General Clinic Policies

1. The clinic is generally open from 8:00 a.m. to 5:00 p.m. Monday through Friday, with therapy scheduled Monday through Thursday only, starting no earlier than 9:00 a.m.. 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. All potentially private or sensitive communication with the caregiver or client (including homework, progress, etc.) must be completed within therapy rooms and not in the corridors or waiting room area. HIPAA compliance is required at all times.

4. Client files and work folder contents are to remain in the clinic at all times. If they are transported to supervisor/faculty offices outside of the clinic, they must be placed in an intercampus envelope for client privacy.

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 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 remain locked at all times. The key may be checked out from the Department office mailbox by leaving a Bay Card or other photo ID. Protocols are available in the locked filing cabinet in the Assessment Room. Only one protocol per client is allowed. Please use pencil and then finalize in pen.

8. All clinicians participating in Clinical Practicum are covered for professional liability through the University as part of registration in clinical practicum courses.

General Observation Policies

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 pre-approved therapy session. The visiting observer badge restricts caregivers to observe only their family member's room; invited visitors may observe any therapy session as specifically allowed by the department.

WHO MAY OBSERVE

Adult family members of clients are encouraged to observe therapy sessions, but observing assessments is prohibited. Young children should not be left alone in the waiting room without adult supervision (e.g., a family friend or relative, or an available clinician). Clinicians should make prior arrangements for supervision of minor children who are not clients when inviting a parent to enter into the session.

Students in Speech Pathology and Audiology classes may observe a diagnostic or treatment session upon approval from the Supervisor, with Class Instructor permission, and under the following constraints: a) the student has signed the program's confidentiality form; b) the client or caregiver has signed the permission to observe and record form; c) the number of student observers does not interfere with clinic activities or exceed available space; and d) student observer follows observation protocol in the clinic, observation room and waiting room.

Visitors and students in other Cal State East Bay classes who have been invited by our Departmental faculty or staff members or who have made prior arrangements through another program on campus may observe.

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 in the observation hallways.

c. Professional discussions may be carried out quietly; however a client's confidentiality must be preserved as previously outlined. Do not discuss a particular client while other parents, students, clinicians, observers, or visitors are present in the observation hallway. Under no circumstances should a client be discussed in the corridor or clinic waiting area.

Initial Planning Meetings

Planning meetings are the first opportunity for clinicians to present themselves and pertinent information about their clinical assignment to their Supervisor, in a professional, organized, comprehensive and coherent manner. The clinician's ability to carefully and thoroughly analyze the client's needs and present an appropriate plan for initial therapy sessions is considered part of the initial Evaluation process, as measured by CALIPSO.

Each clinician is assigned two 30-minute planning meetings 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, if possible.

Before the first planning meeting, the **Clinician and Supervisor** should:

- Review the client's file, paying particular attention to the last STS (Semester 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 the most recent STS and would result in needed additional information). If so, inform the Clinic Director immediately.

- Make notes re: remarkable info, *Results* towards previous goals and *Recommendations* from last STS or DX report.

During this first meeting, the **Clinician** should:

- Summarize the pertinent areas reflected in the Planning Meeting Guidelines (see next page).

During the second planning meeting, the **Clinician** should present any modifications, additional research, justification or specific information requested from the first planning meeting. The final plan for the first week of therapy should be completed at this planning meeting.

During both planning meetings, the **Supervisor** should:

- Provide verbal feedback as to the appropriateness of the clinician's plan. If certain skills/areas are no longer appropriate for therapy, or if there are additional areas that are more of a priority, give this feedback to the clinician. This includes feedback re: use of cues, materials and elicitation techniques.

- Assess the clinician's ability to modify their initial Plan, if appropriate, based on discussion from the first meeting.

- Take written notes on the clinician's overall preparedness, understanding of the client, presentation of information, judgment regarding task and activity selection and consideration toward general goal areas, etc.

- Discuss your expectations, office hours, format for feedback, methods of instruction, etc.

Planning Meeting Guidelines

After a comprehensive client file review, clinicians should use this format to guide their preparation and presentation for Initial Planning Meetings. This document will serve to provide an outline for the initial ITP and will help organize information necessary for the Semester Therapy Plan.

Supervisor(s) will review the verbal or written planning summary in terms of appropriateness and completeness as it relates to competencies reflected in the CALIPSO *Evaluation* section.

Client _____ **Age**_____ **Date of Birth**_____

Semester/Year _____ **Clinician**_____ **Supervisor** _____

A. Briefly summarize pertinent information about the client (age, relevant medical/developmental history, communication diagnosis, relevant info from recent testing, etc.)

