PREFACE

This manual is designed to make the transition from student of speech-language pathology to student clinician in the University of the Pacific’s Department of Speech-Language Pathology clinics a little easier and a little less frightening. This handbook should serve as an introduction to the procedures used in our clinics and should answer many of the questions that may develop during a student’s practicum experience. There is no way to make this handbook thorough enough to answer all questions, but it should prove useful as a supplement to classroom instruction and guidance from clinical instructors.

Each institution of learning, as well as employment setting uses different methods, procedures, etc. This handbook provides one example and should not be viewed as the only “correct way.” However, the procedures outlined in this manual are expected to be followed when working in the University of the Pacific’s Speech and Language Clinics. The information in this handbook should prove useful in completing future job responsibilities, but again these guidelines are not the only correct ways of completing tasks.
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REQUIREMENTS TO PARTICIPATE IN CLINIC
SLPA 183 AND SLPA 189A/189B

In order to participate in Beginning and/or Intermediate Clinical Practicum (SLP 189a/b) and Diagnostic Lab (SLPA 183), the following conditions must be met:

- GPA of 3.2 in all required courses for the degree.
  * This includes non-SLPA courses such as Biology, Physics/Chemistry, Statistics, Child Development and Sociology or Psychology
- Students who have declared the major prior to their junior year (less than 56 units) must complete all three of the following courses before the beginning of the senior year: Biology, Statistics and Physics/Chemistry
- Transfer students who have declared the major during the junior year (more than 56 units) must complete two of the three following courses before the beginning of the senior year: Biology, Statistics or Physics/Chemistry
- No less than a “B-” in any SLPA course

* * * * *

- The GPA requirement will be calculated at the end of the semester before the clinical experience begins.
- If a student is ineligible to participate in SLPA 189 a/b and 183, SLPA 110 and SLPA 181 must be taken in place of these courses.
Prior to taking a course that includes an experiential component; students are required to demonstrate that they have the necessary skills, aptitude and competencies to successfully complete the course. Faculty of departments offering experiential courses have the discretion of denying enrollment in these courses to students evaluated as not possessing the necessary skills, aptitudes and clinical competencies. Procedures used to assess clinical competency vary across programs.

Students who do not demonstrate adequate clinical and experiential competency can be dismissed from a degree program, regardless of academic standing.

To be eligible for an externship assignment, an overall clinical practicum grade of B- or better must be obtained in the two semesters immediately prior to participating in an Internship/externship. If a grade of C+ or lower is earned in any of the semesters, it will delay and may preclude an externship if adequate improvement is not demonstrated within the specified time period listed on the student’s remediation plan.

**NOTE:** Earning a grade of B- or better does not guarantee internship/externship placement. Multiple factors are taken into consideration when determining whether or not students possess and demonstrate the skills necessary to be placed in an off-campus internship/externship placement.
UNIVERSITY OF THE PACIFIC
DEPARTMENT OF SPEECH-LANGUAGE PATHOLOGY
SUPERVISED CLINICAL OBSERVATIONS & PRACTICUM REQUIREMENTS

Clinical Observation (30 clock hours minimum):
- 15 hours must be completed during SLPA 101 Clinical Methods I
- 15 hours must be completed during SLPA 103 Clinical Methods II
* Students may not begin Clinical Practicum without these two requirements

Clinical Practicum (375 total clock hours):
325 clock hours at the graduate level

ASHA Standard IV-F: Supervised practicum must include experience with client/patient populations across the life span and from culturally/linguistically diverse backgrounds. Practicum must include experience with client/patient populations with various types and severity’s of communication and/or related disorders, differences, and disabilities.

The University’s recommended minimums are as follows:
- 50 clock hours in each of three types of clinical settings
- 20 clock hours in each of the following 8 categories:
  1. Evaluation: Children’s Speech
  2. Evaluation: Adult Speech
  3. Evaluation: Children’s Language
  4. Evaluation: Adult Language
  5. Treatment: Children’s Speech
  6. Treatment: Adult Speech
  7. Treatment: Children’s Language
  8. Treatment: Adult Language
- 25 clock hours in audiology:
  - 10 hours of evaluation/screening
  - 15 hours habilitation/rehabilitation

NOTE: **YOU ARE RESPONSIBLE FOR KEEPING TRACK OF YOUR HOURS**
REQUIREMENTS FOR THE SPEECH-LANGUAGE PATHOLOGY SERVICES CREDENTIAL

- The Speech-Language Pathology Services Credential allows students to be employed in California’s public schools.

- At Pacific, this credential is completed in conjunction with a graduate student’s master’s degree.

- The following courses are required:
  * The Exceptional Child – SPED123  
    or an approved course that meets the state of California’s mainstreaming requirements  
  * Child Development – PSYC 29  
  * Public School Issues – SLPA 225  
  * Fieldwork (Student Teaching) – SLPA 287B  
    (must be completed during the graduate year)

- **BEFORE** students are permitted to participate in an internship/fieldwork, they must have passed the California Basic Educational Skills Test (CBEST)

- **BEFORE** students are placed in an internship/fieldwork assignment, they must open a credential file in the School of Education.

- Students must also obtain a passing score of 600 or more on the ETS Praxis II Speech-Language Pathology Examination with a passing score on the National Exam in Speech Pathology (NESPA)

STATE OF CALIFORNIA LICENSE REQUIREMENTS

The Speech Pathology & Audiology Board has set up requirements in the following areas:
- 24 semester hours of course work in speech pathology.
- 300 clock hours of clinical practicum in speech pathology in 3 clinical settings.
- Nine months of full-time or 18 months of part-time professional experience.
- A passing score on the National Examination in Speech Pathology (NESPA)

Refer to the Student Manual for Licensure (available from the State of California) for more information – website: [http://www.slpab.ca.gov](http://www.slpab.ca.gov)
PROFESSIONAL PRACTICES

Please be aware that a lack of professional responsibility related to any of the following issues could result in a lowering of a student’s clinic grade.

Clinician Attendance
- The student will be prompt in meeting clients for evaluations, therapy sessions and meetings with his/her clinical instructor(s).

- In the case of illness, it is the student’s responsibility to:
  - Notify his/her clinical instructor.
  - Contact the client to cancel their session.
  - Call the clinic office manager
    - Pacific - 209-946-2381
    - Scottish Rite - 209-462-2613

** Therefore, all students should have their client and instructor home/work/cell phone numbers with them prior to the start of clinic.

Dress Code
The concept of appropriate dress in clinic is relative rather than absolute, however, in general, care should be taken that the body remains covered during normal clinical movement. All students are expected to be well-groomed and dressed in a conservative, professional manner while in the clinic setting. Clinical instructors reserve the right to dismiss a student clinician from therapy due to inappropriate attire. This could also result in a reduction of your clinic grade.

The following guidelines should be observed:
- Student ID should be worn at all times (supplied by the university)
- Jewelry should be conservative in nature and should not present a hazard for patients or the student
- No visible body piercings, other than earrings; earrings should not be of a design that could interfere with direct client care
- Limit the use of perfume and cologne due to client’s sensitivity and medical conditions
Dress Code (continued):
The following are NOT acceptable when involved with clinic activities or in areas where clients are present (e.g. front office, waiting room, observation hallway, etc.):

- Jeans
- Low-rise pants exposing the midriff
- Sweat pants or leggings
- Low-cut or revealing tops
- Short tops exposing the midriff
- Halter tops or tank tops or spaghetti straps
- Shorts or mini skirts
- Hats
- Sneakers
- Flip-flops
- Tops or pants that expose undergarments
- Clothing with obvious advertisements or decals not pertaining to the profession

Client Confidentiality
All client records at the Pacific Speech, Hearing & Language Center and Scottish Rite Center for Childhood Language Disorders are confidential. Students are granted access to personal/medical information only pertaining to those individuals that they are treating.

To protect client confidentiality, please remember the following:

- Clients are not to be identified or discussed with friends, roommates or any other person outside of the clinic.
- Clients may be discussed with supervisors, faculty members and fellow students ONLY when such discussions serve a clinical or educational purpose.
- Extreme care should be taken when having conversations within the clinic. Clinicians SHOULD NOT discuss clients in hallways, elevators, classrooms or other public spaces. All client-related conversations should be conducted in a private room.
- **DO NOT HOLD CONSULTATIONS WITH PARENTS/GUARDIANS/FAMILY IN THE WAITING AREA.**
- Information in the client’s file SHOULD NEVER be taken from the clinic or left unattended.
- Materials from a client’s folder MAY NOT BE PHOTOCOPIED OR PHOTOGRAPHED (this includes but is not limited to reports, notes, video/voice recordings, etc.).
- **DO NOT** leave reports, lesson plans or any other loose records in workrooms, classrooms, etc.
- Written drafts of reports must be destroyed once they are no longer needed. Take these items to the main office for shredding.
• Student clinicians are not to exchange information regarding clients with other agencies without a signed release from the client/parent/guardian (see pages 33-34).

• Student clinicians **may not** use personal equipment (phones, iPads, iPods, tape recorders, cameras, etc.) to record sessions (whole or part). Clinic equipment must be used and the information must remain in the clinic.

**Cell Phones and Other Electronic Devices**
All cell phones, watch alarms, and other electronic devices must be turned off while conducting clinical services with clients.

