



University of Colorado **Boulder**

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**Clinical Handbook - Audiology**

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## INTRODUCTION

Welcome to the Department of Speech, Language, and Hearing Science (SLHS) at the University of Colorado at Boulder (CU).

The Doctor of Audiology (AuD) degree program at CU is designed to prepare audiologists for autonomous clinical practice encompassing the entire scope of practice of audiology. The clinical doctorate model at CU stresses the integration of academic classroom learning and practical experience across a broad spectrum of clinical specialties and practice environments. Our AuD curriculum provides a strong foundation in the scientific knowledge base and a wide range of clinical field experiences that prepares AuD graduates with the tools necessary for evidence-based clinical practice. The CU AuD curriculum also is designed to enable AuD students to meet current standards required for ASHA certification in audiology as well as Colorado state licensure standards.

The purpose of this handbook is to provide AuD students with the basic information needed regarding the clinical aspect of the program throughout their course of study and to assist students in navigating their way through the graduate degree program and certification process. This handbook is not meant to be an exhaustive collection of all policies at the University of Colorado - Boulder. Students also should review the CU Graduate School website (<http://www.colorado.edu/graduateschool/>), which is the final source regarding University policies on graduate programs. Some of the information provided in the handbook also is available on the department's AuD website ([www.colorado.edu/slhs/](http://www.colorado.edu/slhs/)). If additional questions and/or concerns arise that are not formally addressed in these sources, your advisor will be a valuable asset as you progress through the program. You are urged to maintain close contact with your advisor and to seek additional information as the need arises. Academic and clinical faculty members also are available for advice, guidance, and consultation regarding all academic and clinical requirements, policies, and procedures. It is, however, the responsibility of AuD students to be informed about all academic and clinical requirements of the AuD program at CU.

## Department of Speech, Language & Hearing Sciences

### Mission

The Department of Speech, Language & Hearing Sciences at the University of Colorado-Boulder is dedicated to the pursuit of excellence in education, research and scholarship in the science and practice of human communication in order to benefit individuals and families in the local community, the state of Colorado and the world.

Currently, the Department of Speech, Language and Hearing Sciences has an enrollment of about 300 undergraduate majors, over 100 graduate students, 9 tenure-track faculty, 10 clinical faculty, over 25 adjunct faculty and more than 30 community professionals who participate in various aspects of our academic and/or clinical training programs. The Department offers a broad academic curriculum, comprehensive clinical experiences, and active research programs in a variety of areas. For detailed information regarding SLHS faculty and staff, please visit SLHS's website: <https://www.colorado.edu/slhs/meet-us>

### AuD Program

CU's AuD program is accredited by the Council on Academic Accreditation (CAA) through June 30, 2030. Accreditation ensures our program meets required standards for core knowledge and skills required for entry into the profession of audiology. To maintain accreditation, our program must submit an annual report outlining how we meet accreditation standards. Re-accreditation occurs every 8 years and requires a site visit by a team of volunteers who represent CAA to do an in-depth review to confirm our program continues to meet accreditation standards.

Concerns about our program can be reported to:

Council on Academic Accreditation  
2200 Research Boulevard #310  
Rockville, MD 20850  
(800) 498-2071 or (301) 296-5700

## Description of Facility & Services

### **THE SPEECH, LANGUAGE, & HEARING CLINIC at CU Boulder**

The Department of Speech, Language, and Hearing Sciences houses the Speech, Language and Hearing Clinic (SLHC), which is the primary location of campus-based clinical training for our SLP program and serves as one of many sites for clinical training for our AuD program. Through this clinic, diagnostic and rehabilitative speech language pathology services, auditory processing assessment, and nursing home hearing aid check visits are provided to the general public on a fee-for-service basis.

Two sound booths and their audiometric equipment located in the north hallway on the first floor of the SLHS building are for use in faculty research. One small booth (C162) is available for student use. The sound booth for student learning and practice as well as student research (e.g., capstone) is located on the 3<sup>rd</sup> floor (C316/316A).

The SLHC's Policy and Procedure manual can be found on your practicum's Canvas page.

### **UNIVERSITY OF COLORADO HEALTH – BOULDER HEALTH CENTER**

AuD students begin their on-site clinical experience at the University of Colorado Health – Boulder Health Center. The Hearing and Balance Center at University of Colorado Health provides clinical services, resources, education, and research to support the needs of individuals in metro Denver who are deaf and hard of hearing.

The center, which is a partnership between University of Colorado Health and the University of Colorado School of Medicine, provides resources, education, and research to support the needs of individuals who are deaf and hard of hearing, their families, the community, and hearing health professionals.

The Center values individual and family rights in communication and technology choices and strives to optimize the quality of life for all it serves.

The Hearing and Balance Center is recognized worldwide for its unique leadership and progressive innovations in the realm of hearing and deafness.

The UCHHealth – Boulder Health Center is located at:

5495 Arapahoe Avenue, Boulder, CO 80303

Parking spaces closest to the clinic itself are reserved for patients. Student clinicians and clinic staff are asked to park in the spaces further away from the building. Note: Required clinical attire for this rotation (as well as other UCHHealth sites) is black scrubs.

The phone number to the audiology work area at the Center is 303-544-3665. Given the fact that audiologists and the audiology assistant are most often working with patients, it is very likely that when you call this number, you will reach voicemail. Therefore, be sure to inquire with your preceptor (and refer to your course syllabus) as to his/her preferred contact method.

## Other Clinical Facilities

AuD students will engage in clinical activities at other facilities in the Denver/Boulder area as they progress through the program. Visits to these sites begin as early as during the 2<sup>nd</sup> year of the program (note that observations and experiences may take place at some sites during the 1<sup>st</sup> year).

Examples of other facilities at which students attain clinical experience:

- University of Colorado Hospital Hearing & Balance Center – Aurora
- Marion Downs Center – Denver
- Denver Health – Denver
- Children's Hospital Colorado – Aurora (and other sites)
- Rocky Mountain Ear Center – Englewood
- Denver VA Hospital – Aurora
- Boulder Valley Hearing Center – Boulder
- Longmont Clinic – Longmont
- Cochlear Corporation - Centennial
- Various School Districts – Boulder County, Jefferson County, Douglas County, Cherry Creek, Aurora Public Schools, Adams County, St Vrain Valley, etc.

**Policy/Procedure** - Students must adhere to all policies and procedures of the site to which they are assigned/visiting. These policies may include: HIPAA, confidentiality, Infection Control/Standard Precautions, background checks, drug screening, etc. Note that the drug screening required by many facilities includes marijuana; although marijuana is legal in Colorado, its use is not acceptable for many clinical entities.

**Transportation** - While some sites are accessible by RTD bus, many of these sites will require a student to have his/her own transportation. It is the student's responsibility to ensure that he/she understands where the facility is as well as whether parking is available. The student should discuss these things with preceptors/instructors prior to his/her first day at the site.

**Holidays/Breaks** – While in the 1<sup>st</sup> and 2<sup>nd</sup> year, CU breaks (i.e., fall break, spring break) will be reflected in the clinical assignment schedule. During the 3<sup>rd</sup> and 4<sup>th</sup> year rotations, students are to follow their offsite's schedule. This may mean that there is no break or that a break is given during a time other than CU's campus schedule.

## SLHS Facilities

### Administrative office

The Speech, Language, & Hearing Center's administrative assistant handles issues related to the provision of clinical services in the SLHC such as scheduling and billing. This office is located on the first floor of the SLHS building near the SLHC waiting room.

The SLHS Business Manager handles onboarding for student workers. The Graduate Program Coordinator can assist with registration for classes and ensures all paperwork is completed in a timely manner for exams and graduation. Both of these individuals' offices are located on SLHS' 2<sup>nd</sup> floor.

### Mailboxes

Faculty/staff and AuD student mailboxes are located on the 2nd floor of the SLHS building near the elevator. All graduate students are assigned mailboxes at the beginning of each semester. Be sure to check your mailbox regularly since important messages may be left for you which require prompt attention. Use discretion when leaving items of value in your mailbox.

### Waiting Room

Note that clinical discussions should not take place in a patient waiting room. If important information needs to be exchanged with patients/parents, it should be discussed in the privacy of an exam room or test suite.

### Confidentiality

Patient reports/notes that are done using a method other than the electronic health record system are to be de-identified appropriately per HIPAA regulations (see [Appendix A](#) for more information on HIPAA). Do **not** save patient reports or other patient information on your personal computer or flash drive. Any reports or other material printed with patient identifying information **must** be shredded. Discard these materials in the appropriate bin (this bin is clearly identified). If you do not know where this bin is, ask your preceptor.

### Infection Control

Standard Precautions should be used any time you work with a patient. Infection Control guidelines can be found in [Appendix B](#). The guidelines provided in this handbook reflect those that are in use at University of Colorado Hospital and its clinics. Note that other sites' guidelines may differ slightly. It is the responsibility of the student to inquire with preceptors regarding the site's infection control policies.



## **Maintenance of Audiologic Equipment/Space in SLHS**

It is the responsibility of all individuals who use the audiology space and equipment in SLHS to leave the areas in clean and neat condition and to replace all equipment in the proper location following test procedures. All speculum and immittance probe tips should be cleaned and returned for re-use. The ultra-sonic cleaner is available for this purpose (instructions for use are in the teaching booth). All otoscopes should be re-charged when they are no longer working. All equipment should be turned off after use and all rooms should be locked in order to maintain security.

**No food is allowed in the suites or labs. Drinks must be in a container that is spill-proof and should be set on the floor or another surface that is not near electrical equipment.**

### **Malfunctioning Equipment**

If a piece of equipment is not working properly, the student clinician should first troubleshoot the problem in attempt to correct it. If the problem cannot be fixed, identify, as clearly as possible, what the problem seems to be. This information should be submitted to the Director of Audiology Clinical Education who will respond to the request for equipment repair. A note should also be left on the equipment, indicating the problem and the date.

### **Logbook**

First year AuD students are assigned a month in which they are responsible for ensuring the audiology teaching booth space and equipment are in good working order and clean. The students assigned each month will document in the logbook (kept in Booth) which tasks were finished when as well as note any problems and/or supplies that are low.

## Professionalism for Clinical Practice

Professional behavior is expected of all graduate student clinicians. The following outline provides information as to what professional behavior entails (per current CAA Standards).

Students are expected to demonstrate professionalism throughout their time in the AuD program – both in the classroom and the clinic.

### Accountability

- Conduct all clinical work in accordance with the Code of Ethics set forth by the American Speech-Language-Hearing Association. (See Appendix D)
- Adhere to audiology's Scope of Practice (See Appendix C)
- Understand professional fiduciary responsibility for each client/patient/student served
- Understand federal, state, and institutional regulations and policies related to the profession of audiology and its services, including compliance with confidentiality issues
- Differentiate service delivery based on practice site (e.g., hospital, school, private practice)
- Demonstrate understanding of the effects of your actions and makes appropriate changes as needed
- Explain the landscape of health care and education and how to facilitate access to services in both sectors

### Effective Communication Skills

- Demonstrate the ability to communicate in a responsive and responsible manner with clients/patients/students, families, communities, and interprofessional team colleagues and other professionals

### Evidence-Based Practice

- Access and critically evaluates information sources
- Applies information to appropriate populations
- Integrates evidence into the provision of audiology services.

### Professional Duty

- Demonstrate knowledge of one's own role and those of other professions to appropriately assess and address the needs of the individuals and populations served
- Demonstrate knowledge of the roles and importance of interdisciplinary/interprofessional assessment and intervention and be able to

interact and coordinate care effectively with other disciplines and community resources

- Demonstrate knowledge of the roles and importance of individual and collective (e.g., local, national organizations) advocacy for clients/patients/students' right to care
- Demonstrate knowledge of the role of clinical teaching and clinical modeling as well as supervision of students and other support personnel

While the above items are those outlined by our accreditation body, the following are additional examples/expectations of professional behavior. Please note that this list is not intended to be exhaustive. Also note that sites may have specific requests regarding aspects of professionalism above and beyond this outline.

### Responsibility

- Prepare for and conduct clinical services as assigned (review appropriate files, develop questions and/or key points for discussion).
- Prepare for and conduct meetings/conferences/consultations (review appropriate files, develop questions and/or key points for discussion).
- Carry out all duties to accomplish total case management (e.g., notes, forms, phone calls, referrals, etc.).
- Make appropriate arrangements and notify all concerned regarding any schedule change or cancellation.

### Punctuality

- In case of student clinician illness, accepts responsibility to:
  - (a) Notify clinical preceptor as early as possible
  - (b) Discuss arrangements for make-up time with clinical preceptor.
- Never leave the clinic without notifying/checking with clinical preceptor first.
- Request approval for absence from clinic in writing from Director of Clinical Audiology Education (if student clinician is in an on-site rotation) or his/her preceptor (if student clinician is at an off-site rotation) well in advance of any anticipated absences from professional responsibilities.
  - If CU Boulder closes campus due to inclement weather, students are exempt from attending classes AND clinical assignments. Be sure to email your preceptor as soon as you can to let them know you will not be there due to CU's campus closure policy.
    - If campus is not closed, you are expected to attend classes/clinical assignments as planned.
- Submit all written assignments (e.g., test results, reports, letters, etc.) in acceptable form (appropriate grammatical usage, paragraph structure, punctuation, and spelling) by scheduled deadlines.
- Attend all meetings/conferences/consultations on time.

## Confidentiality

- Abide by HIPAA regulations. The Health Insurance Portability and Accountability Act (HIPAA) was designed to ensure the privacy and security of patient information and give patients greater rights related to their information. (See Appendix A for more information regarding HIPAA.)
- Utilize discretion concerning patient information in written and oral communication with others.
- Access patient information on an “as needed” basis only.

## Personal Appearance

- Wear your name badge to provide patients, family members, and others with a means of easily identifying graduate students.
- Maintain and promote a positive professional image.
- Do not wear scented products (i.e., perfume, hair products, body lotions, etc.).
- Maintain proper personal hygiene.
- Ensure your attire appears neat, pressed and professional looking. While you may wear scrubs (depending on your site), these should still appear neat and professional looking.
- No denim jeans or shorts are allowed. Pants must not be excessively baggy or ride excessively low on the hips. While wearing a cardigan or jacket in cold settings is ok, no hoods are allowed.
- Skirts must cover the knee and be loose enough to allow for movement.
- Any pants/skirt/shirt combination must cover the midriff when the arms are raised and also cover the back when bending over.
- Low-cut tops and shirts that show through are not allowed.
- Shoes should look professional and be closed in the front. Open back shoes such as mules are acceptable. No flip-flops are allowed.
- The following often have limits at clinical sites, so bear this in mind:
  - Unusual hair coloring (e.g., pink, blue, green etc.) and style (e.g., Mohawk) are not commonly allowed.
  - Visible or potentially visible body art should be removed or covered. Oral or facial piercings (tongue, lip, and eyebrow) may not be allowed. Tattoos may need to be covered.
  - Artificial nails may not be allowed; they can harbor germs.
- See Appendix H for specific information regarding University of Colorado Hospital's Dress Code.

## Communication

- Utilize appropriate communication in all professional activities.
- Provide appropriate communication model for patients and families.
- Use appropriate written and oral communication with all persons involved in the case including clinical preceptor, co-clinicians, and other professionals.

