CLINICAL DEFICIENCY PLAN FOR AN ASSISTANT IN SPEECH-LANGUAGE PATHOLOGY FORM (Refer to §741.64)

PROPOSED SUPERVISOR'S NAME: _____ **Texas Lic. #** _____

PROPOSED SUPERVISOR'S EMAIL: _____
Deficient Clinical Deficiency Plans will be emailed to the proposed supervisor's email address.

Qualifications: _____

_____

APPLICANT FOR ASSISTANT LICENSE:

Name: _____ SS#:_____

TRAINING:
Training **must** be conducted under 100% face-to-face supervision by the proposed licensed supervisor named above.

Describe the training that will be provided: (Mark all boxes that apply and give number of hours)

Clinical Observation for _____ hours:

_____ Therapy

_____ Other

(list)_____

Clinical Assisting Experience for _____ hours: (Check all areas in which you will train the assistant.)

- ❑ Conduct or participate in speech, language, and/or hearing screening;
- ❑ Implement the treatment program or the individual education plan (IEP) designed by the licensed speech-language pathologist;
- ❑ Provide carry-over activities which are the therapeutically designed transfer of a newly acquired communication ability to other contexts and situations;
- ❑ Collect data;
- ❑ Administer routine tests as defined by the Board;
- ❑ Maintain clinical records;
- ❑ Prepare clinical materials; and
- ❑ Participate with the licensed speech-language pathologist in research projects, staff development, public relations programs, or similar activities as designated and supervised by the licensed speech-language pathologist-define the activity on a separate sheet of paper.

Describe **where** the training will occur and **length** of sessions: _____

_____

(Note: The plan must be approved by Board staff and the license issued before ANY observation or clinical assisting experience clock hours may begin.)

The clinical observation hours and/or clinical assisting experience must be completed in accordance with the Board approved plan within 60 days of the effective date of the license. If a change in the plan is necessary, the revised plan must be submitted to the Board office and approval granted before the training may begin. The revised plan must be completed within the original 60-day time period. Otherwise, the assistant's license shall be voluntarily surrendered and the assistant will be required to reapply for the license. ***There will be no exceptions.***

COMPLETION DOCUMENTATION:

After the assistant's clinical deficiency plan is approved, the supervisor may download the forms from the Clinical Deficiency Plan section of the board's website. Please use the board prescribed forms.

- ***Supervision Logs*** that verifies the date the hours were acquired, a brief description of the training that was conducted during each session, and comments on the assistant's performance. (The logs are only submitted if selected for supervision audit.)
- ***Clinical Deficiency Plan Completion of Training and Rating Scale of the Assistant in Speech-Language Pathology Form***. (Be sure to include the number of hours.)

AFTER THE TRAINING HAS BEEN COMPLETED:

- The supervisor and the assistant must complete and sign and submit the *Clinical Deficiency Plan Completion of Training and Rating Scale of the Assistant in Speech-Language Pathology Form.*
- The *Clinical Deficiency Plan Completion of Training and Rating Scale of the Assistant in Speech-Language Pathology Form* must be submitted to the board office.
- **Please note *Supervision Logs* will only need to be submitted if selected for supervision audit.**

IF DOCUMENTATION IS NOT RECEIVED WITHIN 60 DAYS OF THE ISSUE DATE OF THE ASSISTANT'S LICENSE, THE LICENSE SHALL BE CONSIDERED VOLUNTARILY SURRENDERED.

_____ _____

Signature of applicant for assistant license Date

_____ _____

Signature of Proposed Supervisor providing the training Date

If you have any questions, please contact us at (512) 834-6627.

Please review to be sure all information is correctly completed and all documentation has been submitted. Missing documentation and incomplete forms may delay your approval.

PLEASE EMAIL THIS COMPLETED FORM TO: Speech@dshs.state.tx.us

Or (512) 834-6677, Attention: SPEECH

Or by mail to:
State Board of Examiners for Speech-Language Pathology and Audiology
Mail Code: MC1982
PO Box 149347
Austin, Texas 78714-9347