. SPPA 4852)

Supervisor Stamp

CCC #

CA SLP License #

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<th>SCREENINGS</th>
<th>RX</th>
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Course: Qtr & Yr:

Course: Qtr & Yr:

Course: Qtr & Yr:

Course: Qtr & Yr:

Course: Qtr & Yr:

Course: Qtr & Yr:

Course: Qtr & Yr:
Clinician:

Supervisor's stamp indicates s/he has observed in accordance with CTC and ASHA (3.5A) accreditation standards for Supervision of Clinical Practicum and observed a minimum of 50% of each diagnostic evaluation and 25% of total treatment sessions/each case and the supervision is commensurate with the clinical knowledge and skills of each student.
IV. DOCUMENTATION: REPORTS, INSTRUCTIONS AND EXAMPLES
Treatment Planning for Initial Conferences

(Format)

After a comprehensive chart review, prepare this document for each of your individual or small group clients to present at your planning meeting. This document will serve to essentially provide a specific outline for your initial ITP and ultimately, QTP in regards to Status at the Beginning of the Quarter and T.O.’s, including task sequences and rationales. Your supervisor(s) will review this Treatment Planning document in terms of appropriateness and completeness as it relates to competencies listed in I. Diagnosis in Therapy Session on the Evaluation of Clinical Practicum.

Client ________________________________         Age_________________ (First)     (Last)                       (Years)   (Months)
Date of Birth ____________________________ Quarter/Year __________ (Month)       (Day)     (Year)
Clinician ______________________________ Supervisor __________________________ (First)     (Last)                          (First)     (Last)   Degree, CCC-SLP

• Please propose at least five specific questions you wish to answer in regards to the communication functioning for each of your two assigned clients during your DX/baselining sessions (e.g., What is client’s phonetic repertoire?, How does client make is needs known?, etc.) (Do not include audiometric/oral mechanism screening procedures).

• In view of these questions, please discuss pertinent and specific observations (e.g., plural markers, specific pragmatic functions, self-corrections, etc.) you’ll want to focus on and in what environments/situations (e.g., in reception area, conversation, board game, etc.) to guide you in assessing client’s needs and ultimately, determining treatment objectives.

• In view of these questions, please propose specific non-standardized (e.g. probes, etc.) procedures you wish to use for each of your clients. For each of these proposed procedures, present a rationale, which includes appropriateness in terms of age, functional level, previous treatment, pertinent history, etc.

• Propose a stimulability task for each of your clients in which you specifically have several options in which to teach/elicit the desired target. (Please realize modeling isn’t enough to assess stimulability. Design a mini therapy task with possible steps/techniques to teach/elicit desired target.)

• Discuss how you plan to collect on-line data by addressing specifics (e.g., how, # of trials, cueing as appropriate, specific examples, etc.) in your initial DX/baselining sessions. That is, plan and problem-solve in advance of your session(s) to optimize efficiency as this information will be the content of Status At Beginning of the Quarter as well as Rationales for your QTP! These sessions need to be focused and productive!
Instructions For Writing An Intended Therapy Plan (ITP)


B. Definition of a behavioral objective: A statement that describes a specific target behavior to be achieved, in observable and measurable terms.

C. Components: Performance, conditions, criteria, rationale.
   - **Performance** – States what the learner is expected to be able to do and what will be demonstrated; equals capability. Written in behavioral terms which clearly state the observable action to be measured. Examples of behavioral terms: write, recite, point to, say, etc. Always reflects what the client will do, not what the clinician will do.
     Examples: "the client will produce initial /s/ blends at the word level"
     "the client will point to named object from a field of 3"
     "the client will follow a 2-step direction"
     "the client will repeat multisyllabic words"
   - **Conditions**: States the situation in which the target behavior is performed. Includes the stimulus, context, and type and amount of cues required and initial stimulus.
     Examples: "while naming 10 pictures given 1 phonemic cue"
     "independently while completing functional writing activities" 
     "given her communication board and a gestural cue"
     "given a general category and 2 verbal cues"
   - **Criteria**: States how well the target behavior must be performed for the objective to be achieved. Can set standards in terms of a) speed, b) accuracy, c) quality.
     Examples: "8 tongue protrusions in 10 sec"
     "correct production of /p/ in 9/10 trials".
     "read a 4 sentence paragraph with no more than 2 errors".
     "with no more than 2 errors in 5 minutes of spontaneous conversation"
   - **Rationale**: Includes Client-based and Literature-based rationales:
     **Client based**: Includes results from the previous session that justifies your behavioral objective for the week (i.e., was criterion met, and task complexity to be increased? Was difficulty still demonstrated, and continuation at established level is needed before advancing? Is probing recommended?). Initial sessions may also include parental concerns or recommendations from DX report or prior QTS.
     **Literature-based**: Includes a sound and recent literature based citation (5-10 years) which supports your treatment plan for the week. For baseline sessions, it may include developmental acquisition data or a proposed treatment approach to determine stimulability. For therapy, it may include a citation regarding developmental norms or justify why a modification in your treatment plan is appropriate. Be thorough and specific.

Once QTP is approved and signed off by the Supervisor, literature-based rationales are no longer required, unless indicated in specific circumstances.

D. See ITP form: III. Clinic Forms or download at http://www20.csueastbay.edu/class/departments/commsci/students/forms.html
Instructions for Writing a Self-Evaluation

A self-evaluation is to be written immediately after each therapy session, on a separate sheet of paper. The purpose of the self-evaluation is for you to evaluate your behaviors and effectiveness as a clinician. Although it is not graded, your supervisor will review and may offer comments. A self-evaluation must be completed for each session. There is an expectation/ASHA standard that each clinician will improve in their ability to objectively critique their therapy, interventions, cues, client’s response, etc, over the course of the quarter. You will find that it is a valuable record of your perception of your clinical skills throughout the quarter. Please do not focus on client’s behaviors. This is a self-evaluation of your clinical skills!

At least the following three points should be covered in each self-evaluation:

1. What three aspects of your session or clinical behaviors seemed particularly effective? Address at least one of the following areas in your response:
   - Choice of activities and materials
   - Verbal stimuli (response elicitation and task instructions)
   - Reinforcement (type, delivery, timing, schedule)
   - Charting client’s responses
   - Facilitation of transitions
   - Time management/maximizing responses
   - Clinical flexibility
   - Behavior management
   - Communication with family members

2. Using the same list, discuss three areas of weakness that were apparent to you during this session.

3. What changes in the above areas do you plan for the next session? Why?
Instructions for Writing Therapy Notes

Chart notes are a required part of a client’s treatment program in most clinical facilities and become a part of the client’s permanent record. They stand as a record of your daily treatment for review by other therapists and professionals. As such, they are expected to be neat, legible, grammatical and correctly spelled and are typically to be brief.

Many facilities have their own formats for chart notes. As part of your CSUEB training in clinical writing you will be exposed to two different modes of charting. Undergraduates will be expected to write notes using complete sentences and regular narrative style. Graduate students will be instructed in different notation systems and will be encouraged to use abbreviations and short phrases. These differences are described below.

Undergraduates— Following the guidelines provided elsewhere in the Clinic Handbook, students are expected to write chart notes using well formed, complete sentences. Corrections of occasional errors may be made by striking through an error with a single line, rewriting and then initialing the change. Only blue or black ink may be used. Notes must meet professional standards of clarity and appearance. Notes are to be reviewed within one week by the supervisor. Rewriting may be required if the supervisor finds the notes unacceptable. When notes are acceptable, a supervisor will sign or initial them.

Graduates— Graduate students will be instructed in the use of a charting system that uses abbreviations and style acceptable in local clinics and hospitals. Supervisors are to guide students to improve writing of chart notes, including directions for brevity and relevance. This should be seen as a process which may take several quarters rather than a skill which is developed through continual rewriting of daily notes.

The following is a list of abbreviations frequently used in clinics and hospitals:

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Meaning</th>
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<td>↑ ing</td>
<td>increasing</td>
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Commonly used mathematical symbols may also be used. (e.g., =, ≥, ≤, ∆, ≈)

General guidelines
Keep notes succinct and try to develop a template. Remember the QTP, once approved, drives your ITP and your therapy notes are the succinct record of your session.
No more than one page in length
Use first name, last initial on bottom of notes
Format of Notes

SOAP Notes

Mo/Day/Yr (After each therapy session)

Subjective Info: which may impact results that day

Objective/Analysis: Briefly state the results of each objective, attempted, accurate. State progress noted since last session, if significant. Include impressions/assessment: Were there factors (i.e., environmental, behavioral, emotional, etc.) which affected results in some way? Did the result suggest changes in task approach, material objective, etc.?

Plan: State specific plan for next session, including any changes which will be needed in the next session. Note if client is ready for a next step in the task sequence.

CONTACT Notes

Mo/Day/Yr Report counseling sessions with family member and telephone contacts with professional.

Indicate receipt of reports or records.

Notate each absence or cancellation.

Each therapy note page must include, the following information: client’s name, age and diagnosis.

All therapy notes must be signed by student clinician and co-signed by the supervisor.
Date: 07/23/08

S: The client arrived fatigued but quickly displayed typical engagement upon entering therapy room. He appeared to have a slight cold (e.g., runny nose).

O/A: Terminal Objective #1 (k, g in CV combos): After participating in auditory bombardment for 2 minutes, client imitated /k/ + vowel in 8/10 trials (80%) and /g/ + vowel in 12/14 trials (85%) with only 3 visual cues required (from 60% and 70% respectively, last session). He accurately produced 3 spontaneous words containing phono targets: go, car, kick (from none in all previous sessions), suggesting that client's sound awareness is improving and accuracy of productions is beginning to spontaneously generalize into meaningful words. TO#2 (use of Wh qu’s): During 10 minute language sample mid-way through session, client spontaneously produced 4 Wh-questions (Where is it?, Where’d he go? What’s it doing?, What that called?), from 2 Wh questions last session. Client appears to benefit from frequent question forms modeled by the clinician within predictable, structured contexts. TO#3 (use present prog verb): The client produced the present progressive verb form in obligatory contexts in 3 of 10 trials (30%) given up to 2 verbal models for each production (same as last session). He continues to use the correct verb but in the present tense form. His ability to imitate the correct verb ending on direct request has increased, but client continues to show significant resistance to such direct production requests.

Plan:
- Continue to target /k/ + vowel and /g/ + vowel to establish 80% consistency x1 more session before upgrading task; increase opportunities for spontaneous naming of toys with velar sounds.
- Increase production of Wh-question forms in play based activities through frequent, natural modeling. Increase the number of communicative temptations and interruptions applied in play.
- Increase present progressive verb form use through action based play (figurines) and books with actions, provide frequent models and opportunities for spontaneous use.

Clinician: __________________________        Supervisor__________________
Client:   _________________________    Age: ___________
Quarterly Therapy Plan (QTP)

FORMAT AND INSTRUCTIONS

Instructions
Rough draft – double spaced on one side of page only.
Final copy – single spaced on one side of page only.
Always submit revised portion of the QTP with rough draft of the QTS.

CALIFORNIA STATE UNIVERSITY, EAST BAY
DEPARTMENT OF COMMUNICATIVE SCIENCES AND DISORDERS
NORMA S. AND RAY R. REES SPEECH, LANGUAGE AND HEARING CLINIC

Quarterly Therapy Plan for ______ Quarter, 20____

Client ___________________________________       Age_____________________________
(First)     (Last)                           (Years)              (Months)

Date of Birth     ______   (Month)        (Day)          (Year)

Student Clinician         Supervisor
(First)     (Last)            (First)     (Last)   Degree, CCC-SLP

Period Covered __/__/__  to  __/__/__    (# sessions this quarter)
(leave blank until QTS is submitted at the end of quarter) (# cancellations)
(total  #  sessions to date at this clinic)

I. Statement of Problem  (PAST TENSE) Summarize pertinent information in client’s background, including age, sex, referral source and medical diagnosis if relevant (when and by whom), services received elsewhere, speech and language diagnosis (most recent only) and length of time enrolled at clinic. If results of prior therapy are relevant, summarize in this section.

II. Status at the Beginning of the Quarter  (PAST TENSE) Describe client’s speech and language behavior at the beginning of the quarter. Include results of tests administered this quarter. Categorize information as suggested below (in order of significance), collapsing headings when appropriate. Use only those categories appropriate for the client.

General Behavioral Description - Briefly describe client’s general behavior and responsiveness in therapy at the beginning of the quarter.

Receptive language

Expressive language

Articulation/Phonology

Voice/Fluency/Other

Hearing
III. Therapy Objectives  The following objectives have been established for completion by the end of this quarter.

1. **Terminal Objective No. 1:** This should consist of an identified target behavior, with the objective written to include the behavior desired by the end of the quarter. Follow the guidelines for writing a behavioral objective. Add a mastery statement which indicates performance criterion (i.e. how many times the client is to demonstrate the desired behavior before the task is at criterion), as well as a marker of trials/opportunities.

   **Task Sequence:** This should include the major steps leading to the Terminal Objective. Sequence the tasks logically beginning with the least complex, leading to the most complex (which is the behavior specified in the Terminal Objective). Keep steps small enough to guarantee success. All tasks should relate directly to the Terminal Objective. Approximately 4-5 steps should be included in the task sequence, with each step an objective in itself, designed to be achievable in a week’s time frame, and written with a behavioral expectation, performance, condition and criterion.

   a. 
   b. 
   c. 
   d. **Terminal Objective**  
      (Continue as needed. Last step will always be T.O.)

   **Rationale:** Provide specific information as to why the terminal objective was selected. Document the decision with selected data from baseline and test information, and references from current literature (within 5-10 years) and class sources.

2. **Terminal Objective No. 2:**

   Same format as above.

   Repeat above outline for each Terminal Objective (typically 3-4 per quarter).

---

**Type Name**  
Student/Graduate Clinician

**Type Supervisor’s Name, Degree, CCC-SLP**  
Clinic Supervisor
Quarterly Therapy Plan
Guidelines and Supervisor Criteria

Supervisors will consider these elements when reviewing and grading the QTP. Information in each QTP will vary by client, but supervisors will focus on these guidelines to ensure essential elements are present in each QTP. Also, refer to the Quarterly Therapy Plan format and instructions in the Clinic Handbook.