- Check email regularly and promptly replies to clinical preceptor emails/phone calls. (Note: Email is the official mode of communication within CU-Boulder (<http://www.colorado.edu/policies/student-e-mail-policy>))

### Accountability

- Keep documentation (including clinical information (such as test results, data on specific goals, correspondence, release of information, hearing aid status etc.) as well as clock hour and compliance data) up-to-date and filed in the appropriate location.
- Complete appropriate chart notes/paperwork in a timely manner.
- Ensure that evidence-based protocols are used each semester enrolled in SLHS 5918/SLHS 5928 (e.g., those that are created as part of coursework).

Failure to meet the standards of professionalism outlined above and in the Technical Standards document signed by all students prior to their start in the program may result in probationary status to be determined by the AuD faculty. The result may also be lowering of the semester clinical grade and/or termination of clinical responsibilities.

### Service Animals and Clinic

Please note that assistance animals (such as therapy animals or emotional support animals) are not allowed in clinical settings as they are not considered a service animal under the Americans with Disabilities Act. Assistance animals differ from service animals in that service animals are trained to perform work or tasks to assist individuals with disabilities. See <https://www.colorado.edu/oiec/ada-accessibility/access-accessibility/service-assistance-animals> for more information.

## Clinical Training Requirements

The Department of Speech and Hearing Science at University of Colorado (CU) has developed a clinical training program for AuD students. Clinical rotations/externships enable students preparing for a career as an audiologist to obtain training at on-campus and off-campus sites.

The AuD clinical training program at CU has been designed such that upon completion, students will have met all clinical requirements for Colorado state licensure and national certification (CCC-A) as an audiologist. In addition, students will have met the standard of excellence that we set for all graduates from our professional training program. In meeting our standards for quality clinical services, it is important for students to understand that they will gain more than the minimum experiences required for certification because we are preparing students to assume the roles and functions of an audiologist across a variety of different settings and service delivery models. This training model is designed to maximize students' employment opportunities upon entry into the professional job market. Clinical placements will result in the accumulation of approximately 2000 hours of clinical experience in different clinical settings and with different populations in order to obtain and demonstrate skills across the scope of practice in audiology (see Appendix C). To be recommended to ASHA for Clinical Certification in Audiology, a student must demonstrate knowledge and skills outlined in Standard II of the 2020 Certification Standards (See Appendix E) while engaged in supervised clinical practicum experiences.

The clinical component of the AuD program stresses the importance of students first gaining exposure, then supervised experience, and eventually independent service provision as they progress through a series of diverse and challenging campus-based and off-campus clinical placements at a variety of facilities. Clinical placements are selected to provide students with experience in audiological service provision across the life span, diverse populations, and entire scope of practice in audiology from diagnostic services through rehabilitative management of hearing-impaired children and adults. Acceptable clinical rotation experience includes clinical and administrative activities directly related to patient care.

## Professional Licensing

As an institution that offers professional licensure programs (such as the AuD) where students can choose to pursue part of their education outside of Colorado (for example, an externship in another state), we are required to inform students of the applicability of the education being delivered to the professional licensing exam/requirements for any educational activities that take place out-of-state. Find information about licensing and requirements for audiologists in other locations by visiting the [Professional Licensure Programs & Degrees website](#).

## Required Clinical Training

The clinical training program is structured around the concept of completing core clinical placement requirements and adding areas of emphasis desired by the student. The clinical rotations are sequenced to evolve in scope and complexity. All AuD students are required to complete a total of 32 clinical credits including two semesters of clinic preparation and observation, three on-campus and three off-campus clinical rotation placements, and the 4<sup>th</sup>-year Audiology Externship, which is the culmination of the AuD program. By definition, a clinical

rotation refers to short-term clinical training within or outside the University and an externship refers to long-term clinical training outside the university. Rotations selected are based on a combination of the student's clinical interest and the fulfillment of their ASHA competency and state licensure requirements.

## General Guidelines

*Student participation in clinical practicum should be considered a privilege rather than a right.*

Clinical practicum participation is different in many ways from class and laboratory assignments. It involves the welfare of the patients in our clinics as well as the training needs of students. We are ethically bound to protect the welfare of the patients in our clinics, so special policies apply to these educational opportunities. Admission to graduate study in audiology in the Department of Speech, Language, and Hearing Sciences at University of Colorado - Boulder does not guarantee participation in clinical practicum. All AuD students must demonstrate competency in basic audiological procedures prior to enrolling in SLHS 5928 by passing an initial Practical Exam that takes place during the 1st year of the AuD program.

Requirements for the ASHA Certificate of Clinical Competence in Audiology (CCC-A) include the completion of supervised clinical practicum by audiologists who hold the Certificate of Clinical Competence in Audiology. CU graduation requirements include the completion of three semesters (summer, fall and spring) in the fourth year even if excess hours are accrued during this time. It is the intent to distribute clinical hours across the 4-year AuD program in settings that provide a breadth of clinical experiences. These experiences may include basic and advanced auditory and vestibular system assessment, hearing amplification, cochlear implants and other implantable devices, pediatric and adult aural rehabilitation, hearing conservation, educational audiology, sedated assessments and intra-operative monitoring using evoked electrophysiological measures, and business practices in audiology.

## Progression of Clinical Assignments

First-year AuD students observe/assist in the audiology clinic, participate in hearing screening programs, and attend clinical laboratory experiences (SLHS 5918) designed to prepare students for their first clinical on-campus rotation. This experience culminates in the Practical Examination.

Beginning in the summer after the 1<sup>st</sup> year, students spend three semesters in university-based clinical rotations at University of Colorado Health – Boulder Health Center while also obtaining experiences in the community through nursing home visits, hearing screenings in school settings, and newborn hearing screening (SLHS 5928). During the 3rd year, students continue their training in approved off-campus clinical rotation placements throughout the Denver Front Range area (SLHS 5938/SLHS 5948). Off-campus clinical rotation sites are chosen to match: (a) program goals, (b) level of student preparation, and (c) student interest(s). Participating clinical sites are selected based on their commitment to the: (a) education of AuD students, (b) certification/licensure status of clinical preceptors, (c) quality of facilities and equipment, and (d) variety of broad-based clinical experiences and diverse clinical populations offered.

The culmination of the clinical portion of the program is the Audiology Externship (SLHS 6938/SLHS 6948), which involves full-time placement in approved regional or national facilities.

Students are responsible for identifying and applying to local and/or national externship opportunities of interest. This includes completing any application and interview processes required by individual clinical externship sites. If a student has not received or accepted an externship offer that fulfills AuD program requirements, the Director of Clinical Education in Audiology will collaborate with the student to secure an appropriate and geographically accessible externship placement. Pending successful completion of pre-requisites, students will register for the Audiology Externship (SLHS 6938/SLHS 6948) starting in the summer semester of their 4th year (no later than 45 days after completing academic coursework requirements). Specific scheduling parameters, including start and end dates as well as time off during the externship year, are determined by individual externship sites (within the bounds of AuD program requirements).

On- and off-campus clinical rotation assignments are designed to fulfill ASHA certification requirements and provide the student with a variety of clinical experiences in preparation for externship placement and a professional career. Students who have been scheduled to provide clinical services are obligated to fulfill each of their clinic responsibilities throughout the semester. Because of our commitment to the clients and facilities, there are no provisions for a student to withdraw from a clinical rotation unless clinical performance is unsatisfactory, or it is in the best interest of the client(s) for the student to be assigned to a different preceptor/site. Additional factors for withdrawal may be considered by the clinical supervisor/preceptor in consultation with the department's AuD Committee Chair and the Director of Audiology Clinical Education.

Students are free to indicate clinical rotation preferences, and when possible, these preferences will be accommodated. It is important to note, however, that the primary obligation of the program is to provide a well-rounded clinical training experience that meets the quality standards of the department and clinic. To maintain the high quality of the training program, students can be assigned to a clinical rotation placement that was not necessarily their first choice but necessary to meet the goals of the training program and ASHA certification and state licensure requirements. Clinical rotation assignments are requested through the Director of Audiology Clinical Education. Each approved site must have a formal affiliation agreement filed with University of Colorado prior to the placement of audiology students. Affiliation agreements are the responsibility of the Director of Audiology Clinical Education and Director of Clinical Operations.

### **Titles**

Students will introduce themselves to patients with their first and last name and state that they are a graduate student in audiology. They will also introduce their clinical instructor by their full name or as Ms. \_\_\_\_\_ or Dr. \_\_\_\_\_ and state they are the 'supervising audiologist'. Off-campus students in placements will use "Audiology Extern" or other title as preferred by their clinical preceptor.

### **Clinical Time Demands**

Enrollment in clinical practicum places significant time demands on students during the work week. Student clinicians registered for clinical practica should be prepared to devote approximately 5 to 10 hours per week to the preparation, implementation, and analysis of clinical experiences *in addition* to the actual time spent in the clinic working with clients. In a typical 15-week semester, students registering for two credits of SLHS 5928 are typically engaged in clinical activity one day per week and are responsible for the service delivery and



reports/chart notes for anywhere from three to thirty patients! Students registering for three credits of SLHS 5938/5948 are typically in clinic two to three full days per week at an offsite placement and are responsible for service delivery and reports/chart notes as directed by the offsite preceptor. SLHS 6938/6948 is a full-time externship where students take part in the provision of services to patients and families on a full-time basis (i.e., 35-40 hours/week).

### **Attendance Policy**

Consistent attendance in clinic is required to gain appropriate clinical skills and make adequate progress each semester. **All students are therefore expected to attend each scheduled clinical session during a semester.** Illness or funeral attendance are the only reasons considered acceptable for missing clinic. Missing significant time in clinic may require that at least some of that time is made up by extending the clinical rotation, which may result in delaying graduation.

If you anticipate that you will miss clinic in order to attend a conference, you are **required** to obtain **written approval** from your clinical preceptor(s) **at the beginning of the semester**. It is highly recommended that you **do not make your travel plans before you obtain approval from your clinical preceptor(s)**. Missing clinic for conference attendance does not necessarily relieve you of clinical hours missed. Be sure to offer your preceptor times/days to make up for time missed.

Tardiness: Students are expected to be **on time** and ready for their scheduled clinical experiences. Tardiness is unacceptable except in cases beyond the graduate student clinician's control (e.g., traffic accident, inclement weather). The student should do his/her best to contact his/her clinical preceptor to let him/her know the student is running late.

## **Documentation of Clinical Hours and Competencies**

### **Tracking Progress**

An online database program (Calipso) has been adopted to help track student progress in the AuD program. Additional tracking documents have been developed to assist the student and the academic advisor(s) in systematically tracking and monitoring the satisfactory completion of academic coursework, clinical practicum, and progress toward the attainment of the knowledge and skills required in the ASHA Standards. According to the ASHA guidelines, applicants for certification should maintain documentation of academic coursework, practicum hours, and practicum supervision verified by the program. This documentation must demonstrate that the applicant possesses the knowledge and skills delineated in Standard II. Documentation must be made available (to ASHA) upon request. By keeping current and accurate advising check sheets, AuD graduate students and advisors know precisely which courses and competencies are needed to complete degree and certification requirements. Please also refer to <https://www.asha.org/Certification/2020-Audiology-Certification-Standards/> for the most current version of the 2020 Standards and Implementation Procedures for the Certificate of Clinical Competence in Audiology (see also Appendix E).

The Doctor of Audiology course schedule (Appendix G) lists all required courses and clinical practica for the AuD degree. All AuD graduate courses are offered on a once-a-year or every-other-year basis. As a result, any failure to complete a required graduate course during the appropriate semester of enrollment will likely delay graduation. Information regarding the

completion of various knowledge/skill competencies in the ASHA certification standards will be addressed on the syllabi of courses.

### Clock hours

Students who are enrolled in practicum and seeing patients in the clinic are required to log the amount of time spent participating in each session including preparation, report writing etc. Each student is required to keep track of his/her clock hours each semester including off-campus sites and in the fourth year. All clock hours need to be logged into Calipso and signed off on by the clinical preceptor. Students should also track clock hours via paper/electronic log each day as backup and keep a copy of these logs while they are in the program. **This information is necessary for graduation as well as ASHA certification. It is the student's responsibility to maintain accurate records.**

The Council for Clinical Certification (CFCC) defines one (1) clinical practicum hour as equal to 60 minutes. When counting clinical practicum hours for purposes of ASHA certification, experiences/sessions that total less than 60 minutes (e.g., 45 minutes or 50 minutes) cannot be rounded up to count as 1 hour. Example: If you spend 52 minutes engaged in direct service delivery, you should log 52 minutes.

What you can count when logging clock hours...

- Face to face service delivery, within the scope of practice of ASHA, provided to a patient or a group of patients. Includes:
  - Screening/Information gathering
  - Evaluation
  - Intervention (e.g., amplification, earplugs)
  - Counseling
  - Education (Patient/Family Member/Guardian)
  - Consultation or Collaboration with other service providers: Team meetings/activities (e.g., IEP meetings, multidisciplinary team meetings) related to service delivery
- Administrative tasks such as:
  - Communication with client/patient or family member/guardian via telephone
  - Email communications with client/family member/guardian.
  - Time spent on documentation (e.g., record keeping and writing reports)
  - Other administrative duties related to service delivery completed without client/family member/guardian present. (e.g., checking in hearing aids, troubleshooting amplification devices)
  - Planning a session with your preceptor where you are presenting your plan for patient care
- Observation of screenings, evaluations or treatment (although these should be logged as observation hours)

What does not count...

- Time spent in planning and preparation (reading journal articles or other references, practicing with equipment)
- Time spent reviewing the day and your performance with your preceptor
- Time spent reviewing/discussing a concept/topic/framework of audiology



## Clinical Rotation Credits

AuD students need to complete a minimum of 32 clinical credits to graduate. Clinical experiences are distributed across eleven semesters. An example of how the clinical experiences progress through the program is shown below. Note that the time indicated includes not only time spent at the clinical site, but also time spent preparing/reviewing/studying for clinical work.

### 1<sup>st</sup> year –

- Fall – observe at UCHHealth Boulder clinic, clinical labs (~6-8 hours/wk) (SLHS 5918 – 1 credit)
- Spring – observe/assist at UCHHealth Boulder clinic, clinical labs (~6-8 hours/wk) (SLHS 5918 – 1 credit)

### 2<sup>nd</sup> year –

- Summer – UCHHealth Boulder clinic, various specialty opportunities (~11-14 hours/wk) (SLHS 5928 – 3 credits)
- Fall – UCHHealth Boulder clinic, various specialty opportunities (~8-12 hours/wk) (SLHS 5928 – 2 credits)
- Spring – UCHHealth Boulder clinic, various specialty opportunities (~8-12 hours/wk) (SLHS 5928 – 2 credits)

### 3<sup>rd</sup> year –

- Summer – off site 3x/week (24+ hours/week) (SLHS 5938 – 3 credits)
- Fall – off site 2x/week (16+ hours/wk) (SLHS 5938/5948 – 4 credits)
- Spring – off site 2x/week (16+ hours/wk) (SLHS 5938/5948 – 4 credits)

### 4<sup>th</sup> year –

- Externship (12 months) (SLHS 6938/6948 – 13 credits total)

## Compliance requirements

Students are required to complete training in Universal Precautions/Bloodborne Pathogens (OSHA) and HIPAA annually (trainings are offered online through CU). CPR BLS training is required; proof of up-to-date CPR training must be provided by uploading documentation into Calipso's compliance area (certification is typically good for two years). Students are also required to provide documentation of immunizations and complete a criminal background check (this is typically done at the onset of the AuD program). These documents should be uploaded to Calipso (see Calipso instructions for details regarding where to save these documents).

