SIDE-BY-SIDE COMPARISON
2012 & 2020 ASHA SPEECH-LANGUAGE PATHOLOGY CERTIFICATION STANDARDS

Implementation: January 1, 2020

2012 SLP Standards	2020 SLP Standards	Rationale for Change
STANDARD I: DEGREE Implementation: The Council for Clinical Certification in Audiology and Speech-Language Pathology (CFCC) has the authority to determine eligibility of all applicants for certification.	Moved the implementation language from Standard I to the Introduction.	The previous implementation language was not related to the standard, which lists the required degree.
STANDARD II: EDUCATION PROGRAM		No changes made to this standard or implementation language.
STANDARD III: PROGRAM OF STUDY		No changes made to this standard or implementation language.
STANDARD IV-A Implementation: Acceptable courses in physical sciences should include physics or chemistry.	**STANDARD IV-A** Implementation: For all applicants who apply beginning January 1, 2020, acceptable courses in physical sciences must include coursework in physics or chemistry.	The 2014 standard required knowledge in physics or chemistry that should be acquired through coursework. The 2020 standard requires that the knowledge must be acquired through coursework.
STANDARD IV-B	No changes made to this standard.	
STANDARD IV-C **The applicant must have demonstrated knowledge of communication and swallowing disorders and differences, including the appropriate etiologies, characteristics, anatomical/physiological, acoustic, psychological, developmental, and linguistic and cultural correlates in the following areas:** • **articulation;** • **fluency;** • **voice and resonance, including respiration and phonation;** • **receptive and expressive language (phonology, morphology, syntax, semantics, pragmatics, prelinguistic communication and paralinguistic communication) in speaking, listening, reading, writing;** • **hearing, including the impact on speech and language;** • **swallowing (oral, pharyngeal, esophageal, and related functions, including oral function for feeding, orofacial myology);** • **cognitive aspects of communication (attention, memory, sequencing, problem-solving, executive functioning);** • **social aspects of communication (including challenging behavior, ineffective social skills, and lack of communication opportunities);**	**STANDARD IV-C** **The applicant must have demonstrated knowledge of communication and swallowing disorders and differences, including the appropriate etiologies, characteristics, anatomical/physiological, acoustic, psychological, developmental, and linguistic and cultural correlates in the following areas:** • **speech sound production, to encompass articulation, motor planning and execution, phonology, and accent modification;** • **fluency and fluency disorders;** • **voice and resonance, including respiration and phonation;** • **receptive and expressive language to include phonology, morphology, syntax, semantics, pragmatics (language use and social aspects of communication), prelinguistic communication, paralinguistic communication (e.g., gestures, signs, body language), and literacy in speaking, listening, reading, and writing;** • **hearing, including the impact on speech and language;** • **swallowing/feeding, including structure and function of orofacial myology, oral, pharyngeal,**	The revised text represents current practice patterns, defines terminology, and provides additional guidance to applicants on the required knowledge areas.

• **augmentative and alternative communication modalities.**	**laryngeal, pulmonary,** esophageal, **gastrointestinal,** and related functions **across the life span;** • **cognitive aspects of communication, including attention, memory, sequencing, problem solving, and executive functioning;** • **social aspects of communication, including challenging behavior, ineffective social skills, and lack of communication opportunities; and** • **augmentative and alternative communication modalities.**	
STANDARD IV-D through IV-H		No changes made to these standards.
STANDARD V-A		No changes made to this standard.
STANDARD V-B	**STANDARD V-B** New Implementation language added: Supervised clinical experiences should include interprofessional education and interprofessional collaborative practice, and should include experiences with related professionals that enhance the student's knowledge and skills in an interdisciplinary, team-based, comprehensive service delivery model.	The new language promotes Interprofessional Education and Interprofessional Practice, which are key skills for current practice patterns.
Implementation: Alternative clinical experiences may include the use of standardized patients and simulation technologies (e.g., standardized patients, virtual patients, digitized mannequins, immersive reality, task trainers, computer-based interactive).	Implementation: Clinical simulation (CS) may include the use of standardized patients and simulation technologies (e.g., standardized patients, virtual patients, digitized mannequins, immersive reality, task trainers, computer-based interactive). These supervised experiences can be synchronous simulations (real-time) or asynchronous (not concurrent in time) simulations.	The use of CS and related supervised clinical experience are more clearly defined in the 2020 standards.
STANDARD V-C **The applicant for certification in speech-language pathology must complete a minimum of 400 clock hours of supervised clinical experience in the practice of speech-language pathology. Twenty-five hours must be spent in clinical observation, and 375 hours must be spent in direct client/patient contact.**	**STANDARD V-C** **The applicant must complete a minimum of 400 clock hours of supervised clinical experience in the practice of speech-language pathology. Twenty-five hours must be spent in guided clinical observation, and 375 hours must be spent in direct client/patient contact.**	Guided has been added to the standard language and defined in the implementation language to provide more guidance to applicants and programs.
Implementation: Guided observation hours generally precede direct contact with clients/patients.	Implementation: Guided clinical observation hours generally precede direct contact with clients/patients. Examples of guided observations may include but are not limited to the following activities: debriefing of a video recording with a clinical educator who holds the CCC-SLP, discussion of therapy or evaluation procedures that had been observed, debriefings of observations that meet course requirements, or written records of the observations. It is important to confirm that there was communication between the clinical educator and observer, rather than passive experiences where the student views sessions and/or videos. It is encouraged that the student observes live and recorded	The revised standards provide a definition and examples of guided clinical observation.