Essential Elements (include General and Specific Elements)
1. General Elements (ensures that the QTP is written in a professional, logical and concise manner).
   - No passive voice
   - Double spaced submissions
   - Parallel verb tenses
   - Correct spelling and grammar
   - Clinical and professional terminology
   - Correct use of punctuation (colons, semi colons, commas, i.e., vs, e.g., etc.)
   - “Period covered” and # of sessions left blank until the end of the quarter
   - Age of client is correct

2. Specific Elements (ensures that QTP reflects the individual client and a carefully designed treatment plan)

A. Statement of the Problem: (written in past tense)
   - Summarize pertinent information (age, DX, relevant history, other services, IEP goals, etc.)
   - Should be thorough, but succinct, with relevant info,
   - Document/discuss earlier assessments and previous TX/progress
   - Provides current speech/language diagnosis
   - Reflects current problem/concerns
   - Final sentence is time enrolled in CSUEB clinic

B. Status at the Beginning of the Quarter: (written in past tense)
   - Description of status at the beginning of the quarter; include any test results (from the current quarter only). Do not discuss prior testing or tx results.
   - Categorize information under headings in order of importance for each client
   - Include quantifiable (baseline) and qualitative/supportive information under each heading; include representative examples when appropriate.
   - Include information re. all skills/behaviors addressed in the subsequent Terminal Objectives as problems/weaknesses.

C. Terminal Objectives: (written in future tense)
   - Each QTP has 3-5 TO’s, including, if appropriate, a caregiver training TO.
   - Each TO addresses 1 goal.
   - Each TO (** includes the client’s observable performance/behavior that will be demonstrated at the end of the quarter, stimulus, conditions, criterion/success marker, opportunities/trials and a marker of consistency (e.g., over 2 consecutive sessions).
D. **Task Sequences**: (written in future tense)
- Each TO should have a Task Sequence of 4-5 steps.
- Each step is an attainable measurable and reasonable mini-goal in proceeding toward achieving the TO.
- Each step in the Task Sequence should contain the same elements as above (**)
- Each step equates to (generally) 1-1/2 weeks of therapy.
- Task Sequence steps progress from least complex to most complex, ending with the Terminal Objective.
- Criterion percentage should not fall below 70%; simply raising percentage doesn't constitute a “step” in task sequence.
- Progression through sequence is reflected by advancing task complexity/skill, modifying conditions and/or reducing cues, and to a much lesser extent, increasing accuracy levels, so that client becomes increasingly independent or advanced in achieving the targeted skill/behavior.

E. **Rationales**:
- Each TO includes a rationale citing current literature (within 5-10 years) or specific academic coursework references.
- Justify choice for each TO in regards to client’s current behaviors/skills, past treatment, personal or caregiver goal preferences, as appropriate.

**Grading reference:**
**A** (report is logical, well organized, professionally written with very few corrections required to content, grammar or style. Data is clearly presented. Analysis is strong. Task Sequences reflect logical progression toward Terminal Objective. Incorporates all essential elements.)
**B** (report requires a moderate amount of correction to content, grammar and style. Baseline data presentation is marginal, analyses are weaker in thoughtful reflection. Some essential elements are weak or missing.)
**C** (report requires a significant amount of feedback due to weaknesses in any of the above areas. Analyses are weak. Minimal inclusion or lack of essential elements).
Quarterly Therapy Summary (QTS)  
Explanation of Procedure

The Quarterly Therapy Summary is written in two parts. The first part (see format for QTP) is written at the beginning of the quarter and is due one week after the third therapy session. It consists of the following sections:

I. Statement of Problem

II. Status at the Beginning of the Quarter

III. Therapy Objectives, with a task sequence and rationale for each objective

The QTP is evaluated by the supervisor and revised by the clinician until it is satisfactory to both. At that point, the Statement of the Problem and Status at the Beginning of the Quarter sections may be typed in their final, single-spaced form if the student wishes to do so.

When the QTS is prepared in its final form at the end of the quarter, task sequences and rationales for Therapy Objectives are omitted. Therapy Objectives are then supported by Results or section III, below.

The QTS (see format for QTS) is completed at the end of the quarter with the addition of the following sections:

III. Therapy Objectives and Results

Terminal objectives only and omit task sequences and rationales. Include any additional Therapy Objectives, not included in approved QTP and Results

IV. Present Status

V. Recommendations
Quarterly Therapy Summary (QTS) Report

FORMAT AND INSTRUCTIONS

Instructions: Rough draft – double spaced on one side of page only.
Final copy – single spaced on one side of page only.
Always submit final QTP as the first section of the QTS along with revised sections of
the Results, Present Status and Recommendations.

CALIFORNIA STATE UNIVERSITY, EAST BAY
DEPARTMENT OF COMMUNICATIVE SCIENCES AND DISORDERS
NORMA S. AND RAY R. REES SPEECH, LANGUAGE AND HEARING CLINIC

CONFIDENTIAL

Quarterly Therapy Summary Report for ____ Quarter, 20_______

Client __________________________________________    Age ____________________
(First)               (Last)                             (Years        (Months)
Date of Birth     ______
(Month)        (Day)          (Year)

Student Clinician         Supervisor
(First)    (Last)                    (First)    (Last)   Degree, CCC-SLP
(First) (Last)

Period Covered __/__/__ to  __/__/__   (# sessions this quarter)
(# cancellations)
(total # sessions to date at this clinic)

I. Statement of Problem: (PAST TENSE) Summarize pertinent information in client’s background,
including age, sex, referral source and medial diagnosis if relevant (when and by whom), receiving
services elsewhere, speech and language diagnosis (most recent only) and length of time enrolled at
clinic. If results of prior therapy are relevant, summarize in this section.

II. Status at the Beginning of the Quarter: (PAST TENSE) Describe client’s speech and language
behavior at the beginning of the quarter. Include results of tests administered this quarter.
Categorize information as suggested below, or listed in terms of primary difficulty. Use only those
categories appropriate for the client.

General Behavioral Description - Briefly describe client's general behavior and responsiveness in
therapy at the beginning of the quarter.

Receptive Language

Expressive Language

Articulation/Phonology

Voice/Fluency/Other

Hearing
III. Therapy Objectives and Results

Terminal Objective – Restate from edited first half of summary.

(Do not include task sequence or rationale!)

- SKIP SPACE –

Results (PAST TENSE) State whether or not the object was met. Discuss baseline status relative to this skill, notable progress, and current status. If the objective as originally stated was dropped or changed, mention here. Describe how it was changed and why. If the goal was met briefly mention those procedures or techniques that resulted in unusual or significant behavior change. If the objective was not met describe the progress made. Give the reader a sense of what the client can now do in terms of the objective (change in material, special reinforcement, etc.) which may be helpful to the next clinician. Repeat this sequence for each Terminal Objective.

Additional Objectives List here any objectives added during the quarter; report results in the above format.

IV. Present Status (PRESENT TENSE) This section should describe the client’s current level of communicative functioning, independent of therapy progress. Although progress toward goals can be stated, it should be described relative to the client as a communicator and as part of their functional communication abilities. Are there significant problems that interfere with communication? Use developmental comparisons or intelligibility criteria as appropriate. This description of the client should be able to stand alone.

V. Recommendations (PRESENT TENSE) Make recommendations, in list form. Indicate whether client should:

1. Continue in therapy (frequency and length of sessions) or be discharged. Include quarter and year in recommendation, e.g., continue therapy, fall quarter, 20____.

2. Be involved in individual or group.

3. Receive further testing in this clinic.

4. Receive additional services elsewhere.

5. Indicate amount and type of parent involvement recommended.

6. Make recommendations for objectives to be continued, added, dropped or modified next quarter.
   a.
   b.
   c.

Type Name
Student/Graduate Clinician

Type Supervisor’s Name, Degree, CCC-SLP
Clinic Supervisor or Appropriate Title
Quarterly Therapy Summary
Guidelines and Supervisor Criteria

Supervisors will consider these elements when reviewing and grading the QTS.

Essential Elements (include General and Specific Elements)

1. General Elements (ensures that the QTS is written in a professional, logical, relevant, and concise but comprehensive manner)
   - Double spaced submission of new QTS content; initial QTP content is single spaced
   - Update client’s age and number of total sessions to date
   - Carefully edited for format (IPA, underline test names, abbreviations, spelling & grammar, etc.)
   - Avoid passive voice and worthless sentences with no content
   - Parallel verb tenses within sentences and following Clinic Handbook format (e.g. headings, etc.)
   - Correct use of punctuation (colons, semi colons, commas, i.e., versus, e.g., etc.)
   - Clinical & professional terminology
   - QTS represents best and most professional documentation to clients or professional community

2. Specific Elements (ensures the QTS reflects the client’s progress and current status in a professionally written and relevant summary)

   A. Results (written in past tense)
   For EACH Terminal Objective:
   - First sentence reflects whether or not objective was met (“the goal was/was not met”, “was partially met”, “almost met”, “not addressed”, etc., followed by relevant and detailed supportive data. The statement by itself is NOT sufficient.
   - Brief statement about why this goal was necessary and/or appropriate for the client. Do not restate the goal.
   - Provide baseline measurement at start of therapy
   - Briefly discuss relevant facilitative techniques, procedures, cues and activities that were helpful for client.
   - Discuss any relevant information re: progression or TO modification
   - Provide any information, relevant to T.O., which would be helpful for the next clinician
   - End section with final data and relevant supportive information

Additional Objectives:
- Note any new objectives added since QTP
- Rationale for additional T.O.
- Discuss status toward objective and report relevant information as noted above
- Include any new objectives for family/caregiver training; otherwise, create separate heading for Family/Caregiver Training, to include training of Home Program
B. **Present Status** (written in present tense)
   - **paragraph #1** to include current identifying information, diagnosis and relevant history (e.g. special day class, recent change in program, medical status)
   - First paragraph also includes a functional description: a specific and clear description of client as a communicator without reference to any test or scores-this functional description does not include progress toward goals. **Briefly reference all domains**, even if to state WNL.
   - **paragraph #2** to reflect a few sentences noting client’s progress toward goals this quarter and overall response to treatment. (e.g., improved speech intelligibility, carryover of grammatical targets XXX, use of targeted PECS icons, self-correction of XXX)
   - Discuss any problems or interfering factors, including positive or negative (e.g., absences, attention, response to token reinforcement, works well in group)
   - Statement which notes, as appropriate, results of family/caregiver participation
   - **paragraph #3** as a final paragraph to include remaining history, noting additional services as applicable, number of quarters at CSUEB Speech Clinic. Avoid redundancy.
   - Follows logically with no new information
   - The Present Status should provide an adequate summary to stand alone

C. **Recommendations** (written in present tense)
   - Opening sentence addresses continuation of TX, individual or group, frequency & duration, including quarter & year
   - CSEUB recommendations presented in prioritized, numerical list form
   - List specific therapy recommendations for the next quarter as specific verb statements (e.g. continue, improve, decrease, eliminate, assess, reinforce, monitor, reassess & treat, etc.)
   - Additional, non-therapy goals presented as a separate list or in narrative form
   - Include need for further assessment, in this clinic or elsewhere, if appropriate
   - Continuation and/or change in reference to another treatment/education program outside of CSUEB
   - Indicate amount of parental/family involvement

Grading reference:
**A** (incorporates essential elements. Logical, sequential, professionally written report, including clearly presented data and supportive details/descriptions, with few corrections required. Strong analysis with appropriate and specific recommendations)
**B** (Report requires a moderate amount of correction to content, grammar and/or format. Data reporting is marginal, analyses are limited and/or incomplete. Some essential elements are weak or missing).
**C** (Report requires a significant amount of feedback with weaknesses in any of the above areas. Analyses are weak, recommendations are inappropriate for client needs. Minimal inclusion or lack of essential elements).
HOME PROGRAM
(Quarter and Year)

Client   First Last Name    Date:    Month/Day/Year
Student Clinician   First, Last Name   Supervisor:  First Last Name, Degree, CCC-SLP

(**The purpose of the Home Program is to help clients maintain the progress they made during the quarter. It should consist of two to three activities that address the quarter’s objectives. Activities are usually very similar to those that have been conducted in therapy, but adapted for clients and/or families to do at home. Keep them simple, functional and time efficient. Make sure activities are manageable for the client or family. It is not necessary to design all new activities for the Home Program. The goal is to describe clearly to families or clients what they are to do at home to maintain or improve the current level of functioning.)

General Directions: Discuss the practice environment. Where and when do you want practice to take place? How often and for how long? Should all activities be practiced at each practice session or should they be alternated? Be specific in describing how you want the practice sessions to be conducted.

Number and Name Each Activity: The name of the activity refers to the topic or behavior being addressed in the activity, e.g., /s/ in sentences, plurals, past tense verbs, intonation, monitoring fluency, reducing nasality, gestures, etc.

Specific Instructions: Tell the client or family what materials they will need or what materials you are providing. Explain how the activity should be carried out. Be specific, and list the steps, if possible. Tell the family what they should say or do when the client responds correctly as well as when he or she responds incorrectly. Be clear about how they should cue, correct, model, etc. Tell them how many times a specific activity is to be completed.

Closing: End the Home Program with:

1) A short statement about your work or relationship with the client, e.g.,
   a) We enjoyed working with __________ this quarter and seeing her/him progress;
   b) Working with _______ has been challenging and rewarding;
   c) _______ has made excellent progress this quarter, and your consistent work with him/her at home during the quarter has contributed to that progress;
   d) We are glad we had the opportunity to work with _______ this quarter.

2) Wish the client success in her/his continuing therapy. If client is being discharged, provide an appropriate closing statement.

Your Name      Supervisor’s Name, Degree, CCC-SLP
Student/Graduate Clinician   Clinical Supervisor or Appropriate Title

Instructions: This should be printed in duplicate. The original is given to the Client/Family member. The copy is filed in the client’s chart. Both require original signatures.
Home Program-Rubric Evaluation/Guidelines

Use this checklist in reviewing components of Home Program prior to submitting to your supervisor

General Requirements

- Inclusion of all client information on first page
- Double-spaced, well edited and grammatically correct, but clearly written and succinct
- Appropriately written without professional jargon
- Appropriately addressed to client, caregiver or both
- Closely follows therapy plan and activities for generalization as opposed to introducing/targeting objectives that are too challenging for the client
- Statement of General Purpose of Home Program
- Follows format of Home Program in Clinic Handbook
- All materials (or a sample thereof) submitted with Home Program
- Reasonable relative to purpose, design and time requirements

General Directions:

- Specifics such as location and time of practice
- Frequency and duration of practice
- Specific instructions regarding how practice sessions are to be conducted

Activities:

- Number and title each activity, referencing the skill or behavior addressed
- Clearly reference necessary and supplied materials
- Clearly list simple but specific instructions necessary to perform the activity
- Specific instructions and information for both client and caregiver
- List steps in numbered format as appropriate
- Explanation of cues and reinforcements necessary to correct or facilitate targeted behaviors
- Clear instructions regarding cues, correction, modeling, etc.
- Examples, as appropriate, for clarity of task, cues, correction, etc.
- Clear description of closure or completion of each task

Closing:

- Simple closure statement
- Appropriate to client and case disposition

Grading reference:

**A (General Requirements are well incorporated. HP is logical, functional, and reasonable. Activities are clearly explained, detailed and steps are listed. Cues and instruction are clear. Materials are appropriate. Program is written with consideration to both client and caregiver roles).