Note that that SLHS has additional requirements beyond those required by CU and these requirements must be completed and kept current throughout your time in the program. Additionally, some sites have requirements beyond SLHS, such as drug testing or updated background check. These additional requirements must be completed and submitted as instructed for the placement to occur. *Any fees for these additional requirements are paid for by the student.*

Some sites (i.e., Denver Health) use a tool called my Clinical Exchange (mCE) to track all student internships/rotations. This tool enables the site to track student compliance and to provide the student with their onboarding materials. Since AuD students enrolled in SLHS 5928 participate in Denver Health's newborn screening program, the Department will pay for student use of mCE during that year. If use of mCE is needed beyond this (e.g., a student is participating in an offsite rotation at a site that uses mCE), *the student is responsible for this fee* (currently ~\$40/year).

### **Liability Insurance**

Liability Insurance needs to be obtained by the beginning of the fall semester, prior to any practicum experience beginning at the commencement of the AuD program. Liability insurance policies are typically valid for one full year. Proof of liability insurance needs to be uploaded to Calipso and kept current throughout the AuD program. Liability insurance is available through ASHA or AAA. Failure to possess up-to-date liability insurance will result in inability of the student to take part in clinical activities.

## **Evaluation of Clinical Practicum**

### **Practical Exams**

Clinical practical exams are conducted during the 1st year of the program. The practical exam typically consists of the following components:

- Ear mold impression
- Electroacoustic evaluation of hearing aid and interpretation of results
- Programming of hearing aid
- Real Ear assessment
- Case history
- Immittance testing
- Basic audiometric test battery
  - Pure tone air and bone conduction
  - Speech audiometry
  - Masking as needed
- Interpretation of test results
- Counseling patient regarding evaluation results

Students should be prepared to answer clinical questions relative to the component being assessed. Each component of the practical exam must be passed for the student to move on to SLHS 5928.

### **Practicum**

Student clinicians will be assigned to one or more clinical preceptors during each semester of practicum. According to requirements for ASHA certification, the amount of supervision will be dependent upon student clinician skill levels and needs.

Students are strongly encouraged to schedule a time to meet with his/her clinical preceptor at the beginning of each semester and as needed throughout the semester. These meetings can

be used to reflect and evaluate clinical performance, discuss areas of strengths and weaknesses, discuss proposed plans and goals, or communicate upcoming responsibilities.

### **Evaluation and Remediation Procedures for Audiology Clinical Practicum**

Students will receive feedback from their clinical preceptors during each semester. Students are encouraged to discuss individual learning styles with their clinical preceptors to facilitate clinical learning. A formal evaluation will be completed by preceptors at midterm (this evaluation is intended to be formative in nature) and the end of the semester (this evaluation is intended to be summative).

At midterm and final evaluations, often the student and preceptor meet to discuss the semester and the completed evaluation form. This is a mechanism for the student and the clinical preceptor to identify areas of strength, as well as areas needing improvement and possibly remediation.

Failure of a student clinician to demonstrate expected levels of performance in any area of clinical or professional skills will be recorded on the evaluation. The Director of Audiology Clinical Education and the clinical preceptor for that practicum assignment will discuss specific recommendations for those areas that are not at expected performance levels; these recommendations will be incorporated into a remediation plan.

Remediation procedures for clinical and professional competencies will result when the student fails to demonstrate clinical knowledge and/or skills at the level expected given the student's level in the program. Guidelines regarding remediation and probation for below satisfactory performance are outlined in the SLHS Graduate Handbook, available on the SLHS website ([www.colorado.edu/slhs](http://www.colorado.edu/slhs)).

### **Lines of Communication**

We hope that students will be able to discuss most concerns directly with the involved parties but know that situations can arise in which other advice is needed. Audiology faculty, the SLHS department chair, and the graduate program director are all available to discuss student concerns. Please see the SLHS Graduate Handbook for the grievance policy.

## Certification and Licensure

Applicants for ASHA's Certificate of Clinical Competence must have met accreditation standards for experience requirements (i.e., the equivalent of one-year full-time experience) in their AuD program in which their clinical preceptors were ASHA-certified and have completed at least 2 hours of professional development in the area of clinical instruction/supervision (<https://www.asha.org/certification/2020-audiology-certification-standards/>). Note that if you obtained clinical experiences under the supervision of a licensed audiologist who is NOT ASHA-certified but at least 1800 of your total number of clock hours were indeed under the supervision of ASHA certified audiologists, you can still apply for the CCC. If you do not have at least 1800 clock hours that were supervised by ASHA certified audiologists, you can work towards meeting this requirement post-graduation. See the previous link for more information as well as this one: <https://www.asha.org/certification/certification-standards-for-aud-clinical-practicum/>.

Most of CU's AuD students will have met the ASHA requirement upon graduation. So, upon successful completion of the AuD program, most students are eligible to apply for ASHA certification (CCC-A). The Praxis II exam in Audiology (code: 5343) is required for ASHA certification. (Note: the previous version of the exam is version 5342; it is no longer offered.) Information about the exam is available at <https://www.asha.org/certification/praxis/about-the-audiology-praxis-exam/>. The Praxis II exam is administered by the Educational Testing Service. The website is <http://www.ets.org/praxis>. The address is:

ETS – Praxis Series  
P.O. Box 6052  
Princeton, NJ 08541-6052  
Phone number: 800-772-9476

It is recommended that students register for and take this exam at the end of Year III after completion of all coursework, but prior to the end of the Fall semester of the 4th year externship. The Praxis II exam scores should be reported directly to CU Boulder. It is strongly recommended that students keep a copy of their results for their records after completing the exam. Students can identify specific recipients to receive a copy of their Praxis score when they register to take the exam. Codes for various recipients are:

- CU Boulder, 4841 (this will send a report to CU – both SLHS and the School of Education will have access to this report; the School of Education will only access your report if you pursue a position in educational audiology in the state of Colorado)
- ASHA, 5031 (if you even *think* you will apply for your Certificate of Clinical Competence after graduation, include this code!)

Note that the state of Colorado's licensing agency does not require the Praxis for audiology licensure in Colorado. They require that you have graduated from an accredited program and that you provide official transcripts. (See <https://drive.google.com/file/d/0BzKoVwvexVATT0Z6YkpIdHJ2VWM/view?usp=sharing>)

Graduates can apply for certification online at <http://www.asha.org>. Contact the ASHA Action Center at 800-498-2071 for assistance/questions. Once submitted, a verification document is sent to the Director of Audiology Clinical Education who will attest that the graduate has indeed

met the Standards for the Certificate of Clinical Competence. Note that the entire process of obtaining the CCC from ASHA can take up to 6-8 weeks, so plan accordingly.

Certification is also available through the American Board of Audiology (ABA). Information about ABA certification can be found at [https://www.boardofaudiology.org/board-certified-in-audiology/documents/HandbookApril2019Final\\_001.pdf](https://www.boardofaudiology.org/board-certified-in-audiology/documents/HandbookApril2019Final_001.pdf). Board Certification in Audiology requires a minimum of 2000 hours of direct patient care supervised by a licensed audiologist. All hours must be obtained AFTER coursework is completed (externship hours can count towards 2000 required hours). See ABA handbook and website for more information.

State licensure/registration is required in most states to practice Audiology, and the requirements vary by state. Colorado state licensure requirement information, instructions and application forms are available at <https://dpo.colorado.gov/Audiology>. Check individual state requirements if you are applying for jobs elsewhere.



## Appendix A: The Health Insurance Portability and Accountability Act (HIPAA)

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### HIPAA and Privacy (from University of Colorado Hospital)

The Health Insurance Portability and Accountability Act (HIPAA) was designed to ensure the privacy and security of patient information and give patients greater rights related to their information.

Patient information is referred to as Protected Health Information (PHI).

- Privacy covers all forms of information maintained or disclosed, including paper, electronic and oral.
- Security refers to electronic PHI only. We are required to control access and protect information from accidental or intentional disclosure to unauthorized persons and to protect it from alteration, destruction or loss

Your responsibilities related to privacy and security.

- Only share information with those that have a “need to know” the information in order to perform their job duties.
- Share only the minimum amount of information required. For example, distributing a report with patient identifying information on it, such as name or medical record #, when those receiving the report did not need to know the information.
  - This does not apply to information needed to treat the patient.
  - Remember that any information, not just name or medical record number can be used to identify a patient. This could include things like a unique injury or occupation. Even if there is no name or medical record number information must be protected if it can be used to identify patients.
  - Refer requests for copies of patient information to Health Information Management. Trained staff will track and release the information. Exceptions may be made if a referring physician requires information in order to treat the patient.
  - Keep your passwords secure. If you believe someone might have learned your password contact the help desk immediately so your password can deactivated and reissued. You are responsible for all accesses under your password.
  - Keep patient information secure. When unattended, lock it up. If information is shared with or learned by someone without a need to know the information it is a disclosure that must be tracked and is a potential violation.
    - Discuss patient information, when possible, in private areas. If a private area is not available speak in a low to moderate voice to prevent the information from being overheard.
    - Ask patients, preferably in private, before sharing their information in front of someone.

- Do not review patient information, including demographic information, unless you have a need to do so in order to perform your job duties.
- Do not store patient information on a mobile device unless it is encrypted.
- Dispose of all paper in confidential trash bins so that it is properly destroyed.
- Report any suspected violations to your manager or director, the privacy officer or the Compliance Hotline, 877-454-6344. Reports can be anonymous and the organization is prohibited from retaliating for reports that are believed to be privacy or security violations.
  - Unfounded, malicious reports, however, may subject you to disciplinary action.
  - Failure to report suspected violations can result in disciplinary action.

Sanctions for failure to follow privacy and security regulations:

- The organization will enforce disciplinary action up to and including termination.
- Health and Human Services/Office for Civil Rights can levy fines (\$100 - \$1.5 million) on the individual as well as the organization for violations. In addition, criminal penalties, including up to 10 years in jail can be assessed.

## Appendix B: Infection Control: Standard Precautions in Health Care

(adapted from WHO 2007)

### Background

**Standard precautions are meant to reduce the risk of transmission of bloodborne and other pathogens from both recognized and unrecognized sources.** They are the basic level of infection control precautions which are to be used, as a minimum, in the care of all patients.

**Hand hygiene** is a major component of standard precautions and one of the most effective methods to prevent transmission of pathogens associated with health care. In addition to hand hygiene, the use of **personal protective equipment** should be guided by **risk assessment** and the extent of contact anticipated with blood and body fluids, or pathogens.

In addition to practices carried out by health workers when providing care, all individuals (including patients and visitors) should comply with infection control practices in health-care settings. The control of spread of pathogens from the source is key to avoid transmission. Among source control measures, **respiratory hygiene/cough etiquette**, developed during the severe acute respiratory syndrome (SARS) outbreak, is now considered as part of standard precautions.

Worldwide escalation of the use of standard precautions would reduce unnecessary risks associated with health care. Promotion of an **institutional safety climate** helps to improve conformity with recommended measures and thus subsequent risk reduction. Provision of adequate staff and supplies, together with leadership and education of health workers, patients, and visitors, is critical for an enhanced safety climate in health-care settings.

### Important advice

- Promotion of a safety climate is a cornerstone of prevention of transmission of pathogens in health care.
- Standard precautions should be the minimum level of precautions used when providing care for all patients.
- Risk assessment is critical. Assess all health-care activities to determine the personal protection that is indicated.
- Implement source control measures for all persons with respiratory symptoms through promotion of respiratory hygiene and cough etiquette.

### Hand hygiene

- Perform hand hygiene by means of hand rubbing or hand washing (see detailed indications in table).
- Perform hand washing with soap and water if hands are visibly soiled, or exposure to spore-forming organisms is proven or strongly suspected, or after using the restroom. Otherwise, if resources permit, perform hand rubbing with an alcohol-based preparation.
- Ensure availability of hand-washing facilities with clean running water.
- Ensure availability of hand hygiene products (clean water, soap, single use clean towels, alcohol-based hand rub). Alcohol-based hand rubs are available at the point of care.

### **Personal protective equipment (PPE)**

- ASSESS THE RISK of exposure to body substances or contaminated surfaces BEFORE any health-care activity. **Make this a routine!**
- Select PPE based on the assessment of risk:
  - clean non-sterile gloves
  - clean, non-sterile fluid-resistant gown
  - mask and eye protection or a face shield.

### **Respiratory hygiene and cough etiquette**

- Cover the mouth and nose when coughing or sneezing.
- Hand hygiene after contact with respiratory secretions.
- Spatial separation of persons with acute febrile respiratory symptoms.

**Health-care facility recommendations for standard precautions: key elements at a glance (Note: these recommendations are ‘pre-COVID’. Updated information due to COVID-19 has been provided to health-care facilities by the CDC and local/state entities. This updated information is available in a separate Policy and Procedure manual for the Speech, Language, and Hearing Clinic in SLHS.)**

### **1. Hand hygiene**

#### **Summary technique:**

- Wash hands whenever they are visibly soiled. Hand washing (40–60 sec): wet hands and apply soap; rub all surfaces; rinse hands and dry thoroughly with a single use towel; use towel to turn off faucet.
- Rub hands for hand hygiene but wash them when they are visibly soiled! Hand rubbing (20–30 sec): apply enough product to cover all areas of the hands; rub hands until dry.

#### **Summary indications:**

- Before and after any direct patient contact and between patients, whether or not gloves are worn.
- Immediately after gloves are removed.
- Before handling an invasive device.
- After touching blood, body fluids, secretions, excretions, non-intact skin, and contaminated items, even if gloves are worn.
- During patient care, when moving from a contaminated to a clean body site of the patient.
- After contact with inanimate objects in the immediate vicinity of the patient.

### **2. Gloves**

- Wear when touching blood, body fluids, secretions, excretions, mucous membranes, nonintact skin.
- Change between tasks and procedures on the same patient after contact with potentially infectious material.

- Remove after use, before touching non-contaminated items and surfaces, and before going to another patient. Perform hand hygiene immediately after removal.

### **3. Facial protection (eyes, nose, and mouth)**

- Wear (1) a surgical or procedure mask and eye protection (eye visor, goggles) or (2) a face shield to protect mucous membranes of the eyes, nose, and mouth during activities that are likely to generate splashes or sprays of blood, body fluids, secretions, and excretions.

### **4. Gown**

- Wear to protect skin and prevent soiling of clothing during activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions.
- Remove soiled gown as soon as possible, and perform hand hygiene.

### **5. Prevention of needle stick and injuries from other sharp instruments<sup>2</sup>**

#### **Use care when:**

- Handling needles, scalpels, and other sharp instruments or devices.
- Cleaning used instruments.
- Disposing of used needles and other sharp instruments.

### **6. Respiratory hygiene and cough etiquette**

#### **Persons with respiratory symptoms should apply source control measures:**

- Cover their nose and mouth when coughing/sneezing with tissue or mask, dispose of used tissues and masks, and perform hand hygiene after contact with respiratory secretions.

#### **Health-care facilities should:**

- Place acute febrile respiratory symptomatic patients at least 1 metre (3 feet) away from others in common waiting areas, if possible.
- Post visual alerts at the entrance to health-care facilities instructing persons with respiratory symptoms to practise respiratory hygiene/cough etiquette.
- Consider making hand hygiene resources, tissues and masks available in common areas and areas used for the evaluation of patients with respiratory illnesses.