**Conflict of Interest**
To protect the objectivity, judgment of the clinician and the integrity of the clinical assignment, clinical activity demands that relationships remain professional. To avoid conflict of interest, clinicians are to refrain from treating family members or close friends/associates. The clinician is expected to inform the clinic director, should such an assignment occur.

**GENERAL CLINIC POLICIES AND PROCEDURES**

Please be aware that failure to adhere to all clinic policies and procedures may affect your grade and eligibility to participate in clinic.

**Clinic Fees**
All children’s therapy services are provided at no charge, courtesy of the Scottish Rite. For all adult clients, while we do not currently have a mandatory fee for services, it is strongly encouraged that clients and/or their families make a voluntary donation of $200 each semester to the clinic to help furnish clinicians with the necessary materials and supplies to conduct therapy sessions. Clinicians should assure their client(s) that we **WILL NOT** turn anyone away due to inability to pay for services.

**Clinical Assignments**
All clients are scheduled for students by the clinic director(s). Clinical assignments will be posted in the materials room during the first few days of the semester. It is the student’s responsibility to call the client prior to their first therapy session to introduce themselves and confirm the days and hour of their scheduled therapy (see page 48). **DO NOT CHANGE THE DAYS AND/OR HOUR OF THERAPY WITH THE CLIENT.** If the client has a problem with the therapy days or time, inform the clinic director immediately.
**Client Files**
Clinicians can access client files by filling out a file placeholder “OUT” card and obtaining the file from the clinic office (at the Pacific clinic, the office manager will retrieve the files for students). Please remember that all information contained in these files is considered confidential and should be treated as such. **Client files or any reports given to the clinician by the parent for the file are NOT to leave the clinic. Turn these in to the office manager for filing.**

If further medical records from healthcare providers is desired, clinicians can have a client/client’s parent/guardian fill out a “HIPAA Authorization to Disclose Protected Health Information” form (see pages 33-34) and turn it in to the office manager. He/she will then contact the healthcare provider and work on obtaining the records. An alternate version of this form must be filled out if the client would like the Pacific clinic or Scottish Rite clinic to share contents in his/her file with a third party.

**Planning Meeting**
Supervisors will be available to meet with the students to assist with planning the first week of therapy, during the week prior to the start of clinic. Dates will be provided by the clinic directors. Students are strongly encouraged to meet with their supervisors at their regularly scheduled therapy time. Prior to their planning meeting, students should review their client file(s) and prepare a “Client Information and Planning Sheet” (see page 31-32) for each of their clients. This form will be turned in to the supervisor and used to discuss each client’s needs, develop a therapy plan and develop objectives/goals for him/her.

**First Day of Clinic**
Clients will be waiting for his/her clinician in the waiting room (at Pacific clients are asked to wait in the Dental Clinic waiting room on the south end of the Health Sciences building). All students are expected to review clinic rules with their client on the first day of clinic. After reviewing each rule, please have the client (or parent/guardian) initial and sign one copy of the rules and turn that copy in to the office manager at the end of the session (the second copy should be sent home with the client as a reminder).

**Client Attendance Policy**
All clients are made aware of the clinic attendance policy in the clinic policy letter and when they sign the clinic rules at the beginning of each semester. The policy is as follows:

- **Tardy** – when a client is late, the student is required to wait a minimum of **15 minutes** and then check with his/her clinical instructor prior to leaving.

- **Absence** – We ask clients to let us know at least 2 hours in advance if they are unable to attend a session. Cancellations will be posted on the cancellation
board (hanging in the main hallway outside of the office manager’s door) at Scottish Rite and in the cancellation log (located in the SLP office) at Pacific. If your client contacts you directly to make a cancellation, please notify the office manager so it can be marked in the clients records. The cancellation board/log should be checked before each session.

No-Show – If your client “no-shows”, make note of this in the cancellation log. If a client fails to meet for three sessions without prior notification (no-shows), the student should inform his/her clinical instructor and a decision will be made regarding the continuation of the client’s therapy. He/she may be dismissed from the program if deemed necessary.

If your client withdrawals or is dismissed from clinic, it is your responsibility to inform the clinic director and request another client. You will also be responsible for writing a final report for the dismissed client. NOTE: For all SRLC clients, you must complete a STAT form stating the reason for dismissal.

Parking
At the Pacific clinic, parking permits are required in ALL parking spaces in the Health Sciences parking lot. Clients (and their families) will receive a clinic parking permit with their therapy appointment letter prior to the start of clinic. Extra permits can be obtained from the office manager.

Clinicians are asked to remind their client(s) that they must have a clinic parking permit displayed on their rearview mirror or dashboard to avoid receiving a parking citation. NOTE: Clients with a handicap placard or plates DO NOT need a clinic parking permit as handicap placards/plates overrule all parking rules in the lot.

Should a client receive a parking citation, the clinician should escort him/her to the office manager for an appeal form.

Parking permits are not required at the SRLC. The main parking lot is reserved for clients, staff, and supervisors only. Students must park in the north end of the parking lot.

Supervision
Clinical supervisors will observe each student for at least 25% of their therapy sessions throughout the semester.

In addition to the requirements outlined in this manual, each supervisor may have requirements for their supervisees. Students should check with each of their supervisors to ensure that they understand what is expected of them.
It is vital that students **schedule appointments** when they have questions or concerns regarding their client or clinical assignment. Each supervisor will provide students with their contact information for this purpose.

**Clinical Observations**
Students enrolled in courses requiring observation hours may do so at both the Pacific and Scottish Rite clinics. Slots are on a first come, first served basis. You **may not** reserve a slot ahead of time.

<table>
<thead>
<tr>
<th>Pacific Speech, Hearing &amp; Language Center</th>
<th>Scottish Rite Childhood Language Center</th>
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<tbody>
<tr>
<td><strong>Location:</strong></td>
<td><strong>Location:</strong></td>
</tr>
<tr>
<td>University of the Pacific</td>
<td>33 W. Alpine Avenue</td>
</tr>
<tr>
<td>757 Brookside Road</td>
<td>Stockton, CA 95204</td>
</tr>
<tr>
<td>Health Sciences Building – 2nd floor</td>
<td></td>
</tr>
<tr>
<td><strong>Phone:</strong></td>
<td><strong>Phone:</strong></td>
</tr>
<tr>
<td>209-946-2381</td>
<td>209-462-2613</td>
</tr>
<tr>
<td><strong>Available Observation Days/Times:</strong></td>
<td><strong>Available Observation Days/Times:</strong></td>
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<tr>
<td>Mondays and Wednesdays, 12:30 – 5:30 PM</td>
<td>Monday and Wednesday, 1:00-6:00 PM</td>
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<tr>
<td><strong>Client Population:</strong></td>
<td>Tuesday and Thursday, 3:00-6:00 PM</td>
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<tr>
<td>Adult Clients</td>
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**Students **DO NOT** need to check-in **

**Check-in with the office manager **

When observing a clinic session, students are to abide by the following rules:

- Observers are expected to be well groomed and dressed in a conservative, professional manner while in the clinic (please see the “Dress Code” section for more detail).
- Turn cell phones **OFF**.
- **No talking** in the observations rooms, except to ask the supervisor questions (if they are available).
- **Supervisors and parents/spouses have priority over seats and headphones**.
- **DO NOT** ask family members about the client; if they offer information, that is acceptable.
- No food or drinks allowed in the observation hallway.
- Place backpacks, purses, etc. **under** your chair. Do not block the walkway.

**NOTE:** Only DEPARTMENT APPROVED FORMS may be used for clinical observation assignments. Students ARE NOT allowed to create their own forms for observation assignments. If electronic versions of a form are desired, students may visit the university’s webpage to access these forms: [http://bit.ly/slpdeptforms](http://bit.ly/slpdeptforms)
**Student Evaluations**
Students will receive a midterm and final evaluation during each clinical semester. During the midterm evaluation conferences, supervisors will sit down with each student to discuss their performance. He/she will also inform the student of the grade they have earned up to that point. Supervisors may also offer suggestions on how the student may improve their performance (and their grade). The midterm meeting also serves as a time for students to discuss any concerns he/she may have regarding the supervisor’s expectations, their clinical assignment, etc.

At the end of each semester, supervisors will review each student’s midterm evaluation, complete a final evaluation and assign a clinic grade. All supervisors will use the department approved clinical competencies and objectives via CALIPSO to determine the student’s grade. Students are encouraged to review the clinical objectives and competencies that they will be graded on (see page 45) at the beginning of the semester – it will answer most questions in terms of what is being evaluated.

**End of the Semester Procedures**
On the last day of clinic, all students should turn in any/all clinic forms and reports to Christina (at SRLC) or Kristen (at Pacific). Failure to do so will result in a reduction of your clinic grade. Please consult the End of the Semester Clinic Checklist (see page 46) for a list of the items that need to be completed/turned in.

**Supervisor Evaluations**
At the end of each clinical semester, students will be asked to complete a supervisor evaluation. Students are asked to be as thoughtful and honest as possible when completing supervisor evaluations. Supervisors use this to make changes in the way they work with students. Evaluations are completed using CALIPSO and while supervisors are provided the information, students’ anonymity is maintained. Student grades will not be affected by negative evaluations; however, failure to complete the evaluation may result in a lowered grade.

**Remediation Plans**
Remediation plans are designed to improve a student’s knowledge and skills in a specific area of weakness. An individualized “Plan of Action” (POA) will be implemented whenever a student received an unsatisfactory grade in any academic course or practicum experience (see page 47).