	sessions across settings with individuals receiving services with a variety of disorders and completes debriefing activities as described above.	
Implementation: The observation and direct client/patient contact hours must be within the ASHA Scope of Practice in Speech-Language Pathology and must be under the supervision of a qualified professional who holds current ASHA certification in the appropriate practice area. Such supervision may occur simultaneously with the student's observation or afterwards through review and approval of written reports or summaries submitted by the student. Students may use video recordings of client services for observation purposes.	Implementation: The observation The observation and direct client/patient contact hours must be within the ASHA Scope of Practice in Speech-Language Pathology and must be under the supervision of a qualified professional who holds a current ASHA CCC in the appropriate practice area. Guided clinical supervision may occur simultaneously during the student's observation or afterwards through review and approval of the student's written reports or summaries. Students may use video recordings of client services for observation purposes.	
Implementation: Applicants should be assigned practicum only after they have acquired sufficient knowledge bases to qualify for such experience. Only direct contact with the client or the client's family in assessment, intervention, and/or counseling can be counted toward practicum. Up to 20% (i.e., 75 hours) of direct contact hours may be obtained through clinical simulation (CS) methods. Only the time spent in active engagement with the CS may be counted. CS may include the use of standardized patients and simulation technologies (e.g., standardized patients, virtual patients, digitized mannequins, immersive reality, task trainers, computer-based interactive). Debriefing activities may not be included.	Implementation: Applicants should be assigned practicum only after they have acquired a base of knowledge sufficient to qualify for such experience. Only direct contact (e.g., the client/patient must be present) with the individual or the individual's family in assessment, intervention, and/or counseling can be counted toward practicum. When counting clinical practicum hours for purposes of ASHA certification, only the actual time spent in sessions can be counted, and the time spent cannot be rounded up to the nearest 15-minute interval. Up to 20% (i.e., 75 hours) of direct contact hours may be obtained through clinical simulation (CS) methods. Only the time spent in active engagement with CS may be counted. CS may include the use of standardized patients and simulation technologies (e.g., standardized patients, virtual patients, digitized mannequins, immersive reality, task trainers, computer-based interactive). Debriefing activities may not be included as clinical clock hours.	The new implementation language clarifies how to count clinical clock hours.
STANDARD V-D **At least 325 of the 400 clock hours must be completed while the applicant is engaged in graduate study in a program accredited in speech-language pathology by the Council on Academic Accreditation in Audiology and Speech-Language Pathology.** Implementation: A minimum of 325 clock hours of clinical practicum must be completed at the graduate level. At the discretion of the graduate program, hours obtained at the undergraduate level may be used to satisfy the remainder of the requirement.	**STANDARD V-D** **At least 325 of the 400 clock hours of supervised clinical experience must be completed while the applicant is enrolled in graduate study in a program accredited in speech-language pathology by the CAA.** Implementation: A minimum of 325 clock hours of supervised clinical practicum must be completed while the student is enrolled in the graduate program. At the discretion of the graduate program, hours obtained at the undergraduate level may be used to satisfy the remainder of the requirement.	The revised standard and implementation language clarifies that the hours must be completed while enrolled in graduate study and are to be supervised.