**B (Some General Requirements are weak or missing. HP is marginal relative to functionality, activity selection, description, and explanation. A moderate amount of correction/feedback is necessary for explanation of activities, instructions, cues, examples and completion of task. Materials are marginal. Program does not clearly address client and caregiver roles).

**C (Many General Requirements are weak and require a significant amount of feedback. Explanation of activities, instructions, cues, examples and completion of task are weak or missing. Client and caregiver roles are not clearly defined; activities not functional, reasonable and/or don’t follow current therapy plan. Materials are weak or inappropriate).
V. DIAGNOSTIC CLINIC
A half-hour planning meeting with the supervisor takes place prior to the evaluation, at a time determined by the supervisor and diagnostic team members. Each case is assigned one Leader and one Assistant; each Diagnostic clinician will have training opportunities in both roles. Assistants for diagnostic cases will accrue diagnostic hours according to ASHA standards. Grades for onsite assessments are assigned for each diagnostic session and averaged at the end of the quarter—Planning (10%), Interview & Wrap-Up (20%), Administration (10%), Analysis and Scoring (20%), Report (20%) and Letter (20%) with the offsite grades—Preparation & Planning (40%), Analysis & Scoring (30%) and Report (40%) (Please see Diagnostic Practicum Grade Sheet-Clinician Form.)

**Team Leader Responsibilities**

1. Prior to a planning meeting
   a) Review client’s chart, research disorder, contact other professionals involved with case as appropriate (e.g., speech pathologist, teacher, doctor, audiologist,).
   b) Review diagnostic tests and interview procedures.
   c) Prepare a typed Diagnostic Plan which includes
      1) Statement of the Problem (nature of case; age, sex, presumed problem, special characteristics, prior testing, etc.)
      2) Suggested test battery in order of presentation with administration times and rationales (what the test assesses; why you have chosen to test this area; and why you have chosen this particular tool for this client-document with references to current literature and client’s suspected level of functioning)
      3) Interview questions (relevant to the client, their history, current status, etc).

2. During a planning meeting
   a) Present plan to supervisor and assistant for discussion.
   b) Make appropriate changes in plan.
   c) Determine duties of Assistant.
   d) Get test protocols from Clinic Receptionist if not available in Resource Room.

3. Prior to an evaluation
   a) Contact parent/caregiver by phone a few days prior to introduce yourself, answer any questions, check for allergies, motivators, etc
   b) Fill in information on test protocols neatly and in ink (or typed).
   c) Have snack ready when appropriate.
   d) Have release forms, permission to record form, and client’s agreement ready.
   e) Place copy of diagnostic plan and copies of test protocols in observation room for Supervisor and Conference Room for observers.
   f) Set up room for interview and organize materials for testing.

4. During the evaluation
   a) Conduct interview.
   b) Explain evaluation procedures.
   c) Administer tests and take on-line data.
   d) Note behavioral observations.

5. Staffing
a) While the client waits in reception area, clinical impressions and recommendations are briefly discussed in preparation for the wrap-up.

6. Exit Interview
   a) Discuss test results, observations and recommendations with parent/client; allow time for questions.

7. Clean-up
   a) Return tests and other materials to Resource Room.
   b) Disinfect and return audiometric equipment
   c) Check that assistant has turned off recording equipment.
   d) Retrieve plan and protocols from Observation Room.

8. Report Writing
   a) Rough draft of report and letter to clients/caregivers is to be typed double or triple spaced and is due as an electronic or hard copy as determined by Supervisor. Late reports will be marked down one-third grade per day according to clinic policy. Include test protocols, language samples and other relevant assessment data with your report.
   b) Write entire diagnostic report without aid of assistant.
   c) Subsequent edits of report will be due as determined by your supervisor, and initial grade can be lowered if timelines are not met.
   d) File final report (original), copy of letter to parent or client and test protocols in client’s chart and file chart under “waiting for therapy” or give to Clinic Director if therapy at CSUEB is not indicated.

9. Other diagnostic case management responsibilities
   a) Have client or family member sign Patient’s Agreement and Release and Permission to Record forms before beginning interview.
   b) Complete Client Summary Data Sheet in client’s chart.
   c) Complete identifying information sections for all test forms.

10. Please be mindful that all information from client’s chart and diagnostic interview/testing/wrap-up is confidential and should not be discussed outside of the clinic conference room.

11. All test manuals and client charts remain in the Clinic at all times. Graduate Diagnostic Team Members may check-out Diagnostic Tools overnight to be returned the following morning. Client charts may not be borrowed overnight or photocopied. Students must review client files within the confines of the Clinic. This is an issue of confidentiality that must be maintained. Students must plan to do work in the Clinic between 8:00 a.m. and 5:00 p.m.

**Assistant**

1. Prior to the planning meeting, review client chart for participation in meeting.

2. During the evaluation, assistant team leader will participate in Dx as determined during planning meeting and as need arises during Dx session.
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<th>Client Assignment</th>
<th>Date</th>
<th>Age Group</th>
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<td>Lead Assistant (include initials)</td>
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TOTAL GRADE POINTS ÷ Number of DX = Average Points (Letter Grade)

Key: A 10-12 — Superior Skills (can work independently)
B 7 – 9 — Intermediate Skills (needs only general direction)
C 4 – 6 — Minimal Skills (needs specific direction and demonstration)
D 1 – 3 — Unsatisfactory
Diagnostic Competencies

Each competency must be achieved at a level consistent with a grade of B- or better. The grade of B implies independent and effective performance with only general supervisory direction. By the end of the quarter, the Clinician will demonstrate the following competencies* which are directly related to the SPPA 6057 syllabus and the Diagnostic Practicum Grade Sheet:

1. Review the available background information in a diagnostic case file and determine the purpose of the evaluation.

2. Plan a complete, well-organized interview, appropriate for the problem and information available.

3. Plan diagnostic testing or screening for the problem presented and for the client’s age and functional level, utilizing behavioral observation, non-standardized and standardized assessment measures, and instrumental procedures.

4. Conduct a well organized interview appropriate to the situation and the informant with careful attention to the needs of the client and/or the family.

5. Correctly administer all diagnostic and screening procedures. This includes completing test protocols, language samples, phonological analyses, behavioral checklists.

6. Correctly score, analyze and interpret all evaluation procedures.

7. Interpret, integrate and synthesize background information from a variety of sources, observations, assessment findings in order to formulate appropriate clinical impressions and recommendations.

8. Present overall impressions and recommendations to clients and or families in a complete and organized fashion using language appropriate to the needs of the listener.

9. Write a complete, accurate professional report that follows the established format and which succinctly, but completely summarizes the outcome of each evaluation.

10. Write an individualized letter to the client of family summarizing the outcome and recommendations of each diagnostic evaluation in terms appropriate to the reader.

11. Promptly complete all written documentation associated with the diagnostic clinic and the maintenance of clinic records, including information releases as necessary to disseminate information to appropriate individuals or agencies for further referrals.

12. Adhere to the ASHA, California Speech-Language-Hearing Association and California Board of Speech-Language Pathology and Audiology Codes of Ethics with special attention to privacy regulations and appropriate referrals. The clinicians will engage in discussion of these issues in the planning meetings and staffings for each assessment.

* ASHA Standard 3.1B
Diagnostic Report Grading Rubric

Statement of the Problem (present tense)
- Written in past tense
- Personal information included
- Statement of the problem is clearly stated
- Succinct, but includes most important, relevant info, including reason for assessment (e.g. family concerns, etc.)

History (past tense)
- Written in past tense
- Includes all pertinent info, including previous testing (what, where, by whom, results) (see clinic manual)
- Headings and/or paragraphs in logical sequence according to supervisory suggestions

Evaluation Results (past tense)
- Subheadings used & organized by area of primary problem first
- Discussion/analysis/presentation of specific communication behaviors within each domain
- Contains information of significance (vs. irrelevance)
- Scores presented relative to norms (i.e., SS and percentiles most meaningful); less meaningful are age scores.
- Areas that are WFL are described in brief, without inclusion of lengthy detail or examples. Do not comment on unremarkable.
- Analysis goes beyond reporting scores and behaviors.
- Analysis synthesizes the language/behaviors into an organized summary of information.
- Analysis answers the why’s of the behaviors that were or were not demonstrated.
- Specific tests are cited and underlined throughout
- Includes, as appropriate, non-verbal behavior, pragmatics, play/cognitive skills, etc.
- Reports client’s response to cues or stimulability, as appropriate.

Diagnostic Impression (present tense)
- Restatement of client information and past remarkable history (e.g., previous treatment, special day class placement, complicating medical history/problems, etc.)
- Summary of significant aspects of findings from eval in functional terms as opposed to test data
- Report any possible contributing factors
- Should be able to stand alone, providing reader with a thumbnail synopsis of case
- Successfully integrates and synthesizes the results with no introduction of new information, etc.
- Relates current findings to past reports, testing, functioning

Recommendations (present tense)
- Recommendation for therapy is stated, with mention of frequency and type.
- Initial goals presented in list form
- Goals are appropriate and specific to the client
- Mention of any additional assessments/referrals needed
- Mention specific recommendation to parent/caregiver, including a Home Program as appropriate.
- Prognostic statement needs to be realistic and specific based on both positive and negative factors, as appropriate.

Grading reference:

**A Report requires minimal correction. Logical, sequential, professionally written, including clearly presented data or summary, with few corrections required. Strong analysis with appropriate and specific recommendations. Verbal interactions (planning, interview, staffing, wrap-up) were professional, with well organized presentation of information.

**B Report requires a moderate amount of correction to content, grammar and/or format. Presentation of information is marginal, analyses are limited and/or incomplete. Editing is weak. Verbal interactions (planning, interview, staffing, wrap-up) were less than professional, presentation of information was slightly disorganized and/or unclear.

**C Report requires a significant amount of feedback/correction relative to content, grammar, format, analysis, data, etc. Verbal interaction (planning, interview, staffing, wrap-up) were inappropriate/unprofessional, presentation of information was disorganized and unclear.
Diagnostic Plan
(Format)

CLIENT ____________________________      GRADUATE CLINICIAN __________________________
DATE OF BIRTH ______________________    ASSISTANT __________________________
AGE ____________________
                           Years - Month                             NATURE OF DISORDER _________________
DATE OF EVAL  _______________                 SUPERVISOR _____________________________
                           Name, Degree, CCC-SLP

STATEMENT OF PROBLEM

Follow format outlined in opening paragraph in Diagnostic Report format. Name, age, referred by, nature
of the problem, relevant history information, reason for diagnostic evaluation.

ASSESSMENT PLAN

List and number assessment measures, including the interview, with approximate times for each.
Indicate which clinician is responsible for each procedure. (Total not to exceed 150 minutes). Allow 15
minutes for staffing with supervisor and 15 minutes for wrap-up discussion with client or client’s family.

RATIONALES

Provide rationale for each of the procedures listed above. What information does each procedure provide
and how is it appropriate for the client’s expected level of functioning?

INTERVIEW QUESTIONS

Using the Diagnostic Report History headings, list proposed interview questions. Begin with a general, all
purpose question concerning the reason for the evaluation then organize the interview by history
sections, i.e., Speech, Medical, etc. Be efficient and do not ask questions which will not yield you new
information.

ETHICS ISSUES

Present a discussion of possible ethics issues you might anticipate given the information you have
regarding the client and the purpose of the CSEB assessment.
DIAGNOSTIC PLAN FORMAT

NAME:  First    Last
EXAMINER(S):
AGE:  (Years – Months)
INFORMANT(S):  (Name and relationship)
BIRTH DATE: Month-Day-Year
NATURE OF DISORDER:
DATE OF EXAMINATION:    Mo-Day-Yr
SUPERVISOR:   First   Last,   Degree, CCC-SLP

I.  STATEMENT OF PROBLEM

State the full name of the client, age, date, and place of examination. Include the name of individual or agency making the referral. Note any previous evaluations or relevant medical problems. Provide a statement of the problem in the words of the client or informant and indicate the type of service requested. This section is usually about as long as this paragraph, but not more than twice as long.

II.  PLAN

Insert a numerical list of all activities, tests and procedures to be included in the evaluation, along with the time (in minutes) allocated to each. All evaluations routinely include client or informant interview, hearing screening, oral exam, consulting time, and wrap-up.

<table>
<thead>
<tr>
<th>Event</th>
<th>Time Allocated</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Interview</td>
<td></td>
</tr>
<tr>
<td>2. Hearing Screening</td>
<td>(concurrent with interview)</td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4. Oral Mechanism Exam</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
</tr>
<tr>
<td>6. Consult/Wrap-up</td>
<td></td>
</tr>
</tbody>
</table>

(Max. time 120 min.)

III.  RATIONALE

For each number item above, a rationale must be included. For specific tests include support for your choice, including appropriateness for age, disorder, linguistic and cultural background. Include data about statistical validity and reliability. For required procedures, simply indicate “routine clinic procedure”.

1.  
2.  
3.  
4.  
5.  
6.  
IV. **INTERVIEW QUESTIONS**

Indicate here the areas of information to be covered during the client interview, along with specific questions for the area. We do not expect these questions will be posed in the order they are listed. This is simply a guideline. As the interview progresses, check to see if you are getting all the information that you need.

V. **ETHICS ISSUES**

Indicate possible ethics issues or questions (e.g. appropriate referrals, collaboration with other personnel, intervention practices, prognostic factors, scope of practice, privacy protection, etc.) in regards to this specific case for discussions in planning meeting and/or staffing. As appropriate, the exit interview, letter and/or Dx report will include these issues as they affect case disposition and specific recommendations.
Instructions  Rough draft submitted typed, double or triple spaced; final copy single spaced. Submit with all test protocols used. Submit previous rough drafts with re-writes and final copies, as requested by supervisors as some review electronic versions only.

CALIFORNIA STATE UNIVERSITY, EAST BAY
DEPARTMENT OF COMMUNICATIVE SCIENCES AND DISORDERS
NORMA S. AND RAY R. REES SPEECH, LANGUAGE AND HEARING CLINIC

CONFIDENTIAL

DIAGNOSTIC EVALUATION

NAME  First Last
AGE   (Years/Months)
BIRTHDATE  Month/Day/Year
DATE OF EXAMINATION

EXAMINER(S)
INFORMANT(S)  (Name; relationship to client)
NATURE OF DISORDER
SUPERVISOR  First Last, Degree, CCC-SLP

I. STATEMENT OF PROBLEM

State the full name of client, age, date, and place of examination. Include the name of the individual or agency making referral. Provide a statement of the problem in the words of the client or informant and note the type of service requested.

II. HISTORY  (past tense)

A. Communication
Describe the onset of the problem, relevant prelinguistic behavior and speech development milestones, response to communication (e.g., attention, comprehension, responsiveness), and current communicative behavior (where and with whom client uses communication). Discuss the general course of the problem, including treatment within the family and through other agencies. Describe the client’s awareness of and response to the problem.

