TEXAS DEPARTMENT OF LICENSING & REGULATION
P.O. Box 12157 • Austin, Texas 78711-2157
www.tdlr.texas.gov

ASSISTANT IN SPEECH-LANGUAGE PATHOLOGY CLINICAL DEFICIENCY PLAN COMPLETION OF TRAINING AND RATING SCALE INSTRUCTIONS

The applicant should return the completed form with the rest of the completed application to the address at the top of this page.

Clinical Deficiency Plan cannot begin until the Assistant license has been issued.

1. ASSISTANT'S NAME – Provide the SLP assistant's legal name in the spaces provided. (Last Name, First Name, Middle Name, Suffix) Examples of a suffix include Jr., Sr., and II. (Mr. is not a suffix.)
2. ASSISTANT'S SOCIAL SECURITY NUMBER – Social security number disclosure is required by Section 231.302(c)(1) of the Texas Family Code to obtain a license. Your social security number is subject to disclosure to an agency authorized to assist in the collection of child support payments. For more information regarding child support payments, contact the ***Texas Attorney General***.
3. SUPERVISOR'S NAME – Provide the supervisor's legal name in the spaces provided. (Last Name, First Name, Middle Name, Suffix) Examples of a suffix include Jr., Sr., and II. (Mr. is not a suffix.)
4. SUPERVISOR'S TEXAS LICENSE # – Provide the supervisor's Speech-Language Pathologist Texas license number.
5. SUPERVISOR'S EMAIL ADDRESS – Provide the supervisor's email address only if the supervisor agrees to the following statement: By providing my email address I authorize the Texas Department of Licensing and Regulation (TDLR) to send licensing communications and required notices to me by electronic mail. I understand that I may revoke this authorization in writing and that I must update my email address, or I will not receive these notices. I understand that the email address I have provided in this application will remain confidential except as permitted or required by law.
6. CLINICAL OBSERVATION – Indicate the box for the type of training and provide the number of clinical hours the licensed assistant observed the supervisor.
7. CLINICAL ASSISTING EXPERIENCE – Indicate the number of hours the supervisor provided direct supervision for the licensed assistant and check all areas that apply. These hours must include actual treatment experience performed under 100% direct supervision.
8. SUPERVISOR'S STATEMENT – Carefully read the statements and check yes or no. If no, please provide additional information.
9. LICENSED ASSISTANT AND SUPERVISING SPEECH-LANGUAGE PATHOLOGIST STATEMENT –Supervising speech-language pathologist and licensed assistant both sign and date the form.

Clinical Deficiency Plan cannot begin until the Assistant license has been issued.

The Clinical Deficiency Plan shall be completed within sixty (60) days of the issue date of the assistant's license or the licensed assistant must submit a new plan.

Immediately upon completion of the Clinical Deficiency Plan, the supervisor identified in the plan shall submit the Assistant in Speech-Language Pathology Clinical Deficiency Plan Completion of Training and Rating Scale.

SEND THIS COMPLETED FORM TO:

Texas Department of Licensing and Regulation
P.O. Box 12157
Austin, TX 78711-2157

Keep a copy of this completed form.

For additional information and questions, visit the ***TDLR website*** or reach Customer Service via ***TDLR webform***. The webform will allow you to submit your request for assistance and include attachments needed. Customer Service Representatives are available Monday through Friday (excluding holidays) at (800) 803-9202 (in state only), (512) 463-6599, or Relay Texas-TDD: (800) 735-2989.

TDLR Public Information Act Policy:
This document is subject to the Texas Public Information Act. With certain exceptions, information in this document may be made available to the public. For more information, view the ***TDLR Public Information Act Policy***.

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ASSISTANT IN SPEECH-LANGUAGE PATHOLOGY CLINICAL DEFICIENCY PLAN COMPLETION OF TRAINING AND RATING SCALE

Clinical Deficiency Plan cannot begin until the Assistant license has been issued.

ASSISTANT'S INFORMATION

1. Assistant's Name:

Last | First | Middle | Suffix

2. Assistant's Social Security Number:(See Instruction Sheet for Disclosure Information) _____

SUPERVISOR'S INFORMATION

3. Supervisor's Name:

Last | First | Middle | Suffix

4. Supervisor's Texas License #: _____

5. Supervisor's Email: _____

TRAINING

6. **Clinical Observation**

I certify that this licensed assistant observed me for - _____ hours while I conducted: (mark the appropriate box)

☐ Therapy ☐ Other: (List other training methods)

7. **Clinical Assisting Experience**

I certify that I have provided 100% direct supervision for this licensed assistant to acquire hours of clinical assisting experience and that these hours included treatment performed by the assistant. I certify the licensed assistant. I certify the licensed assistant worked solely with my assigned cases indicated below: -

Areas of Clinical Assisting Experience	Received Training (Y/N)	Performance Rating 4 = Excellent 3 = Good 2 = Fair 1 = Poor
Conduct or participate in speech, language, and/or hearing screening;	-	-
Implement the treatment program or the individual education plan (IEP) designed by the licensed speech-language pathology supervisor;	-	-
Provide carry-over activities which are the therapeutically designed transfer of a newly acquired communication ability to other contexts and situations;	-	-
Collect data when administering routine tests if the test developer does not specify a graduate degreed examiner and the supervising speech-language pathologist has determined the licensed assistant is competent to perform the test; [refer to §111.52(c)(5)]	-	-
Maintain clinical records;	-	-
Prepare clinical materials;	-	-
Participate with the licensed speech-language pathology supervisors' research projects, staff development, public relations programs, or similar activities as designated and supervised by the licensed speech-language pathologist;	-	-
Write lesson plans based on the therapy program developed by the supervising speech-language pathologist. The lesson plans shall be reviewed and approved by the supervising speech-language pathologist.	-	-

8. SUPERVISOR'S STATEMENT

I certify that I supervised this assistant under 100% direct supervision and I followed the agreement stated in the Clinical Deficiency Plan. ☐ Yes ☐ No

I certify that I have maintained supervision logs and I am aware that I may be randomly audited to provide the logs to TDLR. ☐ Yes ☐ No

I certify that this licensed assistant has successfully completed the specified training with 100% directly supervised training. ☐ Yes ☐ No

9. By the signatures below, we certify that we have read and will comply with all applicable provisions of the Department's enabling statute at Texas Occupations Code, Chapter 51; the Department's procedural rules at 16 Administrative Code, Chapter 60; the Speech-Language Pathologists and Audiologists Act at Texas Occupation Code, Chapter 401; and the Speech-Language Pathologists and Audiologists Administrative Rules Texas Administrative Code, Chapter 111. We understand that providing false information on this form may result in license sanctions and/or administrative penalties.

_____ _____

Signature of Licensed Speech-Language Pathology Assistant — Date

_____ _____

Signature of Supervising Speech-Language Pathologist — Date