If a POA is necessary, the following steps will take place:
1. The graduate program director and clinic director will meet with the student following a discussion with the instructor/supervisor(s) involved.
2. The POA will be created outlining the activities and/or experiences the student must complete to demonstrate adequate improvement of their knowledge and/or
skills. This plan must include measurable goals that can be completed within one semester.

3. The instructor/supervisor(s) will serve as mentor(s) toward the completion of the plan, unless stated otherwise by the graduate program director and clinic director.

4. Failure to make the necessary improvements may result in dismissal from the program.

Grievance Procedure

When a student has a grievance, the chain of command listed below should be followed to resolve the issue:

1. Contact the instructor involved in the grievance.
2. If unsatisfied with the outcome, contact the clinic director.
3. If unsatisfied with the outcome contact the department chair.

Student Dismissal from Clinic

Each student is expected to conduct himself/herself in a professional manner. A student in any program may be dismissed from the clinical facility by the clinic director and/or program director for the following reasons:

1. Conduct that affects the student’s performance while in the affiliate and/or compromises the patient’s safety. For example:
   a. Alcohol consumption
   b. Use or Abuse of Prescription Drugs
   c. Abusive language to patients, instructors, facility personnel, etc.

2. Failure to meet course objectives.
   a. Inability to function in the clinical setting.
   b. Consistently poor clinical evaluations and/or grades.

3. Excessive absenteeism/tardiness.

4. Violation of ethical standards such as falsifying records, violating patient confidentiality.

5. Unsafe clinical practice which places a patient in jeopardy.
   a. Practicing out of your scope of training.
MATERIALS ROOM PROCEDURES

The following procedures for the use of therapy materials from the Pacific and Scottish Rite materials rooms were designed to provide an efficient and accurate means of distributing clinical materials, as well as to provide a measure of security. Please read and follow these guidelines.

Eligibility
Any full- or part-time student enrolled in Pacific’s SLP program may use the therapy materials housed in the materials rooms at the Pacific or Scottish Rite clinics for the purpose of working with a client or completing course assignments. Materials are not to be checked out for personal use. Materials MAY NOT be checked out for use at off-campus internship/fieldwork sites. EVERYONE, students and faculty/staff, are required to use the check-out/check-in procedures as described below. Failure to follow procedures will result in the loss of privileges to use the materials.

Hours of Operation
The materials room is open during regular business hours:

<table>
<thead>
<tr>
<th>Pacific Clinic</th>
<th>Scottish Rite</th>
</tr>
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<tbody>
<tr>
<td>Monday-Friday: 8:30 AM to 5:00 PM</td>
<td>Monday-Thursday: 10:00 AM to 6:00 PM</td>
</tr>
<tr>
<td>Friday: 8:00 AM to 12:00 PM</td>
<td>Friday: 8:00 AM to 12:00 PM</td>
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Materials Room Contents
The materials room at both clinics contains clinical forms/protocols, tests kits, games and other materials (articulation cards, picture puzzles, chips, tokens, toys, mirrors, etc.) for use during therapy sessions at the Pacific and Scottish Rite clinics.

Equipment such as: DAF machines, audiometers, video cameras, CD players, iPads, etc. can be checked out from the office manager.

A current listing of the materials available for checkout is located in the Materials Room Binder.

Daily Checkout

Pacific: The office manager and clinic director will go over the new checkout procedures during clinic bootcamp.

Scottish Rite: Before removing any materials, fill out the following information on the checkout log:
- Your name (printed)
• List of item(s) taken - both item number and item name/description
• Date materials are checked out
• Telephone number in case items are needed urgently
• When returning the item, be sure to initial and date the checkout sheet

DO NOT TAKE ONLY A PORTION OF A KIT (i.e. certain pictures, posters, pieces, etc.). Instead, check out the entire kit. This will help to prevent portions of the kit from being lost or misplaced.

Materials checked out for “Daily Checkout” may be signed out just prior to and kept for the duration of the therapy/diagnostic session and must be returned immediately following the session for use by others. Materials checked out for daily use may not leave the clinic (clinic rooms or clinician’s room). All returned materials must be signed in.

**Overnight Checkout**
In cases of overnight use of materials, materials may not be checked out until the last therapy session of the day has begun:

<table>
<thead>
<tr>
<th>Pacific Clinic</th>
<th>Scottish Rite</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday-Thursday: 4:30 PM</td>
<td>Monday-Thursday: 5:00 PM</td>
</tr>
<tr>
<td>Friday: 12:30 PM</td>
<td>Friday: hours vary (check with clinic director)</td>
</tr>
</tbody>
</table>

Overnight checkouts are limited to 2 items per student. **SRLC overnight checkout is for diagnostic materials only.**

**Reminder:** Both clinics are open during the day. You are encouraged to check out and use materials in the clinic during office hours versus checking them out overnight. **Note:** use of materials for therapy always comes first and has priority.

**Returning Items**
All items checked out from Pacific must be returned no later than 9:15 A.M. the following day. Scottish Rite materials may be dropped off at the Pacific office for pick-up by the Scottish Rite office manager. All Scottish Rite items dropped off after 9:15 A.M. must be taken over to Scottish Rite by the student between 10:30 AM and 11:00 AM.

**Written Notices**
Written notices will be provided for overdue materials. **No more than 3 notices are permitted.** After the third notice, clinic checkout privileges will no longer be permitted. If checkout privileges have been revoked and materials are required for a diagnostic or class assignment, materials must be used in the clinic, checked out and in with the office manager.

If materials are broken or missing, please notify the office manager immediately.
Protocols and Testing Forms
Protocol forms and score sheets for all tests are kept in file cabinets in the materials room. Protocols at Scottish Rite are stored alphabetically while protocols at Pacific are numbered corresponding to the numbers on the test kit. If the number of forms/protocols is getting low (3 or fewer), this should be immediately reported to the office manager so more can be ordered.

CLINIC RESOURCES AND FACILITIES

Clinic Phones
The Pacific and Scottish Rite clinics both have phones available in the clinician’s room/materials room for local calls (at the Pacific clinic only students will need to dial “9” to access numbers off-campus). These phones are for professional use only. When a personal call is necessary, the length of the call should be kept to a minimum. If a long-distance call is necessary for client contact, please ask the office manager for assistance.

Copy Machines
Both the Pacific and Scottish Rite clinics have a photocopier available for student use. Copiers at both the Pacific clinic and Scottish Rite clinic are run by the university’s PacificPrint program. Students will be required to use these copiers/printers for all of their copying and printing needs. Clinics will no longer have computer printers available for student use.

Students can consult the PacificPrint Instructions (located on page 50) for instructions on how to copy and print their documents. All copy charges will be applied directly to the student’s university account. NOTE: documents loaded to PacificPrint queue can be printed on any PacificPrint copier on the university campus.

The copier in the SLP department’s faculty workroom is off-limits to students. Students are NOT allowed to make copies on the faculty machine without permission.

Computers and Printers
There are computers available for student use at both the Pacific clinic and Scottish Rite clinic. These computers are for clinic use only. This means, materials for therapy may be created on these machines (e.g. activities created on Board Maker). The student computers ARE NOT connected to the internet, as they are not intended to be used for personal e-mail or surfing the internet. Students planning to use clinic computers to create printable items will need to have a USB drive available so he/she can print his/her documents on the PacificPrint copier/printer.
Students **ARE NOT** permitted to install programs of any kind to the clinic computers. Likewise, students **ARE NOT** to save any documents to the computer hard drive. Because of HIPAA guidelines, clinical reports, notes, etc. are **NEVER** to be saved to the department computer hard drive.

**Fax Machine**
Both clinic offices have a fax machine that can be used for clinic/school-related use. Students that need to request client medical records can ask the office manager to assist them in faxing the request to the healthcare provider. The fax machines **ARE NOT** to be used for personal correspondence.

**Laminating Machine**
Both Pacific and Scottish Rite clinics have laminating machines available.

**Pacific:** Students can purchase laminating sheets from the office manager for $1 each. If a student has their own laminating sheet, he/she must still see the office manager to obtain a carrier sheet; laminating cannot be done without a carrier sheet. Please read the instructions (located on the machine) prior to operating the machine.

**SRRLC:** Read all instructions prior to using machine. Laminating sheets can be purchased from the office manager for $1 each. Do not use sheets other than purchased from the office manager (machine warranty.) When done be sure to turn off the machine!

**Mailboxes**
Clinical instructors and faculty members use student folders/mailboxes to return assignments/reports and deliver other important correspondence; therefore, students are expected to check their mailboxes on a regular basis.

**Pacific:** All students in the Speech-Language Pathology Department are given a student folder (referred to as a mailbox) which is located in a pull-out drawer in the materials room.

**Scottish Rite:** All students seeing clients at Scottish Rite are assigned a folder. These are located in a pull-out drawer in the clinician’s room.

**Video Taping Sessions**
As part of your clinical experience, you will be required to record a session and complete a self-evaluation of your performance.
**Pacific Clinic:** Video cameras can be checked out in the observation hallway (please be sure to collect and sign-out all **three** items needed to record – camera, power cord and tripod). You can check out your memory card from the office manager. The memory card should be turned back in to the office manager before leaving the clinic.

