

Maryland Department of Health
**Board of Examiners for Audiologists, Hearing Aid Dispensers
and Speech-Language Pathologists**

4201 Patterson Avenue, Baltimore, Maryland 21215-2299

Phone 410-764-4725 Fax 410-358-0273

TTY/ Maryland Relay Service 1-800-735-2258

Application for Licensure for Speech-Language Pathology Assistant



Date _____

Please Read The Application Checklist Before Completing Application Below:

Name _____
Last First Middle/Maiden

Date of Birth _____ Social Security # _____

Residence _____
Street Apt.

City State Zip Code

Phone # _____ Alternate# _____ E-Mail _____

What is your first language? English Other _____

If answered Other, TOEFL Scores are required. English as a Second Language (ESL) applicants are required to have a minimum combined Test of English as a Foreign Language (TOEFL) score of 80% within the previous two years from the date of the application. A copy of you exam scores must be submitted with your application.

Professional Address _____
Facility or Company's Name

Street Suite #

City State Zip Code

Telephone # _____ Fax _____ E-mail _____

Beginning Date of Employment _____

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Have you ever been convicted of a felony or a misdemeanor involving moral turpitude?

No Yes If "Yes" attach full details.

Waiver of Requirements

A. Do you hold a valid American Speech-Language-Hearing Association Registration as a speech-language pathology assistant?

No Yes If yes, date originally granted: _____

Attach copy of ASHA SLP Assistant Registration or letter from ASHA verifying registration as an SLP Assistant. Also attach Delegation Agreement (Form SA6) completed by each supervising speech-language pathologist.

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

If yes, list State(s): _____

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

Has any disciplinary action ever been taken against your license in any other jurisdiction?

No Yes If yes, please attach full explanation.

C. Have you practiced as a SLP Assistant for at least two years prior to submitting this application?

No Yes If yes, attach a letter from your supervising speech-language

pathologist attesting to the dates you have practiced as a SLP Assistant. Also attach Delegation Agreement (Form SA6) for each supervising Speech-Language Pathologist and completed Competency Skills Check List, (Form SA7).

Education

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

A. School attended: _____

Address: _____

Dates Attended: From _____ To: _____

Degree Granted: _____ Date: _____

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

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

1. Associate Degree from an approved SLP Assistant Program? Yes No

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2. Associate Degree in an allied health field with 15 hours in required minimum course work?
 Yes No

If you have an Associate Degree in an allied health field, complete **Form SA2** describing required minimum coursework as stated on transcript. If the title of the course is not self-explanatory, attach catalog description or syllabus.

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

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

25 hours of clinical observation Yes No

75 hours of clinical assistance Yes No

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

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

Pactice Setting Where Limited Licensee Will Practice

Name of Facility _____

Address: _____

Phone Number: _____ Beginning Date: _____

Description of Duties: _____

Supervising Speech-Language Pathologist (s):

Name	Title
------	-------

Name	Title
------	-------

Name	Title
------	-------

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

Please review the regulations and sign the following affirmation:

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

Signature of Applicant

Date

Applicant Must Have This Affidavit Completed by a Notary Public

State of _____

City or County of _____

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

Signature of Applicant

Signature of Notary

Subscribed and sworn to before this _____ day of _____

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

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

Race/Ethnic Identification

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

Male Female Other _____

Race/Ethnic Identification – Please Check All That Apply

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

Select one or more of the following racial categories:

- 1. American Indian or Alaska Native (A person having origins in any of the original peoples of North or South America, including Central America, and who maintains tribal affiliations or community attachment.)
- 2. Asian (A person having origin in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)
- 3. Black or African American (A person having origins in any of the black racial groups of Africa.)
- 4. Native Hawaiian or other Pacific Islander (A person having origins in the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
- 5. White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

SLP-A

Form SA2

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**Associate Degree in Allied Health Field
Verification of Minimum Required Coursework**

Applicant (please type or print)

