

Application to Upgrade to Speech-Language Pathology Assistant Certificate



Board of Examiners
For Speech-Language
Pathology & Audiology
(971) 673-0220
(971) 673-0226 fax
800 NE Oregon St
Ste 407
Portland OR 97232
www.bspa.state.or.us

Fill out and submit this form if you are upgrading from a Provisional Speech-Language Pathology Assistant (SLPA) certificate.

To issue your certificate, we need to have:

1. This form (originals, no faxes or copies, please) completed in its entirety.
2. A check or money order payable to "Oregon Speech Board" for the licensing fee, which is \$65 for a license that expires on January 30, 2018. The license must be renewed prior to December 31, 2017.
3. The SLPA Clinical Competency Checklist —(See Supplement 3)
4. The SLPA Clinical Fieldwork Log —(See Supplement 4)
5. Supervision Change Notice—(See Supplement 5) - All certificate holders working as SLPAs must be supervised by qualified individuals. If you do not currently have a supervisor you can keep the form to use when you are assigned a supervisor. Supervision change forms must be submitted within 30 days of any change.

Note: There are no professional development (PD) hours required with this application, however you will need to submit PD to renew your SLPA Certificate. See our PD page for details.

Personal / Contact Information

Name: _____
First Middle Last

Email: _____

Home Address - Required

Street1: _____

Street2: _____

City State Zip Code

Home Phone Number Cell Phone Number

Current Work Address - Title: _____ (Or mark "not employed")

Employer: _____

Address: _____

City State Zip Code

Work Phone Number

Oregon SLPA Employment Offer (if any) Expected Start Date: _____

Employer: _____

Address: _____

City State Zip Code

Work Phone Number

Your email address will be used for Board correspondence and not shared with others. This is the primary way that the Board communicates with licensees.

Check the box indicating which address you like to use for Board correspondence. This address will be printed on your license.

REMEMBER WHILE LICENSED: Board rules require licensees to update contact information within 30 days of the change.

NOTE: If you have a job offer in Oregon pending licensure, provide that address and planned start date. Remember you **MAY NOT** practice as an SLPA before receiving your regular SLPA Certificate.

Clinical Fieldwork Details

Fill in the details of your supervised clinical fieldwork. You must include with your application a completed copy of your "Clinical Competency Checklist" & "SLPA Clinical Fieldwork Log"

Supervisor: _____

Fieldwork Participant: _____

Site: _____

Start Date: _____ End Date: _____ Hours/Week: _____

Criminal / Adverse Professional History

Answer all questions below with yes or no. Failure to answer truthfully may result in denial of your application and/or disciplinary action by the Board.

Since you applied for your Provisional SLPA Certificate:

Have you been arrested for any reason?

(Even if not charged and/or charges dismissed)

Have you been charged in court with any violation of the law (other than minor traffic violations)?

Have you been convicted of any violation of the law (other than minor traffic violations)?

Have you been the subject of a complaint reported to another licensing agency?

Have you been the subject of any disciplinary investigation or action by another licensing agency?

Have you voluntarily surrendered or resigned a professional license/certificate?

Yes*

No

* If you answer yes to any of the questions, please include a copy of the related court proceedings, police reports and/or Board order for each conviction and/or disciplinary action. You must also attach a written narrative (your own personal statement) describing the surrounding facts and circumstances.

Certification and Affidavit

I have read the provisions of the Oregon Law (ORS 681) and Oregon Administrative Rules (OAR 335). I agree to abide by all the Laws and Rules pertaining to my license. I understand that the burden of proof in meeting the requirements for licensure is upon myself and not the Board. I agree to be responsible for the collection and accuracy of required materials.

You are expected to read and comply with Oregon Revised Statute (ORS) 681 and Oregon Administrative Rules (OAR) 335.

Affidavit of Applicant

I, _____, depose and say that all of the above statements are true and correct; that I am the person described and identified above and on all attached documents.