All recordings must be viewed in the clinician’s room or ADL room on a clinic computer (the office manager can provide a memory card reader).

**SRLC Clinic:** Video cameras are located in the observation hallway. A video sign-up sheet is located in the office manager’s office. The clinician must sign up for the desired hour in which they want to record prior to the actual recording day. On the day of the recording, the clinician must check out their memory card from the office manager and must be returned to the office manager before leaving the clinic.

All recordings must be viewed in the clinician’s room on a clinic computer (the office manager can provide a memory card reader).

**NOTE:** Under no circumstances should a memory card leave the clinic. Memory cards should never be copied or downloaded to a laptop.

Prior to recording a therapy session, clinicians must ensure that a video consent/release for media recording form has been signed and is in the client’s file. (Pacific = dark pink form; Scottish Rite = yellow form)

**Prep and Study Rooms**
There is a clinician’s prep/study room available at both the Scottish Rite and Pacific Clinics. These rooms are open to all SLP students and **do not** require a prior reservation to use the room.

At Pacific, there is also an Activities of Daily Living (ADL) room available for studying. This room (room 245) is located across from clinic rooms 2 and 3 and requires a reservation to use the room. Reservations are made by putting the student's name and hours of use on the calendar posted on the door. **NOTE: IF A CLINIC SESSION REQUIRES USE OF THE ROOM, IT WILL TAKE PRIORITY.**

Students may also utilize the Pacific therapy rooms for studying if it is a non-clinic day (typically Tuesday, Thursday and Friday). Please check with the office manager for availability.

Students **may not** use the faculty break/work room or conference room for prepping/studying, unless given special permission by faculty/staff. If all of the above options are unavailable, study rooms are available at the Health Sciences Library, located in the main pharmacy building.
Therapy Rooms
Each therapy room is set up to be identical to one another in terms of furniture. Clinicians are not to remove furniture from therapy rooms unless it is absolutely necessary to carry out their therapy session. By order of the Fire Marshall, all furniture removed from a therapy room must be stored in another room, keeping the hallways free of obstructions in the event of an emergency. If it is necessary to move furniture from a therapy room, the clinician will be held responsible to return the furniture to its proper place.

Magnetic dry-erase boards have been installed in every clinic room at Pacific. Scottish Rite rooms have dry erase boards and are also equipped with cork boards that may also be used to hang items. To help keep our clinic rooms looking as neat as possible, clinicians are asked to refrain from taping or pinning items to the walls, instead, clinicians should hang items on the dry-erase board or cork board.

At the end of each session, clinicians are asked to wipe down the table in their therapy room, using disinfecting items found in the biohazard kit found in each therapy room. Clinicians should inform the office manager if the supplies in the biohazard kit are running low.
GENERAL INFORMATION

Universal Precautions
These precautions are hygienic measures used to prevent the spread of all infectious diseases including HIV/AIDS and HEPATITIS B.

Therapy rooms will be equipped with: latex gloves, facial tissues, antibacterial hand sanitizer, and disinfectant wipes (please let the office manager know if you need any of the above).

When providing therapy to clients, students will follow these universal precautions:
1. Clinicians will wash hands prior to beginning therapy. When water is not available, a no rinse antibacterial hand disinfectant should be used.
2. Gloves will be worn when any therapy or evaluation procedure may create exposure to bodily substances. Gloves will be used one time and will be properly disposed of in a plastic bag lined garbage can after use.
3. Clinicians will disinfect all chairs, tables, and therapy items before and after use. Disinfectant wipes are located in the white baskets in each therapy room at Pacific and in the cabinet at SRLC.
4. If there is an incident during therapy when bodily fluids are spilled (e.g. mucus from running noses or sneezing), the clinician will use the disinfectant wipes to clean up the area. If a client is bleeding or vomiting, notify the supervisor immediately.
5. Clinicians will wash hands after therapy sessions.

Emergency Procedures
Follow these steps in case of an emergency:

Illness or Injury
1. Contact a staff member who will call Public Safety (209-946-3911) or 911.
2. Describe the client’s condition and what happened.
3. Return to the client as soon as possible and make him/her comfortable.
4. DO NOT panic!
5. Wait for emergency crew to arrive.

Fire
1. Familiarize yourself with the fire exit procedures available in the clinic office.
2. Always be aware of the closest exit at any given time.

Earthquake
1. Stay indoors.
2. Get under a table or doorjamb.
3. After the earthquake, check for injuries and follow above procedures for any serious injuries.
Hardcopies of clinic forms can be found at both the Pacific Clinic and the Scottish Rite Clinic.

Electronic/downloadable copies of all forms can be found on the speech-language pathology webpage:

CLIENT CONTACT LOG

The contact log (see page 22) is attached to the left side of the client’s file and is to remain in the client’s file at all times. Clinicians/clinical supervisors are expected to use this log to document pertinent information received from the client/client’s family. Pertinent information includes, but is not limited to: address changes, change of phone number, change of educational placement, changes in medical treatment, etc. Clinicians/clinical supervisors should date and initial each entry they make in the log.
# CLIENT CONTACT LOG

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>VIA</th>
<th>SUBJECTS DISCUSSED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>T = Telephone</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>P = Person</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>M = Mail</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>N = Note</td>
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</tbody>
</table>


STATS

In June 1997 University of the Pacific and the Scottish Rite Temple contracted to provide therapy services to children using Speech-Language Pathology faculty, students, and staff. This contract includes the mandatory count of all children who receive services, diagnostic or therapy, at this site or a school site. The office manager must submit a monthly report. This report is reviewed monthly by:

Speech-Language Pathology Department Chair
Scottish Rite Language Center Director
Scottish Rite Temple Business Director
Scottish Rite Temple Board Member

At the end of the first month of treatment in the semester and every time a child enters our program after our semester has started you must fill out the STAT Form #1. This form is filed with the various clinic forms in the clinician’s room/materials room. This form provides the office manager with the primary information and status of a child.

Client status options on the #1 statistical form:

New: The child has never received therapy at Scottish Rite Language Center OR the child received services in the past but not during the previous semester or summer session.

Drop: The child has started therapy but was dropped during the semester or summer session. Indicate the date and reason for dismissal at the bottom of the form.

Returning: The child has received our services during the prior semester or summer session and is returning.

For each subsequent months of therapy use STAT Form #2. This form is filed with the various clinic forms in the clinician’s room/materials room. Use this form for every month of therapy after the first month. This is due the last clinic day of each month.

On both forms there is a section at the bottom for clients that have been discontinued from therapy. If you have a discontinued client, you do not have to wait to turn in a statistical form at the beginning of the following month. These can be submitted at any time.

These forms must be submitted for each client after the last therapy session of each month (sample forms on page 24).

* Reminder: If you cancel a therapy session because you are testing another client, this is not a clinician cancellation.
#1

SCOTTISH RITE CENTER FOR CHILDHOOD LANGUAGE DISORDERS
STAT Form for Children Only  (use first month of therapy in semester)

→ File Number: ______________

Month and Year: ________________________  Client Status: New ☐  Drop ☐  Returning ☐

Last Name: ____________________________  First Name: ______________________________

Age (years/months): _____________________  DOB: ____________________  Sex: ______

Disorder (please mark ALL disorders that apply:
☐ Articulation  ☐ Autism  ☐ Aural Rehab
☐ expressive language  ☐ receptive-expressive language  ☐ phonology  ☐ other

Number of times client came to therapy this month: ______________
Number of times client canceled this month: ______________
Number of times client “No Showed” this month: ______________
Number of times clinician cancelled this month: ______________

Clinician Name: ________________________________

_______________________________

IF YOU ARE DISCONTINUING THERAPY FOR THIS CLIENT, COMPLETE THIS SECTION:
Therapy discontinued (date): ________________  Reason: ____________________________

#2

Scottish Rite Center for Childhood Language Disorders
Stat Form for Children Only  (use second month of therapy and continuing)

Month and Year: ________________________

Client Last Name: ____________________________  Client First Name: ____________________________

Number of times client came to therapy this month: ______________
Number of times client canceled this month: ______________
Number of times client “No Showed” this month: ______________
Number of times clinician cancelled this month: ______________

Name of clinician: ________________________________

_______________________________

Use This Section If Therapy For This Client Is Being Discontinued.
*Therapy discontinued (date): ________________  Reason: ____________________________
SUPERVISED CLINICAL PRACTICUM HOURS

The University of the Pacific uses CALIPSO to document all clinical practicum clock hours. Please follow the procedures outlined by CALIPSO to document your hours.

It is highly recommended that clock hours be input on CALIPSO on the last day of your clinical experience.

Hours must be input on CALIPSO for supervisor approval no later than 3 days after completion of the clinical experience. Failure to do so will result in a reduction of your clinic grade.

www.calipsoclient.com/pacific

Step-by-step instructions on how to login and access your CALIPSO account can be found on our webpage:

THERAPY LOG

Students are expected to keep a daily record of therapy sessions with each client. These logs should be **NEAT and completed in blue or black ink.**

Log entries should indicate the date of each scheduled session and include a brief statement of the session goals. This form will also serve as an attendance record. If the client did not appear and did not call, students should record a "no show" for that session. If the reason for the absence is known, the student should indicate “unknown”.

Students should indicate consistent tardiness on this form as well.

The log should be completed after each session and will be turned in to the student’s clinical supervisor at the end of the semester.