Name: _____
Last First Middle/Maiden

Address: _____
Street Apt. #

_____ City State Zip Code

Phone #: _____ Alternate #: _____

Educational Institution

Name of Institution: _____

Address: _____

Street _____

_____ City State Zip Code

Dates Attended: From _____ To _____

Associate Degree in _____ granted _____
(major) (date – mm/dd/yyyy)

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Form SA2

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

Normal Speech-Language Development

Name of Course _____

Semester Taken _____

Additional Courses in this area: _____

Speech Disorders

Name of Course _____

Semester Taken _____

Additional Courses in this area: _____

Anatomy and Physiology of Speech Systems

Name of Course _____

Semester Taken _____

Additional Courses in this area: _____

Language Disorders

Name of Course _____

Semester Taken _____

Additional Courses in this area: _____

Phonology

Name of Course _____

Semester Taken _____

Additional Courses in this area: _____

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Form SA3

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Educational Institution Verification of Completion of Required Clinical Hours

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

Applicant (Please Type or Print)

Name: _____
Last First Middle/Maiden

Address: _____
Street Apt. #

City State Zip Code

Phone: _____ Alternate Phone: _____

Name of Educational Institution: _____

Address: _____
Street

City State Zip Code

Dates Attended (mm/yy): From _____ to _____

Verification

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

25 Clinical Observation Hours Completed From _____ to _____

75 Clinical Assistance Hours Completed From _____ to _____

Signature _____ Title _____

Print Name _____ Phone _____

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FORM SA4

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Alternative Plan for Obtaining Required Clinical Hours

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

Applicant (Please Type or Print)

Name: _____
Last First Middle/Maiden

Address: _____
Street Apt. #

City State Zip Code

Phone: _____ E-mail _____

Supervising Speech-Language Pathologist

Name: _____
Last First Middle/Maiden

Professional Address: _____
Facility or Company's Name

Street Suite #

City State Zip Code

Telephone # _____

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

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

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FORM SA4

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

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

Alternative Plan for Clinical Hours

First Month: Week One from _____ to _____
Estimated Observation Hours _____ Estimated Assistance Hours _____

First Month: Week Two from _____ to _____
Estimated Observation Hours _____ Estimated Assistance Hours _____

First Month: Week Three from _____ to _____
Estimated Observation Hours _____ Estimated Assistance Hours _____

First Month: Week Four from _____ to _____
Estimated Observation Hours _____ Estimated Assistance Hours _____

Second Month: Week Five from _____ to _____
Estimated Observation Hours _____ Estimated Assistance Hours _____

Second Month: Week Six from _____ to _____
Estimated Observation Hours _____ Estimated Assistance Hours _____

Second Month: Week Seven from _____ to _____
Estimated Observation Hours _____ Estimated Assistance Hours _____

Second Month: Week Eight from _____ to _____
Estimated Observation Hours _____ Estimated Assistance Hours _____

Signature of Applicant _____ Date _____

Signature of Supervisor _____ Date _____

Supervisor: (select one of the following)

- Holds MD License in Speech-Language Pathology
- Holds ASHA CCC-SLP
- Holds Licensure in SLP in State of _____

FORM SA5

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Verification of Completion of Required Clinical Hours

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

Applicant (Please Type or print)

Name: _____
Last First Middle/Maiden

Address: _____
Street Apt. #

City State Zip Code

Phone: _____

Supervising Speech-Language Pathologist

Name: _____
Last First Middle/Maiden

Professional Address: _____
Facility or Company's Name

Street Suite #

City State Zip Code

Phone # _____ E-Mail _____

FORM SA5

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

First Month: Week One from _____ to _____

Observation Hours _____ Assistance Hours _____

First Month: Week Two from _____ to _____

Observation Hours _____ Assistance Hours _____

First Month: Week Three from _____ to _____

Observation Hours _____ Assistance Hours _____

First Month: Week Four from _____ to _____

Observation Hours _____ Assistance Hours _____

Second Month: Week Five from _____ to _____

Observation Hours _____ Assistance Hours _____

Second Month: Week Six from _____ to _____

Observation Hours _____ Assistance Hours _____

Second Month: Week Seven from _____ to _____

Observation Hours _____ Assistance Hours _____

Second Month: Week Eight from _____ to _____

Observation Hours _____ Assistance Hours _____

Signature of Supervisor _____ Date _____

Supervisor: (check one of the following)