The ORS and OARs can be found from our Rules/ Statutes page on our website:

<http://www.oregon.gov/bspa/Pages/rules.aspx>

Signature of Applicant

Date

Supplement 3 Speech-Language Pathology Assistant (SLPA) Clinical Competency Checklist



Board of Examiners
For Speech-Language
Pathology & Audiology
(971) 673-0220
(971) 673-0226 fax
800 NE Oregon St
Ste 407
Portland OR 97232
www.oregon.gov/bspa

The clinical fieldwork supervisor must complete the ratings below for each rating period—that is, after each 25 hours of clinical interaction time. Your initials indicate that you met and discussed these ratings.

Fieldwork Participant Name: _____

Area of Examination	Rating #1 Date:	Rating #2 Date:	Rating #3 Date:	Rating #4 Date:
Knowledge of universal health and safety precautions.	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds
Basic Knowledge of workplace policies. Choose work setting below.				
<input type="checkbox"/> Public Schools / Early Childhood Programs Special Education Procedural Safeguards	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds
<input type="checkbox"/> Private Practice / Clinic Settings Ethical standards, policies and procedure	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds
<input type="checkbox"/> Hospital Setting Ethical standards, policies and procedure	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds
Ability to follow a therapy plan over time.	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds
Completes individual therapy sessions.	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds
Completes group sessions with behavior management.	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds
Collects data on therapy sessions.	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds
Demonstrates understanding and ability to address client confidentiality issues.	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds	<input type="checkbox"/> Does Not Meet <input type="checkbox"/> Meets <input type="checkbox"/> Exceeds
Participant Initials	1st Qtr:	2nd Qtr:	3rd Qtr:	4th Qtr:
Supervisor Initials	1st Qtr:	2nd Qtr:	3rd Qtr:	4th Qtr:

Supervisor Signature _____

Date _____

Oregon License # or ASHA Certification # _____

Supervisor Name (Print) _____

Site (Print) _____

Supplement 5 SLPA Supervision Change Notice



Board of Examiners
For Speech-Language
Pathology & Audiology
(971) 673-0220
(971) 673-0226 fax
800 NE Oregon St
Ste 407
Portland OR 97232
www.bspa.state.or.us

You are required to be supervised by a SLP that meets the qualifications listed in [OAR 335-095-0040](#).

The SLPA must complete sections 1 and 2, and have the supervisor complete sections 3, 4, 5 (if appropriate) and 6 (if appropriate).

You are required by OAR 335-005-0020(10) to notify the Board of changes (additions/subtractions/replacements) in your supervision within 30 days of the change.

Section 1

Effective Start Date of Supervision: _____

Section 2

Assistant Information

Name: _____
Cert #: _____ Expiration Date: _____
Phone: _____ Email: _____

Affidavit:

I have read and agree to abide by the provisions of [Oregon Administrative Rules Chapter 335, Division 95, regarding SLPA supervision](#) (http://arcweb.sos.state.or.us/rules/OARs_300/OAR_335/335_095.html).

Signature Date

Supervisor Information

- Adding to my existing list of supervisors
- Replacing Provisional Supervisor

Name: _____
Phone: _____ Email: _____
BSPA Lic. #: _____ Expires: _____

Years of Professional Experience since obtaining graduate degree: _____

If qualifying via TSPC licensure with endorsement, please fill out section 5 & 6 as well.

Your SLP supervisor must hold an active SLP license from this Board, or meet additional requirements if licensed by TSPC. See the [Licensee Directory](#) on our website.

If you are not currently working as an SLPA, write "NOT EMPLOYED" across the effective Start Date of Supervision section. When you begin work as an assistant, be sure to submit an SLPA Supervision Change Form (available on the Forms page of our website).

IMPORTANT:

If you have multiple supervisors, make a copy of this page for each supervisor and attach all of the supervisor sheets to this application.

REMEMBER WHILE LICENSED: All added or deleted supervisors must be reported within 30 days of the change.

Section 3: Requirements for Supervision

All new supervisors must read and initial the following statements, certifying that you will abide by them.