This log should be kept in a twin-pocket folder (with lesson plans) on the left-hand side.

Note: If you have a group, you must complete a separate log for each client.
# THERAPY LOG

<table>
<thead>
<tr>
<th>Date</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

X

Supervisor Signature
LESSON PLANS

Lesson plans are a major factor in each student’s clinical practicum experience – students must complete them with thought and organization.

Written lesson plans **MUST** be placed in a pocket folder in the observation hallway before each session.

Students are strongly encouraged to consider the following when writing their lesson plans:

**OBJECTIVES:**
- these are client objectives, not clinician objectives
- these should be stated using behavioral verbs which describe an observable action
- state the criterion level of performance you want achieved
- state the conditions under which the behavior is to be performed
- state the **rationale** for choosing this particular objective

**THERAPY TECHNIQUES:**
- these are clinician oriented -- what you will do
- state the methods and techniques you will use to elicit the desirable behavior
- state the type and level of reinforcement that will be used
- list the materials you will use

Following therapy, students will write a session evaluation. Student comments should address the following areas:

- proficiency level(s) obtained
- effectiveness of teaching techniques and materials
- describe adaptations you made and why
- describe trends/patterns observed in the client’s responses
- analyze your results -- relate to past observations and data
- evaluate your own performance
- make suggestions to yourself for future lessons
- comment on your discussions with parents/spouses
- list questions to discuss with your clinical instructor
- describe general client behavior

Students should complete the self-evaluation portion of the lesson plan after each session. Leave in the pocket folder. Your supervisor will read and respond while observing your session. Keep all lesson plans in your folder with the most recent on top. Students are expected to respond to any questions that supervisors have asked.
## Lesson Plan

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>Objectives/Rationale (related to ICS Goals):</th>
<th>Teaching Techniques and Materials:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

 Clinician ___________________________ Date ___________________________ Supervisor/Observed ___________________________

 Client(s) ___________________________ Age ___________________________ Problem ___________________________

Rev. 09.11
## Clinician Hierarchy for Advancing Treatment

### CHAT Reference Chart

<table>
<thead>
<tr>
<th>Level</th>
<th>Client Ability</th>
<th>Clinician Support to Achieve Target Success</th>
<th>Parents/Teachers/Outside of Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 5</strong></td>
<td><strong>Getting There!</strong>&lt;br&gt;Able to self-monitor for errors with minimal support in unstructured activities&lt;br&gt;Client is consistently 80-100% accurate in the therapy setting</td>
<td>Provide very minimal or indirect cues&lt;br&gt;Provide opportunities for production in unstructured activities and/or linguistically complex tasks&lt;br&gt;Provide opportunities for self-monitoring in unstructured activities and outside of therapy setting</td>
<td>Client is able to self-monitor most of the time outside of therapy&lt;br&gt;Parents/teachers report client is generally accurate in most circumstances&lt;br&gt;Provide Level 4-Level 5 activities</td>
</tr>
<tr>
<td><strong>Level 4</strong></td>
<td><strong>Carrying it Over</strong>&lt;br&gt;Able to use target in new or exciting games; discourse with some support&lt;br&gt;Able to self-monitor for errors with moderate support in structured or familiar activities&lt;br&gt;Target is consistently accurate in structured activities&lt;br&gt;Target is inconsistent in unstructured activities</td>
<td>Provide occasional/subtle cues&lt;br&gt;Generally not necessary to provide a model of the target&lt;br&gt;Provide opportunities for production in increasingly distracting, less structured activities in therapy&lt;br&gt;Use increasingly complex linguistic stimuli&lt;br&gt;Provide opportunities for client to self-evaluate accuracy&lt;br&gt;Reinforce evidence of self-monitoring &amp; generalization&lt;br&gt;Provide many opportunities for production outside of therapy room</td>
<td>Client is able to produce target consistently in structured activities outside of therapy, 10-20 minutes&lt;br&gt;Client is able to self-monitor for specified periods of time outside of therapy&lt;br&gt;Parents/teachers may comment that target is spontaneously produced more frequently&lt;br&gt;Provide Level 3 activities for home/school</td>
</tr>
<tr>
<td><strong>Level 3</strong></td>
<td><strong>Moving Along</strong>&lt;br&gt;Aware of target goal in structured speech/language activity&lt;br&gt;May need more cues initially in session; fewer cues towards end of session&lt;br&gt;May need review of previously acquired steps initially in session</td>
<td>Provide explicit/subtle cues&lt;br&gt;Use delayed imitation may be needed initially; fewer cues needed later in session&lt;br&gt;May initiate activity with drill review, then proceed with less structured activity&lt;br&gt;Use of intermittent feedback is sufficient&lt;br&gt;Promote self-monitoring of accuracy&lt;br&gt;Increase linguistic complexity for productions</td>
<td>Client is able to practice Level 2 skills in specific, structured activities with parents, teachers&lt;br&gt;Emerging spontaneous use of target in structured settings (therapy, homework)&lt;br&gt;Generally does not produce target independently outside of therapy</td>
</tr>
<tr>
<td><strong>Level 2</strong></td>
<td><strong>A Conscious Effort</strong>&lt;br&gt;Able to produce target with conscious effort&lt;br&gt;Needs frequent cues to maintain accuracy&lt;br&gt;Needs consistent models to maintain accuracy&lt;br&gt;Can be accurate with slightly more complex stimuli</td>
<td>Provide moderate level of cues&lt;br&gt;Use prompts frequently, but not consistently&lt;br&gt;Use both direct imitation and delayed imitation&lt;br&gt;Elicit target with simple stimuli; slightly more complex than in Level 1</td>
<td>Support client in identifying new target to parent/teacher&lt;br&gt;Send home materials that promote awareness of new target&lt;br&gt;May practice Level 1 skills for short periods of time</td>
</tr>
<tr>
<td><strong>Level 1</strong></td>
<td><strong>Beginning a New Goal</strong>&lt;br&gt;Generally unaware of target&lt;br&gt;Requires maximum, explicit cues to produce new target accurately&lt;br&gt;Produces target correctly only in direct imitation&lt;br&gt;Accurate with only very simple stimuli</td>
<td>Demonstrate/explain new target&lt;br&gt;Provide explicit auditory/visual/tactile cues&lt;br&gt;Provide models of target consistently&lt;br&gt;Elicit target through direct imitation&lt;br&gt;Provide consistent (100%), contingent feedback&lt;br&gt;Provide explicit feedback for correct production&lt;br&gt;Elicit target with linguistically simple stimuli</td>
<td>Clinician will discuss new target, approach to therapy&lt;br&gt;Discuss initial steps to achieve long-term goal&lt;br&gt;May send home products from activities to stimulate awareness of target</td>
</tr>
</tbody>
</table>

### Continuum of Clinician Supports Throughout the Intervention Process

- **Social Linguistic Complexity:**
  - Simple
  - Complex
- **Feedback:**
  - Frequent
  - Rare
- **Model:**
  - Direct Imitation
  - Delayed Imitation
  - No Model
- **Cues & Prompts:**
  - Explicit
  - No Cues

*Remember to adjust your techniques while your client remains “fairly” accurate*

### Questions?
Contact Jill Duthie, PhD, CCC-SLP
jlduthie@pacific.edu

©2008 Duthie
## Lesson Plan - SAMPLE

<table>
<thead>
<tr>
<th>Clinician</th>
<th>Carrie O’Vur</th>
<th>Date</th>
<th>September 12, 2012</th>
<th>Supervisor/Observed</th>
<th>Germino</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client(s) Age</td>
<td>Johnnie R’Tick - 6 years</td>
<td></td>
<td></td>
<td>Problem</td>
<td>Articulation and Language</td>
</tr>
</tbody>
</table>

### Objectives/Rationale (related to ICS Goals):

1. Johnnie will produce the /s/ in the initial position of monosyllabic words with 75% accuracy.
   
   **Rationale** - Johnnie achieved the stated criterion of 95% on production of /s/ in isolation and syllables.

2. Johnnie will expressively identify 15 nouns (school and household objects) when presented with the object 10/15 times without verbal prompts.
   
   **Rationale** - Johnnie receptively identified these objects 29/30 attempts but has difficulty recalling the label to request the object.

### Teaching Techniques and Materials:

1. Modeling will initially be used. Visual feedback utilizing a mirror and tactile feedback using a tongue depressor will be utilized to elicit a consistent, correct response. To involve Johnnie in the process, he will draw his own articulation cards given choices of appropriate words. For each 10 correct responses he will earn a bean bag to throw at the end of the activity.

2. A "grab bag" activity will be utilized. Modeling will be used if he doesn't respond. During play Johnnie will be encouraged to request items by its label. Partial models will be used if necessary. Social praise will be used intermittently for staying on task.
Client Information and Planning Sheet

Clinical Supervisor: __________________________ Date: __________________

Clinician: __________________________ Client: __________________________


Background Information:

Assessment Plan (include rationale; include both formal and informal measures you plan to use):

Treatment Plan (include rationale):

NOTE: DO NOT write goals here. List and provide rationale for possible goals/treatment areas based on review of the client’s file.
Client Information and Planning Sheet - SAMPLE

Clinical Supervisor: Germino Date: _______________
Clinician: ____________________ Client: Johnny

Background Information:

Developmental milestones met WNL
Dx’d with ADHD @ 3½
Allergic to peanuts

Assessment Plan (include rationale; include both formal and informal measures you plan to use):

Goldman-Fristoe Test of Articulation – assess speech sound production. Previous report states client has several speech sound errors.