- Holds MD License in Speech-Language Pathology, License # _____
- Holds ASHA CCC-SLP, Certificate # _____
- Holds Licensure in SLP in State of _____, License # _____

If the Board does not receive within 90 days, proof of successful completion of the clinical hours within 60 days, the assistant's Limited License is void and the assistant will need to reapply.

FORM SA5

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FORM SA6

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Delegation Agreement

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

Speech-Language Pathology Assistant Information:

Applicant's Name: _____

Mailing Address: _____

Day Phone: _____ Evening Phone: _____

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

Supervising Speech-Language Pathologist

Name: _____

Address: _____

Day Phone: _____ Evening Phone: _____

Maryland SLP License Number: _____ and/or ASHA Number: _____

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

Facility Name: _____

Facility Address: _____

Contact Person: _____ Phone: _____

FORM SA6

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

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

Delegation Agreement

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

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

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

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

Signature of SLP Assistant

Date

Signature of Supervising SLP

Date

FORM SA7

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Competency Skills Checklist

At the beginning of the Assistant's Limited Licensure:

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

After 9 months of supervised practice:

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

The Speech-Language Pathology Assistant shall submit the completed Competency Skills Checklist to the Board at least 30 days before the limited license expiration date.

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Competency Skills Checklist

Speech-Language Pathology Assistant: _____

Supervising Speech-Language Pathologist: _____

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

I. Interpersonal Skills:

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

1. Criteria: Deals effectively with the attitudes and behaviors of the patients/clients

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

2. Criteria: Communicates and interacts effectively with supervisor

	Yes	No
a. Accepts and responds appropriately to constructive criticism	<input type="checkbox"/>	<input type="checkbox"/>
b. Requests assistance from supervisor appropriately	<input type="checkbox"/>	<input type="checkbox"/>
c. Actively participates in interactions with supervisor	<input type="checkbox"/>	<input type="checkbox"/>
d. Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

II. Personal Qualities:

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

1. Criteria: Demonstrates behaviors of a dependable team member, which may include:

	Yes	No
a. Arrives punctually to appointments with prepared assignments	<input type="checkbox"/>	<input type="checkbox"/>
b. Submits documentation on time	<input type="checkbox"/>	<input type="checkbox"/>
c. Completes assigned tasks within designated treatment session	<input type="checkbox"/>	<input type="checkbox"/>

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

- a. Maintains confidentiality of client information at all times
- b. Maintains professional appearance for work environment
- c. Recognizes own professional limitations and performs within the boundaries of training and job responsibilities

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

III. Technical-Assistant Skills

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

- 1. Criteria: Maintains a facilitating environment for all tasks
 - a. Adjusts environment to facilitate learning (i.e. lights, noise, etc)
 - b. Organizes treatment space appropriately
 - c. Other _____

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

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

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

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

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

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

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

IV. Screenings

Standard: The speech-language pathology assistant will provide appropriate screening procedures.

- 1. Criteria: Administers screening tools appropriately as directed by the supervisor for communication and/or swallowing disorders which may include:
 - a. Differentiates correct vs. incorrect responses
 - b. Completes screening protocol form accurately
- 2. Criteria: Manages screening
 - a. Reports any difficulties encountered with screening procedures
 - b. Schedules Screenings
 - c. Organizes screening materials

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

3. Criteria: Communicates results to supervising speech-language pathologist
- | | | |
|--|--------------------------|--------------------------|
| a. Seeks guidance when appropriate | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Provides descriptive behavioral observations that contribute to results | <input type="checkbox"/> | <input type="checkbox"/> |