### **7. Environmental cleaning**

- Use adequate procedures for the routine cleaning and disinfection of environmental and other frequently touched surfaces.

### **8. Linens**

#### **Handle, transport, and process used linen in a manner which:**

- Prevents skin and mucous membrane exposures and contamination of clothing.
- Avoids transfer of pathogens to other patients and or the environment.

### **9. Waste disposal**

- Ensure safe waste management.
- Treat waste contaminated with blood, body fluids, secretions and excretions as clinical waste, in accordance with local regulations.
- Human tissues and laboratory waste that is directly associated with specimen processing should also be treated as clinical waste.
- Discard single use items properly.

### **10. Patient care equipment**

- Handle equipment soiled with blood, body fluids, secretions, and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and transfer of pathogens to other patients or the environment.
- Clean, disinfect, and reprocess reusable equipment appropriately before use with another patient.

1 For more details, see: WHO Guidelines on Hand Hygiene in Health Care (Advanced draft), at:

[http://www.who.int/patientsafety/information\\_centre/ghhad\\_download/en/index.html](http://www.who.int/patientsafety/information_centre/ghhad_download/en/index.html).

2 The SIGN Alliance at:

[http://www.who.int/injection\\_safety/sign/en/](http://www.who.int/injection_safety/sign/en/)

## University of Colorado Hospital - Hand Hygiene Policy

### Policy

Hand antisepsis is the single most effective modality for preventing the spread of infection. Many recent studies have shown that alcohol-based waterless antiseptic agents are significantly more effective in reducing the microbial load on hands than washing with soap and water. Other studies have demonstrated that inclusion of emollients and lotions in these waterless antiseptic agents may actually be more effective in maintaining skin integrity than repeated use of soap and water. Therefore, the Center for Disease Control and Prevention has recommended that the use of waterless antiseptic agents for hand hygiene in the health care setting is "highly preferable" to the use of antimicrobial soap and water when the hands are not visibly soiled.

#### I. Indications for hand antisepsis

If hands are not visibly soiled, use an alcohol-based waterless antiseptic agent for routinely decontaminating hands:

- A. **before entry into an occupied patient room**
- B. **upon exit from an occupied patient room**
- C. after contact with a patient's skin (does not apply in situations involving mass immunization/skin testing of healthy employees/healthcare workers.)
- D. after contact with body fluids or excretions, mucous membranes, non-intact skin or wound dressings, as long as hands are not visibly soiled
- E. if moving from a contaminated body site to a clean body site during patient care
- F. after contact with inanimate objects (including medical equipment, furniture and environmental surfaces) in the occupied patient room
- G. **before** caring for patients with severe neutropenia or other forms of severe immune suppression
- H. **before** donning sterile gloves when inserting a central intravenous catheter
- I. **before** inserting indwelling urinary catheters, peripheral vascular catheters, or other invasive devices that do not require a surgical procedure
- J. **ALWAYS** after removing gloves
- K. After smoking, or applying make-up/lipstick/lip balm.
- L. After coughing, sneezing and/or blowing your nose.
- M. After completion of the work shift prior to leaving the health care delivery environment.

#### II. Indications for handwashing

- A. Wash hands with a non-antimicrobial soap and water or an antimicrobial soap and water
  1. when hands are visibly soiled or contaminated with proteinaceous material.
  2. after contact with body fluids or excretions, mucous membranes, non-intact skin or wound dressings, especially if hands are visibly soiled
  3. After using the bathroom.

4. Before and after eating and drinking.
  5. Wash hands with non-antimicrobial soap and water or with antimicrobial soap and water if exposure to *Clostridium difficile* or *Bacillus anthracis* is suspected or proven. The physical action of washing and rinsing hands under such circumstances is recommended because alcohols, chlorhexidine, iodophors and other antiseptic agents have poor activity against spores.
- B. Hand antisepsis using an antimicrobial soap may be practiced
1. in settings where time constraints are not an issue and easy access to hand hygiene facilities are insured, or
  2. in rare instances, when a caregiver is intolerant of the waterless antiseptic agent used in the institution.

**III. Effective Hand Hygiene Procedures** - to be effective, hand hygiene should be performed according to one of the following procedures.

**A. ANTISEPTIC HANDRUB PROCEDURE**

1. Alcohol-based waterless antiseptic agents will be used.
2. Apply dime-sized quantity of product to palm of one hand and rub hands together, covering all surfaces (between fingers, palms, backs of hands, wrists, forearms, under and around fingernails) until hands are dry.
3. If an adequate volume of alcohol-based handrub is used, it should take 15-25 seconds for hands to dry.

**B. HANDWASHING PROCEDURE:**

1. Antimicrobial soap is generally used in patient care areas for handwashing.
2. Administrative and support departments are not required to use antimicrobial soap for routine handwashing. If bar soap is used in any of these areas, the used bar must be stored for use on/in a holder/rack that allows for drainage of water away from the soap.
3. Steps for effective handwashing:
  - a. Remove jewelry.
  - b. Turn on water – adjust to comfort level. Avoid using hot water; repeated exposure to hot water may increase risk of dermatitis.
  - c. Wet hands under running water.
  - d. Keeping hands lower than elbows, apply 3-5 ml of soap from dispenser.
  - e. Rub hands together, using friction to clean between fingers, palms, backs of hands, wrists, forearms, and under fingernails.
    1. For routine handwashing, this procedure should last at least 15 seconds.
    2. For preparation to perform or assist with invasive procedures (outside of the operating room suites), this procedure should last 30-45 seconds.
  - f. Keeping fingers lower than wrists, rinse under running water. Let water run from wrists, over hands and off ends of fingers. Do not touch faucet handles with clean bare hands – let water run until hands are dried.
  - g. Dry hands with paper towel. Discard paper towel.
  - h. Using clean, dry paper towel, turn off faucet (if hand operated).
  - i. Use paper towel to open bathroom door. Discard paper towel at first opportunity.
4. Standing water (basins or bowls of collected, caught or poured standing water) may not be used for effective handwashing at any time. The contained pool of water is thoroughly contaminated by the initial entry, becoming increasingly contaminated as more entries are made, and subsequently contaminating everything entering or contacting the water in the bowl or basin.

#### **IV. Skin Care**

- A. Lotion may be applied to keep skin smooth and free of cracking. As petroleum-based lotions and creams can degrade latex and some vinyl gloves, non-petroleum-based products are recommended for use.
- B. Barrier lotions and hand creams may be used to protect hands from problems caused by excess water, harsh soaps, or irritation caused by prolonged exposure to irritant substances. Use of a barrier lotion or cream does not relieve the employee of the responsibility of appropriate hand hygiene or proper glove utilization.
- C. Lotion and cream dispensers:
  - 1. Pump or squirt dispensers containing lotion or cream must be provided if more than one person on the unit will use the product.
  - 2. A “tub” or “jar” containing lotion or cream may only be used by one person, as the first person to use the product contaminates the contents. The remaining product in the tub can become a source of contamination for all others who access it. If “tub” or “jar” product MUST be used, it must be assigned to a specific patient or employee, be labeled with the name of the sole user, and be used by that person only.

#### **V. Other Aspects of Hand Hygiene**

- A. Direct patient care providers (see Definitions and Appendix B) may not wear artificial fingernails or extenders when providing direct care for or having direct contact with patients at University of Colorado Hospital. Natural nail tips should be kept less than 1/4-inch long.
- B. Wear gloves when contact with blood or other potentially infectious materials, , mucous membranes, and non-intact skin could occur.
- C. Remove gloves after caring for a patient. Do not wear the same pair of gloves for the care of more than one patient, and do not wash gloves between patients (does not apply in situations involving mass immunization/skin testing of healthy employees/healthcare workers.).
- D. Change gloves and perform hand hygiene during patient care if moving from a contaminated body site to a clean body site.
- E. No recommendation on wearing rings in healthcare settings. (Unresolved issue at CDC)
- F. Do not add soap to a partially empty soap dispenser. This practice of “topping off” dispensers can lead to bacterial contamination of soap. Use of liquid soap dispensed from collapsible bags that cannot be refilled is recommended.

#### **References:**

- 1. Association for Professionals in Infection Control and Epidemiology; “Hand Hygiene”, APIC Text of Infection Control and Epidemiology, 3<sup>rd</sup> Edition, 2009. LEVEL VI
  - 2. Boyce, John M., Infection Control and Hospital Epidemiology; 18:622. LEVEL VI
  - 3. Centers for Disease Control and Prevention (HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force), Guideline for Hand Hygiene in Healthcare Settings; October, 2002. LEVEL VI
  - 4. Mayhall, C. Glenn, editor. Hospital Epidemiology and Infection Control, Lippincott, Williams & Wilkins, 3<sup>rd</sup> Edition, 2004. LEVEL VI
  - 5. Rutala, Wm.; Chemical Germicides in Health Care; Polyscience and APIC, 2010. LEVEL VI
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## University of Colorado Hospital Policy and Procedure: Cleaning and Disinfection of Toys and Play Materials

### Policies/Procedures:

- I. Toys that are provided by University of Colorado Hospital, and are acceptable for use in health care areas include only those that can be cleaned and disinfected. Acceptable toys include toys made of plastic, metal and vinyl. No toys will be used that cannot be immersed in cleaning solution. Fabric, fur toys, dolls or stuffed animals are prohibited as community/shared playthings. Wooden toys that absorb fluids are not acceptable.
- II. Toys that have been played with will be cleaned and disinfected after use by each child. All toys will be cleaned at least daily. Play materials are inspected regularly by staff and discarded if worn or heavily soiled.
- III. Infant and toddler toys that have been put in the child's mouth should be cleaned and disinfected between individual children's use. When an infant or toddler finishes playing with a toy, the toy should be retrieved and placed in a bin reserved for dirty toys. This bin should be out of the reach of children. Toys can be cleaned at a later time and transferred back to the area for clean toys.
- IV. To clean and disinfect toys:
  - A. Remove surface contamination
    1. Soap and water -
      - a. Scrub the toy in warm, soapy water. If necessary use a brush to reach into crevices.
      - b. Rinse toy in clean water, OR
    2. Use a commercial, disposable, pre-moistened cloth "wipe" according to manufacturer's instructions on label to remove surface contamination
  - B. Disinfect toy after cleaning -
    1. Immerse toys in, or squirt onto and cover toys with, a properly diluted solution of hospital approved disinfectant. Assure 10-minute contact time for disinfectant on toy. Rinse well and let air dry.
    2. Use a commercial, disposable, cloth "wipe" pre-moistened with hospital approved disinfectant(s) to wipe down toy. Assure contact of wipes into crevices on toy. Use wipes according to manufacturer's directions on label, making sure to achieve recommended 5 minute contact time for solution.
- V. Daily documentation of cleaning and disinfection of toys will be maintained on each unit where toys are provided.

### References:

- **CDC, Division of Healthcare Quality Promotion:** "Washing and Disinfecting Toys". January 1997. LEVEL VI
- Colorado Department of Health. The ABC's of Safe and Healthy Child Care, 2/13/98. LEVEL VI
- The Children's Hospital, Denver Colorado. Cleaning of Toys and Play Area, 6/98.
- Kaiser Permanente, Colorado Region. "Toys in Patient Waiting and Patient Care Areas". May 1993.
- Association for Professionals in Infection Control and Epidemiology, Inc., APIC Text of Infection Control and Epidemiology. 2010. LEVEL VI

### **Handling ITE's and Earmolds**

There is a danger of spreading bacterial and fungal infections through handling earmolds and hearing aids without disinfecting them first. Also, there may be blood or ear drainage on the device, which may or may not be visible at first glance. Therefore, do not handle these devices with your bare hands before disinfecting them. Here are several precautionary options:

1. Use a disinfectant wipe to handle the hearing aid/earmold. Have the patient place the device directly into the wipe. You can then wipe the device before handling it **OR**
2. Use a bowl or tissue to capture the device, and then disinfect it with a wipe

Other notes to remember:

1. It is possible there could be dried blood or mucous in the sound ports or vents. Gloves are available if needed.
2. Always sterilize tools used to clean the aid when blood or mucous is found. Disinfect the tools when blood or mucous is not present.
3. Never use any tool or instrument that has not been cleaned, disinfected, or sterilized properly.

### **Toys**

In audiology clinics many times there are toys in the waiting room, exam room, and/or in the sound booth. Follow these guidelines to help control infection:

1. Disinfect used toys daily.
2. Use care when handling the toys. Wash your hands after handling/disinfecting the toys.
3. Always replace broken or old toys.

### **Disposable Items in SLHS**

The following items are disposable, therefore eliminating the need for infection control:

1. Insert earphones

### **Non-Disposable Items in SLHS**

These are not disposable:

1. Ear impressions syringes and probe light tips are to be cleaned and disinfected after each use. If blood or mucous is noted, sterilize these items.
2. Immittance probe tips are to be sterilized after each use.
3. Otoscopic specula

## Appendix C: Scope of Practice in Audiology

*Ad Hoc Committee on Scope of Practice in Audiology*  
American Speech-Language-Hearing Association. (2004). *Scope of Practice in Audiology* [Scope of Practice].

Available from [www.asha.org/policy](http://www.asha.org/policy).

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### About This Document

This scope of practice in audiology statement is an official policy of the American Speech-Language-Hearing Association (ASHA). The document was developed by the Coordinating Committee for the ASHA vice president for professional practices in audiology and approved in 2003 by the Legislative Council (11-03). Members of the coordinating committee include Donna Fisher Smiley (chair), Michael Bergen, and Jean-Pierre Gagné with Vic S. Gladstone and Tina R. Mullins (ex officios). Susan Brannen, ASHA vice president for professional practices in audiology (2001–2003), served as monitoring vice president. This statement supersedes the Scope of Practice in Audiology statement (LC 08-95), (ASHA, 1996).

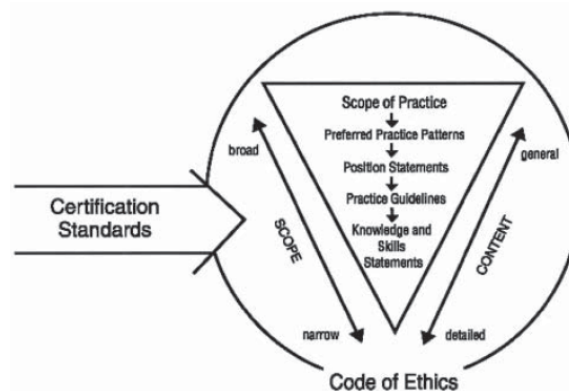
**Statement of Purpose** The purpose of this document is to define the scope of practice in audiology in order to (a) describe the services offered by qualified audiologists as primary service providers, case managers, and/or members of multidisciplinary and interdisciplinary teams; (b) serve as a reference for health care, education, and other professionals, and for consumers, members of the general public, and policy makers concerned with legislation, regulation, licensure, and third party reimbursement; and (c) inform members of ASHA, certificate holders, and students of the activities for which certification in audiology is required in accordance with the ASHA Code of Ethics. Audiologists provide comprehensive diagnostic and treatment/rehabilitative services for auditory, vestibular, and related impairments. These services are provided to individuals across the entire age span from birth through adulthood; to individuals from diverse language, ethnic, cultural, and socioeconomic backgrounds; and to individuals who have multiple disabilities. This position statement is not intended to be exhaustive; however, the activities described reflect current practice within the profession. Practice activities related to emerging clinical, technological, and scientific developments are not precluded from consideration as part of the scope of practice of an audiologist. Such innovations and advances will result in the periodic revision and updating of this document. It is also recognized that specialty areas identified within the scope of practice will vary among the individual providers. ASHA also recognizes that credentialed professionals in related fields may have knowledge, skills, and experience that could be applied to some areas within the scope of audiology practice. Defining the scope of practice of audiologists is not meant to exclude other appropriately credentialed postgraduate professionals from rendering services in common practice areas.