Informal probe of regular & irregular past tense verbs. Previous report states this is an area of need.

Probe sequencing and re-telling of stories/events (informal). Previous clinician recommends probing this for a possible goal.

OWLS – if time permits. Assess receptive/expressive language. Previous reports reveal language needs. Full language assessment has not been completed in over 1 year.

Treatment Plan (include rationale):

NOTE: DO NOT write goals here. List and provide rationale for possible goals/treatment areas based on review of the client’s file.

K & G @ sentence level – previous goal. Progress report indicates 80-90% @ word level.

Irregular past tense verbs, previous SPELT results indicate errors. Last progress report reveals worked on regular past tense and has mastered.

Sequencing and re-telling stories/events – recommended by previous clinician.

07/13
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Explanation
This authorization for use or disclosure of my health information is required by state and federal law. Failure to provide all information requested may invalidate this authorization.

Patient Name: __________________________  DOB: ______________

I authorize __________________________________________

Name of hospital, physician, health care provider

Street Address
City
State
ZIP
to use and/or disclose my health information to:

University of the Pacific – Speech and Hearing Center

Name of hospital, physician, health care provider

3601 Pacific Avenue Stockton CA 95211

Type of records to be released:
☐ Speech Therapy Records Only  ☐ Speech therapy and Audiology Records
☐ Audiology Records Only  ☐ Complete Medical Records

Purpose for disclosing information: speech therapy/speech treatment

Expiration
This authorization will expire on ________________ (not to exceed 2 years from the original date of signature) or one year from the date of this authorization.

Restrictions
California law prohibits the recipient of this form from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.
Your Rights:
- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment, payment or health plan enrollment or eligibility for benefits.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to:
  
  University of the Pacific
  Speech and Hearing Center
  3601 Pacific Avenue
  Stockton, CA 95211

- My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.
- I may inspect and obtain a copy of the health information of which I am authorizing the use or disclosure of my health information.
- I have a right to receive a copy of this authorization.

If this box □ is checked, a copy of this authorization was requested and received.

Signature: __________________________ Date: __________________________

Patient or Legal Representative

If signed by other than patient, print name and relationship to the patient:

Name: __________________________ Relationship: __________________________

Witness Signature: __________________________ Date: __________________________

□ Check if you have Power of Attorney (POA) for the above patient. Please attach a copy of your POA form.
CONSENT FOR EXCHANGE OF INFORMATION

Child’s Name (please print) | Birthdate

I hereby give permission for the exchange of information as listed below:

<table>
<thead>
<tr>
<th>Send information to:</th>
<th>Obtain information from:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Scottish Rite Language Center</td>
<td>1. __________________________</td>
</tr>
<tr>
<td>33 W. Alpine</td>
<td>__________________________</td>
</tr>
<tr>
<td>Stockton, CA 95204</td>
<td>__________________________</td>
</tr>
<tr>
<td>Fax: (209) 462-1720</td>
<td>Fax #:</td>
</tr>
<tr>
<td>2. __________________________</td>
<td>2. __________________________</td>
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</tbody>
</table>

☐ Speech Therapy Records only
☐ Speech Therapy & Audiology Records
☐ Audiology Records only
☐ Complete Medical Records

I also authorize use of clinical observations, videotaping, photographs, and case discussion for professional, research, and training purposes.

Parent/Legal Guardian | Date

NOTE: A copy of this form is as valid as the original.

—Affiliated with the Department of Speech-Language Pathology at University of the Pacific—
Scottish Rite Client Profile Sheet

Client Name: ___________________________ DOB: ___________ Age: ________

Gender: □ Male □ Female
Disorder: ___________________________________ Severity: ______________________
Significant History: __________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

SPEECH

1. Speech Intelligibility: ______ normal ______ fair ______ poor ______% intelligible
2. Target Sounds: __________________________________________________________
3. Phonological Processes: _______ _______ _______ _______ _______

LANGUAGE

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

FLUENCY/VOICE:

Therapy Recommended: □ Yes □ No--If not, Why? ____________________________
Level of Priority: □ Low □ Medium □ High

Recommended Therapy Goals:

1. ________________________________________________________________
2. ________________________________________________________________
3. ________________________________________________________________
4. ________________________________________________________________

Child’s Ability to Participate in Group Therapy: ______Excellent ______OK ______No
Would work well in a group with _______________________________________

Behavioral Characteristics: (Circle the terms that best apply.)
Attention span: Normal Low
Level of hyperactivity: High Normal Low
Cognitive functioning relative to C.A.: Normal <1-2 yrs <3-4 yrs
Amount of structure required High Medium Low
Social skills re: relating with others: Good Fair Poor
Ability to follow rules: High Medium Low

Clinician: ___________________________________________ Date: ____________
Supervisor: ___________________________________________ Supervisor’s Initials: ________

12/13
Pacific Adult Clinic
Client Profile Sheet

Client Name: ________________________________  Age: __________
Gender: □ Male  □ Female
Disorder: ________________________________  Severity: ________________________________

Significant History:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Attendance: □ Excellent  □ Good  □ Fair  □ Poor
Punctuality: □ Excellent  □ Good  □ Fair  □ Poor
Motivation: □ Excellent  □ Good  □ Fair  □ Poor

Therapy Recommended:  □ Yes  □ No
If not, Why? ________________________________________________________

Level of Priority:  □ Low  □ Medium  □ High

Recommended Therapy Goals:
1. ________________________________________________________________
2. ________________________________________________________________
3. ________________________________________________________________
4. ________________________________________________________________

Is the client an appropriate candidate for the Aphasia Group? □ Yes  □ No

Clinician: ________________________________  Date: ________________________________
Supervisor: ________________________________  Supervisor’s Initials: __________

11/14
CLIENT FEEDBACK QUESTIONNAIRE

Please read each question carefully and circle the answer that is best for you. After you have completed this questionnaire, please return it to your clinician/supervisor or the office manager. Thank you for your time.

☐ Pacific Clinic       ☐ Scottish Rite Clinic
☐ Individual Therapy  ☐ Group Therapy

SA = Strongly Agree  N = Neutral  SD = Strongly Disagree
A = Agree            D = Disagree  NA = Not Applicable

1. It is important that you benefit from speech-language therapy.
   A. My child or I have improved as a result of receiving services.
      SA  A  N  D  SD  NA
   B. My family and I better understand the problem.
      SA  A  N  D  SD  NA

2. You are important to us; we are here to work with you.
   A. The support staff (e.g. office manager) who served me was courteous and pleasant.
      SA  A  N  D  SD  NA
   B. The clinician/supervisor who served me/my child was courteous and pleasant.
      SA  A  N  D  SD  NA
   C. The clinician/supervisor considered my/my child’s special needs (age, culture, education, handicapping condition, eyesight and hearing).
      SA  A  N  D  SD  NA
   D. The clinician/supervisor included my family or other persons important to us in the services provided.
      SA  A  N  D  SD  NA
   E. I am able to discuss my concerns with the clinician/supervisor.
      SA  A  N  D  SD  NA

3. Our speech-language staff is trained and qualified to serve you.
   A. The clinician/supervisor was prepared and organized.
      SA  A  N  D  SD  NA
   B. The services were explained to me in a way that I could understand.
      SA  A  N  D  SD  NA
   C. The clinician/supervisor was experienced and knowledgeable.
      SA  A  N  D  SD  NA

4. It is important that our environment is secure, comfortable, attractive, distraction free, and easy to reach.
   A. The environment was clean and pleasant.
      SA  A  N  D  SD  NA
   B. The environment was quiet and distraction free.
      SA  A  N  D  SD  NA
   C. Parking was available and convenient.
      SA  A  N  D  SD  NA

5. We respect and value your comments.
   A. Overall, the program services were satisfactory.
      SA  A  N  D  SD  NA
   B. I would seek your services again if needed.
      SA  A  N  D  SD  NA
   C. I would recommend your services to others.
      SA  A  N  D  SD  NA

Comments: ____________________________________________________________
Initial Case Summary
Speech and language assessments should be completed during the first three sessions; therefore, students must plan these sessions carefully. Students should use observations along with formal and informal tests to determine areas in need of remediation and to design an appropriate therapy plan. All test protocols will become part of the client’s permanent record. Protocols should be neatly filled-out in blue or black ink – ORIgINAL protocols should be submitted (i.e. DO NOT rewrite the protocols).

The initial case summary is due 72 hours following the third session. Students should refer to the template on the following page and verify that they are addressing each area, even if there is no problem. Remember that you MUST use your own wording when writing a report. DO NOT COPY OTHER STUDENT’S WORK. Also, do not take information for granted – always verify the content with the client or parent.

All reports are to be written in a professional style. Should the student have questions, he/she should ask his/her clinical instructor for clarification. The rough draft of the report should be typed and double-spaced.

The final draft of all reports should be single-spaced, carefully proofread and signed by the student, clinical supervisor and client/parent. Clinicians should include all protocols used up to this point when submitting their report to their instructor. Student should ALWAYS submit the completed report to their clinical supervisor – students ARE NOT to place reports/protocols in the client’s file themselves.
INITIAL CASE SUMMARY

Client Name: (first name, last initial)  
File #: Date of Summary:  
Sex: Age: Student Clinician:  
Supervisor:

Statement of the Problem
Include information regarding referral and diagnosis from the client’s diagnostic report, as well as your current impressions.