V. Treatment

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

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Criteria: Performs treatment tasks as outlined by the supervisor | | |
| a. Accurately and efficiently follows treatment plans developed by the speech-language pathologist | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Incorporates feedback from speech-language pathologist for modifying own behavior with the client, caregivers and other professional staff | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Criteria: Manages client behavior and provides appropriate treatment | | |
| a. Maintains on-task behavior | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Provides appropriate feedback to the client as to the accuracy of the response | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Uses feedback and reinforcement that are consistent, discriminating and meaningful | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Gives direction and instructions that are age, education and culturally appropriate | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Implements treatment objectives/goals in specified sequence | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Applies behavior modification and other reinforcement behavior appropriately as designated by the speech language pathologist | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Criteria: Demonstrates knowledge of treatment objectives and plan | | |
| a. Demonstrates understanding of client disorder and needs | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Identifies correct vs. incorrect responses | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Identifies client behaviors which demonstrate an improvement in function | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Accurately reports completion of tasks | <input type="checkbox"/> | <input type="checkbox"/> |

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

 Supervising Speech-Language Pathologist

 Date

FORM SA8

Department of Health
**Board of Examiners for Audiologists, Hearing Aid Dispensers
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4201 Patterson Avenue, Baltimore, Maryland 21215-2299

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Affidavit To Be Completed By Licensure Board

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

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

First Name Middle Last Name

Date of Birth _____ Social Security Number _____

License/Certificate/Registration Number: _____

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

License/Certificate /Registration Number: _____ Date Issued: _____

Is License/Certificate/Registration in good standing? _____

Expiration Date: _____

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

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

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

If yes, please explain why or attach additional explanation.

Has License/Certificate/Registration been reinstated? _____

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

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

If yes, please explain or attach additional explanation.

Signature _____ Date _____

Title _____

State Board of _____

State of _____

State Seal Here

FORM SA8

For Office Use Only
Received _____ CK () MO () Number _____

Revised April, 2020

AGENCY PRIVACY REQUIREMENTS FOR NONCRIMINAL JUSTICE APPLICANTS

Authorized governmental and non-governmental agencies/officials that conduct a national fingerprint-based criminal history record check on an applicant for a noncriminal justice purpose (such as employment or a license, immigration or naturalization matter, security clearance, or adoption) are obligated to ensure the applicant is provided certain notices and that the results of the check are handled in a manner that protects the applicant's privacy. All notices must be provided in writing.¹ These obligations are pursuant to the Privacy Act of 1974, Title 5, United States Code (U.S.C.), Section 552a, and Title 28, Code of Federal Regulations (CFR), Section 50.12, among other authorities.

- Officials must ensure that each applicant receives an adequate written FBI Privacy Act Statement (dated 2013 or later) when the applicant submits his/her fingerprints and associated personal information.²
- Officials must advise all applicants in writing that procedures for obtaining a change, correction, or update of an FBI criminal history record are set forth at 28 CFR 16.34. Information regarding this process may be found at <https://www.fbi.gov/services/cjis/identity-history-summary-checks> and <https://www.edo.cjis.gov>.
- Officials must provide the applicant the opportunity to complete or challenge the accuracy of the information in the FBI criminal history record.
- Officials should not deny the employment, license, or other benefit based on information in the FBI criminal history record until the applicant has been afforded a reasonable time to correct or complete the record or has declined to do so.
- Officials must use the FBI criminal history record for authorized purposes only and cannot retain or disseminate it in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council.³

The FBI has no objection to officials providing a copy of the applicant's FBI criminal history record to the applicant for review and possible challenge when the record was obtained based on positive fingerprint identification. If agency policy permits, this courtesy will save the applicant the time and additional FBI fee to obtain his/her record directly from the FBI by following the procedures found at 28 CFR 16.30 through 16.34. It will also allow the officials to make a more timely determination of the applicant's suitability.