B. Physical Development
Discuss any complications or abnormal circumstances surrounding the mother’s pregnancy, the birth and delivery of the child, or the motor development of the client. Report any difficulties in vision or hearing. If no difficulties are reported, state: “Pregnancy, birth, and delivery were reportedly unremarkable. No problems were reported in the areas of physical and/or motor development.”

C. Medical
Describe any major illnesses or injuries reported, as well as any medications which the client uses regularly. If none, state: “Informant denied any significant medical problems.”

D. Family – Social
Discuss the client’s family constellation and the relationships among the family members which appear relevant to the client’s problems. Describe any other speech, language, or hearing problems within the family. Include exposure to languages other than English. Include information concerning the client’s social relationships which may be related to the problem. Describe the child’s general personality or temperament.
E. **School History / Cognitive Development**
Discuss any relevant information relating to client’s academic performance, behavior in the classroom, or special problems noted. For pre-school children, include any relevant information concerning client’s attention span, memory, concept development, etc.

III. **GENERAL IMPRESSIONS / BEHAVIORAL OBSERVATIONS** *(past tense)*
Describe the client’s behavior. This paragraph may include a description of the behavior during an initial observation period with the parent, separation from the parent for testing, behavior during testing (cooperation, attention span, etc.), how child related to the examiner, child’s primary means of communication. This should include speech and non-speech behaviors noted outside of standardized testing. Give your general impressions of the client.

IV. **EVALUATION RESULTS** *(past tense)*
Use a subheading for each area tested. Begin with the primary problem area and list other areas in decreasing order of severity. Group together any areas which are within normal limits in a concluding statement. When reporting results of a formal test, state and underline the full name of the test and compare client’s performance to norms in test manual. Raw scores are not reported. If testing was invalidated, state why, providing a more qualitative description of test performance.

A. **Receptive Language**
(In the event that assessment included a mixed language assessment, combine Sections A & B, into Language.)
Analyze results of testing for all receptive language tests, such as PPVT, etc., (e.g., child demonstrated difficulty following complex and lengthy directions, etc). Report results of informal testing for receptive skills when appropriate. If possible, include a general summary statement concerning child’s level or receptive functioning. If normal, state (e.g., receptive language performance revealed adequate single word and syntactic comprehension).

B. **Expressive Language**
Analyze results of testing for all expressive language tests. Describe language performance in terms of semantics, syntax and pragmatics. Analyze child’s spontaneous language using structured analysis or informal measure An analysis and interpretation of tests may include: description of child’s syntactic and morphological errors, level of complexity of grammatically correct sentences, use of child’s utterances to illustrate errors, child’s response to clinician model, etc. If possible, make a general statement about child’s communicative behavior (e.g. rarely initiated conversation, poor eye contact, behavior, etc.) With a nonverbal child, describe all attempts at communication, (e.g., gestures, facial expressions, laughing, crying, etc.). Describe play behavior. If normal, state (e.g., expressive language performance appeared appropriate).

C. **Articulation / Phonology**
Report results of phonological testing. An analysis and interpretation of tests should include: description of error patterns (with examples), developmental levels, response to stimulation (stimulability), facilitating phonetic contexts, consistency of errors, level of intelligibility. If normal, state (e.g., with regard to phonological skills, John is functioning within normal expectations for a child of his chronological age).
D. Structure and Function of the Oral Mechanism
Describe structure, symmetry, functioning of facial, lip and tongue musculature. Describe structure of hard and soft palate, efficiency of velopharyngeal closure. Describe dental occlusion, appearance of tonsils. Report diadochokinetic rates, and describe motor sequencing and patterning skills. Describe structural deviations, strength, force, range of motion, and consistency where appropriate. If normal state, (e.g., an examination of the oral mechanism revealed adequate physiologic support for speech).

E. Voice
Describe voice quality, pitch, volume and consistency of patterns. Describe the effects of various modifications on these parameters.

F. Hearing Screening
State results of audiometric screening, (e.g., a pure tone, air conduction audiometric screening for the frequencies 500 to 8000 Hz administered at 25 db (ISO) indicated that hearing sensitivity was within normal limits bilaterally). In addition, a tympanometric screening was conducted, with results within normal limits. Discuss ear canal volume and middle mobility, pressure, and reflexes.

F. Fluency
Describe speech behaviors, rate, secondary characteristics.

V. DIAGNOSTIC IMPRESSIONS (present tense)
Reiterate client’s name, age, and state the client’s speech and language diagnosis, including severity. Describe in general (summarize) the reason for evaluation, the significant aspects of the problem(s) identified during the evaluation. Present, in separate paragraphs, each area of significance, in order of severity as it relates to the diagnoses provided. Discuss possible contributing and maintaining factors, e.g., poor oral motor functioning, foreign language influences in the home, low intellectual functioning, etc.

This portion of the report should provide the reader with an overall picture of the client, even if the rest of the report has not been read. In this section the clinician attempts to integrate and synthesize the findings of the evaluation. It is not sufficient to merely restate test scores or re-present information. It is in this section that the clinician’s hypotheses, impressions, and predictions are noted.

VI. RECOMMENDATIONS (present tense)
Based on the results of the evaluation, state whether therapy is recommended and if not, why. If therapy is recommended, discuss frequency and type of therapy (group, individual, intensive), and suggest initial therapy goals. List and discuss other recommendations (e.g., psychological evaluation, family counseling, implementation of a home program). Discuss prognosis in terms of the recommendations made and your knowledge of the client’s behavior, e.g., based on the child’s inconsistent attention during the evaluation, it is expected that progress in therapy will be slow initially. Where relevant, make a statement concerning the client’s or family’s acceptance of the recommendations.

(Your Name: First Last) Graduate Clinician

(Supervisor’s Name: First, Last) Degree, CCC-SLP
**Instructions** Rough draft submitted typed, double or triple spaced; final copy single spaced. Submit with all test protocols used. Submit previous rough drafts with re-writes and final copies, as requested by supervisors as some review electronic versions only.

CALIFORNIA STATE UNIVERSITY, EAST BAY
DEPARTMENT OF COMMUNICATIVE SCIENCES AND DISORDERS
NORMA S. AND RAY R. REES SPEECH, LANGUAGE AND HEARING CLINIC

CONFIDENTIAL

**SPEECH-LANGUAGE RE-EVALUATION**

<table>
<thead>
<tr>
<th>NAME</th>
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<tr>
<td>DATE OF EXAMINATION</td>
<td></td>
<td>SUPERVISOR First Last, Degree, CCC-SLP</td>
</tr>
</tbody>
</table>

**I. PRESENTING PROBLEM**

Include the client’s age, sex, etiology, speech and language problem(s), total number of quarters at CSUEB, dates and overall assessment of response to treatment. Indicate any treatment elsewhere since last seen and the outcome of treatment. State purpose of re-evaluation.

**II. HISTORY**

Include a general statement that history is not inclusive and only covers information since last seen or evaluated at CSUEB. Information gathered from documentation from other facilities, client/caregiver interviewer, including current concerns, etc.

**III. BEHAVIORAL OBSERVATIONS** Same as in the Initial Evaluation report.

**IV. RESULTS** (Same as the Initial Evaluation report.)

**V. DIAGNOSTIC IMPRESSIONS** (Same as Initial Evaluation report if the re-evaluation is comprehensive.)

**VI. RECOMMENDATIONS** (Same as Initial Evaluation report.)

Your Name ____________________________ Supervisor's Name, Degree, CCC-SLP
Student/Graduate Clinician Clinical Supervisor or Appropriate Title
SELECTED GUIDELINE FOR PREPARING DIAGNOSTIC REPORTS AND LETTERS

FORMAT:

1. Only page 1 of letters in on letterhead; subsequent pages on plain bond.

2. Margins of 1 inch at top and bottom of page for reports and letters.

3. Cannot have topic heading, e.g., **RECEPTIVE LANGUAGE**, alone at the bottom of the page without additional text. Adjust your page breaks accordingly.

4. Cannot have signatures alone on page; adjust text if this occurs.

5. Double space between paragraphs.

6. Allow 4 spaces between end of text and signature lines.

PUNCTUATION/STYLE:

1. Refer to adults as Mr., Mrs., or Ms.

2. Do not include months in reporting the age of adults (over 18).

3. Write ages with a dash, not a period, i.e., 3 years, 3 months = 3-3.

4. Quotes must be exactly what the client said. Cannot say: Miss Smith reported that “people do not understand her due to her speech.” This would have to be “people do not understand me due to my speech.”

5. Only use quotes when the statement is important or significant enough to quote. Otherwise, report the client’s information in direct form, e.g., the client said that people do not understand her.

6. Avoid using the client’s name in every sentence. Use pronouns as referents after mentioning the client’s name the first time.

7. The first mention of any test or formal procedure must be written out in full and underlined, e.g., the Peabody Picture Vocabulary Test – Revisited (PPVT-R). Subsequent references may use abbreviations, e.g., PPVT-R.

8. Punctuation goes inside of quotation marks. “She seems to understand everything.” He omitted the final sound in the words “house,” “book,” and “watch.”

9. You must keep your constructions parallel or equivalent. For example, you cannot say: She washes and dries her hands, plays interactive games and will attend kindergarten in the fall.
PUNCTUATION/STYLE:

10. Commas: In a compound sentence, use a comma if there is a separate subject in the second clause. For example:

    She reported that he walked early, but he was late in all other developmental areas.

    vs.

    She reported that he walked early but was late in all other developmental areas.

He is able to dress and undress himself and take care of his toilet needs.

    vs.

He is able to dress and undress himself, and he takes care of his toilet needs.

He initiated conversation and used a variety of sentence types.

    vs.

He initiated conversation, and he was responsive to conversation addressed to him.

11. Semicolons: Connects two closely related sentences. Frequently used with conjoining words such as however, nevertheless, or yet. Semicolon follows the first sentence. The conjoining word follows, set off by a comma, e.g., He was quiet and reserved throughout the testing; however, while walking back to the waiting room, he initiated conversation and used several complex sentences.

12. e.g. and i.e.: Examples are listed using e.g., which means “for example.” You will see many examples of e.g. used throughout this paper. The other form, i.e., means “that is” and is used to clarify or define your meaning, i.e., to specify exactly what you mean. During the next quarter, i.e., fall, we will be introducing a new course.

13. PROOFREAD your work.

PROFESSIONAL:

1. Do not report raw scores. Report percentiles, age equivalents, ranges, etc.
   Example: On the Peabody Picture Vocabulary Test-Revised (PPVT-R), Form L, Nick scored at the 75th percentile.

2. Try to include a brief statement of what a test or subtest assesses, e.g., On the Peabody Picture Vocabulary Test-Revised (PPVT-R), a test of single word receptive vocabulary, Nick scored at the 75th percentile with an age equivalent of 6 years, 6 months. This score falls in the high average range.

3. Do not submit work with missing phonetic symbols.

4. Refer to sample reports and letters for professional style and content.

Instructions: Submit with test protocols of any tests used. Rough draft should be doubled spaced.
PATHOLOGICAL WRITING

Mary Virginia Moore*

Report writing is defective when it is (1) unintelligible, (2) conspicuous, or (3) causes the reader to be confused. Every professional worker in speech pathology and audiology occasionally reads a clinic report that is built on a rickety skeleton, loosely hung with rambling sentences, and embellished with fancy, empty works. Let us be honest! Every professional worker occasionally writes such a report!

The penalties for pathological writing are much the same as those for pathological speech, with one important addition. No written word remains after the oral word is spent. The case for cleanliness, accuracy and brevity in the use of English is seldom greater than in clinical writing. Yet, the professional which gives primacy to oral communication sometimes fails miserably in written communication.

Few guidebooks are more helpful in the diagnosis and correction of defective writing than Strunk and White’s pithy collection of “Thou Shalts” and “Thou Shalt Nots,” The Elements of style (1959). The theme of this small book is a 63-word quotation from the master teacher, William Strunk, Jr., quoted by his master pupil, E.S. White:

Vigorous writing is concise. A sentence should contain no unnecessary words, a paragraph no unnecessary sentences, for the same reason that a drawing should have no unnecessary lines and a machine no unnecessary parts. This requires not that the writer make all his sentences short, or that he avoid all detail and treat his subjects only in outline, but that every word tell.

The authors boldly dictate a series of rules that may serve the hesitant and the timid among us by allowing no leeway for ambivalence. With each rule go “before and after” excerpts of offensive writing and how it may be purged. These examples of unintelligible, conspicuous, or confusing writing might well have been drawn from clinical reports, had Strunk and White been privy to that information.

The Strunk and White dicta may be applied in heavy doses to the ills of report writing. I will discuss the three symptoms of defective writing with Strunk and White prescriptions (underlined), and give illustrations of the before and after treatment.

SYMPTOM: WRITING IS UNINTELLIGIBLE

The first requirement of clinic reporting is that information be accurately transmitted. The goal of “clarity, clarity, clarity” is a moral as well as a literary obligation. (Read The Moral Obligation to be intelligible, Stevens, 1960). To fall short of intelligibility is of grave concern when the welfare of living persons rather than storybook heroes is at stake.

Strunk and White Rule: Use definite, specific, concrete language. Prefer the specific to the general, the definite to the vague, the concrete to the abstract.

* Reproduced with permission from December, 1969, ASHA, Vol. 11, No. 12.
This discipline of this rule forces the clinician to report particulars (right column) instead of generalizations (left column).

The child appeared to be mentally retarded. The child, 10 years, did not match colors, did not hand the examiner three blocks, did not draw a recognizable man.

The mother had little understanding of her child’s problem. The child’s mother said that his stuttering was caused by his missing teeth.

The child’s speech was characterized by numerous articulation defects, especially involving the sibilant sounds. The child made these errors: S/g, sh/s and th/sh.

Strunk and White Rule: **Do not take shortcuts at the cost of clarity.** Avoid the use of initials unless they will be easily and accurately translated by all readers. Even the sophisticated reader appreciates having test names written out in full until he get his bearings.

This assessment included the Western Aphasia Battery-Revised (WAB-R), etc.

**SYMPTOM: WRITING IS CONSPICUOUS**

Unintelligibility may strike the moral blow to good writing, but conspicuousness, like a subclinical infection, saps writing of its vitality. Report writing is conspicuous when a reader pays more attention to how the report is written than to what it says. Conspicuousness must be excised without leaving the report dull and stereotyped.

Strunk and White Rule: **Avoid fancy words.** The line between fancy and the plain, between the atrocious and the felicitous, is sometimes alarmingly fine, Strunk and White warn. It is a question of “ear”. Cultivating ear, as every Van Riper student appreciates, is not quick and is not simple. During the ear-training process, the report writer is wise to deliberately avoid an elaborate word when a simple one will suffice. The clinic report must not become a two-page exhibition of the writer’s professional vocabulary. The speech pathologist or audiologist comes of age when he declares independence from the mimeographed glossary distributed in Speech Pathology 608. He writes best when he uses vocabulary true to his own experience. How does the ear respond to the following:

The patient exhibited apparent partial paralysis of motor units of the superior sinistral fibers of the genioglossus resulting in insufficient lingual approximation of the palato-alveolar region. A condition of insufficient frenulum development was noted, producing not only a sigmaic distortion but also obvious ankyloglossia.

