

Clinical Fellowship Report and Rating Form

Speech-Language Pathology

Certification File Number or ASHA Account #

Please refer to the instructions on page 31 before completing this Clinical Fellowship Report and Rating Form. An Application for Certification/Membership (Form A) must be submitted at this time if you have not already done so. **Note: A separate CF Report and Rating Form must be submitted for each change in site, supervisor, or category of hours worked per week (15-19 hrs., 20-24 hrs., 25-29 hrs., 30 or more hrs.) throughout the clinical fellowship.**

1. Clinical Fellow Name _____
LAST FIRST MIDDLE MAIDEN

Address _____
STREET CITY STATE ZIP CODE

Home Phone Number (____) _____ Social Security Number ____-____-____

Academic Status _____
GRADUATE UNIVERSITY DEGREE DATE CONFERRED

Date course work and practicum requirements completed ____/____/____
MUST PRECEDE CF BEGINNING DATE

2. CF Supervisor's Name _____

ASHA Account Number _____ Social Security Number ____-____-____

Area of ASHA Certification: Speech-Language Pathology Audiology

3. CF Setting _____
FACILITY NAME

Address _____
STREET CITY STATE ZIP CODE

Telephone Number (____) _____

Is facility accredited by ASHA Professional Services Board? Yes No

If yes, area of accreditation Speech-Language Pathology Audiology

4. Beginning Date of CF* ____/____/____ **Ending Date of CF** ____/____/____

**Course work and practicum required for certification must be completed before this date*

Is this Report and Rating Form for a portion of the CF experience? Yes No

If yes, beginning date of this portion ____/____/____ Ending date of this portion ____/____/____

How many weeks of the CF does this report and rating form cover? _____ weeks

How many hours per week were spent in: Speech-Language Pathology _____ Audiology _____

Clinical fellows performing the CF in a facility accredited by the Professional Services Board (PSB) are not required to complete Section 5. This section must be completed only if the program is not PSB accredited.

5. Direct Clinical Activities. At least 80% of the CF work-week must be in direct client contact (assessment/ diagnosis/evaluation, screening, treatment, report writing, family/client consultation, and/or counseling) related to the management process of individuals who exhibit communication difficulties. Specify how many hours per week were spent in each of the following activities: **Please do not include travel time or lunch hours.** Total hours must be the same as those listed in Section 4 above.

<u>hrs/wk</u>	_____ In-service training
_____ Assessment, diagnosis/evaluation	_____ Other (specify here) _____
_____ Screening	_____
_____ Treatment (direct and indirect services)	_____
_____ Activities related to client management (report writing, family/client consultation and/or counseling, etc.)	_____ TOTAL HOURS PER WEEK

6. Supervisory Activities (please check response)

- A. There were at least 36 supervisory activities during the entire CF, including 18 hours of on-site observation in direct client contact and 18 other monitoring activities.
 Yes No (If no, attach explanation.)
- B. Clinical fellowship supervision was divided equally among three segments (1/3 length of CF), including 6 hours of on-site observation and 6 other monitoring activities during each segment. (See “Mandatory Supervision Requirements,” page 33) Yes No (If no, attach explanation.)
- C. Alternative methods of supervision were used and had prior approval by the Clinical Certification Board (see page 32) Yes No

7. Clinical Fellowship Skills Rating Chart—Circle the rating that corresponds to each skill. See Form E for descriptors for each skill. Rate Speech-Language Pathology (SLP) clinical fellows on 18 skills (1-18). Not Applicable (NA) may be used only for the skill(s) indicated. Core skills are noted by an asterisk (*) next to the skill number.

8. As the CF supervisor, do you recommend that the clinical fellow’s CF experience reported above be approved as meeting the requirements for the CCC? Yes No (If no, refer to page 34 of the Handbook and attach a rationale and documentation for a negative recommendation.)

9. We, the clinical fellowship supervisor and the clinical fellow, have discussed this report. We have verified that the supervisor’s certification was current throughout the CF and we have completed the required evaluations. We are not related in any manner.

Signature of Supervisor: _____

Date: _____

Signature of Fellow: _____

Date: _____

10. FOR CF’S COMPLETED IN PSB PROGRAMS ONLY:

As the director of the PSB-accredited program, I verify that this CF was completed in accordance with the “Clinical Fellowship Requirements and Procedures.”

Signature of PSB Director: _____

Date: _____

Segment 1						Segment 2						Segment 3								
Beginning date _____						Beginning date _____						Beginning date _____								
Ending date _____						Ending date _____						Ending date _____								
SLP Skills	Ratings					SLP Skills	Ratings					SLP Skills	Ratings							
1	5	4	3	2	1	1	5	4	3	2	1	1	5	4	3	2	1			
2*	5	4	3	2	1	2*	5	4	3	2	1	2*	5	4	3	2	1			
3*	5	4	3	2	1	3*	5	4	3	2	1	3*	5	4	3	2	1			
4*	5	4	3	2	1	4*	5	4	3	2	1	4*	5	4	3	2	1			
5*	5	4	3	2	1	5*	5	4	3	2	1	5*	5	4	3	2	1			
6	5	4	3	2	1	6	5	4	3	2	1	6	5	4	3	2	1			
7	5	4	3	2	1	7	5	4	3	2	1	7	5	4	3	2	1			
8*	5	4	3	2	1	8*	5	4	3	2	1	8*	5	4	3	2	1			
9*	5	4	3	2	1	9*	5	4	3	2	1	9*	5	4	3	2	1			
10*	5	4	3	2	1	10*	5	4	3	2	1	10*	5	4	3	2	1			
11*	5	4	3	2	1	11*	5	4	3	2	1	11*	5	4	3	2	1			
12	5	4	3	2	1	12	5	4	3	2	1	12	5	4	3	2	1			
13	5	4	3	2	1	N/A	13	5	4	3	2	1	N/A	13	5	4	3	2	1	N/A
14*	5	4	3	2	1	14*	5	4	3	2	1	14*	5	4	3	2	1			
15*	5	4	3	2	1	15*	5	4	3	2	1	15*	5	4	3	2	1			
16*	5	4	3	2	1	16*	5	4	3	2	1	16*	5	4	3	2	1			
17*	5	4	3	2	1	17*	5	4	3	2	1	17*	5	4	3	2	1			
18	5	4	3	2	1	N/A	18	5	4	3	2	1	N/A	18	5	4	3	2	1	N/A
SUPERVISOR’S SIGNATURE: _____						SUPERVISOR’S SIGNATURE: _____						SUPERVISOR’S SIGNATURE: _____								
CLINICAL FELLOW’S SIGNATURE: _____						CLINICAL FELLOW’S SIGNATURE: _____						CLINICAL FELLOW’S SIGNATURE: _____								
DATE OF FEEDBACK SESSION: _____						DATE OF FEEDBACK SESSION: _____						DATE OF FEEDBACK SESSION: _____								