Audiologists serve diverse populations. The patient/client population includes persons of different race, age, gender, religion, national origin, and sexual orientation. Audiologists' caseloads include individuals from diverse ethnic, cultural, or linguistic backgrounds, and persons with disabilities. Although audiologists are prohibited from discriminating in the provision of professional services

based on these factors, in some cases such factors may be relevant to the development of an appropriate treatment plan. These factors may be considered in treatment plans only when firmly grounded in scientific and professional knowledge.

This scope of practice does not supersede existing state licensure laws or affect the interpretation or implementation of such laws. It may serve, however, as a model for the development or modification of licensure laws. The schema in Figure 1 depicts the relationship of the scope of practice to ASHA's policy documents that address current and emerging audiology practice areas; that is, preferred practice patterns, guidelines, and position statements. ASHA members and ASHA-certified professionals are bound by the ASHA Code of Ethics to provide services that are consistent with the scope of their competence, education, and experience (ASHA, 2003). There are other existing legislative and regulatory bodies that govern the practice of audiology.

**Figure 1.** Conceptual Framework of ASHA Standards and Policy Statements



### Framework for Practice

The practice of audiology includes both the prevention of and assessment of auditory, vestibular, and related impairments as well as the habilitation/rehabilitation and maintenance of persons with these impairments. The overall goal of the provision of audiology services should be to optimize and enhance the ability of an individual to hear, as well as to communicate in his/her everyday or natural environment. In addition, audiologists provide comprehensive services to individuals with normal hearing who interact with persons with a hearing impairment. The overall goal of audiologic services is to improve the quality of life for all of these individuals.

The World Health Organization (WHO) has developed a multipurpose health classification system known as the International Classification of Functioning, Disability, and Health (ICF) (WHO, 2001). The purpose of this classification system is to provide a standard language and framework for the description of functioning and health. The ICF framework is useful in describing the role of audiologists in the prevention, assessment, and habilitation/rehabilitation of auditory, vestibular, and other related impairments and restrictions or limitations of functioning.

The ICF is organized into two parts. The first part deals with Functioning and Disability while the second part deals with Contextual Factors. Each part has two components.

The components of Functioning and Disability are:

- **Body Functions and Structures:** Body Functions are the physiological functions of body systems and Body Structures are the anatomical parts of the body and their components. Impairments are limitations or variations in Body Function or Structure such as a deviation or loss. An example of a Body Function that might be evaluated by an audiologist would be hearing sensitivity. The use of tympanometry to assess the mobility of the tympanic membrane is an example of a Body Structure that might be evaluated by an audiologist.
- **Activity/Participation:** In the ICF, Activity and Participation are realized as one list. Activity refers to the execution of a task or action by an individual. Participation is the involvement in a life situation. Activity limitations are difficulties an individual may experience while executing a given activity. Participation restrictions are difficulties that may limit an individual's involvement in life situations. The Activity/Participation construct thus represents the effects that hearing, vestibular, and related impairments could have on the life of an individual. These effects could include the ability to hold conversations, participate in sports, attend religious services, understand a teacher in a classroom, and walk up and down stairs.

The components of Contextual Factors are:

- **Environmental Factors:** Environmental Factors make up the physical, social, and attitudinal environment in which people live and conduct their lives. Examples of Environmental Factors, as they relate to audiology, include the acoustical properties of a given space and any type of hearing assistive technology.
- **Personal Factors:** Personal Factors are the internal influences on an individual's functioning and disability and are not a part of the health condition. These factors may include but are not limited to age, gender, social background, and profession.

Functioning and Disability are interactive and evolutionary processes. Figure 2 illustrates the interaction of the various components of the ICF. Each component of the ICF can be expressed on a continuum of function. On one end of the continuum is intact functioning. At the opposite end of the continuum is completely compromised functioning. Contextual Factors (Environmental and Personal Factors) may interact with any of the components of functioning and disability. Environmental and Personal Factors may act as facilitators or barriers to functioning.

The scope of practice in audiology encompasses all of the components of the ICF. During the assessment phase, audiologists perform tests of Body Function and Structure. Examples of these types of tests include otoscopic examination, puretone audiometry, tympanometry, otoacoustic emissions measurements, and speech audiometry. Activity/Participation limitations and restrictions are sometimes addressed by audiologists through case history, interview, questionnaire, and counseling. For example, a question such as "Do you have trouble understanding while on the telephone?" or "Can you describe the difficulties you experience when you participate in a conversation with someone who is not familiar to you?" would be considered an assessment of Activity/Participation limitation or restriction. Questionnaires that require clients to report the magnitude of difficulty that they experience in certain specified settings can sometimes be used to measure aspects of Activity/Participation. For example: "Because of my hearing problems, I have difficulty conversing with others in a restaurant." In addition, Environmental and Personal Factors

also need to be taken into consideration by audiologists as they treat individuals with auditory, vestibular, and other related impairments. In the above question regarding conversation in a restaurant, if the factor of “noise” (i.e., a noisy restaurant) is added to the question, this represents an Environmental

Factor. Examples of Personal Factors might include a person's background or culture that influences his or her reaction to the use of a hearing aid or cochlear implant. The use of the ICF framework (WHO, 2001) may help audiologists broaden their perspective concerning their role in evaluating a client's needs or when designing and providing comprehensive services to their clients. Overall, audiologists work to improve quality of life by reducing impairments of body functions and structures, Activity limitations/Participation restrictions and Environmental barriers of the individuals they serve.

**Figure 2.** Application of WHO (2001) Framework to the Practice of Audiology



### Definition of an Audiologist

Audiologists are professionals engaged in autonomous practice to promote healthy hearing, communication competency, and quality of life for persons of all ages through the prevention, identification, assessment, and rehabilitation of hearing, auditory function, balance, and other related systems. They facilitate prevention through the fitting of hearing protective devices, education programs for industry and the public, hearing screening/conservation programs, and research. The audiologist is the professional responsible for the identification of impairments and dysfunction of the auditory, balance, and other related systems. Their unique education and training provides them with the skills to assess and diagnose dysfunction in hearing, auditory function, balance, and related disorders. The delivery of audiologic (re)habilitation services includes not only the selecting, fitting, and dispensing of hearing aids and other hearing assistive devices, but also the assessment and follow-up services for persons with cochlear implants. The audiologist providing audiologic (re)habilitation does so through a comprehensive program of therapeutic services, devices, counseling, and other management strategies. Functional diagnosis of vestibular disorders and management of balance rehabilitation is another aspect of the professional responsibilities of the audiologist. Audiologists engage in research pertinent to all of these domains. Audiologists currently hold a master's or doctoral degree in audiology from a program accredited by the Council

on Academic Accreditation in Audiology and Speech-Language Pathology (CAA) of the American Speech-Language-Hearing Association. ASHA-certified audiologists complete a supervised postgraduate professional experience or a similar supervised professional experience during the completion of the doctoral degree as described in the ASHA certification standards. Beginning January 1, 2012, all applicants for the Certificate of Clinical Competence in Audiology must have a doctoral degree from a CAA-accredited university program. Demonstration of continued professional development is mandated for the maintenance of the Certificate of Clinical Competence in Audiology. Where required, audiologists are licensed or registered by the state in which they practice.

## **Professional Roles and Activities**

Audiologists serve a diverse population and may function in one or more of a variety of activities. The practice of audiology includes:

### **A. Prevention**

1. Promotion of hearing wellness, as well as the prevention of hearing loss and protection of hearing function by designing, implementing, and coordinating occupational, school, and community hearing conservation and identification programs;
2. Participation in noise measurements of the acoustic environment to improve accessibility and to promote hearing wellness.

### **B. Identification**

1. Activities that identify dysfunction in hearing, balance, and other auditory related systems;
2. Supervision, implementation, and follow-up of newborn and school hearing screening programs;
3. Screening for speech, orofacial myofunctional disorders, language, cognitive communication disorders, and/or preferred communication modalities that may affect education, health, development or communication and may result in recommendations for rescreening or comprehensive speech-language pathology assessment or in referral for other examinations or services;
4. Identification of populations and individuals with or at risk for hearing loss and other auditory dysfunction, balance impairments, tinnitus, and associated communication impairments as well as of those with normal hearing;
5. In collaboration with speech-language pathologists, identification of populations and individuals at risk for developing speech-language impairments.

### **C. Assessment**

1. The conduct and interpretation of behavioral, electroacoustic, and/or electrophysiologic methods to assess hearing, auditory function, balance, and related systems;
2. Measurement and interpretation of sensory and motor evoked potentials, electromyography, and other electrodiagnostic tests for purposes of neurophysiologic intraoperative monitoring and cranial nerve assessment;
3. Evaluation and management of children and adults with auditory-related processing disorders;
4. Performance of otoscopy for appropriate audiological management or to provide a basis for medical referral;
5. Cerumen management to prevent obstruction of the external ear canal and of amplification devices;

6. Preparation of a report including interpreting data, summarizing findings, generating recommendations and developing an audiologic treatment/ management plan;
7. Referrals to other professions, agencies, and/ or consumer organizations.

#### D. Rehabilitation

1. As part of the comprehensive audiologic (re)habilitation program, evaluates, selects, fits and dispenses hearing assistive technology devices to include hearing aids;
2. Assessment of candidacy of persons with hearing loss for cochlear implants and provision of fitting, mapping, and audiologic rehabilitation to optimize device use;
3. Development of a culturally appropriate, audiologic rehabilitative management plan including, when appropriate:
  - a. Recommendations for fitting and dispensing, and educating the consumer and family/caregivers in the use of and adjustment to sensory aids, hearing assistive devices, alerting systems, and captioning devices;
  - b. Availability of counseling relating to psychosocial aspects of hearing loss, and other auditory dysfunction, and processes to enhance communication competence;
  - c. Skills training and consultation concerning environmental modifications to facilitate development of receptive and expressive communication;
  - d. Evaluation and modification of the audiologic management plan.
4. Provision of comprehensive audiologic rehabilitation services, including management procedures for speech and language habilitation and/or rehabilitation for persons with hearing loss or other auditory dysfunction, including but not exclusive to speechreading, auditory training, communication strategies, manual communication and counseling for psychosocial adjustment for persons with hearing loss or other auditory dysfunction and their families/caregivers;
5. Consultation and provision of vestibular and balance rehabilitation therapy to persons with vestibular and balance impairments;
6. Assessment and non-medical management of tinnitus using biofeedback, behavioral management, masking, hearing aids, education, and counseling;
7. Provision of training for professionals of related and/or allied services when needed;
8. Participation in the development of an Individual Education Program (IEP) for school-age children or an Individual Family Service Plan (IFSP) for children from birth to 36 months old;
9. Provision of in-service programs for school personnel, and advising school districts in planning educational programs and accessibility for students with hearing loss and other auditory dysfunction;
10. Measurement of noise levels and provision of recommendations for environmental modifications in order to reduce the noise level;
11. Management of the selection, purchase, installation, and evaluation of large-area amplification systems.

#### E. Advocacy/ Consultation

1. Advocacy for communication needs of all individuals that may include advocating for the rights/funding of services for those with hearing loss, auditory, or vestibular disorders;
2. Advocacy for issues (i.e., acoustic accessibility) that affect the rights of individuals with normal hearing;
3. Consultation with professionals of related and/or allied services when needed;



4. Consultation in development of an Individual Education Program (IEP) for school-age children or an Individual Family Service Plan (IFSP) for children from birth to 36 months old;
  5. Consultation to educators as members of interdisciplinary teams about communication management, educational implications of hearing loss and other auditory dysfunction, educational programming, classroom acoustics, and large-area amplification systems for children with hearing loss and other auditory dysfunction;
  6. Consultation about accessibility for persons with hearing loss and other auditory dysfunction in public and private buildings, programs, and services;
  7. Consultation to individuals, public and private agencies, and governmental bodies, or as an expert witness regarding legal interpretations of audiology findings, effects of hearing loss and other auditory dysfunction, balance system impairments, and relevant noise-related considerations;
  8. Case management and service as a liaison for the consumer, family, and agencies in order to monitor audiologic status and management and to make recommendations about educational and vocational programming;
  9. Consultation to industry on the development of products and instrumentation related to the measurement and management of auditory or balance function.
- F. Education/ Research/Administration
1. Education, supervision, and administration for audiology graduate and other professional education programs;
  2. Measurement of functional outcomes, consumer satisfaction, efficacy, effectiveness, and efficiency of practices and programs to maintain and improve the quality of audiologic services;
  3. Design and conduct of basic and applied audiologic research to increase the knowledge base, to develop new methods and programs, and to determine the efficacy, effectiveness, and efficiency of assessment and treatment paradigms; disseminate research findings to other professionals and to the public;
  4. Participation in the development of professional and technical standards;
  5. Participation in quality improvement programs;
  6. Program administration and supervision of professionals as well as support personnel.

## Practice Settings

Audiologists provide services in private practice; medical settings such as hospitals and physicians' offices; community and university hearing and speech centers; managed care systems; industry; the military; various state agencies; home health, subacute rehabilitation, long-term care, and intermediate-care facilities; and school systems. Audiologists provide academic education to students and practitioners in universities, to medical and surgical students and residents, and to other related professionals. Such education pertains to the identification, functional diagnosis/assessment, and non-medical treatment/management of auditory, vestibular, balance, and related impairments.

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## Appendix D: ASHA Code of Ethics



AMERICAN  
SPEECH-LANGUAGE-  
HEARING  
ASSOCIATION

### CODE OF ETHICS

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### PREAMBLE

#### ASHA Code of Ethics

The American Speech-Language-Hearing Association (ASHA; hereafter, also known as “the Association”) has been committed to a framework of common principles and standards of practice since ASHA’s inception in 1925. This commitment was formalized in 1952 as the Association’s first Code of Ethics. This code has been modified and adapted to reflect the current state of practice and to address evolving issues within the professions.

The ASHA Code of Ethics reflects professional values and expectations for scientific and clinical practice. It is based on principles of duty, accountability, fairness, and responsibility and is intended to ensure the welfare of the consumer and to protect the reputation and integrity of the professions. The Code of Ethics is a framework and a guide for professionals in support of day-to-day decision making related to professional conduct.

The Code of Ethics is obligatory and disciplinary as well as aspirational and descriptive in that it defines the professional’s role. It is an integral educational resource regarding ethical principles and standards that are expected of audiologists, speech-language pathologists, and speech, language, and hearing scientists.