Each agency should establish and document the process/procedures it utilizes for how/when it gives the applicant the FBI Privacy Act Statement, the 28 CFR 50.12 notice, and the opportunity to correct his/her record. Such documentation will assist State and/or FBI auditors during periodic compliance reviews on use of FBI criminal history records for noncriminal justice purposes.

Name: _____

Date: _____

¹ Written notification includes electronic notification, but excludes oral notification.

² See <https://www.fbi.gov/services/cjis/compact-council/privacy-act-statement>

³ See 5 U.S.C. 552a(b); 28 U.S.C. 534(b); 34 U.S.C. § 40316 (formerly cited as 42 U.S.C. § 14616), Article IV(c); 28 CFR 20.21(c), 20.33(d), 50.12(b) and 906.2(d).



MARYLAND

Department of Health

Larry Hogan, Governor • Boyd K. Rutherford, Lt. Governor • Robert R. Neall, Secretary

BOARD OF EXAMINERS FOR AUDIOLOGISTS, HEARING AID DISPENSERS & SPEECH-LANGUAGE PATHOLOGISTS

Jennifer L. Mertes, Board Chair • Candace G. Robinson, Executive Director

Criminal History Records Check - In Maryland

A full Criminal History Records Check is a requirement to obtain a license issued by the Maryland Board of Examiners for Audiologists, Hearing Aid Dispensers and Speech-Language Pathologists. This includes all initial licenses, transfers from limited to full licensure, and all renewal licenses. Each individual only needs to complete the process once for this Board.

These instructions are for individuals who reside in Maryland or reside near Maryland. It is best to obtain fingerprints in Maryland. If it is not convenient to get fingerprinted in Maryland please follow the procedure in the Out-of-State instructions.

The Department of Public Safety and Correctional Services, Criminal Justice Information System (CJIS) oversees Criminal History Records Checks. The criminal history records check is initiated by the applicant/licensee being fingerprinted.

CJIS Authorization#:	1600003672
FBI ORI#:	MD920528Z
Reason Fingerprinted:	Audiology license Hearing Aid Dispenser license Speech-Language Pathology license Speech-Language Pathology Assistant license
Type of Check:	Governmental Licensing/Certification

Electronic Fingerprinting

It is best to have your fingerprints taken electronically in the State of Maryland.

Electronic fingerprinting is available at CHS-approved private providers, most Maryland MVA locations and most local law enforcement offices.

Please note that the cost of fingerprinting services from private providers may vary. The total fee must be paid to the provider and the cost is borne by the applicant for initial licensure and renewal candidates. Private providers in Maryland do not accept cash or money orders.

For additional information regarding fingerprinting in Maryland please contact CJIS:

via telephone at 410-764-4501; or
via their website at <http://www.dpscs.maryland.gov/publicservs/:fingerprint.shtml>.

Applicants for Initial Licensure, Reinstatement, or Reactivation

Effective October 1, 2016 all initial applicants for full or limited licensure in Maryland will be required to submit fingerprints. All applicants for reinstatement or reactivation who have not previously fulfilled this requirement must submit fingerprints. This is a requirement of the application process and cannot be waived for any reason. An initial license will not be issued unless proof of the CHRC is on file with the Board.

Maryland residents and individuals who reside near Maryland may have fingerprints taken prior to mailing an application to the Board. Maryland residents and individuals who reside near Maryland must use the pre-filled form specific to this Board (link at end of this document and also available on this Board's Forms page). If an individual is unable to use the pre-filled form the individual must have the CJIS Authorization number and FBI ORI numbers to ensure that the required reports are issued to the Board (on the first page of this document and on the Board's homepage). Please note that these numbers are specific to this Board.

After your fingerprints are taken you will be given a receipt for payment that includes a tracking number; the tracking number is unique to you. Include a copy of the receipt with the tracking number when submitting the initial application to the Board. Hand-write the professional license you are applying for and specify either full license or limited license.

Once the results of the background check are received by the Board the application process will be completed in accordance to Board regulations and policies.