B. Summarize relevant information from last term of therapy (e.g., goals, progress, challenges or problems, recommendations.)

C. Discuss areas for initial baselining/probing in first 1-2 sessions (e.g., rationale for decision, functionality of goal area, types/delivery of cues.). What is most relevant, foundational, functional or necessary for this client? Is this decision justified?

D. Describe proposed facilitating techniques, activities, cues and materials for each skill within the first 1-2 sessions.

E. Discuss when and how to elicit a spontaneous speech and language sample (e.g., interview with client, during play, specific time within the session).

F. Discuss relevant topics and questions for the initial caregiver/client interview (within first session), including client/caregiver concerns, changes in status, progress with Home program, client areas of interest and potential therapy priorities.

G. Know history of hearing and oral mechanism functions and plan these screenings, as appropriate (e.g., consider delaying Audio and OM screens until session #2-3 unless a priority for the client).

Therapy

1. Therapy planning and evaluation are ongoing processes. Therapy objectives are set at the beginning of each semester using the Semester Therapy Plan (STP) and are based on the results of informal assessment, baseline data collection and clinical observations. Objectives are set for each session on the Intended Therapy Plan (ITP) and revised each week based on client progress from the previous week.

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

3. At the first therapy session, the clinician should 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 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.

4. Clinicians are encouraged to implement specific approaches based on current research and evidence-based practice. Clinicians are also encouraged to try various approaches and determine what works best for their client, as mutually determined with their supervisor.

5. A mid-term conference with the parent, family member, caregiver or client is required to discuss results of the client's baseline assessment and the therapy objectives for the semester.

6. A final conference with the parent, family member, caregiver or client is required to discuss progress in therapy and activities for skill maintenance and generalization, as described in the Home Program.

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

8. If a make-up session is necessary 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. Offsite supervision is provided by Speech-Language Pathologists working at the assigned offsite location. All supervisors are CA-licensed and ASHA-certified.

2. Supervision is highly individualized in terms of content and style, depending on the skills and needs of each clinician. Verbal feedback is given both formally and informally. The amount and type of written feedback varies by supervisor, but is intended to guide the clinician's learning process with both positive and constructive feedback.

3. Supervisors may also enter the therapy room to demonstrate, model or assist with the clinician's assessment, therapy implementation, and/or counseling. This type of direct support is highly encouraged to as a clinical training strategy.

4. Three scheduled supervisor-clinician conferences are required each semester: an initial planning meeting, a mid-term conference and a final conference held during finals week. Clinicians are encouraged to meet with their supervisors during office hours as needed and/or if requested.

5. Written feedback is given for written documentation and the portions of therapy sessions which are observed. All therapy notes and reports are reviewed and provided edits for revision, if needed, or cosigned by the supervisor if note is in its final form.

6. Clinicians are encouraged to record and review each session. Clinicians should consider reviewing for accuracy of data collection as well as to lend insight into their own verbal and nonverbal behaviors within the session.

7. Supervisors will hold clinical rounds, which serve as educational and problem-solving opportunities for therapy implementation, behavior management, or other relevant issues or specific client concerns. Rounds may be supervisor-specific and/or diagnosis related. Frequently, solutions to problems emerge from a supportive group setting.

Record Keeping

WORK FOLDER

1. Each semester, the clinician prepares a work folder for each client enrolled in therapy. The work folder is to be kept in the clinician's mailbox. Work folders and their contents are not to leave the clinic for any reason.

2. All therapy notes, ITPs, self-evaluations, session data and Supervisor written feedback are to be kept in this folder at all times.

3. Each folder has 2 pockets. All clinical documentation is kept in the RIGHT pocket, including ITPs, Therapy Notes, Self-Evaluations, data and any written supervisor feedback. Dividers should be placed between each section. Documentation should be organized so that the most recent document is placed on the top; once signed, the clinician should file it under the appropriate tab.

5. The *Student Clock Hours Log* is kept in the LEFT pocket. The clinician and Supervisor will mutually decide which of the 9 CALIPSO areas the clinician is addressing, and divide the session minutes appropriately between these areas. The supervisor will indicate in the appropriate space if he/she has observed the session, reviewed the ITP, SOAP note, self evaluation and clinician's data.

6. The clinician should transfer their minutes from the *Clinician Clock Hours Log* to CALIPSO weekly or biweekly.

CLIENT FILE

1. Client files are considered **CONFIDENTIAL**. Active files 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 when removing a file for review; remove the "out" card when returning the file to the drawer. Files taken to supervisor offices outside the main clinic (MB1099) must be transported in intercampus envelopes to maintain confidentiality.