The patient was tongued-tied.
Strunk and White Rule: **Omit needless words. Make every word tell.** Strunk and White give the first five reducing hints: The next should also be added to the clinician’s writing diet.

the question as to whether he is a man who call your attention to the fact His brother, who is a member of the same firm due to the fact that the patient, a forty-eight year old male according to the history given by mother Although it cannot be definitely established, it is quite possible that the patient, in all likelihood is suffering from some degree of aphasia.

Strunk and White Rule: **Express coordinate ideas in similar form.** The content, not the style, should protect the clinic report from monotony.

The patient sat alone at six months. At eight months crawling began. Walking was noted at twelve months.

The patient sat alone at 6 months, crawled at 8 months, and walked at 12 months.

Strunk and White Rule: **Express coordinate ideas in similar form.** “Be professional, serious, sincere in tone” (Johnson, Darley and Spriesterback, 1963). Avoid pet ideas and phrases (Huber, 1961). Cultivate a natural rather than a flippant style of writing. To write as one speaks is as artificial as to speak as one writes. But consider Herger’s powerfully presented philosophy, “Write it the way you would say it” (1967).

Would you believe, Ma and Pa had fuss right in the middle of the interview over when the child began to walk.

The evaluation got off with a bang with the child yelling his head off.

The patient’s parents disagreed on the date of walking.

The patient cried when separated from his mother.
SYMPTOM: THE READER IS CONFUSED

The etiology of a confused reader is probably a confused writer. Two possibilities exist when a report is ambiguous. The writer may have a muddy report because his thinking is muddy. However, the writer may be thinking clearly. Clear thinking (even, “I don’t know”) should not be dissipated by fuzzy writing. The Strunk and White rules do speak to this problem:

Strunk and White Rules: Do not overstate. When you overstate, the reader will be instantly on guard, and everything that had preceded your overstatement, as well as everything that follows it, will be suspect in his mind because he has lost confidence in your judgment or your prose. The inexperienced clinician is vulnerable to this mistake and is poorly equipped to place superlatives into a frame of reference.

There is no tension in the home. The farther reported no tension in the home.

The patient is absolutely brilliant. The patient scored 141 on the Stanford-Binet Intelligence Scale, presented an all-A report card, and was voted “most intelligent” by the high school faculty.

Strunk and White Rule: Avoid the use of qualifiers. Rather, very, little, pretty – these are the leeches that infest the pond of prose, sucking the blood of words. The clinician knows other leeches:

Somewhat, probably, seems to be, appears, quite, sort of.

It may give the clinician courage to omit these if he remembers that the clinic report is not and does not purport to be a divine revelation of wisdom. It is not the “pure” truth. It is the truth according to a particular writer. Certainly it must not be overstated, but neither should it be a timid collection of “maybes”.

The patient was very attentive. The patient was attentive.

She was a pretty good student. She was a good student.

- OR -

She was a mediocre student.

- OR -

She had a grade point average of 1.4.

The mother was somewhat reluctant. The mother was reluctant.

A pretty important rule. An important rule.

Strunk and White Rule: Work from a suitable design. The blue print for a clinic report may be supplied by a more experienced architect, such as Van Riper (1963), Johnson, Spiesterback, and Darley (1963), Huber (1961), or others. Hopefully, it will be adapted for the information that must be transmitted, for the audience who will read the report, and for the peculiarities of the writer. The structure of the report should be flexible, complete and logical. The design must serve the writer – it is the means to an end rather than the end itself.

Planning must be a deliberate prelude to writing. The first principle of composition, therefore, is to foresee or determine the shape of what is to come and pursue that shape …the more clearly he perceives the shape, the better his chances of success.

Strunk and White (1959)
Strunk and White Rule: **Put statements in positive form. Make definite assertions. Avoid tame, colorless, hesitating, noncommittal language.** Consciously or unconsciously, the reader is dissatisfied with being told only what is not; he wishes to told what is. Let’s go over that last sentence again: Tell what is as well as what is not. If the clinician can delineate the threshold between what a patient can and cannot do, and if he can accurately report this threshold to another person, the danger of a confused or confusing report is negligible.

The child did not know his colors. The child did not name the colors of red and blue blocks. He did separate the blocks by color and matched them to other red and blue objects in the room.

The patient did not have good fine motor control for stacking blocks. The patient stacked two blocks. Motor control. He did not stack three blocks.

The patient was uncooperative. The patient did not point to the pictures in the Peabody test. He did point to his nose, mouth and eyes.

Strunk and White Rule: **Do not inject opinion.** The clinician must amend this law: Do not inject opinion unless it is labeled. Opinion is the reason for the existence of a clinic report. It is not the accumulation, but the interpretation of the data that makes the report valuable. The two must be differentiated, however. The reader must know when the reporter is acting as newscaster and when he is a commentator.

John was a late walker. Mrs. Smith said, “John was a late walker.”

- OR -

John was reported to walk at 16 months.

- OR -

Impressions:

John was a late walker.

The umbrella, "Impressions," is useful equipment for the report writer. Statements that are labeled as impressions can be clearly separated from the data itself.

**CONCLUSION**

The plague of unintelligible, conspicuous, and confusing writing is attacked by Strunk and White. The recommendations which are illustrated in this paper are only a few of the suggestions made in *The Elements of Style*. Linguist John Nist, in his chapter “The Future of the English Language,” criticizes the puritanical approach of scholars who, “by duty and by conscience,” proscribe laws of decent English usage. Nist challenges students of language:

… to encourage creative imagination and inventive language rather than merely to discourage lapses in logic and violations of the rules.

… to eradicate both the fear of error and the mania for correctness in speaking and writing English.

… to respect function rather than rule in the study and use of English (1966).

Do Strunk and White offer “prejudiced prescriptions” rather than “positive prescriptions?” Do they denounce, forbid, interdict? Are they whacking us with prohibitions and chaining us with the fear of error? Are their rules picayunish and petty?

I don’t think so. The power for abandoned writing is rooted in the precision for controlled writing. The “mania for correctness” is most often found in the self-consciousness of the unsure. It is from discipline that grows freedom and from rules that discipline grows.
Strunk and White do not guarantee that adherence to a regime of correct usage will produce writing that is distinguished and distinguishing. They seem to agree that “it is easier to say what cannot be done than what is desirable.” (Mukarovsky, 1959). They promise no sugar-coated pill, no wonder drugs. “Writing is, for most, laborious and slow,” they warn. “Writing good standard English is not a cinch, and before you have managed it you will have encountered enough rough country to satisfy even the most adventurous spirit.”

(The author is indebted to her colleagues in the Auburn University Speech and Hearing Clinic for isolating the examples of poor writing from her clinic reports and diligently calling them to her attention.)

REFERENCES


**Technical Writing Style**

Clinical reports are formal documents that must be written in an appropriate technical style (Hegde & Davis. 1992: Kneplar & May. 1989). In many cases, written reports may be the first or the only avenue of contact between a speech-language pathologist and other professionals. Poorly written reports can severely compromise a clinician’s professional credibility. Imagine the reaction of a physician when reading the following section of a speech-language pathologist’s professional report:

Shirley was initially nervous in the therapy room, particularly when her mother, she thought was going to leave her, she cried. Difficult to illicit spontaneous utterances from her, though she was willing to imitate.

For this reason, the ability to communicate effectively in writing is as important as a clinician’s knowledge of communication disorders and their treatment. The guidelines presented below can assist in the development of professional reports that are clear, concise and well-organized.

- Avoid writing clinical reports in a conversational style (e.g., “He just didn’t get the point” versus “He did not appear to understand the task”).
- Use correct spelling, grammar, and punctuation and write in complete sentences.
- Write in the third person (e.g., “Results from the Token Test…” rather than “I administered the Token Test…”).
- Avoid use of contracted verb forms (e.g., isn’t, can’t, I’ve).
- Give the full names of tests when first mentioned before using acronyms and other abbreviations in the remainder of the report.
- Express information in behavioral terms (e.g., “followed two-step commands” versus “is able to follow two-step commands”)
- Present information (particularly case history) in chronological sequence.
- Differentiate clearly between information reported by others versus information obtained directly through clinician observation.
- List all data such as test scores or baseline measures before providing any interpretative statements. This approach facilitates interpretation of a client’s overall profile rather than presenting unrelated descriptions of isolated communication skills.
- Include information about a client’s strengths as well as weaknesses in the body of the report.
- Avoid presenting information in the summary section of any report that was not introduced previously in the body of the report.
- Write reports to communicate with colleagues using professional terminology, but include simple explanations and clear examples to make reports meaningful to family members and other non-professionals.
- Use language that is specific and unambiguous (e.g., ”He demonstrated language skills characteristic of 4-year-old children” versus “He demonstrated poor language skills”).
- Avoid exaggeration and overstatement (e.g., “completely uncooperative,” absolutely intelligible,” “never produces /s/,” “extremely motivated”).

Pann Backer & Middleton (2001)

VI. INTERNSHIP INFORMATION
Clinical Internship Requirements – SPPA 6066

The purpose of SPPA 6066 is to provide field placements for our graduate students in supervised and approved clinical settings, such as public schools, hospitals, and community clinics. To be successful, positive, working relationships between our program and the intern sites are important. Open lines of communication are encouraged. The expectations and responsibilities of the onsite supervisors, university supervisors and students are stated below to clarify and insure successful participation of all parties in SPPA 6066. In addition, the Clinic Director maintains close communication with speech pathologists in the community, who have previously supervised or might supervise in the future.

I. COURSE REQUIREMENTS
   A. Interns
      1. Eligibility
         a. Intern must be a second year graduate student.
         b. Intern must have successfully completed pertinent course work indicated on the Internship Preference Form.
         c. Intern must have completed at least 90 in-residence hours of clinical practicum at the graduate level, including SPPA 6057.
      2. Submission of a completed Intern Preference Form signed by an academic advisor.
      3. Units to be completed: 6 (30 contact hours = 1 unit), unless other arrangements made.
      4. Minimum hours required for 6 units of internship, unless other arrangements made:
         a. Typically, for a 6 unit internship; 210 onsite hours to be broken down as follows:
            (1) 150 contact hours (including approximately 30+ assessment hours) to meet current ASHA standards. Students keep track of ASHA contact hours, weekly on the Intern Clock Hour Form.
            (2) Remaining 60 hours spent in counseling, conferences, staffings, observation, written documentation task, etc. While ASHA does not recognize consultation hours (time spent NOT in the presence of client/patient and/or a family member), the CA Teachers Commission does allow a maximum of 25 total ours in the graduate program. The Record of Internship Hours has a separate column for you to include all such consultative hours, up to a maximum of 25 across both internships. This column has two sections: those with client/patient or family present in first mini column—accepted by both ASHA and CTC, vs. all others (staffings, rounds, consultations with other professionals, staff in absence of client/patient & family member), which are only acceptable for CTC.
         b. Recommended arrangement of hours:
            (1) At least 15-20 hours weekly, but medical setting typically want a full time commitment.
            (2) 1/2 day, 5 days per week or 3 days per week for 12-13 weeks. Schedule to be arranged between site supervisor and student intern.

Much will depend on the background, interests and general competence of the intern. The on-site supervisor will have to make decisions (with intern’s input) as to how early in the internship direct patient contact will begin and how soon after the cases will be assigned. The intern should gradually assume the caseload and is expected to eventually work independently with the onsite supervisor’s entire caseload.
This goal will be achieved through systematic transfer of responsibilities of case management to the intern. A suggested schedule is as follows:

- 2-3 weeks observation and directed participation;
- 6 weeks gradual assignment of cases and directed participation;
- 3-4 weeks management of full caseload.

5. Interns should be aware of and subscribe to the Code of Ethics established by the American Speech-Language Hearing Association. They must understand their role as learners and comply with the professional directives of the supervisor. They must consult the supervisor before making client or program related decisions.

B. Onsite Supervisors
   1. Eligibility
      a. School Speech-Language Pathologists: C.C.C., Credential (CRS or CH) and at least three years post Masters experience and one year in current placement.
      b. Clinic Speech-Language Pathologist: C.C.C., CA SLP License and at least three years full time post Masters experience and one year at the internship facility.

   2. Onsite supervisors are expected to be competent clinicians who provide “best practices in their current settings. They serve as role models for the interns in their first clinical situation in the community. They introduce the intern to the complexities of the internship site. They should understand that the intern is a learner and should be able to evaluate the intern’s work objectively. They should discuss their evaluations with the intern in a supportive and direct manner appropriate to the needs of the individual intern.

   3. The Clinic Director verifies current ASHA Certification by requiring that the onsite supervisor signs a statement verifying their current status on the Internship Information and Agreement form completed at the beginning of each internship. The Clinic Director keeps a log of ASHA and CA SLP license numbers on a quarter by quarter basis.

II. FACILITY REQUIREMENTS
   To be specified in contract negotiated with the internship facility.

III. INTERN PREPARATION RESPONSIBILITES

   A. Pre-therapy:
      1. Complete the facility’s recommended reading list.
      2. Read records of assigned cases.
      3. Review the facility’s diagnostic and therapeutic materials.
      4. Review the facility’s procedures for case management and written documentation.

   B. Therapy:
      1. Submit treatment plans to the onsite supervisor as directed by the supervisor.
      2. Complete chart notes for cases, as required.
      3. Prepare pertinent letters and other communications regarding the cases, as appropriate.
      4. Prepare case summaries at the conclusion of the internship.
IV. RESPONSIBILITIES OF ONSITE SUPERVISORS

A. Clinic Director sends intern placement letter(s) to each site supervisor, which includes a copy of the Clinical Internship Requirement, Current ASHA Clinical Practicum Standards, Record of Internship Hours and Clinical Internship Evaluation form.

B. Complete the Clinical Internship Evaluation form once at mid-term and again at the end of the internship, based on-going observation of the intern during diagnostic and therapeutic sessions. The intern’s performance will be graded according to the following criteria:
   - A = Clear & convincing evidence, can work independently
   - B = Clear evidence, needs only general supervision
   - C = Partial evidence, requires specific direction and demonstration
   - D = Minimal or no evidence of specified skill/ineffective.

C. Provide the intern with consistent, frequent written and verbal feedback regarding clinical skills, written work, interpersonal communication, time management, etc., beginning with the first week of the internship.

V. RESPONSIBILITIES OF CSUEB SUPERVISOR

A. Participate in one or two phone visits, to take place approximately midway and possibly near the conclusion of the internship. Each of these phone conferences will include the onsite supervisor and the intern. During the conferences, the onsite supervisor will review the completed CSUEB evaluation form with the intern and the CSUEB supervisor. In the event that the intern’s skills are marginal, the CSUEB supervisor will immediately conference with the onsite supervisor and intern to develop an action plan. (Please refer to How Grades Relate to Satisfactory Progress Toward Graduate Degree Completion policy statement.)