Renewal Applicants

Individuals who obtained a full license before October 1, 2016 will be required to submit evidence of the CHRC to the Board prior to the issuance of a renewal license. Additional information has been provided to renewal applicants via e-mail.

General Information

Pursuant to federal law a criminal history records check is only effective for one purpose. Accordingly, any prior fingerprinting and criminal history records check was only good for the educational institution, employer, licensing entity, etc. that it was completed for.

When getting fingerprinted please ensure the following:

that the fingerprint operator spells your name correctly; and

that the proper OIR and authorization numbers are used.

A list of private providers that have electronic fingerprinting services are provided on the State of Maryland's Department of Public Safety & Correctional Services website. Click below for immediate access to fingerprinting locations in Maryland. **Call ahead to make sure the provider is open and has the October 1, 2016 software update.**

<https://www.dpscs.state.md.us/publicservs/fingerprint.shtrnl>

Print LiveScan Pre-Registration Application

<https://health.maryland.gov/boardsahs/DocumentsaudLiveScan.pdf>

All applicants must print the LiveScan Pre-Registration Application and take it to the fingerprinting location in Maryland.

Please **do not** call the Board's offices for an update on a background check. The background check is completed by a separate state agency. The Board has no control over the amount of time it takes to complete the check. If you have not received the results of the criminal history background check after thirty days, you may contact CJIS directly at 410-764-4501.

Please refer to § 2-303.1 Criminal History Record Checks of the Maryland Board of Examiners for Audiologists, Hearing Aid Dispensers and Speech-Language Pathologists for a full description of the requirements.



STATE OF MARYLAND
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES
CRIMINAL JUSTICE INFORMATION SYSTEMS – CENTRAL REPOSITORY

LIVESCAN PRE-REGISTRATION APPLICATION

APPLICANT INFORMATION *(PLEASE TYPE OR PRINT CLEARLY)*

Name:					
Date of birth:		SSN:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <i>(Please check)</i>	
Height:	ft. inches	Weight:	lbs.	Eye Color:	Hair Color:
Race:	<input type="checkbox"/> Black	<input type="checkbox"/> White	<input type="checkbox"/> Asian/Pacific Islander	<input type="checkbox"/> Native American	<input type="checkbox"/> Other <i>(Please check)</i>
Place of Birth:			Citizenship:		
Current address:					
City:			State:		ZIP Code: -
Daytime Phone:		Evening Phone:		Driver's License #:	

AGENCY INFORMATION

Agency Authorization #: 1600003672	
ORI # (if required): MD920528Z	Reason fingerprinted? Licensing
Position Applied for: Board of AUD HAD and SLP	
Request Type: <i>(Choose one ONLY)</i>	
<input type="checkbox"/> Adult Dependent Care <input type="checkbox"/> Attorney/Client <input type="checkbox"/> Child care <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Gold Seal/ Adoption <input type="checkbox"/> Gold Seal/Letter/VISA <input type="checkbox"/> Government Employment	<input checked="" type="checkbox"/> Government Licensing or Certification <input type="checkbox"/> Immigration/VISA <input type="checkbox"/> Individual Challenge <input type="checkbox"/> Individual Review <input type="checkbox"/> MSP Licensing <input type="checkbox"/> Private Party Petition <input type="checkbox"/> Public Housing

Mail Response to:

(Mailing option only available for Visa Gold Seal and/or Individual Review)

Name: Do Not Mail This Form To The Board

Address: Do Not Mail This Form To The Board

City, State, Zip code: Do Not Mail This Form To The Board



MARYLAND

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BOARD OF EXAMINERS FOR AUDIOLOGISTS, HEARING AID DISPENSERS & SPEECH-LANGUAGE PATHOLOGISTS

Jennifer L. Mertes, Board Chair • Candace G. Robinson, Executive Director

Criminal History Records Check - Out of State Applicants

A full Criminal History Records Check is a requirement to obtain a license issued by the Maryland Board of Examiners for Audiologists, Hearing Aid Dispensers and Speech-Language Pathologists. This includes all initial licenses, transfers from limited to full licensure, and all renewal licenses (including reinstatement of a license or reactivation of a license). Each individual only needs to complete the process once for this Board.