Requirements for Supervision	Sup. Initials
<p>1 For the first 90 calendar days of licensed employment, with a given employer, a minimum of 30% of all the time a SLPA is providing clinical interaction must be supervised. A minimum of 20% of hours spent in clinical interaction must be directly supervised.</p>	
<p>2 Subsequent to the first 90 calendar days of licensed employment with a given employer, a minimum of 20% of all the time a SLPA is providing clinical interaction must be supervised. A minimum of 10% of hours spent in clinical interaction must be directly supervised.</p>	
<p>3 The supervising SLP must be able to be reached throughout the work day. A temporary supervisor may be designated as necessary.</p>	
<p>4 If the supervising SLP is on extended leave, an interim supervising SLP who meets the requirements stated in 335-095-0040 must be assigned.</p>	
<p>5 The caseload of the supervising SLP must allow for administration, including SLPA supervision, evaluation of clients and meeting times.</p> <p>SLPAs may not have a caseload; therefore, all clients are considered part of the supervising SLP's caseload. The supervising SLP is responsible to make all diagnostic and treatment related decisions for all clients on the caseload. Supervision requirements must be met for all clients on the caseload who receive treatment from the SLPA.</p>	
<p>6 The supervising speech-language pathologist may not supervise more than the equivalent of two full-time SLPAs.</p>	
<p>7 The supervising SLP must co-sign each page of records.</p>	
<p>8 Supervision of SLPAs must be documented.</p> <p>(a) Documentation must include the following elements: date, activity, clinical interaction hours, and direct or indirect supervision hours.</p> <p>Clinical logs documenting supervision must be completed and supervision hours calculated for each calendar month for each caseload.</p> <p>Each entry should be initialed by the supervising speech-language pathologist. Each page of documentation should include the supervising speech-language pathologist's signature and license numbers issued by this Board and the Teacher Standards and Practices Commission if applicable. Supervision documentation must be retained by the speech-language pathology assistant for four (4) years.</p> <p>(b) Documentation must be available for audit requests from the Board.</p>	

Section 4: Supervisor Certification

I have read the provisions of Oregon Administrative Rules [Chapter 335, Division 95](#) and agree to abide by them. I certify that the information submitted on this form is true and correct and that I am the person identified as the supervisor on this form.

The Board audits SLPA supervision annually to ensure compliance with the OARs. If you have any questions regarding SLPA supervision rules, please contact us.

Signature of Supervisor

Date

Section 5: TSPC License Information for New Supervisor

Only fill out this section if the new supervisor is qualifying via TSPC licensure.

TSPC License Number: _____ TSPC Expiration Date: _____

TSPC License Type and Endorsement: _____

SLP degree/date: _____

Note: Work experience while holding a restricted transitional license, conditional assignment permit, or other provisional license issued by the TSPC is excluded from qualifying work experience.

Method of Qualification for Supervision of SLPAs (check one and follow instructions under it)

Initially licensed by the Teacher Standards and Practices Commission prior to 1999

Have the following statement signed and dated by a third party that can verify the information and testify to its truth.

I hereby certify that this individual has a minimum of 5 years of professional work experience in speech-language pathology within the last 10 years, performed while he/she held an active basic or standard teaching license with an endorsement in standard speech impaired or an initial or continuing teaching license with an endorsement in communication disorders issued by the Teacher Standards and Practices Commission.

Signature of third party

Date

Name (print): _____ Phone: _____

Title/District: _____ Email: _____

OR

Initially licensed by the Teacher Standards and Practices Commission in 1999 or after

Have the following statement signed and dated by a third party that can verify the information and testify to its truth.

I hereby certify that this individual has a minimum of 2 years of professional work experience in speech-language pathology following completion of their graduate degree in Speech-Language Pathology or Communication Disorders.

Signature of third party

Date

Name (print): _____ Phone: _____

Title/District: _____ Email: _____

If you do not hold licensure from BSPA please provide your demographic / contact information on the following page. >>

Section 6: Contact Information for TSPC-Licensed Supervisor

Please complete this contact information if you do not hold BSPA licensure.

Name: _____
First Middle Initial Last

Maiden / Other Names Used: _____ Gender: Male Female

Work Address

Employer Name: _____

Address: _____

City State Zip Code

Telephone: _____

Home Address

Address: _____

City State Zip Code

Telephone: _____

Email: _____

SLP degree/date: _____

Have you been granted ASHA CCC's? yes no