STANDARD V-E **Supervision must be provided by individuals who hold the Certificate of Clinical Competence in the appropriate profession. The amount of direct supervision must be commensurate with the student's knowledge, skills, and experience, must not be less than 25% of the student's total contact with each client/patient, and must take place periodically throughout the practicum. Supervision must be sufficient to ensure the welfare of the client/patient.**	**STANDARD V-E** **Supervision of students must be provided by a clinical educator who holds ASHA certification in the appropriate profession, who has the equivalent of a minimum of 9 months of full-time clinical experience, and who has completed a minimum of 2 hours of professional development in clinical instruction/supervision after being awarded ASHA certification.** **The amount of direct supervision must be commensurate with the student's knowledge, skills, and experience; must not be less than 25% of the student's total contact with each individual receiving services; and must take place periodically throughout the practicum. Supervision must be sufficient to ensure the welfare of the individual receiving services.**	The new standard language provides additional requirements for individuals who supervise applicants.
Implementation: Direct supervision must be in real time. A supervisor must be available to consult with a student providing clinical services to the supervisor's client. Supervision of clinical practicum is intended to provide guidance and feedback and to facilitate the student's acquisition of essential clinical skills. The amount of direct supervision must be commensurate with the student's knowledge, skills, and experience, must not be less than 25% of the student's total contact with each client/patient, and must take place periodically throughout the practicum. Supervision must be sufficient to ensure the welfare of the client/patient.	Implementation: Effective January 1, 2020, supervisors for ASHA certification must complete 2 hours of professional development/continuing education in clinical instruction/supervision. The professional development/continuing education must be completed after being awarded the CCC and prior to the supervision of a student. Direct supervision must be in real time. A supervisor must be available and onsite to consult with a student providing clinical services to the clinical educator's client. Supervision of clinical practicum is intended to provide guidance and feedback and to facilitate the student's acquisition of essential clinical skills. In the case of asynchronous clinical simulation, supervision must include debriefing activities that are commensurate with a minimum of 25% of the clock hours earned for each simulated client/patient.	The new implementation language: • expands upon the requirements for clinical educators; • clarifies that a supervisor must be onsite; and • clarifies how asynchronous supervision of hours earned through clinical stimulation can be counted. Language that was repeated in both the 2014 standard and implementation language now appears only in the 2020 standard.
STANDARD V-F		No changes made to this standard.
STANDARD VI		No changes made to this standard.
STANDARD VII-B **The Clinical Fellow must have received ongoing mentoring and formal evaluations by the CF mentor.**	**STANDARD VII-B** **The Clinical Fellow must receive ongoing mentoring and formal evaluations by the Clinical Fellowship (CF) mentor. Mentorship must be provided by a clinician who holds the CCC-SLP, who has the equivalent of a minimum of 9 months of full-time clinical experience, and who has completed a minimum of 2 hours of professional development/continuing education in clinical instruction/supervision after being awarded the CCC-SLP.**	The new standard and implementation language provides additional requirements for CF mentors.