These instructions are for individuals who reside outside of Maryland where it is inconvenient to come to Maryland to complete the fingerprinting process. Please note that it is best to obtain fingerprints in Maryland. If fingerprints are able to be completed in Maryland please follow the procedure in the In-State instructions.

The Department of Public Safety and Correctional Services, Criminal Justice Information System (CJIS) oversees Criminal History Records Checks. The record checks are conducted by the applicant/licensee being fingerprinted.

CJIS Authorization #:	1600003672
FBI ORI#:	MD920528Z
Reason Fingerprinted:	Audiology license Hearing Aid Dispenser license Speech-Language Pathology license Speech-Language Pathology Assistant license
Type of Check:	Governmental Licensing/Certification

In order to comply with the Criminal History Records Check requirement and to not delay the issuance of a license, please abide by these instructions. Please note that it may take up to five weeks for CJIS to issue the required reports to the Board.

Out-of-state residents may use a location outside the State of Maryland, but must use the CJIS fingerprint card that has pre-printed Board-specific information.

Call the Board at 410-764-4725 to request a fingerprint card. Applicants for an initial license should request a fingerprint card at least six weeks in advance of the anticipated date that licensure is required. License renewal candidates should request a fingerprint card no later than April 15,

2018 to ensure sufficient time to complete the process and complete the online renewal process. These timeframes assume an individual mails the fingerprint card to Maryland CJIS within a week of receiving the fingerprint card and having the fingerprints taken.

Once the fingerprint process is complete you must mail the fingerprint card to the following address with a check for \$31.25 payable to the "CJIS Central Repository."

CJIS Central Repository
PO Box 32708
Pikesville, MD 21282-2708

Make a copy of the receipt with the tracking number that was issued to you. Legibly write your full name and profession on the copy being mailed to the Board (may be included with the application for licensure). Mail a copy of the receipt for fingerprinting to:

Maryland Board of AUD HAD SLP
ATTN: Background Check
4201 Patterson Avenue, 3rd Floor
Baltimore, MD 21215

For applicants for initial licensure: Once the results of the background check are received the application process will be completed in accordance with Board regulations and policies.

For renewal applicants: Once the results of the background check are received the Board will make the necessary changes to allow access to the online renewal process within 48 hours (notice will be provided via e-mail).

For additional information contact CJIS:

via telephone at 410-764-4501; or

via their website at [http://www.dpscs.maryland.gov /publicserv s/fingerprint.shtml](http://www.dpscs.maryland.gov/publicserv s/fingerprint.shtml).

Effective October 1, 2016

Every new applicant submitting an application on or after October 1, 2016 for a license issued by the Board must submit a criminal history records check (CHRC) to the Board. This includes license reinstatement and license reactivation when this requirement has not previously been fulfilled.

This is a requirement of the application process and it is a one-time requirement. All fees associated with the criminal history records check requirement must be borne by the applicant/licensee.

A license will not be issued unless proof of the CHRC is on file with the Board.

Individuals with an incomplete application as of October 1, 2016, with the Board must submit a CHRC to the Board. This is a requirement prior to the issuance of a license.

Individuals holding a full license on or after October 1, 2016 will be required to submit evidence of the CHRC to the Board prior to the issuance of a renewal license.

Please **do not** call the Board's offices for an update on a background check. The background check is completed by a separate state agency. The Board has no control over the amount of time it takes to complete the check. If you have not received the results of the criminal history background check after thirty days, you may contact CJIS directly at 410- 764-4501.

Please refer to § 2-303.1 Criminal History Record Checks of the Maryland Board of Examiners for Audiologists, Hearing Aid Dispensers and Speech-Language Pathologists for a full description of the requirements.