Pertinent History
Medical history (prenatal, birth, postnatal)  
Developmental history  
Previous hearing test results  
Special testing (psychological, etc.)  
Previous therapy (UOP, school, elsewhere, dates, goals and progress)  
School (name of school, teacher, grade, performance, adjustment, etc.)  
Family (information about parents, siblings, familial history or speech problems, etc.)

Test Results/Current Level of Functioning
Include the most recent test findings and your clinical observations. Take into account the following:

Speech
Articulation (words, connected speech, stimulability, discrimination)  
Phonology  
Voice (pitch, quality, loudness, intonation)  
Fluency and Rate (cluttering, stress, repetitions, hesitations, prolongations)  
Oral Periphery Examination (indications of structural and muscular problems)  
Judgment of intelligibility

Language
Receptive and Expressive (vocabulary, grammar, syntax, etc.)  
Formal Tests  
Language Sample (description of language including MLU)  
Phonemic Awareness

Hearing
Report results if screened by you. If you do not conduct a hearing screening, report results of most recent screening including who screened who and when.

Communicative Competence  
Pragmatic Skills  
Interpretations and Discussion:  
Provide a descriptive summary of your assessment results and impressions.
If there is a discrepancy between current test results and your own observations, or previous test results, state it here

Include impressions relative to casual factors.

**Goals and Therapy Techniques:**
State the goals for the semester. Describe therapy techniques and materials you plan to use to implement the goals. Include:

- Goal
- Baseline
- Rationale
- Therapy Techniques and Materials

This section should be descriptive, not just a list. Describe what you (the clinician) will do to help the client achieve the goal. Materials to be used can be listed (versus described).

**Prognosis**
Make a realistic statement about the probable outcome of the goals, mentioning factors that might interfere with progress and factors that might facilitate progress.

Student Clinician: __________________________

Supervisor: ________________________________

Parent: ________________________________
Progress Report
This report is due approximately two weeks before the final session of clinic. Students are responsible for checking the clinic calendar for the specific date.

Students should refer to the template on the following page indicating what should be included on this report. The rough draft of the report should be typed and double-spaced.

The final draft of all reports should be single-spaced, carefully proofread and signed by the student, clinical supervisor and client/parent. Clinicians should include all protocols used up to this point when submitting their report to their instructor. Student should ALWAYS submit the completed report to their clinical supervisor – students ARE NOT to place reports/protocols in the client’s file themselves.
PROGRESS REPORT

Client: (first name, last initial)  File #:  Date of Summary:
Sex:  Age:  Student Clinician:

Supervisor:  Number of Sessions:

Statement of the Problem
(Taken from Tx. plan)

Assessment Results
(Include this section only if additional assessment was conducted after the Initial Case Summary was completed. State the reason additional assessment was conducted)

Goals and Therapy Techniques
(Taken from Tx. Plan and/or modified if changes were made during the semester. NOTE: Change verbs to past tense where appropriate (baselines and techniques). You are reporting on what has occurred, not what will happen.)

Include:
  Goal:
  Baseline:
  Rationale:
  Therapy Techniques and Materials:
  Progress:

Summary and Recommendations
(Summarize what has occurred during the semester and make recommendations. Consider the following: continuation or dismissal, individual or group therapy, future goals, parental/family involvement. Mention factors that facilitated or hindered progress including attendance patterns (including tardiness), attitude and participation during sessions, completion of homework assignments, etc…..)

Student Clinician: ___________________________
Supervisor:  ______________________________
Parent:____________________________________
Diagnostic Report
Diagnostic reports are to be written following a diagnostic evaluation conducted by the student’s diagnostic team. Depending on the team, students may write the report as a group or individually with input from the teammates. Students responsible for writing the report should refer to the template on the following page showing what should be included in this report. Due dates for these reports will differ so students should check with their clinical instructor.

The final draft of all reports should be single-spaced, carefully proofread and signed by the student clinicians and clinical supervisor. Clinicians should include all protocols used when submitting their report to their instructor. Students should ALWAYS submit the completed report to their clinical supervisor – students ARE NOT to place reports/protocols in the client's file themselves.
University of the Pacific
Scottish Rite Language Center

DIAGNOSTIC REPORT

Client Name: (first name, last initial)  
File #:  
Date of Evaluation:  
Sex:  
Age:  
Student Clinicians:  
Supervisor:  

REFERRAL
Include referral sources, date of referral, statement of problem by referral source, and date of evaluation.

HISTORY
Include prenatal, birth (delivery), medical, developmental (motor, speech, etc.), educational, familial, social, etc.

FINDINGS
- Language (receptive and expressive) – address each area (i.e. semantics, syntax, pragmatics, etc.)
- Articulation (isolated word test, stimulability, connected speech)
- Phonology
- Voice (pitch, loudness, quality, and intonation)
- Fluency and Rate (repetitions, prolongations, hesitations, cluttering, stress)
- Intelligibility
- Hearing (screening and tympanometry)
- Speech Mechanism Examination
- General Behavior (description of behavior during the evaluation and communicative competence)

CLINICAL IMPRESSIONS
- What the problem is.
- Why it exists.

RECOMMENDATIONS AND PROGNOSIS
- Include whether or not speech and/or language therapy is recommended, as well as whether or not therapy at our clinic is recommended. Keep in mind that not all clients are appropriate for our clinic. If they are not appropriate for our clinic, explain why.
- State the predicted outcome, mentioning factors that might interfere with progress and factors that might facilitate progress.

Student Clinicians: ________________________________
Supervisor: ________________________________
GRADING POLICY

Progress toward meeting clinical competencies (see page 45) is documented using CALIPSO software and grade form.

When a student clinician has more than one supervisor, the grades will be averaged and information from all supervisors will be used to determine the student’s final grade.

A clinical practicum grade lower than a B- is not considered a passing grade. Hours will not be counted as clock hours at the graduate level. For undergraduates, a clinic grade of lower than a B- means you will not be eligible for clinic. For graduates, a clinic grade lower than a B- will result in a Remediation Plan of Action.

The following items must be completed and turned in before a student will receive his/her clinic grade:

- Progress Report - signed by supervisor and client/client’s guardian
- Protocols
- Therapy Log - signed by supervisor
- Client Profile Sheet
- Supervisor Evaluation(s) - submitted online via CALIPSO
- Clinical Clock Hours - submitted online via CALIPSO (submit within 3 days of the end of clinic for supervisor review and approval)

Failure to complete/submit any of the above by the designated dates will result in a lowered and/or incomplete grade. Upon completion of the requirements, a grade will be assigned but will reflect the student’s failure to meet deadlines.
University of the Pacific
Scottish Rite Language Center

CLINICIAN LEVELS AND EXPECTATIONS

BEGINNING CLINICIAN (0-50 HOURS)
1. Student functions efficiently within the Direct-Active Style of Supervision.
2. Consistently follows through on supervisors directives.
3. Takes initiatives to ask questions.
4. Works to understand independence/dependence issues.
5. Anticipates deadlines and works to meet them without reminders.
6. Emerging ability to explain rationale for decisions.
7. Demonstrates understanding of competencies.
8. Explores the meaning of excellence concerning professional development.

INTERMEDIATE CLINICIAN (50-100 HOURS)
1. Student functions effectively within the Collaborative Style of Supervision.
2. Demonstrates emerging ability to identify client needs without directives.
3. Asks questions which demonstrate independent thought and problem solving.
4. Demonstrates good understanding of independence/dependence issues.
5. Demonstrates effective planning with respect to deadlines.
6. Able to articulate rationale for clinical decisions.
7. Shows emerging ability to identify own competencies which need improvement.
8. Begins to identify own areas of potential excellence.

ADVANCED CLINICIAN (100+ HOURS)
1. Student functions effectively within the Consultative Style of Supervision.
2. Student works effectively without directives, modifies when directed by supervisor.
3. Asks questions which demonstrate careful thought; provides possible solutions.
4. Functions independently while understanding the implications of working under the supervision of another's license or certificate.
5. Effectively meets all deadlines.
6. Able to articulate clearly the rationale for clinical decisions.
7. Demonstrates ability to identify competencies that need improvement and develops a plan for those areas.
8. Demonstrates progress in areas of excellence.
University of the Pacific
Scottish Rite Language Center

CLINICAL OBJECTIVES AND COMPETENCIES

I. Demonstrates careful thought and planning
   a. Demonstrates application of course work in clinical setting
   b. Gives evidence of considering consequences before acting
   c. Plans carefully and is adequately prepared
   d. Considers the intent of supervisor directives and acts accordingly
   e. Analyzes established clinical procedures and modifies if needed

II. Seeks to facilitate ongoing learning process
   a. Willing to ask questions
   b. Receives constructive comments without resistance or negativity
   c. Demonstrates professional curiosity
   d. Seeks to deepen understanding of the profession
   e. Understands how one's own behavior influences others

III. Understands diagnostic and assessment information
   a. Develops clinical hypotheses based on available information
   b. Designs diagnostic plan to address all hypotheses
   c. Administers and scores tests and procedures appropriately
   d. Interprets results accurately and develops valid recommendations
   e. Approaches diagnosis systematically to ensure thoroughness