B. The CSUEB supervisor will discuss grades earned by the intern, and in consultation with the onsite supervisor, assign a final grade upon complete of the internship.

C. Serve as a liaison between the university and the intern site. The CSUEB supervisor should possess the insight necessary to facilitate a positive working relationship between the onsite supervisor and the site’s administrative personnel, the intern and the university personnel. The Clinic Director will also serve as a liaison professional as needed by the intern, site supervisor or assigned CSUEB supervisor.
Internship Procedures

Preliminary Arrangements

1. See advisor at least six months prior to the start of the planned internship quarter. Complete the internship preference form with your advisor four months prior to the start of the planned internship. In addition, you may consult with the Clinic Director regarding interests and possible placements.

2. Return the intern preference form, signed by your advisor, to the Clinic Director who will initiate arrangements for the internship. You will be kept informed of progress in arranging the internship.

3. A meeting of all prospective interns is held quarterly, to assist students in preparing for internships. The meeting will discuss your responsibilities and other necessary information and paperwork/documentation required for and related to the internship.

Once Internship Arrangements are Final

1. Interns are responsible for contacting onsite supervisor to arrange schedule, including start date and making sure that they have fulfilled requirements of assigned internship site (e.g., TB clearance, Live Scan, etc.)

2. As soon as the internship begins, interns are responsible for the following, which is detailed in an Interns Memo sent out via email at the beginning of the quarter from the Clinic Director.
   a. Completing the Internship Information and Agreement in duplicate and returning one copy to the CSUEB supervisor by the end of the second week of the internship.
   b. Maintaining accurate records of clinical hours obtained. A Record of Supervised Clock Hour – Internship form is provided by the clinic; it is a BLUE form.

Following the Internship

1. When the internship is completed, interns are responsible for completing evaluations of their internship experience and internship supervisor.
CALIFORNIA STATE UNIVERSITY, EAST BAY
DEPARTMENT OF COMMUNICATIVE SCIENCES AND DISORDERS
STUDENT PREFERENCE FORM FOR INTERNSHIP

Instructions: To be completed by student with their advisor approval at least 4 months prior to first internship. Forward completed form to Clinic Director Note that internship placements, especially adult placements, are not guaranteed for the quarter preferred due to limited availability.

NAME: ____________________________________ Net ID: ___________________________ □ CCI admit □ CCII admit

DATE: __________________________ Email address: ___________________________________________________

1. Are there specific populations within your internships that you are of special interest to you? Please realize that your internship in a school setting requires a minimum of 100 contact hours and is required for the CA Rehabilitation Credential-Speech, Language and Hearing Specialist.

2. List your preferences and prioritize choices within each of your two internship placements. Please note that summer placements are typically limited to non-school settings, with the exception of a few exclusively special needs programs or year round schools. The latest you can begin a regular school placement in the spring is March 1st, because schools typically conclude in the first or second week of June.)

Internship #1 - Type: _________________________ Internship #2 - Type: __________________________

Quarter: ______________________  Quarter: _______________________

1st preference: _____________________________ 1st preference: _______________________________

2nd preference: _____________________________ 2nd preference: _______________________________

3rd preference: ______________________________ 3rd preference: ______________________________

3. Are there any special factors that should be considered in arranging your internship, e.g., out of S.F. Bay area placement, distance restrictions, transportation, need for clock hours in a specific disorder area, etc.? Please be advised that an internship outside the Bay Area requires a lengthy procedure to secure a contract with CSUEB.

4. Anticipated date/quarter of comprehensive examination ____________________________.

Minimum Requirements for Clinical Internship - Lack of completion may cancel your internship placement.

1. The following requirements must be completed prior to starting an Internship:
Write in the following below; C=complete, IP=in progress, TBC=to be completed

School Internship – SPPA 6066 - 6 units  –Pediatric Population (Required for CA Clinical Rehab Services Credential)

a. _____All B.S. Requirements b. _____SPPA 4863 – Artic. and Phonological Disorders c. _____SPPA 6000 – Research Methods
   _____SPPA 6064 – Fluency Disorders d. _____SPPA 6064 – Fluency Disorders
   _____Certificate of Clearance e. _____SPPA 6064 – Fluency Disorders
   _____Basic Skills Requirement (CBEST)
   _____Negative TB test

Hospital Internship – SPPA 6066- 6 units – Adult Population

a. _____All B.S. Requirements b. _____SPPA 4863 – Artic. and Phonological Disorders c. _____SPPA 6000 – Research Methods
   _____SPPA 4864 – Neurocognitive Disorders d. _____SPPA 6020 – Vocal Pathology and Rehab.
   _____SPPA 4866 – Neurocognitive Disorders e. _____SPPA 6020 – Vocal Pathology and Rehab.
   _____SPPA 6064 – Fluency Disorders f. _____SPPA 6050 – Neurogenic Motor Speech Disorders
   _____SPPA 6220 – Dysphagia

2. Comments: Be sure to apply for graduation two quarters before your final quarter!

Academic Advisor: _____________________________________________________________

(Signature) (Date)

☐ by checking this box, I also approve enrollment in more than 17 units for either quarter of internship if the student is planning to enroll in a maximum of four courses including internship.

May enroll concurrently with approval of advisor.

8/2015
# Internship Information Form

Please complete and submit copy to CSUEB supervisor & one to your site supervisor! *  
* In the event you have two site supervisors, submit one for each.

<table>
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<tr>
<th>Intern:</th>
<th>Net ID#:</th>
<th>Quarter/Year:</th>
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<tbody>
<tr>
<td>Intern's Phone No.:</td>
<td>CSUEB University Supervisor:</td>
<td></td>
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<tr>
<td>On-Site Supervisor:</td>
<td>Email:</td>
<td></td>
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<tr>
<td>Name of Site &amp; Address:</td>
<td></td>
<td></td>
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<tr>
<td>Phone No:</td>
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<tr>
<td>Possible Mid-Term Phone Conference Dates:</td>
<td>(Date/time of conference TBD after communication with CSUEB Supervisor in a timely manner as detailed in Intern Memo)</td>
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<tr>
<td>Planned Internship Start Date:</td>
<td>Planned Internship End Date:</td>
<td>Planned Hours per Week:</td>
</tr>
<tr>
<td>Internship Weekly Schedule:</td>
<td>(Day(s) &amp; Time on site. Ex: Monday and Wednesday 9:00-2:30, Tuesday and Thursday 10:30-4:00)</td>
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</table>

This internship will result in at least 210 hours on-site and 150 hours of direct clockhour contact. The intern is responsible for keeping track of clockhours on a daily basis and then submitting these weekly for site supervisor confirmation. The intern is expected to abide by the schedule set up in this agreement and any changes require prior approval by the site supervisor. (The intern may not be excused to take off time to study for comprehensive exams. Furthermore, the intern agrees to review her/his specific clockhour needs (within audiology minor as well DX) with site supervisor within the first two weeks of the internship. Evaluation and grades will be discussed at the required mid-term phone conference. A final phone conference is at the discretion of the site and CSUEB supervisors. The site supervisor and intern should contact the CSUEB supervisor at any time to discuss any concerns/problems in regards to expectations, commitment, professionalism, etc.

- □ By checking the box and with my signature below, I, as the site supervisor, am verifying that my ASHA certification associated with the account # provided above is current.
- □ By checking the box and with my signature below, I, as the site supervisor, am verifying that I will respect student confidentiality as outlined by the ASHA Board of Ethics and CSUEB FERPA

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<thead>
<tr>
<th>Signature: Site Supervisor</th>
<th>Date</th>
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<tr>
<td>Supervisor ASHA Acct. #</td>
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<td>Supervisor CA SLP License #</td>
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<th>Signature: Intern</th>
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<tr>
<th>Signature: CSUEB Supervisor</th>
<th>Date</th>
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CC: Intern  
Site Supervisor  
CSUEB University Supervisor
CSUEB DEPARTMENT OF COMMUNICATIVE SCIENCES AND DISORDERS — CLINICAL INTERNSHIP EVALUATION

Intern: ____________________________________  Supervisor: ________________________________  Site: _________________________________________  Quarter: __________________

Client Types:  Adult □  Pediatric □  Disorder Types:  Language □  Speech □  Voice □  Fluency □  Dysphagia □  Aural Rehab □  (Check all that apply)

Grading Key:  
10-12  Clear & convincing evidence (can work independently)  
7-9  Clear evidence (needs only general direction)  
4-6  Partial evidence (needs specific direction & demonstration)  
1-3  Little or Minimal-no evidence of specified skill (unsatisfactory performance)

Profile of Clinical Skills  

For Mid Quarter, indicate grade using “X”  
For Final, indicate grade using “O”  

I. Diagnosis in Therapy Setting
   A. Familiarity with, and choice of, appropriate diagnostic tools ensuring use of least biased testing techniques
   B. Demonstrates effective use of translators/interpreters for assessment of English Language Learners (ELLs) when appropriate
   C. Administers and scores according to established procedures
   D. Observes and identifies relevant behaviors
   E. Interprets, analyzes and communicates diagnostic information accurately
   F. Establishes appropriate short and long term objectives
   G. Collects and uses baseline data as appropriate

II. Development & Preparation for Therapy
   A. Applies theory and research knowledge in treatment
   B. Demonstrates creative selection/preparation of treatment techniques and materials, and, if applicable, ensuring appropriate accommodations and modifications to support client access to academic curriculum.
   C. Plans and organizes lessons to meet individual & group goals

III. Therapy Implementation
   A. Uses materials and/or equipment proficiently
   B. Provides clear, concise instruction in a manner appropriate to the age, attention and functional level of the client/patient
   C. Uses appropriate cues and task modifications, as needed to maintain attention while eliciting/facilitating therapy objectives
   D. Demonstrates appropriate reinforcement/behavior mgt.
   E. Responds to/modifies treatment based on changes in client/patient performance
   F. Uses time in therapy session effectively to maximize learning

IV. Written Documentation
   A. Includes information that is relevant, accurate and appropriate
   B. Writes in a style that is clear, well-balanced and complete

V. Interpersonal Skills
   A. Sensitivity and responsiveness to the emotional as well as the behavioral needs of clients/patients
   B. Appropriate interaction w/ family members/other professionals

VI. Personal & Professional Qualities
   A. Professionalism: Oral communication model, dependability, appearance, level of involvement, seeks help when needed
   B. Manages time, documentation & caseload demands w/flexibility
   C. Responds to supervisor’s suggestions appropriately
   D. Takes initiative and works in a self-directed manner
   E. Trains family/support staff to enhance therapy, as appropriate, and, if applicable, plans, implements, and evaluates transitional life experiences for clients and families.

Mid-Quarter Profile Points _______   Grade _____  

Final Grade Profile Points _______   Grade _____  

Sum of points ÷ total number of items scored = Profile Points  
.7 breaks to next highest letter grade; Ex: 9.7 = A-

Profile of Clinical Skills:  

A+  A  A-  B+  B  B-  C+  C  C-  D+  D  D-  NA  
12  11  10  9  8  7  6  5  4  3  2  1  0  
Clear & Convincing  Clear  Partial  Little/Minimal

87
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<th>Mid-Quarter</th>
<th>Final</th>
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<td><strong>Strengths</strong></td>
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<td><strong>Challenges</strong></td>
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<td><strong>Areas of Most Improvement</strong></td>
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Mid-Quarter: ____________________________  Mid-Quarter: ____________________________  Mid-Quarter: ____________________________  
(Intern Signature/Date)  (Site Supervisor Signature/Date)  (CSUEB Supervisor Signature/Date)

End of Quarter: ____________________________  End of Quarter: ____________________________  End of Quarter: ____________________________  
(Intern Signature/Date)  (Site Supervisor Signature/Date)  (CSUEB Supervisor Signature/Date)
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<td>Observation</td>
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<td>Preschool</td>
<td>Week 8</td>
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**By signature below, I confirm having completed live observation of a minimum of 50% of each diagnostic evaluation and 25% of treatment sessions for each case, and my supervision is commensurate with the clinical knowledge and skills of each student.**

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<thead>
<tr>
<th>LANG HRS</th>
<th>SPEECH HOURS</th>
<th>DYSPHAGIA HOURS</th>
<th>AUDIO HRS</th>
<th>CONSULTATION-COLLABORATION</th>
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**Dates by Week**

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**Preschool**

**School**

**Adult**

**Observation**

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**TOTAL**
VII. POLICY STATEMENTS
Department of Communicative Sciences and Disorders  
CSU East Bay, Hayward, CA

ESSENTIAL FUNCTIONS

In order to acquire the knowledge and skills requisite to the practice of speech-language pathology including the ability to function in a broad variety of clinical situations and to render a wide spectrum of client care, students enrolled in the CSD Program at CSUEB must demonstrate skills and attributes in five areas: Academic Performance, Written Language, Oral Communication, Hearing, and Interpersonal Management & Professional Skills as described below. If proficiency is not demonstrated in any area noted, a follow-up plan of action will be implemented with input from the Graduate Coordinator, student, advisor and Clinic Director) before a student is cleared to enter Clinical Practicum.

1. Academic Performance:
   a. All students must achieve a grade of at least a “B” in both Clinical Methods (SPPA 4852/6052) and in Diagnosis of Speech Language Disorders (SPPA 4854/6854) in order to enter and/or continue in Clinical Practicum in Speech Pathology and Audiology (SPPA 4856/6056).
   b. All students must maintain at least a 3.5 GPA in the major (speech-language pathology coursework) and have two faculty members’ recommendations to enter Clinical Practicum.

2. Written Language:
   a. During the first two quarters of enrollment, all students will complete a written assignment which will serve as an initial assessment of their writing proficiency.
   b. Prior to enrollment in Clinical Practicum, all students will complete a second writing sample.
   c. Students who do not pass the writing assessment will meet with their advisor to design a plan of action to remediate their writing deficiencies.
   d. When Plan of Action is successfully completed and approved by advisor, students may schedule a writing re-screening with their advisor. Students’ writing samples will be evaluated by at least two CSD faculty/staff members.
   e. Students who pass the re-screening will be cleared to enter Clinical Practicum. Clearance must occur by the fifth week of the quarter preceding entrance into the first Clinical Practicum.
   f. Students who do not pass the writing re-screening will not be allowed to enter Clinical Practicum. Students will meet with their advisor to discuss options.
3. Oral Communication:

All students will participate in an oral communication screening sometime during their first two quarters of enrollment in the CSD Program by graduate student clinicians under the supervision of an ASHA certified professional who will confirm oral communication proficiency. Initial “passing” of CSD Screening is based on a brief one time meeting and does not necessarily assure readiness for clinic if during the course of other interactions with faculty and staff, concerns arise which indicate a failure to demonstrate Essential Functions, including Interpersonal Management and Professional Skills, which may be identified as pragmatics in the CSD Screening Process.