2. When a client file is full and a second file must be started, refer it to the Clinic Receptionist for splitting.

3. All telephone communications, therapy sessions, conferences, cancellations and other pertinent contacts must be documented in the client's file. All notations made in client files must be made in ink, dated with the month, day and year, and initialed by the person making the entry.

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. Only finalized documents are placed in the Client File, including finalized reports and SOAP notes with both clinician and Supervisor signatures.

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

b. All diagnostic clients or their designate receive a copy of their assessment report for their personal records to distribute as they choose. If the client wants copies of a report sent to other individuals, the client or designate must complete and 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.

7. Client files 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 Cal State East Bay, and contact notes.

c. Right side contains Cal State East Bay documentation, e.g., evaluation and therapy reports, letters, notes, test protocols, and the original application for services.

d. Test protocols are to be placed immediately underneath the report that describes results.

ORGANIZATION OF CLIENT FILES

LEFT SIDE

(top) Client Summary Data Sheet
(next) Client Disposition
Contact Notes
Cal State East Bay permission forms
- Authorization for Release Info
- Client's Agreement and Release
- Permission to Observe/Record

All reports outside of Cal State East Bay *
- IEP/IFSP
- Medical Reports
- Speech and Language Reports
- Discharge Summaries

RIGHT SIDE *

(top) STS Report
(next) Home Program
Tx protocols
Tx notes
Dx report
Dx letter
Dx notes
Dx protocols
Clinic Application
Intake Form

** Materials should be in chronological order, with the most recent 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 Cal State East Bay 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-5 even if 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 protocols, check to see how many 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 protocol; instead, please make copies and return last one to folder.
e) The maintenance of materials and equipment requires a team effort to maximize their longevity. Therapy materials are expensive, and while wear and tear is inevitable, clinicians should do everything possible to return items promptly, intact, and carefully boxed or bagged.
f) Assessments and related diagnostic materials are to be checked out by DX clinicians only. Any clinicians in need of DX materials should request this from their Supervisor.
g) Supplementary resources are located outside of the Clinic workroom. These resources should also be returned promptly and carefully after use.
h) Individual Supervisors may have additional diagnostic or therapy resources in their offices, including specific treatment interventions for articulation and language. Clinicians should check with the Clinic Director to inquire about availability of additional resources.

3. Clinicians 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 clinicians old workbooks which may form the basis for a good collection of therapy materials.

4. Clinical forms are kept in lateral file drawers beneath the clinician's mailboxes.

5. Lockers are available in MB1593 for storage of therapy materials. A $10.00 cash deposit is required for use. Lockers may be renewed Spring and Summer only. Deposits are refunded when the locker is cleaned at the end of use. Deposits are not refunded if clinicians leave the Clinic without renewing or cleaning out their locker.

6. Notify the department administrator of any malfunctioning equipment, incomplete activity sets or damaged materials.

Evaluation of Performance in Clinical Practicum

Cal State East Bay uses CALIPSO for evaluation of performance in clinical practicum.

PERFORMANCE RATING SCALE

1 **Not evident:** Skill not evident most of the time. Clinician requires direct instruction to modify behavior and is unaware of need to change. Supervisor must model behavior and implement the skill required for client to receive optimal care. Supervisor provides numerous instructions and frequent modeling (skill is present <25% of the time).

2 **Emerging:** Skill is emerging, but is inconsistent or inadequate. Clinician shows awareness of need to change behavior with supervisor input. Supervisor frequently provides instructions and support for all aspects of case management and services (skill is present 26-50% of the time).

3 **Present:** Skill is present and needs further development, refinement or consistency. Clinician is aware of need to modify behavior, but does not do this independently. Supervisor provides on-going monitoring and feedback; focuses on increasing clinician's critical thinking on how/when to improve skill (skill is present 51-75% of the time).

4 **Adequate:** Skill is developed/implemented most of the time and needs continued refinement or consistency. Clinician is aware and can modify behavior in-session, and can self-evaluate. Problem-solving is independent. Supervisor acts as a collaborator to plan and suggest possible alternatives (skill is present 76-90% of the time).

5 **Consistent:** Skill is consistent and well developed. Clinician can modify own behavior as needed and is an independent problem-solver. Clinician can maintain skills with other clients, and in other settings, when appropriate. Supervisor serves as consultant in areas where clinician has less experience; Provides guidance on ideas initiated by clinician (skill is present >90% of the time).

Performance rating scores are converted to grades according to the CALIPSO Grading Scale on the following page. If a clinician has multiple clinical assignments within a term, the grades will be averaged. Please refer to the CLINICAL GRADES AND ASSESSMENT Policy Statement on grade expectations.