The preservation of the highest standards of integrity and ethical principles is vital to the responsible discharge of obligations by audiologists, speech-language pathologists, and speech,

language, and hearing scientists who serve as clinicians, educators, mentors, researchers, supervisors, and administrators. This Code of Ethics sets forth the fundamental principles and rules considered essential to this purpose and is [applicable to the following individuals](#):

- a member of ASHA holding the Certificate of Clinical Competence
- a member of ASHA not holding the Certificate of Clinical Competence
- a nonmember of ASHA holding the Certificate of Clinical Competence
- an applicant for ASHA certification or for ASHA membership and certification

ASHA members who provide clinical services must hold the Certificate of Clinical Competence and must abide by the Code of Ethics. By holding ASHA certification and/or membership, or through application for such, all individuals are [subject to the jurisdiction](#) of the ASHA Board of Ethics for ethics complaint adjudication.

The fundamentals of ethical conduct are described by Principles of Ethics and by Rules of Ethics. The four Principles of Ethics form the underlying philosophical basis for the Code of Ethics and are reflected in the following areas: (I) responsibility to persons served professionally and to research participants; (II) responsibility for one's professional competence; (III) responsibility to the public; and (IV) responsibility for professional relationships. Individuals shall honor and abide by these Principles as affirmative obligations under all conditions of applicable professional activity. Rules of Ethics are specific statements of minimally acceptable as well as unacceptable professional conduct.

The Code of Ethics is designed to provide guidance to members, certified individuals, and applicants as they make professional decisions. Because the Code of Ethics is not intended to address specific situations and is not inclusive of all possible ethical dilemmas, professionals are expected to follow its written provisions and to uphold its spirit and purpose. Adherence to the Code of Ethics and its enforcement results in respect for the professions and positive outcomes for those who benefit from the work of audiologists, speech-language pathologists, and speech, language, and hearing scientists.

## **PRINCIPLE OF ETHICS I**

Individuals shall honor their responsibility to hold paramount the welfare of persons they serve professionally or who are participants in research and scholarly activities.

## **RULES OF ETHICS**

- A. Individuals shall provide all clinical services and scientific activities competently.

- B. Individuals shall use every resource, including referral and/or interprofessional collaboration when appropriate, to ensure that quality service is provided.
- C. Individuals shall not discriminate in the delivery of professional services or in the conduct of research and scholarly activities on the basis of age; citizenship; disability; ethnicity; gender; gender expression; gender identity; genetic information; national origin, including culture, language, dialect, and accent; race; religion; sex; sexual orientation; or veteran status.
- D. Individuals shall not misrepresent the credentials of aides, assistants, technicians, students, research assistants, Clinical Fellows, or any others under their supervision, and they shall inform those they serve professionally of the name, role, and professional credentials of persons providing services.
- E. Individuals who hold the Certificate of Clinical Competence may delegate tasks related to the provision of clinical services to aides, assistants, technicians, or any other persons only if those persons are adequately prepared and are appropriately supervised. The responsibility for the welfare of those being served remains with the certified audiologist or speech-language pathologist.
- F. Individuals who hold the Certificate of Clinical Competence shall not delegate tasks that require the unique skills, knowledge, judgment, or credentials that are within the scope of their profession to aides, assistants, technicians, or any nonprofessionals over whom they have supervisory responsibility.
- G. Individuals who hold the Certificate of Clinical Competence may delegate to students tasks related to the provision of clinical services that require the unique skills, knowledge, and judgment that are within the scope of practice of their profession only if those students are adequately prepared and are appropriately supervised. The responsibility for the welfare of those being served remains with the certified audiologist or speech- language pathologist.
- H. Individuals shall obtain informed consent from the persons they serve about the nature and possible risks and effects of services provided, technology employed, and products dispensed. This obligation also includes informing persons served about possible effects of not engaging in treatment or not following clinical recommendations. If diminished decision-making ability of persons served is suspected, individuals should seek appropriate authorization for services, such as authorization from a legally authorized/appointed representative.
- I. Individuals shall enroll and include persons as participants in research or teaching demonstrations/simulations only if participation is voluntary, without coercion, and with informed consent.
- J. Individuals shall accurately represent the intended purpose of a service, product, or research endeavor and shall abide by established guidelines for clinical practice and the responsible conduct of research, including humane treatment of animals involved in research.



- K. Individuals who hold the Certificate of Clinical Competence shall evaluate the effectiveness of services provided, technology employed, and products dispensed, and they shall provide services or dispense products only when benefit can reasonably be expected.
- L. Individuals who hold the Certificate of Clinical Competence shall use independent and evidence-based clinical judgment, keeping paramount the best interests of those being served.
- M. Individuals may make a reasonable statement of prognosis, but they shall not guarantee—directly or by implication—the results of any treatment or procedure.
- N. Individuals who hold the Certificate of Clinical Competence may provide services via telepractice consistent with professional standards and state and federal regulations, but they shall not provide clinical services solely by written communication.
- O. Individuals shall protect the confidentiality and security of records of professional services provided, research and scholarly activities conducted, and products dispensed. Access to these records shall be allowed only when doing so is legally authorized or required by law.
- P. Individuals shall protect the confidentiality of information about persons served professionally or participants involved in research and scholarly activities. Disclosure of confidential information shall be allowed only when doing so is legally authorized or required by law.
- Q. Individuals shall maintain timely records; shall accurately record and bill for services provided and products dispensed; and shall not misrepresent services provided, products dispensed, or research and scholarly activities conducted.
- R. Individuals shall not allow personal hardships, psychosocial distress, substance use/misuse, or physical or mental health conditions to interfere with their duty to provide professional services with reasonable skill and safety. Individuals whose professional practice is adversely affected by any of the above-listed factors should seek professional assistance regarding whether their professional responsibilities should be limited or suspended.
- S. Individuals who have knowledge that a colleague is unable to provide professional services with reasonable skill and safety shall report this information to the appropriate authority, internally if such a mechanism exists and, when appropriate, externally to the applicable professional licensing authority or board, other professional regulatory body, or professional association.
- T. Individuals shall give reasonable notice to ensure continuity of care and shall provide information about alternatives for care in the event that they can no longer provide professional services.

## PRINCIPLE OF ETHICS II

Individuals shall honor their responsibility to achieve and maintain the highest level of professional competence and performance.

## RULES OF ETHICS

- A. Individuals who hold the Certificate of Clinical Competence shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their certification status, education, training, and experience.
- B. ASHA members who do not hold the Certificate of Clinical Competence may not engage in the provision of clinical services; however, individuals who are in the certification application process may provide clinical services consistent with current local and state laws and regulations and with ASHA certification requirements.
- C. Individuals shall enhance and refine their professional competence and expertise through engagement in lifelong learning applicable to their professional activities and skills.
- D. Individuals who engage in research shall comply with all institutional, state, and federal regulations that address any aspects of research.
- E. Individuals in administrative or supervisory roles shall not require or permit their professional staff to provide services or conduct research activities that exceed the staff member's certification status, competence, education, training, and experience.
- F. Individuals in administrative or supervisory roles shall not require or permit their professional staff to provide services or conduct clinical activities that compromise the staff member's independent and objective professional judgment.
- G. Individuals shall use technology and instrumentation consistent with accepted professional guidelines in their areas of practice. When such technology is warranted but not available, an appropriate referral should be made.
- H. Individuals shall ensure that all technology and instrumentation used to provide services or to conduct research and scholarly activities are in proper working order and are properly calibrated.

## **PRINCIPLE OF ETHICS III**

In their professional role, individuals shall act with honesty and integrity when engaging with the public and shall provide accurate information involving any aspect of the professions.

### **RULES OF ETHICS**

- A. Individuals shall not misrepresent their credentials, competence, education, training, experience, or scholarly contributions.
- B. Individuals shall avoid engaging in conflicts of interest whereby a personal, professional, financial, or other interest or relationship could influence their objectivity, competence, or effectiveness in performing professional responsibilities. If such conflicts of interest cannot be avoided, proper disclosure and management is required.
- C. Individuals shall not misrepresent diagnostic information, services provided, results of services provided, products dispensed, effects of products dispensed, or research and scholarly activities.
- D. Individuals shall not defraud, scheme to defraud, or engage in any illegal or negligent conduct related to obtaining payment or reimbursement for services, products, research, or grants.
- E. Individuals' statements to the public shall provide accurate information regarding the professions, professional services and products, and research and scholarly activities.
- F. Individuals' statements to the public shall adhere to prevailing professional standards and shall not contain misrepresentations when advertising, announcing, or promoting their professional services, products, or research.
- G. Individuals shall not knowingly make false financial or nonfinancial statements and shall complete all materials honestly and without omission.

## **PRINCIPLE OF ETHICS IV**

Individuals shall uphold the dignity and autonomy of the professions, maintain collaborative and harmonious interprofessional and intraprofessional relationships, and accept the professions' self-imposed standards.

### **RULES OF ETHICS**

- A. Individuals shall work collaboratively with members of their own profession and/or members of other professions, when appropriate, to deliver the highest quality of care.
- B. Individuals shall exercise independent professional judgment in recommending and providing professional services when an administrative directive, referral source, or prescription prevents them from keeping the welfare of persons served paramount.

- C. Individuals' statements to colleagues about professional services, products, or research results shall adhere to prevailing professional standards and shall contain no misrepresentations.
- D. Individuals shall not engage in any form of conduct that adversely reflects on the professions or on the individual's fitness to serve persons professionally.
- E. Individuals shall not engage in dishonesty, negligence, deceit, or misrepresentation.
- F. Individuals who mentor Clinical Fellows, act as a preceptor to audiology externs, or supervise undergraduate or graduate students, assistants, or other staff shall provide appropriate supervision and shall comply—fully and in a timely manner—with all ASHA certification and supervisory requirements.
- G. Applicants for certification or membership, and individuals making disclosures, shall not make false statements and shall complete all application and disclosure materials honestly and without omission.
- H. Individuals shall not engage in any form of harassment or power abuse.
- I. Individuals shall not engage in sexual activities with persons over whom they exercise professional authority or power, including persons receiving services, other than those with whom an ongoing consensual relationship existed prior to the date on which the professional relationship began.
- J. Individuals shall not knowingly allow anyone under their supervision to engage in any practice that violates the Code of Ethics.
- K. Individuals shall assign credit only to those who have contributed to a publication, presentation, process, or product. Credit shall be assigned in proportion to the contribution and only with the contributor's consent.
- L. Individuals shall reference the source when using other persons' ideas, research, presentations, results, or products in written, oral, or any other media presentation or summary. To do otherwise constitutes plagiarism.
- M. Individuals shall not discriminate in their relationships with colleagues, members of other professions, or individuals under their supervision on the basis of age; citizenship; disability; ethnicity; gender; gender expression; gender identity; genetic information; national origin, including culture, language, dialect, and accent; race; religion; sex; sexual orientation; socioeconomic status; or veteran status.
- N. Individuals with evidence that the Code of Ethics may have been violated have the responsibility to either work collaboratively to resolve the situation where possible or to inform the Board of Ethics through its [established procedures](#).
- O. Individuals shall report members of other professions who they know have violated standards of care to the appropriate professional licensing authority or board, other

professional regulatory body, or professional association when such violation compromises the welfare of persons served and/or research participants.

- P. Individuals shall not file or encourage others to file complaints that disregard or ignore facts that would disprove the allegation; the Code of Ethics shall not be used for personal reprisal, as a means of addressing personal animosity, or as a vehicle for retaliation.
- Q. Individuals making and responding to complaints shall comply fully with the policies of the Board of Ethics in its consideration, adjudication, and resolution of complaints of alleged violations of the Code of Ethics.
- R. Individuals involved in ethics complaints shall not knowingly make false statements of fact or withhold relevant facts necessary to fairly adjudicate the complaints.
- S. Individuals shall comply with local, state, and federal laws and regulations applicable to professional practice and to the responsible conduct of research.
- T. Individuals who have been convicted of, been found guilty of, or entered a plea of guilty or nolo contendere to (1) any misdemeanor involving dishonesty, physical harm—or the threat of physical harm—to the person or property of another or (2) any felony shall self-report by notifying the ASHA Ethics Office in writing within 60 days of the conviction, plea, or finding of guilt. Individuals shall also provide a copy of the conviction, plea, or nolo contendere record with their self-report notification, and any other court documents as reasonably requested by the ASHA Ethics Office.
- U. Individuals who have (1) been publicly disciplined or denied a license or a professional credential by any professional association, professional licensing authority or board, or other professional regulatory body; or (2) voluntarily relinquished or surrendered their license, certification, or registration with any such body while under investigation for alleged unprofessional or improper conduct shall self-report by notifying the ASHA Ethics Office in writing within 60 days of the final action or disposition. Individuals shall also provide a copy of the final action, sanction, or disposition—with their self-report notification—to the ASHA Ethics Office.

## TERMINOLOGY

The purpose of the following Terminology section is to provide additional clarification for terms not defined within the Principles of Ethics and Rules of Ethics sections.

### **ASHA Ethics Office**

The ASHA Ethics Office assists the Board of Ethics with the confidential administration and processing of self-reports from and ethics complaints against individuals (as defined below). All complaints and self-reports should be sent to this office. The mailing address for the ASHA Ethics Office is American Speech-Language-Hearing Association, attn: Ethics Office, 2200 Research Blvd., #309, Rockville, MD 20850. The email address is [ethics@asha.org](mailto:ethics@asha.org).

### **advertising**

Any form of communication with the public regarding services, therapies, research, products, or publications.

### **diminished decision-making ability**

The inability to comprehend, retain, or apply information necessary to determine a reasonable course of action.

### **individuals**

Within the Code of Ethics, this term refers to ASHA members and/or certificate holders and applicants for ASHA certification.

### **informed consent**

An agreement by persons served, those with legal authority for persons served, or research participants that constitutes authorization of a proposed course of action after the communication of adequate information regarding expected outcomes and potential risks. Such an agreement may be verbal or written, as required by applicable law or policy.

### **may vs. shall**

*May* denotes an allowance for discretion; *shall* denotes something that is required.

### **misrepresentation**

Any statement by words or other conduct that, under the circumstances, amounts to an assertion that is false, erroneous, or misleading (i.e., not in accordance with the facts).

**negligence**

Failing to exercise a standard of care toward others that a reasonable or prudent person would use in the circumstances, or taking actions that a reasonable person would not.

**nolo contendere**

A plea made by a defendant stating that they will not contest a criminal charge.

**plagiarism**

Representation of another person's idea, research, presentation, result, or product as one's own through irresponsible citation, attribution, or paraphrasing.

**publicly disciplined**

A formal disciplinary action of public record.

**reasonable or reasonably**

Being supported or justified by fact or circumstance and being in accordance with reason, fairness, duty, or prudence.

**self-report**

A professional obligation of self-disclosure that requires (a) notifying the ASHA Ethics Office in writing and (b) sending a copy of the required documentation to the ASHA Ethics Office (see definition of "written" below).

**shall vs. may**

*Shall* denotes something that is required; *may* denotes an allowance for discretion.

**telepractice**

Application of telecommunications technology to the delivery of audiology and speech-language pathology professional services at a distance by linking clinician to client/patient/student or by linking clinician to clinician for assessment, intervention, consultation, or supervision. The quality of the service should be equivalent to that of in-person service. For more information, [see Telepractice](#) on the ASHA Practice Portal.

**written**

Encompasses both electronic and hard-copy writings or communications.