In accordance with ASHA policy, to demonstrate oral English proficiency, the student should be easily understood by familiar and unfamiliar listeners. The student’s articulation, phonology, grammar and syntax abilities must be sufficient to enable them to provide reasonably accurate models in spoken English for their clients/patients.

a. Students who do not pass the oral screening will meet with the advisor and/or Clinic Director to design a Plan of Action to address possible concerns. Possible actions might include one or more of the following: re-screen, full assessment with recommendations (e.g., home program, therapy and/or re-check.)

b. When Plan of Action is successfully completed, students will be re-screened by advisor and/or Clinic Director. Students who pass the re-screening will be cleared to enter Clinical Practicum. Clearance must occur by the eighth week of the quarter preceding entrance into the first Clinical Practicum.

c. Students who do not pass the re-screening will not be allowed to enter Clinical Practicum. Students will meet with their advisor to discuss options.

4. Hearing:

All students will participate in an audiometric screening during their first quarter of enrollment in the CSD Program by graduate student clinicians under the supervision of an ASHA certified professional who will confirm hearing proficiency.

5. Interpersonal Management & Professional Skills:

All students must be recommended for clinic by two CSD faculty members, where in students’ interpersonal management and professional skills, (e.g., effective relationships, respect, reasoning, ethics, compassion, maturity, integrity and social interaction) have been evaluated.

6. Appeals:

Students who are denied entrance into Clinical Practicum may formally appeal the decision by requesting a meeting with the CSD Department Chair and Clinic Director for a review.
Policy Statement

Criminal Background Check

Per the University President’s Executive Directive #11-09, student, volunteer or employee activity in the campus’ Norma S. and Ray R. Rees Speech, Language and Hearing Clinic and the Department of Communicative Sciences and Disorders is contingent upon a satisfactory criminal records check.

Should a student not clear the criminal records check, the details of the criminal records are communicated to the VP of Human Resources. The VP of Human Resources will either disqualify the student from work, volunteer, or practicum participation, or contact the Department Chair and/or the college MPP to determine if the nature of the conviction(s) will allow the student to participate.

Because clinical practicum is a requirement for the graduate program, if a graduate student is excluded from practicum participation, the student must be academically declassified from the program. If an undergraduate student is excluded from practicum participation and the course is required for the awarding of the degree, the student must enroll in a substitution course.

Offsite and internship placements may require their own criminal background check process. Thus, satisfactory clearance of the CSUEB background check does not guarantee that the student will pass subsequent checks required by outside entities. In addition, if a student fails to clear any background check required for offsite placements, the program is not obligated to find additional placements to meet the requirements of the M.S. degree.
DEPARTMENT POLICY ON STUDENT LITERACY

The intention of the following policy is to encourage student to establish a level of competency in communication to meet academic and professional requirements.

There is a direct relationship between communication skills and critical thinking. Scientific achievements are meaningless unless they can be articulated succinctly and unambiguously to others. Written reports and oral presentations must clearly and precisely communicate observations and criteria for professional advancement. In addition, literacy is an attribute of a well educated person. Skillful communication can also provide considerable personal satisfaction.

All faculty will expect student to prepare all written work in the department at a university level. This includes consideration of spelling, punctuation, grammar, sentence and paragraph construction, organization, conciseness, clarity and neatness. This expectation applies to exams, term papers, reports, bibliographies, etc. Grading of all work will include evaluation of the above (literacy criteria).

Resources:


Client files require confidential treatment. It is the department’s policy that all active client files should only be accessed by the clinician(s) currently working with the clients. The files must remain in the clinic at all times and either be in use by the clinician or clinical supervisor, or filed at the reception desk. Client files may not be used as teaching tools or direct sources for writing reports, planning treatment goals or designing therapy tasks. If appropriate, your supervisor may provide anonymous or archival client data to assist you in these areas.

Under FERPA guidelines, student academic records also require confidential treatment. The department maintains a type of academic record file defined as “academic progress”. These files must remain in the department student file cabinet at all times. File access is available under the following guidelines:

1) Files are allowed to be checked out and back in by faculty or designated staff at any time.
2) Files are to be checked out by faculty or staff prior to student meetings that require the file to be present.
3) Students can check out their file ONLY to bring to meetings with faculty or staff IMMEDIATELY prior to the meeting. The file should be left with the faculty or staff member for later return.
4) Student requests for copies of file documents are to be directed to the Department ASC, who will provide copies of appropriate documents.
5) Students may review their academic progress file by making a request to review their records in writing to the Department ASC. The ASC will contact the student to make an appointment for the student to review their records in a secure location.

More information is at: http://www20.csueastbay.edu/students/student-services/student-records/ferpa-privacy-policy.html

Both client and student files must stay within the department and/or clinic and are not allowed to leave the campus. Clinician work folders are also to remain in the clinic at all times.

Clinician-supervisor conferences will not be audio taped unless it is a specific and necessary accommodation approved by SDRC. Such meetings are confidential to protect client and student confidentiality. Clinicians are welcome to take notes and to have access to the written evaluations placed in their department files.
APPEARANCE AND IDENTIFICATION BADGE

PURPOSE: To establish an appearance and dress policy that promotes a positive image and professional work environment in addition to identifying student clinicians for the clinic community.

POLICY: Student clinicians are expected to maintain a high standard of dress and appearance and are required to wear department-issued identification badges while in clinic. Student clinicians will appear and dress in a professional manner in keeping with the functions and responsibilities of their positions.

The following department policy provisions, which should be used by supervisors deciding department-specific appearance and dress standards, have been adopted for all student clinicians.

1. Student clinician clothing and footwear should be clean, neat appearing, and in good repair.
2. Dress and appearance should be in a manner that conveys professionalism.
3. Dress and/or appearance should not impede the student clinician’s ability to perform his/her duty.
4. Dress and/or appearance should not be revealing or provocative.

Extreme and/or casual fashions (e.g. shorts, sweats, jeans, etc.), tight and revealing clothing (that show midriffs, navel, undergarments, etc.) is unacceptable. Footwear should be appropriate and safe for the clinic environment.

Identification Badge

Student clinicians are required to wear their department-issued identification badge while in the clinic. The badge serves as a valuable means of identification for employees, client visitors, and volunteers.

Compliance

Supervisors and Administration will be responsible for ensuring policy compliance. Student clinicians who are inappropriately groomed and dressed may be sent home or directed to wear a lab coat. Student clinicians with repeat violations will be subject to disciplinary action.
1. Exercise professional judgment in the use of make-up.

2. Hair should be neat and kept away from face and front of body to avoid contact with clients. A minimum of ornamentation is permitted.

3. Jewelry should be kept to a minimum. Ornamental body piercing other than ear must not be apparent to clients. Two small earrings per ear are permitted if professional in appearance. One small, inconspicuous stud worn in the nose is acceptable. Nose rings/hoops and visible ornamental body piercing of the eyebrows, lips, tongue, cheek, etc. are not acceptable.

4. Dept.-issued ID badges must be worn at all times while providing therapy.

5. Fingernails must be neat and clean and of reasonable length, ½ inch over fingertip. Colored polish is acceptable in pinks and reds.
During the 2004-2005 academic year the Communicative Sciences and Disorders Department modified an existing policy which stated that students must have passed a CPR course and have documentation showing this skill in the department. The modification related to the specifics of the course content. Effective January 2004, ALL students expecting to take a practicum course must complete an Adult & Child CPR course.

This must be completed prior to enrollment in clinic (4856, 6056, 6156).

When you have completed the CPR Training, please submit a copy of your certificate card to the Clinic Director.
Department of Communicative Sciences and Disorders  
Norma S. and Ray R. Rees Speech, Language, Hearing Clinic  
California State University East Bay  

Policy Statement  

HOW GRADES RELATE TO SATISFACTORY PROGRESS TOWARD GRADUATE DEGREE COMPLETION  

I. Grades: Required Academic Course Work in the Major  

A  
Good work: recommended for continuation in the program  

B  
Adequate for continuation in the program  

B-  
Weak academic work: recommended for continuation but student must strengthen work  

C, D or F  
Not acceptable toward completion of the degree. The student is on area probation and depending on other grades may be on University wide probation or disqualified. If not disqualified, the coursework in question should be repeated or a substitute course work may be chosen by the graduate advisor.  

CR / NC  
No provision currently exists on the CSUH campus to take graduate level courses on a CR/NC basis. Graduate students taking SPPA level courses may under current University regulations take these courses on a CR/NC basis; however, courses taken CR/NC may not be used toward the graduate degree. In addition the SPPA faculty does not encourage M.S. students to take any SPPA undergraduate courses on a CR/NC basis.  

II. Grades: Clinical Practicum  

Clinical practicum is a progressive activity. It is expected that a student will continue to develop new insights and skills. Therefore, the repetition of the same quality work in subsequent quarters will not insure the same grade. In accordance with ASHA standards growth is essential.  

It is typical for a graduate student to be assigned clients who belong to different disorder types or age groups. The student is graded separately for each client. The grade assigned for one unit of credit reflects a summation of the grades received for each client. However, a ‘C’, ‘D’, or ‘F’ grade is not considered satisfactory and a B- grade is marginal. Therefore, a ‘B-’ or poorer for any client will yield a ‘B-’ or poorer grade for the one unit course. For example: The following grade summation for two clients would be typical:  

A/A  

A/B  
Average of two grades  

B/B  

NOTE: B-/Any grade = B-  
C/ Any grade = C  

An A+, A, or A- grade in Clinical Practicum denotes excellent work. Clear & convincing evidence that clinician can work independently and the student is being recommended for continuation in the graduate program.  

B+, or B grade in Clinical Practicum is adequate for continuation in the program. Clear evidence that clinician needs only general direction.
B- grade is warning that Clinical Practicum work is weak and must improve. Repetition of the same quality work in a subsequent quarter will yield a ‘C’ or poorer grade. It should also be noted that a graduate student receiving less than a B- grade in Clinical Practicum will not be credited those contact hours and the Clinic Director will put into place an Action Plan for the subsequent quarter. However, it should be noted that if the at risk clinician’s cumulative or quarterly GPA for courses applied toward the major fall below 3.0, he/she will NOT qualify for clinic, until his/her GPA rises to a 3.0 again. Historically, at students on academic probation and identified as at risk clinicians do not succeed in completing the M.S. in SPPA.

C+, C or C- grade is not acceptable; the quarter’s work must be redone, and the student is on probation as an “at risk” clinician. A second ‘B-’ or lower in Clinical Practicum will cause the student to be dismissed from the program. Partial evidence of necessary skills and requires specific direction/demonstration.

D or F grade is unacceptable and the student is disqualified from the program. Little or Minimal evidence of specified skill/ineffective.

III. Actions: By Advisor/Clinical Director

At the end of each quarter the supervising staff will meet and discuss the progress of all graduate students. Any student achieving a B- or lower will have an Action Plan designed by the Clinic Director, for the subsequent practicum. (Please note that given the expectation of progression in clinical competencies, the probationary clinician will qualify for only one quarter of therapy on an Action Plan. If at all possible the “probationary clinician” will be supervised by a permanent department member.

1. All students who receive a ‘B-’ grade in clinical practicum will be sent a letter stating:

   “Your work in Clinical Practicum during the _______ quarter was adequate but needs improvement if you are to continue. Please check with your graduate advisor if you have any questions regarding your program of study.”

2. All students who receive a ‘C’ grade in Clinical Practicum will receive the following letter stating:

   “Your work in Clinical Practicum during the _______ quarter was not adequate. A ‘C’ grade does not count toward your degree and constitutes a warning to you that your clinical work must improve. A second ‘B-’ or lower grade in clinic will be cause for your disqualification for the M.S. program in SPPA.”

3. All students who receive a ‘D’ or ‘F’ grade or a second ‘B-‘ grade will receive a letter stating:

   “Your work in Clinical Practicum during the _______ quarter has been unsatisfactory for continuation in the program. This letter is to advise you that you will not be allowed to enroll for further clinical work. Please meet with your advisor so that all your records may be reviewed.”
We would like to share with you some of our thoughts regarding the clinical training process:

First and foremost is the issue of grading in the clinic. We seem to have reached a point in our program where students consider a “B” or “B+” an unacceptable grade. We hear that students have “worked hard”, “spent hours”, and “improved tremendously” and put forth “lots of effort”. However, we must emphasize that grading in clinic is not and CANNOT be based on either effort or good intentions. This is a professional preparation program! We are preparing individuals to work in and represent our profession. Grading is based on “ability to manage a client’s program effectively and independently”. No one expects a student clinician to be able to do that at the onset. Clinic is an enormous learning experience with a given client(s) and/or disorder. We want to reaffirm that a grade of ‘B’ in clinic indicates just what ‘B’ means in other grading schema – good work, but not excellent, and not yet independently able to manage a case effectively. A ‘B+', on the other hand, suggests successful management with general direction and guidance needed, with demonstration of emerging independence. Likewise, a ‘B-' indicates inability to manage a case successfully, (e.g. difficulty exhibited in, preparation, implementation and/or interpretation of therapy and/or progress, specific direction or frequent modeling/demonstration is required, timeline for professional paperwork is not met and/or content is inappropriate. A ‘B-' grade is treated differently as detailed in the previous policy statement— How Grades Relate to Satisfactory Progress Toward Graduate Degree Completion. As clinical supervisors, we must uphold high standards and adhere to the descriptions for grading criteria noted at the top of the clinical profile (i.e., Intermediate skills = B = only general direction is required).

A second issue concerns what supervisors expect from student clinicians, and what the primary concerns are. The consensus is that supervisors look for and expect initiative, effort, and responsibility in students. That is, the student is expected to be responsible for her or his own learning. This is not to say that students cannot and should not ask questions, on the contrary, good thoughtful questions are desired and promoted, as are focused requests for assistance. However, supervisors react poorly to a student who has not shown initiative or effort, and who says, “I don’t know what to do” or “Tell me what to do.” It is the supervisor’s assumption that a certain amount of coursework has been completed, that textbooks and notes are available, and that the student knows how to research the disorders she or he is assigned to work with. We, as supervisors, are responsible for guiding our students. We need to assist them or provide them with direction in locating appropriate resources or generating more appropriate or creative therapy implementation activities.

The issues of effort and initiative also are raised when we think about student response to supervisory input. If a problem is identified and strategies defined for changing the problem are identified, supervisors expect that the student is moving toward a resolution of the problem. If it is necessary to point out the same areas repeatedly, something is wrong. We should re-visit the situation and think of other ways to communicate the same message so that the student is provided with ample opportunity to make a change. It has been our consensus, that for the most part, our students in clinic are working hard toward independence and have shown increasing competence, so we should be mindful in looking for evidence of the student’s active participation in this growth process.