Grading Scale

SLHS 694

Start	End	Letter
4.00	5.00	A
3.66	3.99	A-
3.35	3.65	B+
3.04	3.34	B
2.73	3.03	B-
2.42	2.72	C+
2.11	2.41	C
1.80	2.10	D
1.00	1.79	F

SLHS 695

Start	End	Letter
4.27	5.00	A
3.96	4.26	A-
3.65	3.95	B+
3.34	3.64	B
3.03	3.33	B-
2.72	3.02	C+
2.41	2.71	C
2.10	2.40	D
1.00	2.09	F

AREAS FOR EVALUATION OF PERFORMANCE

EVALUATION	ASHA CCC	CAA	CTC
Conducts screening and prevention procedures	IV-D, V-B	1a	SLP 4
Collects case history information and integrates information from clients/patients	V-B	1b	SLP 4
Selects appropriate evaluation instruments/procedures	V-B	1c	SLP 4
Administers and scores diagnostic tests correctly	V-B	1c	SLP 4
Adapts evaluation procedures to meet client/patient needs	V-B, 1d	1d	SLP 4
Demonstrates knowledge of etiologies and characteristics, anatomical/physiological, acoustic, psychological, developmental, linguistic and cultural factors for each cognitive, communication and swallowing disorders	IV-C		SLP 2
Observes and identifies relevant client/patient behaviors			
Interprets, integrates, and synthesizes test results, history, and other behavioral observations to develop diagnoses	V-B	1e	SLP 4
Makes appropriate recommendations for intervention	V-B	1e	SLP 7
Completes administrative and reporting functions necessary to support evaluation	V-B	1f	SLP 7
Refers clients/patients for appropriate services	V-B	1g	SLP 7

INTERVENTION			
Develops setting appropriate intervention plans with measurable and achievable goals.	V-B	2a, 3.1.1B	SLP 5
Implements intervention plans (involves clients/patients and relevant others in the intervention process)	V-B,	2b, 3.1.1B	SLP 5
Selects or develops and uses appropriate materials/instrumentation	V-B	2 c	SLP 5
Sequences tasks to meet objectives			SLP 5
Provides appropriate introduction/explanation of tasks			SLP 5
Measures and evaluates clients'/patients' performance and progress	V-B	2d	SLP 5
Uses appropriate models, prompts or cues. Allows time for patient response.			SLP 3
Uses feedback/reinforcement which is consistent, discriminating and meaningful			
Modifies intervention plans, strategies, materials, or instrumentation to meet individual client/patient needs	V-B	2e	SLP 3
Completes administrative and reporting functions necessary to support intervention	V-B	2f	
Identifies and refers patients/clients for services as appropriate	V-B	2g	SLP 3
Structures treatment sessions to maximize learning			

Professional Practice, Interaction, and Personal Qualities	ASHA CCC	CAA	CTC
Demonstrates knowledge of basic human cognition, communication and swallowing processes	IV-B	3.1.6B	SLP 3
Uses clinical reasoning and demonstrates knowledge of and ability to integrate research principles into evidence-based clinical practice	IV-F	3.1.1B	SLP 3
Adheres to federal, state, and institutional regulations and demonstrates knowledge of contemporary professional issues and advocacy (includes trends in best professional practices, privacy policies, models of delivery, and reimbursement procedures/fiduciary responsibilities)	IV-G	3.1.1B, 3.1.6B, 3.8B	SLP 7
Communicates effectively, recognizing the needs, values, preferred mode of communication, and cultural/linguistic background of the patient, family, caregiver, and relevant others	V-B	3a, 3.1.1B	SLP 5
Collaborates with clients/patient and relevant other in the planning process	IV-G	2a	
Provides counseling regarding cognitive, communication and swallowing disorders to clients/patients, family, caregivers, and relevant others	V-B	3c, 3.1.6B	SLP 5
Collaborates with other professionals in case management	V-B	3b, 3.1.1B, 3.1.6B	SLP 7
Displays effective oral communication with patient, family, or other professionals	V-A	3.1.1B	SLP 5
Displays effective written communication for all professional correspondence	V-A	3.1.1B	SLP 5
Adheres to the ASHA Code of Ethics and Scope of Practice documents and conducts him or herself in a professional, ethical manner	IV-E, V-B	3d, 3.1.1B, 3.1.6B	SLP 5
Establishes rapport and shows care, compassion, and appropriate empathy during interactions with clients/patients and relevant others		3.1.1B	
Demonstrates professionalism		3.1.1B, 3.1.6B	