## Appendix E: Audiology Certification Standards (2020)

From: Council for Clinical Certification in Audiology and Speech-Language Pathology of the American Speech-Language-Hearing Association. (2018). *2020 Standards for the Certificate of Clinical Competence in Audiology*. Retrieved from [www.asha.org/certification/2020-Audiology-Certification-Standards/](http://www.asha.org/certification/2020-Audiology-Certification-Standards/)

# 2020 Standards and Implementation Procedures for the Certificate of Clinical Competence in Audiology

**Effective Date: January 1, 2020**

## Introduction

The Council for Clinical Certification in Audiology and Speech-Language Pathology (CFCC) is a semi-autonomous credentialing body of the American Speech-Language-Hearing Association. The charges to the CFCC are: to define the standards for clinical certification; to apply those standards in granting certification to individuals; to have final authority to withdraw certification in cases where certification has been granted on the basis of inaccurate information; and to administer the certification maintenance program.

A [Practice and Curriculum Analysis of the Profession of Audiology](#) was conducted in 2016 under the auspices of the Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA) and the CFCC. The survey analysis was reviewed by the CFCC, and the following standards were developed to better fit current practice models.

The 2020 standards and implementation procedures for the Certificate of Clinical Competence in Audiology (CCC-A) go into effect on January 1, 2020. View the [Audiology Standards Crosswalk](#)[PDF] and consult [Changes to Audiology Standards](#) for more specific information on how the standards will change.

The Standards for the CCC-A are shown in bold. The CFCC implementation procedures follow each standard.

- [Standard I—Academic Qualifications](#)
- [Standard II—Knowledge and Skills Outcomes](#)
- [Standard III—Verification of Knowledge and Skills](#)
- [Standard IV—Examination](#)
- [Standard V—Maintenance of Certification](#)



## Standard I: Academic Qualifications

**Applicants for certification must hold a doctoral degree in audiology from a program accredited by the Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA) or equivalent.**

Implementation: Verification of the graduate degree is accomplished by submitting (a) an official transcript showing that the degree has been awarded or (b) a letter from the university registrar verifying completion of requirements for the degree. Applicants must have graduated from a program holding CAA accreditation or candidacy status in audiology throughout the period of enrollment.

Applicants from non-CAA-accredited programs (e.g., PhD programs, internationally educated, etc.) with a doctoral degree and audiology coursework will have their application evaluated by the Council for Clinical Certification in Audiology and Speech-Language Pathology (CFCC) to determine substantial equivalence to a clinical doctoral degree program accredited by the CAA. **Individuals educated outside the United States or its territories** must submit official transcripts and evaluations of their degrees and courses to verify equivalency. These evaluations must be conducted by **credential evaluation services agencies** recognized by the National Association of Credential Evaluation Services (NACES). Evaluations must (a) confirm that the degree earned is equivalent to a U.S. clinical doctoral degree, (b) show that the coursework is equivalent to a CAA-accredited clinical doctoral program, (c) include a translation of academic coursework into the American semester-hour system, and (d) indicate which courses were completed at the graduate level.

## Standard II: Knowledge and Skills Outcomes

**Applicants for certification must have acquired knowledge and developed skills in the professional areas of practice as identified in Standards II A–F, as verified in accordance with Standard III.**

Implementation: The knowledge and skills identified in this standard, although separated into areas of practice, are not independent of each other. The competent practice of audiology requires that an audiologist be able to integrate across all areas of practice. Therefore, assessments used to verify knowledge and skills acquisition must require that the candidate for certification demonstrate integration of the knowledge and skills found in Standards II A – F below.

### Standard II-A: Foundations of Practice

**Applicant has demonstrated knowledge of:**

- A1. Genetics, embryology and development of the auditory and vestibular systems, anatomy and physiology, neuroanatomy and neurophysiology, and pathophysiology of hearing and balance over the life span**
- A2. Effects of pathogens, and pharmacologic and teratogenic agents, on the auditory**

and vestibular systems

**A3. Language and speech characteristics and their development for individuals with normal and impaired hearing across the life span**

**A4. Principles, methods, and applications of acoustics, psychoacoustics, and speech perception, with a focus on how each is impacted by hearing impairment throughout the life span**

**A5. Calibration and use of instrumentation according to manufacturers' specifications and accepted standards**

**A6. Standard safety precautions and cleaning/disinfection of equipment in accordance with facility-specific policies and manufacturers' instructions to control for infectious/contagious diseases**

**A7. Applications and limitations of specific audiologic assessments and interventions in the context of overall client/patient management**

**A8. Implications of cultural and linguistic differences, as well as individual preferences and needs, on clinical practice and on families, caregivers, and other interested parties**

**A9. Implications of biopsychosocial factors in the experience of and adjustment to auditory disorders and other chronic health conditions**

**A10. Effects of hearing impairment on educational, vocational, social, and psychological function throughout the life span**

**A11. Manual and visual communication systems and the use of interpreters/transliterators/translators**

**A12. Effective interaction and communication with clients/patients, families, professionals, and other individuals through written, spoken, and nonverbal communication**

**A13. Principles of research and the application of evidence-based practice (i.e., scientific evidence, clinical expertise, and client/patient perspectives) for accurate and effective clinical decision making**

**A14. Assessment of diagnostic efficiency and treatment efficacy through the use of quantitative data (e.g., number of tests, standardized test results) and qualitative data (e.g., standardized outcome measures, client/patient-reported measures)**

**A15. Client-centered, behavioral, cognitive, and integrative theories and methods of counseling and their relevance in audiologic rehabilitation**

**A16. Principles and practices of client/patient/person/family-centered care, including the role and value of clients'/patients' narratives, clinician empathy, and shared decision making regarding treatment options and goals**

**A17. Importance, value, and role of interprofessional communication and practice in patient care**

**A18. The role, scope of practice, and responsibilities of audiologists and other related professionals**

**A19. Health care, private practice, and educational service delivery systems**

**A20. Management and business practices, including but not limited to cost analysis, budgeting, coding, billing and reimbursement, and patient management**

**A21. Advocacy for individual patient needs and for legislation beneficial to the profession and the individuals served**

**A22. Legal and ethical practices, including standards for professional conduct,**

patient rights, confidentiality, credentialing, and legislative and regulatory mandates  
A23. Principles and practices of effective supervision/mentoring of students, other professionals, and support personnel

## **Standard II-B: Prevention and Screening**

Applicant has demonstrated knowledge of and skills in:

- B1. Educating the public and those at risk on prevention, potential causes, effects, and treatment of congenital and acquired auditory and vestibular disorders**
- B2. Establishing relationships with professionals and community groups to promote hearing wellness for all individuals across the life span**
- B3. Participating in programs designed to reduce the effects of noise exposure and agents that are toxic to the auditory and vestibular systems**
- B4. Utilizing instrument(s) (i.e. sound-level meter, dosimeter, etc.) to determine ambient noise levels and providing strategies for reducing noise and reverberation time in educational, occupational, and other settings**
- B5. Recognizing a concern on the part of medical providers, individuals, caregivers, or other professionals about hearing and/or speech-language problems and/or identifying people at risk to determine a need for hearing screening**
- B6. Conducting hearing screenings in accordance with established federal and state legislative and regulatory requirements**
- B7. Participating in occupational hearing conservation programs**
- B8. Performing developmentally, culturally, and linguistically appropriate hearing screening procedures across the life span**
- B9. Referring persons who fail the hearing screening for appropriate audiologic/medical evaluation**
- B10. Identifying persons at risk for speech-language and/or cognitive disorders that may interfere with communication, health, education, and/or psychosocial function**
- B11. Screening for comprehension and production of language, including the cognitive and social aspects of communication**
- B12. Screening for speech production skills (e.g., articulation, fluency, resonance, and voice characteristics)**
- B13. Referring persons who fail the screening for appropriate speech-language pathology consults, medical evaluation, and/or services, as appropriate**
- B14. Evaluating the success of screening and prevention programs through the use of performance measures (i.e., test sensitivity, specificity, and positive predictive value)**

## **Standard II-C: Audiologic Evaluation**

Applicant has demonstrated knowledge of and skills in:

- C1. Gathering, reviewing, and evaluating information from referral sources to facilitate assessment, planning, and identification of potential etiologic factors**
- C2. Obtaining a case history and client/patient narrative**

- C3. Obtaining client/patient-reported and/or caregiver-reported measures to assess function**
- C4. Identifying, describing, and differentiating among disorders of the peripheral and central auditory systems and the vestibular system**
- C5. Providing assessments of tinnitus severity and its impact on patients' activities of daily living and quality of life**
- C6. Providing assessment of tolerance problems to determine the presence of hyperacusis**
- C7. Selecting, performing, and interpreting a complete immittance test battery based on patient need and other findings; tests to be considered include single probe tone tympanometry or multifrequency and multicomponent protocols, ipsilateral and contralateral acoustic reflex threshold measurements, acoustic reflex decay measurements, and Eustachian tube function**
- C8. Selecting, performing, and interpreting developmentally appropriate behavioral pure-tone air and bone tests, including extended frequency range when indicated**
- C9. Selecting, performing, and interpreting developmentally appropriate behavioral speech audiometry procedures to determine speech awareness threshold (SAT), speech recognition threshold (SRT), and word recognition scores (WRSS); obtaining a performance intensity function with standardized speech materials, when indicated**
- C10. Evaluating basic audiologic findings and client/patient needs to determine differential diagnosis and additional procedures to be used**
- C11. Selecting, performing, and interpreting physiologic and electrophysiologic test procedures, including electrocochleography, auditory brainstem response with frequency-specific air and bone conduction threshold testing, and click stimuli for neural diagnostic purposes**
- C12. Selecting, performing, and interpreting otoacoustic emissions testing**
- C13. Selecting, performing, and interpreting tests for nonorganic hearing loss**
- C14. Selecting, performing, and interpreting vestibular testing, including electronystagmography (ENG)/videonystagmography (VNG), ocular vestibular-evoked myogenic potential (oVEMP), and cervical vestibular evoked myogenic potential (cVEMP)**
- C15. Selecting, performing, and interpreting tests to evaluate central auditory processing disorder**

**Applicant has demonstrated knowledge of:**

- C16. Electrophysiologic testing, including but not limited to auditory steady-state response, auditory middle latency response, auditory late (long latency) response, and cognitive potentials (e.g., P300 response, mismatch negativity response)**
- C17. Posturography**
- C18. Rotary chair tests**
- C19. Video head impulse testing (vHIT)**

## **Standard II-D: Counseling**

**Applicant has demonstrated knowledge of and skills in:**

- D1. Identifying the counseling needs of individuals with hearing impairment based on their narratives and results of client/patient and/or caregiver responses to questionnaires and validation measures**
- D2. Providing individual, family, and group counseling as needed based on client/patient and clinical population needs**
- D3. Facilitating and enhancing clients'/patients' and their families' understanding of, acceptance of, and adjustment to auditory and vestibular disorders**
- D4. Enhancing clients'/patients' acceptance of and adjustment to hearing aids, hearing assistive technologies, and osseointegrated and other implantable devices**
- D5. Addressing the specific interpersonal, psychosocial, educational, and vocational implications of hearing impairment for the client/patient, family members, and/or caregivers to enhance their well-being and quality of life**
- D6. Facilitating patients' acquisition of effective communication and coping skills**
- D7. Promoting clients'/patients' self-efficacy beliefs and promoting self-management of communication and related adjustment problems**
- D8. Enhancing adherence to treatment plans and optimizing treatment outcomes**
- D9. Monitoring and evaluating client/patient progress and modifying counseling goals and approaches, as needed**

## **Standard II-E: Audiologic Rehabilitation Across the Life Span**

**Applicant has demonstrated knowledge of and skills in:**

- E1. Engaging clients/patients in the identification of their specific communication and adjustment difficulties by eliciting client/patient narratives and interpreting their and/or caregiver-reported measures**
- E2. Identifying the need for, and providing for assessment of, concomitant cognitive/developmental concerns, sensory-perceptual and motor skills, and other health/medical conditions, as well as participating in interprofessional collaboration to provide comprehensive management and monitoring of all relevant issues**
- E3. Responding empathically to clients'/patients' and their families' concerns regarding communication and adjustment difficulties to establish a trusting therapeutic relationship**
- E4. Providing assessments of family members' perception of and reactions to communication difficulties**
- E5. Identifying the effects of hearing problems and subsequent communication difficulties on marital dyads, family dynamics, and other interpersonal communication functioning**
- E6. Engaging clients/patients (including, as appropriate, school-aged children/adolescents) and family members in shared decision making regarding treatment goals and options**

- E7. Developing and implementing individualized intervention plans based on clients'/patients' preferences, abilities, communication needs and problems, and related adjustment difficulties**
- E8. Selecting and fitting appropriate amplification devices and assistive technologies**
- E9. Defining appropriate electroacoustic characteristics of amplification fittings based on frequency-gain characteristics, maximum output sound-pressure level, and input-output characteristics**
- E10. Verifying that amplification devices meet quality control and American National Standards Institute (ANSI) standards**
- E11. Conducting real-ear measurements to (a) establish audibility, comfort, and tolerance of speech and sounds in the environment and (b) verify compression, directionality, and automatic noise management performance**
- E12. Incorporating sound field functional gain testing when fitting osseointegrated and other implantable devices**
- E13. Conducting individual and/or group hearing aid orientations to ensure that clients/patients can use, manage, and maintain their instruments appropriately**
- E14. Identifying individuals who are candidates for cochlear implantation and other implantable devices**
- E15. Counseling cochlear implant candidates and their families regarding the benefits and limitations of cochlear implants to (a) identify and resolve concerns and potential misconceptions and (b) facilitate decision making regarding treatment options**
- E16. Providing programming and fitting adjustments; providing postfitting counseling for cochlear implant clients/patients**
- E17. Identifying the need for—and fitting—electroacoustically appropriate hearing assistive technology systems (HATS) based on clients'/patients' communication, educational, vocational, and social needs when conventional amplification is not indicated or provides limited benefit**
- E18. Providing HATS for those requiring access in public and private settings or for those requiring necessary accommodation in the work setting, in accordance with federal and state regulations**
- E19. Ensuring compatibility of HATS when used in conjunction with hearing aids, cochlear implants, or other devices and in different use environments**
- E20. Providing or referring for consulting services in the installation and operation of multi-user systems in a variety of environments (e.g., theaters, churches, schools)**
- E21. Providing auditory, visual, and auditory-visual communication training (e.g., speechreading, auditory training, listening skills) to enhance receptive communication**
- E22. Counseling clients/patients regarding the audiologic significance of tinnitus and factors that cause or exacerbate tinnitus to resolve misconceptions and alleviate anxiety related to this auditory disorder**
- E23. Counseling clients/patients to promote the effective use of ear-level sound generators and/or the identification and use of situationally appropriate environmental sounds to minimize their perception of tinnitus in pertinent situations**
- E24. Counseling clients/patients to facilitate identification and adoption of effective**

coping strategies to reduce tinnitus-induced stress, concentration difficulties, and sleep disturbances

E25. Monitoring and assessing the use of ear-level and/or environmental sound generators and the use of adaptive coping strategies to ensure treatment benefit and successful outcome(s)

E26. Providing canalith repositioning for patients diagnosed with benign paroxysmal positional vertigo (BPPV)

E27. Providing intervention for central and peripheral vestibular deficits

E28. Ensuring treatment benefit and satisfaction by monitoring progress and assessing treatment outcome

## **Standard II-F: Pediatric Audiologic (Re)habilitation**

Applicant has demonstrated knowledge of and skills in:

F1. Counseling parents to facilitate their acceptance of and adjustment to a child's diagnosis of hearing impairment

F2. Counseling parents to resolve their concerns and facilitate their decision making regarding early intervention, amplification, education, and related intervention options for children with hearing impairment

F3. Educating parents regarding the potential effects of hearing impairment on speech-language, cognitive, and social-emotional development and functioning

F4. Educating parents regarding optional and optimal modes of communication; educational laws and rights, including 504s, individualized education programs (IEPs), individual family service plans (IFSPs), individual health plans; and so forth

F5. Selecting age/developmentally appropriate amplification devices and HATS to minimize auditory deprivation and maximize auditory stimulation

F6. Instructing parents and/or child(ren) regarding the daily use, care, and maintenance of amplification devices and HATS

F7. Planning and implementing parent education/support programs concerning the management of hearing impairment and subsequent communication and adjustment difficulties

F8. Providing for intervention to ensure age/developmentally appropriate speech and language development

F9. Administering self-assessment, parental, and educational assessments to monitor treatment benefit and outcome

F10. Providing ongoing support for children by participating in IEP or IFSP processes

F11. Counseling the child with hearing impairment regarding peer pressure, stigma, and other issues related to psychosocial adjustment, behavioral coping strategies, and self-advocacy skills

F12. Evaluating acoustics of classroom settings and providing recommendations for modifications

F13. Providing interprofessional consultation and/or team management with speech-language pathologists, educators, and other related professionals

## Standard III: Verification of Knowledge and Skills

**Applicants for certification must have completed supervised clinical experiences under an ASHA-certified audiologist who has completed at least 2 hours of professional development in the area of clinical instruction/supervision. The experiences must meet CAA standards for duration and be sufficient to demonstrate the acquisition of the knowledge and skills identified in Standard II.**

Implementation: The applicant's doctoral program director or designated signatory must verify that the applicant has acquired and demonstrated all of the knowledge and skills identified in Standard II.