	Implementation: Effective January 1, 2020, CF Mentors for ASHA certification must complete 2 hours of professional development/continuing education in clinical instruction/supervision that must be completed after being awarded the CCC and prior to mentoring the Clinical Fellow. Direct observation must be in real time. A mentor must be available to consult with the Clinical Fellow providing clinical services. Direct observation of clinical practicum is intended to provide guidance and feedback and to facilitate the Clinical Fellow's independent use of essential clinical skills.	
Implementation: Mentoring must have included on-site observations and other monitoring activities. These activities may have been executed by correspondence, review of video and/or audio recordings, evaluation of written reports, telephone conferences with the Fellow, and evaluations by professional colleagues with whom the Fellow works. The CF mentor and Clinical Fellow must have participated in regularly scheduled formal evaluations of the Fellow's progress during the CF experience. The Clinical Fellow must receive ongoing mentoring and formal evaluations by the CF Mentor.	Implementation: Mentoring must include on-site, in-person observations and other monitoring activities, which may be executed by correspondence, review of video and/or audio recordings, evaluation of written reports, telephone conferences with the Clinical Fellow, or evaluations by professional colleagues with whom the Clinical Fellow works. The CF Mentor and the Clinical Fellow must participate in regularly scheduled formal evaluations of the Clinical Fellow's progress during the CF experience. The Clinical Fellow must receive ongoing mentoring and formal evaluations by the CF Mentor. The amount of direct supervision provided by the CF Mentor must be commensurate with the Clinical Fellow's knowledge, skills, and experience, and must not be less than the minimum required number of direct contact hours. Supervision must be sufficient to ensure the welfare of the client/patient.	The new implementation language provides clarification on direct observation and makes it clear that a portion of the mentoring must be completed on-site and in person.
Implementation: The mentoring SLP must engage in no fewer than 36 supervisory activities during the clinical fellowship experience. This supervision must include 18 on-site observations of direct client contact at the Clinical Fellow's work site (1 hour = 1 on-site observation; a maximum of six on-site observations may be accrued in 1 day). At least six on-site observations must be conducted during each third of the CF experience. On-site observations must consist of the Clinical Fellow engaged in screening, evaluation, assessment, and/or habilitation/rehabilitation activities. Use of real-time, interactive video and audio conferencing technology is permitted as a form of on-site observation, for which pre-approval must be obtained. Additionally, supervision must also include 18 other monitoring activities. At least six other monitoring activities must be conducted during each third of the CF experience. Other monitoring activities are defined as evaluation of reports written by the Clinical Fellow, conferences between the	Implementation: The mentoring SLP must engage in no fewer than 36 supervisory activities during the CF experience and must include 18 on-site observations of direct client contact at the Clinical Fellow's work site (1 hour = 1 on-site observation; a maximum of six on-site observations may be accrued in 1 day). At least 6 on-site observations must be conducted during each third of the CF experience. On-site observations must consist of the Clinical Fellow engaging in screening, evaluation, assessment, and/or habilitation/rehabilitation activities. Mentoring must include on-site, in-person observations; however, the use of real-time, interactive video and audio conferencing technology may be permitted as a form of observation, for which pre-approval must be obtained. Additionally, supervision must also include 18 other monitoring activities. Other monitoring activities are defined as evaluation of reports written by the Clinical Fellow, conferences between the CF Mentor and the Clinical Fellow,	The revised implementation language highlights that the amount of supervision may vary based upon the independence of the Clinical Fellow.

mentoring SLP and the Clinical Fellow, discussions with professional colleagues of the Fellow, etc., and may be executed by correspondence, telephone, or reviewing of video and/or audio tapes.	discussions with professional colleagues of the Clinical Fellow, and so forth, and may be executed by correspondence, telephone, or reviewing of video and/or audio tapes. At least 6 other monitoring activities must be conducted during each third of the CF experience.	
Implementation: On rare occasions, the CFCC may allow the supervisory process to be conducted in other ways. However, a request for other supervisory mechanisms must be submitted in written form to the CFCC, and co-signed by the CF mentor, before the CF is initiated. The request must include the reason for the alternative supervision and a description of the supervision that would be provided. At a minimum, such a request must outline the type, length, and frequency of the supervision that would be provided. A CF mentor intending to supervise a Clinical Fellow located in another state may be required to also hold licensure in that state; it is up to the CF mentor and the Clinical Fellow to make this determination before proceeding with a supervision arrangement.	Implementation: If the Clinical Fellow and their CF Mentor want to use supervisory mechanisms other than those outlined above, they may submit a written request to the CFCC prior to initiating the CF. Written requests may be emailed to cfcc@asha.org or mailed to: CFCC, c/o ASHA Certification, 2200 Research Blvd. #313, Rockville, MD 20850. Requests must include the reason for the alternative supervision, must include a detailed description of the supervision that would be provided (i.e., type, length, frequency, etc.), and must be co-signed by both the Clinical Fellow and the CF Mentor. On a case-by-case basis, the CFCC will review the circumstances and may or may not approve the supervisory process to be conducted in other ways. Additional information may be requested by the CFCC prior to approving any request.	The revised implementation language clarifies the policy and procedures when Clinical Fellows/CF mentors want to use alternative methods for any portion of the CF experience.
STANDARD VII-C		No changes made to this standard.
STANDARD VIII: MAINTENANCE OF CERTIFICATION Implementation: Individuals who hold the Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP) must accumulate 30 certification maintenance hours of professional development during every 3-year maintenance interval.	**STANDARD VIII: MAINTENANCE OF CERTIFICATION** Implementation: Clinicians who hold the CCC-SLP must accumulate and report 30 Certification Maintenance Hours (CMHs) (or 3.0 ASHA continuing education units [CEUs]), which must include a minimum of 1 CMH (or 0.1 ASHA CEU) in ethics during every 3-year maintenance interval beginning with the 2020–2022 certification maintenance interval.	The new implementation language includes the requirement of at least one certification maintenance hour each interval in ethics.