IV. Conducts effective therapy sessions
   a. Writes goals and objectives appropriate for the client
   b. Procedures are clearly related to objectives
   c. Materials selected are appropriate for task and client
   d. Records and tracks client performance systematically
   e. Reviews performance and modifies therapy in response

V. Demonstrates good technical skills in therapy
   a. Changes task difficulty in response to client feedback
   b. Uses effective reinforcement and motivational techniques
   c. Provides accurate and timely feedback to client
   d. Paces therapy appropriately, neither too fast nor slow
   e. Conducts sessions efficiently and with confidence

VI. Demonstrate ethical behavior
   a. Makes best interest of client first priority
   b. Treats everyone with respect and safeguards confidentiality
   c. Provides accurate accounts of events
   d. Works to enhance respect for profession and institution
   e. Adheres to ASHA Code of Ethics

VII. Demonstrates effective communication skills
   a. Listens to client, family and supervisors
   b. Explains concepts, procedures and rationale clearly to client
   c. Writes professionally with clear content and technical accuracy
   d. Facilitates communication between others when appropriate
   e. Changes personal style of relating when situation demands

VIII. Works effectively as a team member
    a. Demonstrates ability to functions effectively on a team
    b. Inquires about and follows lines of authority
    c. Works to support excellence of team functioning
    d. Anticipates problems and proposes solutions as appropriate
    e. Follows through with assignments and meets deadlines

IX. Develops practices that support professional excellence
    a. Takes initiative to suggest new approaches to therapy
    b. Advocates for clients and families
    c. Conducts ongoing self-analysis and develops improvement plans
    d. Solves problems independently; seeks advice when needed
    e. Conducts therapy within a research framework

X. Relates to client and family from a holistic perspective
   a. Maintains professional focus on communication needs
   b. Considers physical needs as appropriate
   c. Considers psychological needs as appropriate
   d. Considers spiritual needs as appropriate
   e. Functions with an awareness of one's own belief system
END OF THE SEMESTER
CLINIC CHECKLIST

☐ Clinical Clock Hours - submitted online via CALIPSO (submit within 3 days of the end of clinic for supervisor review and approval)

☐ Progress Report – signed by all parties involved

☐ Therapy Log – completed in black or blue pen; signed by your supervisor(s)

☐ Protocols – ALL protocols used throughout the semester

☐ Supervisor Evaluation(s) – one needs to be completed for each of your clinical instructors; completed online via CALIPSO

☐ Internship/Fieldwork Site Midterm/Final Grade

☐ Client Profile Sheet – Turn in to your supervisor one week before the end of clinic.

☐ Client Feedback Questionnaire

  PACIFIC – clinicians will distribute to his/her client(s) and clients will return the form to Kristen.
  SRLC – office manager will distribute and collect from parents.

All items (except those completed online via CALIPSO) should be turned in to the office manager on the last day of clinic.

NOTE: Failure to turn in any of these items will result in a lowering of your clinic grade.
REMEDIATION PLAN OF ACTION

Name: ______________________________________

Date: ______________________________________

The following remediation plan is based on the following:

The academic/clinical faculty and Graduate Program Director discussed the following plan:

- Each semester you will meet with clinical and academic faculty at midterm to discuss your progress in all areas
- At the end of each semester you will meet with clinical and academic faculty to evaluate your progress in all areas; at that point a determination will be made as to the type of clinical practicum experience/s will be provided the following semester
- There is no guarantee that completing these experiences will result in completion of the program

I understand and agree with the remediation plan:

__________________________________________  _____________________________
Student name  Date
CONFIRMATION PHONE CALL SCRIPT

Call to Client:
Hello Mr. /Ms. /Mrs. __________________
This is (your name) from the Pacific Speech, Hearing & Language Center calling to remind you of your appointment for speech therapy tomorrow, (day of the week) at (time). Thank you. I look forward to seeing you tomorrow 😊

If leaving a recorded message, add: If you are unable to make this appointment, please call 209-946-2381. Thank you.

Call to Parent/Guardian of Client:
Hello Mr. /Ms. /Mrs. __________________
This is (your name) from the Scottish Rite Childhood Language Center calling to remind you of your son/daughter’s appointment for speech therapy tomorrow, (day of the week) at (time). Thank you. I look forward to seeing you tomorrow 😊

If leaving a recorded message, add: If you are unable to make this appointment, please call 209-462-2613. Thank you.
TIPS FOR WRITING REPORTS

1. Keep the tense consistent throughout the report.
2. Report your findings objectively; all conclusions must be supported by the data.
3. Address persons with the appropriate title (Mr., Mrs., Dr., etc.)
4. Make sure complete, correct addresses are included.
5. Write in complete sentences, using correct spelling, grammar, and punctuation.
6. Avoid redundant vocabulary.
7. Avoid writing in conversational style; reports should be written using professional language.
8. Present information in a logical sequence . . . not necessarily in the same order you performed the tests.
9. State the full name of tests, diagnostic labels, institutions, facilities, etc. the first time you use them in a report. Thereafter, you can use abbreviations or acronyms.
10. Check for misused words (e.g., affect/effect, among/between, accept/except, principle/principal, ensure/assure).
11. Beware of unusual singulars and plurals (e.g., datum/data, criterion/criteria, phenomenon/phenomena, locus/loci, parenthesis/parentheses).
12. Write in the third person (e.g., "The Token Test was administered" rather than "I administered the Token Test").
13. Express information in behavioral terms (e.g., "followed two-step commands" versus "is able to follow two-step commands").
14. Avoid use of contracted verb forms (e.g., isn't, can't, I've).
15. Read your completed report before turning it in and make sure it makes sense (you will be surprised what you find).
PACIFIC PRINT INSTRUCTIONS

Below are steps for you to print an item from your personal laptop or USB drive:

WEB PRINT:
You can upload a file to the PacificPrint website at print.pacific.edu and use web print to submit to either the PacificPrint B&W or PacificPrint Color queue. Then release the job from any PacificPrint device per normal.

To load a print project to PacificPrint Web Print:
1. Login to the PacificPrint website at print.pacific.edu with your PacificNet ID and password.
2. Select Web Print from the left menu
3. Select Submit a Job >>
4. Select which printer queue you'd like to use: PacificPrint B&W or PacificPrint Color
5. Click on the 2.Print Options and Account Selection >> button
6. Type in the number of copies you are requesting
7. Click on the 3.Upload Document button
8. Click on the Choose File button to locate and select a document to upload and print.
9. Click on the Upload & Complete >> button
10. The webpage will update the status of your file upload and availability to print the job. Once it reads Held in a queue you can release it per normal from any PacificPrint device by swiping your ID card and selecting the file from the touchscreen.

Note: WebPrint is limited to the following file types: Microsoft Word, Microsoft Excel, PDF and Microsoft PowerPoint

USB PRINTING
You can also save your item on from your laptop/computer to a USB device and plug the device into the copier to print. Once you have plugged your USB into the copier, swipe your ID card and choose the file using the touchscreen and print the job.

Note: USB Printing is limited to PDF files.
ASHA Code of Ethics

Preamble
The preservation of the highest standards of integrity and ethical principles is vital to the responsible discharge of obligations by speech-language pathologists, audiologists, and speech, language, and hearing scientists. This Code of Ethics sets forth the fundamental principles and rules considered essential to this purpose.

Every individual who is (a) a member of the American Speech-Language-Hearing Association, whether certified or not, (b) a nonmember holding the Certificate of Clinical Competence from the Association, (c) an applicant for membership or certification, or (d) a Clinical Fellow seeking to fulfill standards for certification shall abide by this Code of Ethics.

Any violation of the spirit and purpose of this Code shall be considered unethical. Failure to specify any particular responsibility or practice in this Code of Ethics shall not be construed as denial of the existence of such responsibilities or practices.

The fundamentals of ethical conduct are described by Principles of Ethics and by Rules of Ethics as they relate to the responsibility to persons served, the public, speech-language pathologists, audiologists, and speech, language, and hearing scientists, and to the conduct of research and scholarly activities.

Principles of Ethics, aspirational and inspirational in nature, form the underlying moral basis for the Code of Ethics. Individuals shall observe these principles as affirmative obligations under all conditions of professional activity.

Rules of Ethics are specific statements of minimally acceptable professional conduct or of prohibitions and are applicable to all individuals.

For the most current copy of the ASHA Code of Ethics can be viewed here: http://www.asha.org/Code-of-Ethics
Confidentiality/Technology Agreement

As a student in the Speech-Language Pathology program at the University of the Pacific, I__________________________________________, understand that I am bound by the policies and procedures outlined in the clinic handbook, HIPPA, and the ASHA Code of Ethics. To honor my commitment, I understand that:

- Client files and contents may not leave the clinic
- No part of client files or paperwork (including lesson plans) may be photocopied or photographed
- The client information is to be kept confidential and may not be discussed outside of the clinic or classroom
- Personal equipment (iPhones, iPads, etc.) may not be used to photograph or record (audio or visual) clients.
- Only department equipment may be used to photograph or record clients after the appropriate release form has been signed. This information is not to leave the clinic. It may not be copied or downloaded.

I understand that failure to follow the above will result in disciplinary actions which may include dismissal from the clinical practicum experience or the program.

_________________________________________  __________________________
Student Signature                       Date

08.12