Written Communication			
Uses correct grammar, spelling, terminology, punctuation, tense consistency, “voice” consistency, etc.	V-A	3.1.1B	SLP 5
Uses the correct format for required clinical documents	V-A	3.1.1B	SLP 5
Writes relevant case history in concise, organized form	V-A	3.1.1B	SLP 5
Accurately and concisely describes results of tests and informal procedures and covers all relevant information and areas, including client/patient strengths	V-A	3.1.1B	SLP 5
Writes in lay-person terms, as appropriate, using examples to clarify	V-A	3.1.1B	SLP 5
Provides an accurate summary of impressions and recommendations	V-A	3.1.1B	SLP 5
Generates clinical documents in an acceptable time frame	V-A	3.1.1B	SLP 5
Incorporates supervisory feedback into document revisions	V-A	3.1.1B	SLP 5
Writes documents that are professional in presentation and tone	V-A	3.1.1B	SLP 5

Written Work in Clinical Practicum

TYPE	PURPOSE	WHEN DUE	WHERE	LENGTH	FORM	FEEDBACK
Intended Therapy Plan (ITP)	provides a detailed plan for weekly therapy sessions – one per week	at least 1 hour before the first session of the week	work folder in mailbox	1 – 2 pages	typed on ITP template	written on ITP in work folder or on separate supervisor notes
Self-Evaluation	analyzes your impressions of your performance in a session and your clinical skills	at least 1 hour before next session (although clinicians are encouraged to complete immediately after each session)	work folder in mailbox	½-1 page	separate sheet of paper	written in work folder
SOAP Notes	describes objective results and impressions of therapy sessions as well as brief plan for next session	at least 1 hour before next session	work folder in mailbox	½ to 1 page	Typed on Therapy Notes template	co-signature if approved or noted for revision if necessary
Semester Therapy Plan (STP)	reports statement of problem, initial status, semester objectives, task sequences and therapy rationales	Refer to Clinic Calendar	work folder in mailbox or electronic submission, per supervisor preference	2 – 5 pages	typed, double spaced	graded with supervisor feedback; returned with revision due date
Semester Therapy Summary (STS)	documents progress during semester and current status; provides recommendations for further therapy or discharge	Refer to Clinic Calendar	work folder in mailbox	3 – 4 pages	Double spaced. Part I of STP is submitted single spaced; Part II omits task sequence and rationale from STP	graded with supervisor feedback; returned with revision due date.
Home Program	generalizes skills achieved in therapy	Refer to Clinic Calendar	work folder in mailbox or electronic submission, per supervisor preference	1-2 pages	typed/double spaced	Graded with supervisor feedback; returned with revision due date

Mid-Term Conference Guidelines

In addition to reviewing the profile of skills as outlined in the CALIPSO Performance Evaluation, these topics are offered to help clinicians assess their clinical skills at mid-term. Clinicians should ask themselves these questions for each of their assigned clients, which will help facilitate an active discussion during the mid-term 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 cuing?

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 Semester Checklist

Complete this checklist prior to your Final Conference

Client #1	Client #2	
_____	_____	Discussed client continuation or discharge with supervisor.
_____	_____	Completed and submitted *Clinician Background Sheet* to Clinic Director if enrolling in practicum for the following term. **Be sure to continue to check Black Board and Horizon email for information regarding next semester's clinic.
_____	_____	Completed final conference with client, parent, family member or caregiver to discuss progress in therapy and review Home Program.
_____	_____	Returned any outstanding completed client schedule sheets to Clinic Director.
_____	_____	Cleared out clinician mailbox, leaving work folder containing all original copies of notes, drafts, self-evaluations, etc. with supervisor feedback. Signed treatment notes, reports and home program are filed in client files.
_____	_____	Completed FINAL CLIENT FILE CHECK, bringing file to final conference for supervisor's review and any missing signatures. Filed signed *STS*, *Home Program and* treatment notes in client's file. Place discharged client files in Clinic Director's mailbox for archiving.
_____	_____	Documented all contacts in client's file, including letters to other agencies, record of reports sent, etc. (A signed *Request for Information* form is necessary to release STS or DX report to client, family member or any other agent/agency. Cal State East Bay does not release any other information such as treatment notes, test protocols or recordings.)
_____	_____	Updated client disposition in the client file.
_____	_____	Entered and submitted your clinical minutes in CALIPSO.
_____	_____	Completed *CALIPSO Supervisor Evaluation*
_____	_____	Completed *CALIPSO final Performance Evaluation* as a self-evaluation of performance in preparation for final conference with supervisor.
_____	_____	Returned all borrowed materials to appropriate clinic areas or to supervisors.
_____	_____	Cleaned out locker, removed storage bins, and notified clerical staff for deposit refund (if applicable)