Clinical instructors and supervisors must have:

- current CCC-A certification,
- a minimum of 9 full-time months of clinical experience after earning the CCC-A, and
- **completed at least 2 hours of professional development** (2 certification maintenance hours [CMHs], or 0.2 ASHA continuing education units [ASHA CEUs]) in the area of clinical instruction/supervision.

Clinical instruction and supervision within a doctoral program must:

- be conducted for a variety of clinical training experiences (i.e., different work settings and with different populations) to validate knowledge and skills across the scope of practice in audiology;
- include oversight of clinical and administrative activities directly related to client/patient care, including direct client/patient contact, consultation, recordkeeping, and administrative duties relevant to audiology service delivery;
- be appropriate to the student's level of training, education, experience, and competence;
- include direct observation, guidance, and feedback to permit the student to (a) monitor, evaluate, and improve performance and (b) develop clinical competence; and
- be provided on site.

Any portion of the applicant's supervised clinical experience that was not completed under an audiologist meeting the requirements above can be completed post-graduation. The applicant's post-graduation clinical instructor/ supervisor must also meet the above requirements will also verify that the applicant has demonstrated and acquired the knowledge and skills for ASHA certification following completion of the required supervised clinical experience.

Applicants who apply for certification without completing a full, supervised clinical experience under a clinical instructor/supervisor who meets the requirement above within their degree program will have 24 months from their application-received date to initiate



the remainder of their experience and will have 48 months from the initiation date of their post-graduation supervised clinical experience to complete the experience.

If clinical instruction and supervision are completed post-graduation, they must comply with the requirements above with the exception of on-site clinical instruction and supervision. Remote supervision or telesupervision methods may be used, provided they are permitted by the employer(s) and by local, state, and federal regulations.

The supervised clinical experience should include interprofessional education and interprofessional collaborative practice (IPE/IPP). Under the supervision of their audiologist supervisor, students'/applicants' experience should include experiences with allied health professionals who are appropriately credentialed in their area of practice to enhance the student's knowledge and skills in an interdisciplinary, team-based, comprehensive health care delivery setting.

## Standard IV: Examination

**The applicant must pass the national examination adopted by ASHA for purposes of certification in audiology.**

Implementation: Results of the [Praxis Examination in Audiology](#) must be submitted directly to ASHA from ETS. A passing exam score must be earned no earlier than 5 years prior to the submission of the application and no later than 2 years following receipt of the application. If the applicant does not successfully pass the exam and does not report the results of the exam to ASHA within the 2-year application period, then the applicant's certification file will be closed. If the applicant passes or reports the results of the exam at a later date, then the individual will be required to reapply for certification under the standards that are in effect at that time.

## Standard V: Maintenance of Certification

**Individuals holding certification must demonstrate (1) continuing professional development, including 1 hour of continuing education in ethics; (2) adherence to the ASHA Code of Ethics; and (3) payment of annual dues and fees.**

Implementation: Individuals who hold the CCC in Audiology (CCC-A) must accumulate and report 30 CMHs (or 3.0 ASHA CEUs) of professional development, which [must include 1 CMH \(or 0.1 ASHA CEU\) in ethics](#) during every [3-year certification maintenance interval](#). Individuals will be subject to [random audits](#) of their professional development activities.

Individuals who hold the CCC-A must adhere to the ASHA [Code of Ethics](#) ("Code"). Any violation of the Code may result in professional discipline by the ASHA Board of Ethics and/or the CFCC.

Annual payment of certification dues and/or fees is also a requirement of certification maintenance. If [certification maintenance requirements](#) are not met, certification status will become [Not Current](#), and then certification will expire. In order to regain certification,

individuals must meet the reinstatement requirement that is in effect at the time they submit their reinstatement application.

## Appendix F: Association Information

### **ASHA - The American Speech-Language-Hearing Association**

ASHA is the national scientific and professional association for speech-language pathologists, audiologists, and speech-language and hearing scientists concerned with communication behavior and disorders. ASHA also accredits our graduate programs in Speech-Language Pathology and Audiology. We urge you to become familiar with its goals, its programs, and its publications. You will learn about ASHA in your coursework, from your clinical preceptors, and from publications that will be made available to you at various times.

The manner in which you receive your clinical training follows certain guidelines prescribed by ASHA. The guidelines call for a minimum number of clinical clock hours of experience in and require supervised clinical experiences. However, it is the philosophy of our program that merely meeting minimum requirements does not necessarily mean that you have received adequate practicum experience. Our objective is to provide students with the number and quality of clinical experiences that will make them competent professionals. Meeting competency requirements often means that students will accumulate academic and clinical experiences in excess of the ASHA minimum requirements. More information regarding ASHA can be found at [www.asha.org](http://www.asha.org)

### **NSSLHA - The National Student Speech-Language and Hearing Association**

NSSLHA is the national organization for students interested in the study of normal and disordered communication behavior. Membership is open to undergraduate graduate students. Many universities, including CU, maintain active chapters, which meet during the year on a regular basis. The CU Chapter of NSSLHA encourages your membership and support of its activities. Through CU Chapter programs, you will learn more about the opportunities that can result from your professional training, more about the national NSSLHA Chapter, and about the workings of the ASHA. More information regarding NSSLHA can be found at <http://www.nsslha.org/default.htm>

### **SAA - CU Student Academy of Audiology**

SAA is the student division of the American Academy of Audiology. Learn more about SAA here: <http://www.audiology.org/SAA/aboutus/Pages/default.aspx>. CU-Boulder's SAA Chapter has a bulletin board on SLHS' 2nd floor (north hallway) where meeting information, activities, and contact information for officers is located.

### **CAA - Colorado Academy of Audiology**

CAA is the state organization for individuals working or interested in the field of audiology. Membership is open to undergraduate, masters and doctoral level graduate students. CAA encourages you to become a member and participate in its activities. Through involvement in CAA you will learn more about the opportunities available in Indiana. More information regarding CAA can be found at <https://coaudiology.org/>

### **AAA – American Academy of Audiology**

AAA is the professional organization for audiologists. Student membership allows you to receive JAAA, the Journal of the American Academy of Audiology and Audiology Today. The annual convention is a site for clinical presentations, new amplification products and job opportunities. More information regarding AAA can be found at [www.audiology.org](http://www.audiology.org).

**ASA – Acoustical Society of America**

ASA is the professional organization for acousticians, engineers, psychoacousticians and hearing scientists. Like ARO, this organization is also a research organization suited for students interested in a career in hearing research, particularly psychoacoustics. More information regarding ASA can be found at <http://asa.aip.org/>

**ABA – American Board of Audiology**

ABA is a professional organization that offers certification to practicing audiologists. This certification is similar to ASHA's Certificate of Clinical Competence. They also offer Certificate Programs in precepting and in tinnitus management as well as Specialty Certification in Pediatrics and in Cochlear Implants to practicing audiologists. Learn more at <https://www.boardofaudiology.org/>

## Appendix G: Course Schedule

Course Schedule: The following is a typical course schedule for the AuD program. Note that changes may occur due to faculty availability.

### *Year 1 Fall:*

<u>Course #</u>	<u>Course Title</u>	<u>Credit Hours</u>
SLHS 5576	Neuroanatomy	3
SLHS 5918	Audiology Clinical Practica: Level 1	1
SLHS 6544	Auditory Processes: Adult Assessment	3
SLHS 6006	Advanced Hearing Science	3
SLHS 5012	Evidence-Based Practice and Research Methods	3

### *Year 1 Spring:*

<u>Course #</u>	<u>Course Title</u>	<u>Credit Hours</u>
SLHS 5918	Audiology Clinical Practica: Level 1	1
SLHS 6614	Fundamentals of Amplification	3
SLHS 6554	Auditory Processes: Child Assessment	3
SLHS 6564	Auditory Processes: Neurodiagnostics	3

### *Year 2 Summer:*

<u>Course #</u>	<u>Course Title</u>	<u>Credit Hours</u>
SLHS 5928	Audiology Clinical Practica: Level 1	3

### *Year 2&3 Fall (Even Academic Years: 2020-21, 2022--23):*

<u>Course #</u>	<u>Course Title</u>	<u>Credit Hours</u>
SLHS 5674	Signals, Systems, & Calibration	2
SLHS 7614	Implantable Devices: Technology and Clinical Application	3
SLHS 7640	Communication Processes and Hearing Loss: Birth through Six	3
SLHS 7800	Seminars in Audiology	1
SLHS 5928	Audiology Clinical Practica: Level 1 (2nd year students)	2
SLHS 5938/5948	Audiology Clinical Practica: Level 2 (3rd year students)	4

*Year 2&3 Spring (Even Academic Years: 2020-21, 2022--23):*

<u>Course #</u>	<u>Course Title</u>	<u>Credit Hours</u>
SLHS 7540	Auditory Processes: Physiology, Assessment, and Management of the Vestibular System	3
SLHS 7714	Advanced Topics in Amplification	3
SLHS 5928	Audiology Clinical Practica: Level 1 (second year students)	2
SLHS 5938/5948	Audiology Clinical Practica: Level 2 (third year students)	4
SLHS 7450	Audiology Capstone Project (all students)	3

*Year 2&3 Summer (Even Academic Years: 2020-21, 2022--23):*

<u>Course #</u>	<u>Course Title</u>	<u>Credit Hours</u>
SLHS 5938	Audiology Clinical Practica: Level 2 (third year students)	3
SLHS 6938	Audiology Clinical Externship	4

*Year 2&3 Fall (Odd Years: 2021-2022, 2023-24):*

<u>Course #</u>	<u>Course Title</u>	<u>Credit Hours</u>
SLHS 7530	Auditory Processes: Theory and Application in School Environment	3
SLHS 7520	Auditory Processes: Medical and Genetic Bases	3
SLHS 7200	Business, Management & Ethics in Audiology	3
SLHS 5928	Audiology Clinical Practica: Level 1 (second year students)	2
SLHS 5938/5948	Audiology Clinical Practica: Level 2 (third year students)	4

*Year 2&3 Spring (Odd Years: 2017-2018, 2019-20):*

<u>Course #</u>	<u>Course Title</u>	<u>Credit Hours</u>
SLHS 7550	Hearing Loss from a Public Health Perspective	3
SLHS 6670	Aging and Hearing Loss	3
SLHS 6650	Counseling and Multicultural Issues	3
SLHS 5928	Audiology Clinical Practica: Level 1 (second year students)	2
SLHS 5938/5948	Audiology Clinical Practica: Level 2 (third year students)	4

*Year 2&3 Summer (Odd Years: 2017-2018, 2019-20):*

SLHS 5948	Audiology Clinical Practica: Level 2 (third year students)	3
SLHS 6948	Audiology Clinical Externship	4

*Year 4:*

*Fall:*

<u><i>Course #</i></u>	<u><i>Course Title</i></u>	<u><i>Credit Hours</i></u>
SLHS 6938/6948	Audiology Clinical Externship	4

*Spring:*

<u><i>Course #</i></u>	<u><i>Course Title</i></u>	<u><i>Credit Hours</i></u>
SLHS 6938/6948	Audiology Clinical Externship	5

## Appendix H: University of Colorado Hospital Dress Code

While each site may have its own guidelines regarding dress code (including things like perfumes, artificial nails, etc.), below are those for University of Colorado Hospital. These guidelines are likely similar if you are in other fast-paced hospital settings. Be sure to check with your preceptor(s) regarding particular guidelines for their site.

- Students are asked to wear black scrubs while in clinic at UCH. Closed toe shoes are a requirement in patient care.
- You are required to wear your UCH badge at all times while in clinic. This needs to be easily viewable. Either on a lanyard, attached near your shoulder, or at your waist.
- 1<sup>st</sup> years should wear their CU name tags while until they receive UCH badges
- Drinks and food are not allowed in patient care areas. A water bottle may be kept tucked away (ask your preceptor where), but should not be consumed during patient appointments.
- Any patient identifying documents should be stored in a private place during clinic and CANNOT be brought home. Patient documents should not be left in the patient care rooms during another patient's appointment. EPIC needs to be secured whenever you step away from a computer.
- All staff and students are required to abide by the UCH Dress Code and Appearance policy.

### Hygiene

- Employees must exhibit good personal hygiene at all times. This means clean nails, teeth, hair, shoes, body, and clothes.
- Fingernails should be kept clean and of an appropriate length. For clinical areas, nails should be kept short for safety purposes. Artificial nails and nails with decal are prohibited to those providing direct patient care.
- Employees must remain free of odors or scents that might be offensive or unhealthy to others, including, but not limited to, cigarette smoke, body odor, bad breath and excessive use of perfume or cologne. Staff providing direct patient care are not permitted to wear fragrances.

### Jewelry

- Jewelry must not interfere with job performance or safety. Ear piercings, including studded earrings and small hoops, must be discreet and not create a safety hazard. Gauged or plug earrings must be less than ¼ inch in diameter. No more than three (3) items may be worn in an ear at any one time. A small nose stud may be worn. Any other visible jewelry worn in piercings is prohibited, including the tongue. Pins, buttons, jewelry, emblems, or insignia bearing a political, controversial, inflammatory, or provocative message are not permitted. Anyone providing patient care may be required to limit jewelry and accessories for safety reasons.



**Hair**

- Hair should be clean and groomed. Hair color or style may not be extreme. Staff working in patient areas or areas where a hair tie, net or cap is required must adhere to departmental guidelines and regulatory requirements.

**Tattoos**

- Department leadership may require tattoos to be covered when practical. Tattoos that are excessive, or may be construed as vulgar or offensive, must be covered.