Finally, we want to acknowledge the beginning student’s feelings of confusion and frustration as she or he embarks on clinic. These feelings are entirely reasonable and to be expected in this situation. It may be the student’s failure to expect and respect these feelings that is a problem. We acknowledge that there are no cookbooks or recipes for working with various disorders; the clinical process requires analysis and synthesis. It takes time. The supervisor’s role is to guide the clinician as he/she develops the skills necessary to participate in the clinical process. Toward that end, a certain amount of “constructive feedback” is necessary. We want to
affirm that this feedback is not personal; it is directed at the clinical process and should be presented to the student in a positive and constructive manner. Our goal should be to train our students to become “competent clinicians”, rather than harp on negative criticisms. Student clinicians that respond defensively to feedback of their work may not be allowing themselves to develop optimally. The supervisor’s ultimate goal is to become dispensable so the student eventually becomes capable of self-supervision. ***But, no one begins at this level, and many people don’t achieve it for many years. Feedback, constructive we hope, is a necessary part of the learning process.

These are some of the major issues in clinical training as we see them. We thank you for your cooperation in looking at and thinking about them in relation to yourself and your clinical training. We hope you will join us in our efforts to maintain consistency throughout our program.
Policy Statement

CLINIC POLICY FOR LATE WRITTEN WORK

1. All written work is due on time, as specified by the individual supervisor, on the date due. Extensions must be approved in advance by the student's immediate supervisor.

   Work not turned in by the due date or extension date will be reduced by one full letter grade.

2. As speech-language pathologists in an outpatient clinic, we have professional and ethical responsibilities to our clients and to the community to complete written reports promptly.

   All written work for clinic must be completed (final copy form) by the last day of the quarter. An incomplete will not be granted for failure to complete written work; a failing grade (F) will be assigned.

   Extension of due dates may be granted for diagnostic and therapy reports, but in no case will an extension go beyond the last day of the quarter. Exceptions may be granted under extreme circumstances.
The graduate faculty met on October 8, 1986, and reviewed the existing policy regarding required clinical activity. After a spirited discussion they reaffirmed the following policy:

1. As a graduate student in the M.S. program in SPPA, you are required to take at least 2 units of clinic each quarter that you are in attendance or until you have satisfactorily completed the equivalent of 6 units of undergraduate clinic and the required 10 units of 6000 level clinic. Graduate Clinic units typically include: 2 units of 6056 – Diagnostics, 4 units of 6056 – Speech and Language, and 2 units of 6156 – half of which would be diagnostic activity and the remainder in aural rehabilitation. The last two units of Graduate Clinical Therapy Practicum may be waived at the discretion of the Clinic Director. Ideally, these activities should be completed prior to doing your internship. In no case, however, can internship be taken prior to completing 6 units of 6056 or 6156, two of which must be Speech-Language Diagnostics.

2. A typical quarter of Clinic in Speech and Language consists of 30 contact hours, that is, 2 clients seen for 15 hours each. At times, a student may opt to take only 1 client upon approval of the Clinic Director. In this case, the student will receive an incomplete grade until the second half of Clinic is completed.

3. If you believe that you have a compelling reason to deviate from the required pattern, you must first discuss this with your advisor. Do not request changes of your supervisor or clinic coordinator.

4. If after meeting with your advisor, you still believe that you have a compelling reason for a variance, you may submit a written request for a variance to the graduate faculty for consideration. All requests must be submitted in writing to the department chair no later than the Monday of the 9th week of the quarter preceding the quarter for which you are seeking a variance.
MINIMUM ACADEMIC REQUIREMENTS PRIOR TO INTERNSHIP

The following course work shall be completed prior to starting an Internship:

1. School Internship – SPPA 6066
   a. All B.S. Requirements
   b. SPPA 4863 – Articulation and Phonological Disorders
      SPPA 6064 – Fluency Disorders
   c. SPPA 6000 – Research Methods in Communicative Sciences and Disorders
      SPPA 6020 – Vocal Pathology and Rehabilitation
      SPPA 6060 – Advanced Study of Language Disorders in Children

2. Hospital Internship – SPPA 6066 – Adult Population
   a. All B.S. Requirements
   b. SPPA 4863 – Articulation and Phonological Disorders
      SPPA 4866 – Neurocognitive Communication Disorders
      SPPA 6064 – Fluency Disorders
   c. SPPA 6000 – Research Methods in Communicative Sciences and Disorders
      SPPA 6020 – Vocal Pathology and Rehabilitation
      SPPA 6050 – Neurogenic Motor Speech Disorders: Adults and Children
      SPPA 6220 – Dysphagia in Adults and Children

For hospitals with pediatric caseloads, SPPA 6060, Advanced Study of Language Disorders in Children, is required.

Variance from these minimum requirements must be approved by a majority vote of the graduate faculty.

\(^1\) May be taken concurrently with advisor approval.
MEMORANDUM

TO: All Graduate Students
FROM: Department Chair
Communicative Sciences and Disorders

SUBJECT: POLICIES REGARDING INTERNSHIP IN THE SCHOOLS

The laws of the State of California require that you must complete a Certificate of Clearance including fingerprinting, prior to acceptance in a student teaching program. Within our program we call this “Internship in the Schools.”

Since processing of the Certificate of Clearance may take as long as two to three months, it is recommended that you start the process within the first quarter after acceptance into our program.

The law also requires that you be advised that if you have been convicted of a felony that you may be denied a credential to work in the public schools. If you have any concerns regarding this issue please talk with the Department Chair or notify the Chair in writing.

Additionally, completion of the California Basic Skills Requirement (most commonly completed by taking the CBEST) is also a requirement for participation in a school-based internship. More information is available at http://www.ctc.ca.gov/credentials/leaflets/cl667.pdf
CLINIC/Therapy Room Infection Control
For Student Clinicians

1. Each therapy room contains supplies to disinfect surfaces.
2. Disinfect table surfaces, chair backs, and door knobs after each therapy/diagnostic session.
3. All devices used for cleaning in the clinic should be thrown away promptly.
4. Closely watch toddlers and preschoolers during therapy sessions, so they do not get into/handle trash can contents.
5. STAY HOME IF YOU ARE CONTAGIOUS.
6. During any therapeutic oral motor exercises or stimulation/phonetic placement activities, gloves should be worn.
7. If young children need assistance with Kleenex tissue use (e.g., runny nose) put on gloves before you help them.
8. Diaper changing is prohibited in therapy rooms or lobby; parents should be instructed to use nearby restrooms.
9. Report any client or clinician related injury situations to department administrators, particularly any involving direct contact with body fluids or blood, so that an incident report can be written and proper clean-up/disinfection procedures can be followed.
10. An Environmental Protection Agency (EPA) registered germicide can be used for disinfection or a 1:10 solution of household bleach to water.
1. **WASH YOUR HANDS**

2. Place a paper towel on the table, with the following items on it: stopwatch, flashlight, box of tissues, cup of water, 2 tongue blades, 3 disposable gloves, alcohol wipes and an otoscope. Have a plastic bag ready for disposable items at the end of the examination.

3. Glove both hands

4. Consider the paper towel a “clean” field so that items returned to the towel can be used again during the exam, e.g. tongue blade can be used to depress the tongue, returned to the paper towel, and used again to depress the tongue again.

5. Tongue blades should be marked (x) or kept covered at one end. The marked end is the one held by you.

6. When you have completed the use of the disposal item, e.g. tongue blade, either place on a separate tissue (away from permanent items such as your flashlight) for disposal later or dispose of immediately. Tongue blades should be covered in their paper wrapper or tissue and then broken prior to disposal.

7. When the exam is completed including disposal of the tongue blade, remove the gloves from the cuff down (so glove is rendered inside out) and throw away. All disposable items should be placed in plastic bag and disposed of in the trash.

8. Replenish used items in the kit.

9. Immediately wipe down your flashlight, otoscope, glass, other non-disposable items with alcohol – hold items with tissue while cleaning.

10. **WASH YOUR HANDS**

**NOTE:** If you are working with a client where blood, saliva or other bodily fluids may be touched or splashed, it is recommended that eye goggles and a mask be worn.
The following article is reprinted from the August, 1987, Newsletter of the Speech Pathology and Audiology Examining Committee.

Section 11166 of the Penal Code requires any child-care custodian, medical practitioner, non-medical practitioner, or employee of the child-protection agency who has knowledge of or observes a child in his or her employment whom he or she knows or reasonably suspects has been the victim of child abuse to report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

"Child care custodian" includes teachers, administrative officers, supervisors of child welfare and attendance, or certificated pupil personnel employees of any public or private school; administrators of a public or private day camp; licensed to care for children; headstart teachers; licensing workers or institution including (but not limited to) foster parents, group home personnel, and personnel of residential care facilities; and social workers or probation officers.

"Medical practitioner" includes physicians and surgeons, psychiatrists, psychologists, dentists, residents, interns, podiatrists, chiropractors, licensed nurses, dental hygienists, speech pathologists, audiologists, or any other persons who are licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.
TECHNIQUES FOR THE PREVENTION OF CHILD ABUSE & NEGLECT

Educators should take special note if the parents:

Show little concern for their child’s problems;

 ★ Do not respond to the teacher’s inquires and are never present for the teacher’s visits or for parent’s nights;
 ★ Take an unusual amount of time to seek health care for the child;
 ★ Do not adequately explain an injury;
 ★ Give different explanations for the same injury;
 ★ Continue to complain about irrelevant problems unrelated to the injury;
 ★ Suggest that the cause of an injury can be attributed to a third party;
 ★ Are reluctant to share information about the child;
 ★ Respond inappropriately to the seriousness of the problem;
 ★ Cannot be found;
 ★ Are using alcohol or drugs;
 ★ Have no friends, neighbors, or relatives to turn to in crisis;
 ★ Have unrealistic expectations for the child;
 ★ Are very strict disciplinarians;
 ★ Were themselves abused, neglected, or deprived as children;
 ★ Have taken the child to different doctors, clinics or hospitals for past injuries (often called “doctor shopping” or “hospital shopping”);
 ★ Show signs of loss of control or a fear of losing control; or
 ★ Are unusually antagonistic and hostile when talking about the child’s health problems

(Taken from Child Abuse and Neglect: Handbook for Educators
Published by the Foundation for Educational Services)

SAN FRANCISCO CHILD ABUSE COUNCIL
1757 WALLER STREET
SAN FRANCISCO, CALIFORNIA  94117
(415) 668-0494
EMOTIONAL MALTREATMENT

Emotional maltreatment, also known as emotional abuse, verbal abuse, verbal assault and psychological abuse is broadly defined as any chronic and persistent act by an adult that endangers the mental health or emotional development of a child. It is a series of acts, or lack of action, that deprives the child of needed love, affection, support and encouragement to grow into a healthy adult.

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<th>Care Provider’s Behavior</th>
<th>Effects</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Adult</td>
<td>Child</td>
</tr>
<tr>
<td>Too anxious to please</td>
<td>Harsh &amp; inflexible</td>
<td>Running away</td>
</tr>
<tr>
<td>Seeking out adult contact</td>
<td>Ineffective handling of stress &amp; crises</td>
<td>Suicide/attempt</td>
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<td>Unrealistic expectations of child</td>
<td>Low Self-esteem</td>
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<tr>
<td>Changes in normal behavior patterns</td>
<td>Scapegoating child</td>
<td>Gradual impairment of health/personality</td>
</tr>
<tr>
<td>Depression</td>
<td>Inconsistency/unpredictable responses</td>
<td>Developmental delay</td>
</tr>
<tr>
<td>Unwillingness to discuss problems</td>
<td>Excessive verbal assault</td>
<td>Negative self-image</td>
</tr>
<tr>
<td>Sleep disorders (bedwetting, nightmares, restlessness)</td>
<td>(belittling, screaming &amp; threatening)</td>
<td>Difficulty in forming/sustaining relationships</td>
</tr>
<tr>
<td>Feeding/eating disorders</td>
<td>Objectifies child by referring to him or her as “it”</td>
<td>Provoking the abuse</td>
</tr>
<tr>
<td>Developmental lags (stunting growth)</td>
<td>Child of privation/abuse</td>
<td>Unrealistic goal setting</td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>Socially isolated</td>
<td>Impatience</td>
</tr>
<tr>
<td>Aggressive/bizarre behavior</td>
<td>Concept of self as “no good”</td>
<td>Inability to communicate or express feelings, wants, needs or desires</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>Identifies child with something/someone hated</td>
<td>Sabotaging success</td>
</tr>
<tr>
<td>Emotional apathy</td>
<td>or of wrong sex</td>
<td>Lack of self-confidence</td>
</tr>
<tr>
<td>Passivity</td>
<td>Blaming and sarcastic</td>
<td>Self-deprecation</td>
</tr>
<tr>
<td>Unprovoked yelling/screaming</td>
<td>Heavy/persistent teasing or ridicule</td>
<td></td>
</tr>
<tr>
<td>Crying</td>
<td>Constant family discord</td>
<td></td>
</tr>
<tr>
<td>Inconsistent behavior at home or school</td>
<td>Verbally lashing out in anger or frustration</td>
<td></td>
</tr>
<tr>
<td>Feeling responsible for abuser</td>
<td>Mechanically responsive to child’s needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Uninterested in child as a person, child’s needs, interests or concerns</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Providing little or no comfort, support or guidance</td>
<td></td>
</tr>
</tbody>
</table>

Some words or phrases used in emotional maltreatment of children are: “stupid”, “dumb”, ignorant”, “bad”, “rotten”, “ungrateful brat”, “good-for-nothing”, “sissy”, “ugly”, “sinful”, “you are no good”, “you will never amount to anything”, etc. In spite of the saying, “sticks and stones may break my bones, but words will never hurt me”, we are finding that a constant barrage of negative words, with supporting actions, dramatically affect the child’s individual growth and development. When you suspect emotional maltreatment, don’t ignore the situation. Call the Children’s Emergency Service (415) 665-0757 for consultation or to report.
Students may file complaints according to the policies and procedures outlined at the CSUEB website. These include policies for academic complaints, sexual harassment, and standards of student conduct. Processes for complaints/appeals vary depending on the category. Please refer to the university website for guidance on complaint procedures:


Students may also consult with the department chair regarding appropriate procedures as needed.

For concerns regarding academic activities:
1. Contact your Instructor; if you are not satisfied, contact
2. Your Academic Advisor; if you are not satisfied, contact
3. The Department Chair

For Clinical activities:
1. Contact your Clinical Supervisor; if you are not satisfied, contact
2. The Clinic Director; if you are not satisfied, contact
3. The Department Chair

For student grievances:
1. Contact the college’s Associate Dean, MB1511, (510) 885-3161, or
2. Contact the college’s Student Services Center, MB1503, (510) 885-4874

If you have questions or concerns regarding your graduate education, you may contact the Council on Academic Accreditation following the procedure outlined at the website below:
http://www.asha.org/academic/accreditation/accredmanual/section8.htm