State of New Hampshire

OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
DIVISION OF LICENSING AND BOARD ADMINISTRATION
7 Eagle Square, Concord, NH 03301-4980
Phone: 603-271-2152

SPEECH-LANGUAGE PATHOLOGY CLINICAL FELLOWSHIP (SLPCF) REPORT AND RATING FORM

2005 CERTIFICATION STANDARDS

INSTRUCTIONS:

- ► An application for Membership and Certification must be submitted at this time if you have not already done so.
- ► A separate SLPCF Report and Rating Form must be submitted for each change in mentor, location, or regularly scheduled hours worked per week.
- ► All blanks and boxes must be filled in. Incomplete Report & Rating forms will be returned and will delay the processing of your application.
- ► A full-time SLPCF consists of a minimum of 35 hours worked per week and equals 1,260 hours throughout the 36-week SLPCF. The SLPCF must consist of at least 36 mentoring activities, including 18 hours of on-site direct client contact observations and 18 other monitoring activities.
- ► Professional experience of less than 5 hours per week **cannot** be used to meet the SLPCF requirement.
- ► Use **black ink only** when completing this form. Print all information clearly.

Section 1. Speech-Language Pathology Clinical Fellow Information

Name _____ _____
Last First Middle Maiden/Former

Home Address _____
Street City State Zip Code

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

I understand that it is my responsibility to verify my SLPCF Mentor holds and maintains current ASHA certification in speech-language pathology throughout the CF experience in order for the experience to be accepted as meeting standards.

_____ _____ _____
Signature of SLP Clinical Fellow Date ASHA Account #

Section 2. SLPCF Mentor Information

Name _____ Mentor's ASHA Account Number _____

I verify that I hold current ASHA certification in speech-language pathology and understand that I must maintain this certification throughout the SLPCF experience in order for the experience to be accepted as meeting standards.

_____ _____
Signature of SLPCF Mentor Date

Section 3. SLPCF Setting Information

Facility Name _____ Phone Number (_____) _____

Address _____
Street City State Zip Code

Section 4. SLPCF Duration (beginning and ending dates)

► The beginning date of this SLPCF is _____/_____/_____ The ending date of this SLPCF is _____/_____/_____

► Total number of weeks for this SLPCF _____

SLP Clinical Fellow's Name_____(please print)

Section 5. SLPCF Activity Information (How many hours per week did you work in direct clinical contact?)

- ► At least 80% of the SLPCF work week must be in direct clinical 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.
- ► Do not include lunch travel or lunch hours.
- ► Do not enter percentages or ranges of time.
- ► If the number of hours you work per week varies, you may estimate the number of hours you work in a typical week. Work weeks that consist of less than 5 hours cannot be counted towards the clinical fellowship experience.
- ► Indicate the number of hours per week you spent in each of the following activities:

_____ Assessment/diagnosis/evaluation
_____ Screening
_____ Treatment (direct and indirect services)
_____ Activities related to client management (report writing, family/client consultation, and/or counseling, etc.)
_____ Other (includes in-service training and presentations)

_____ Total hours per week

Section 6. SLPCF Skills Rating Chart Instructions for the SLPCF Mentor

- ► Circle the rating that corresponds to each skill. See the Clinical Fellowship Skills Inventory for a description of each skill.
- ► Rate the clinical fellow on 18 skills, using the N/A (Not Applicable) rating only for skills 13 and 18.
- ► Discuss the ratings with the SLP Clinical Fellow.
- ► Ensure each segment is equal to one-third of the CF experience. ***The core skills for SLP are 2-5, 8-11, and 14-17.**

SEGMENT 1	SEGMENT 2	SEGMENT 3
Beginning date _____ Ending date _____	Beginning date _____ Ending date _____	Beginning 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
SLPCF Mentor's Signature: _____ **Clinical Fellow's Signature:** _____ **Date of Feedback Session:**_____	**SLPCF Mentor's Signature:** _____ **Clinical Fellow's Signature:** _____ **Date of Feedback Session:**_____	**SLPCF Mentor's Signature:** _____ **Clinical Fellow's Signature:** _____ **Date of Feedback Session:**_____

SLP Clinical Fellow's Name_____(please print)

Section 7. SLPCF Mentor's Recommendations and Verification of Information

☐ Yes ☐ No I recommend that the SLPCF experience documented on this form be accepted by the CFCC as meeting the requirements for the CCC-SLP. (If No, attach a rationale and documentation for your answer.)

☐ Yes ☐ No I affirm that there were at least 12 supervisory activities during each segment of the SLPCF, including 6 hours of on-site observations of direct client contact and 6 other mentoring activities. (If No, attach explanation)

☐ Yes ☐ No I affirm that alternative methods of observation/mentoring activities were not used. (If alternative methods of observation/mentoring activities were used, prior approval was obtained from the CFCC before using those alternative methods.)

Section 8. Signatures of SLPCF Mentor and SLP Clinical Fellow We, the SLPCF Mentor and the SLP Clinical Fellow, verify that we have discussed this report. We have verified that the mentor's certification was current throughout the CF experience. We verify that we have completed the required evaluations. We further verify that we are not related in any manner.

Signature of SLPCF Mentor _____ Date _____

Signature of SLP Clinical Fellow_____ Date _____

NOTE: This report must be signed/submitted AFTER the end date of the experience reported on this form. If it is signed prior to the end date, it will be returned and will delay the processing of your application for certification.