University of Colorado **Boulder**

# Department of Speech, Language, & Hearing Sciences

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# Clinical Handbook

# Spring 2014

# 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 (slhs.colorado.edu). 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 more than 300 undergraduate majors, 110 graduate students, 11 tenure-track faculty, 7 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: slhs.colorado.edu/people/.

## Description of Facility & Services

Graduate students in Department of Speech, Language and Hearing Science (SLHS) provide clinical services under direct supervision of ASHA-certified clinical faculty members.

**THE CENTER FOR SPEECH AND HEARING AT SLHS**

The Department of Speech and Hearing Science houses the Speech and Hearing Clinic, which provides the campus-based clinical training for our SLP program. Through this clinic, diagnostic and rehabilitative speech language pathology services are provided to the general public on a fee-for-service basis.

Sound booths and audiometric equipment is located on the first floor of the SLHS building for use in clinical teaching, research, and student practice.

**THE MARION DOWNS HEARING CENTER**

AuD students begin their on-site clinical experience at the Marion Downs Hearing Center at University of Colorado Hospital - Boulder. The Marion Downs Hearing Center offers services to people of all ages, from infants to adults. The Center's mission is to provide culturally sensitive services, resources, education, and research to support the needs to individuals who are deaf or hard of hearing, their families, and professionals. All activities value individual/family choice in communication and use of technology, striving to optimize the quality of life for all that it serves.

Directions to the Marion Downs Hearing Center - Boulder: University of Colorado Hospital's Family Medicine Boulder clinic is located at 350 Broadway, Suite 130.

Parking spaces closest to the clinic itself are reserved for patients. Should student clinicians wish to drive to the clinic, they are asked to park in the spaces further away from the building (closest to the entrance to the parking lot).

The phone number to the audiologist's office at the Center is 720-848-9265. Your preceptor may prefer to be contacted via email or his/her cell phone, so be sure to inquire as to his/her preference.

Other Offsite Facilities

AuD students will engage in clinical activities at other facilities in the Denver/Boulder area as they progress through the program. 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 must discuss these things with preceptors/instructors prior to his/her first day at the site.

## Facilities

### Administrative office

The Speech, Language, & Hearing Center's administrative assistant handles issues related to student clinical education such as maintenance of the clinical hours database and processing of clinical paperwork such as the application for ASHA's Certificate of Clinical Competence (CCC). This office is located on the first floor of the SLHS building near the SLHC waiting room.

### 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. 2nd year AuD students are also assigned a mailbox in the Marion Downs Hearing Center, where they may store name badges, listening molds, and journals for reflection.

### 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 are to be de-identified appropriately per HIPAA regulations (see Appendix B 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.

## Professionalism for Clinical Practice

Professional behavior is expected of all graduate student clinicians. The following outline provides information as to what professional behavior entails. Please note that this list is not intended to be exhaustive. Note that particular sites may have specific requests regarding particular aspects of professionalism above and beyond this outline.

### A. ETHICAL PRACTICES

- Conducts all clinical work in accordance with the Code of Ethics set forth by the American Speech-Language-Hearing Association. (See Appendix C)

### B. DEPENDABILITY

- Prepares for and conducts clinical services as assigned (reviews appropriate files, develops questions and/or key points for discussion).
- Prepares for and conducts meetings/conferences/consultations (reviews appropriate files, develops questions and/or key points for discussion).
- Carries out all duties to accomplish total case management (e.g., forms, phone calls, referrals, etc.).
- Makes appropriate arrangements and notifies all concerned regarding any schedule change or cancellation.

### C. 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 leaves the clinic without notifying/checking with clinical preceptor first.
- Requests approval for absence from clinic in writing from Coordinator 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.
- Submits all written assignments (e.g., test results, reports, letters, etc.) in acceptable form (appropriate grammatical usage, paragraph structure, punctuation, and spelling) by scheduled deadlines.

- Attends all meetings/conferences/consultations on time.

## D. CONFIDENTIALITY

- Abides 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 B for more information regarding HIPAA.)

- Utilizes discretion concerning patient information in written and oral communication with others.

- Accesses patient information on an “as needed” basis only.

## E. PERSONAL APPEARANCE

- Wears name badge to provide patients, family members, and others with a means of easily identifying graduate students.

- Maintains and promotes a positive professional image.

- Does not wear **ANY** scented products (i.e., perfume, hair products, body lotions, etc.).

- Maintains proper personal hygiene.

- All attire must appear neat, pressed and professional looking

- No denim jeans, Capri length pants or shorts are allowed. Pants must not be excessively baggy or ride excessively low on the hips

- 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.

- Shirts for men must have collars and be tucked in. Ties are recommended. T shirts even with collars are not appropriate.

- Low-cut tops that show cleavage, sleeveless tops or shirts that show through are not allowed. Tops should not be so tight as to create a gap in the front.

- Shoes should look professional and be closed in the front. Open back shoes such as mules are acceptable. No flip-flops or athletic shoes are allowed.

- Unusual hair coloring (e.g. pink, blue, green etc.) and style (e.g. Mohawk) are not allowed.

- Any visible or potential visible body art needs to be removed or covered. Oral or facial piercing (tongue, lip, and eyebrow) must be removed. Tattoos must be covered with long sleeves or a high collar. Ankle or foot tattoos should be covered with pants or dark tights.

- **Any student who is not dressed appropriately will not be allowed to participate in clinic.**

## F. COMMUNICATION

- Utilizes appropriate communication in all professional activities.

- Provides appropriate communication model for patients and families.

- Uses appropriate written and oral communication with all persons involved in the case including clinical preceptor, co-clinicians, and other professionals.

- Checks 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))

## G. ACCOUNTABILITY

- Keeps documentation (test results, data on specific goals, correspondence, release of information, hearing aid status etc.) up-to-date and filed in appropriate location, if applicable.

- Fills out appropriate chart notes/paperwork in a timely manner.

- Reviews information in the University of Colorado Hospital Protocol Handbook each semester enrolled in SLHS 5918 so that appropriate protocols are followed.

Failure to meet these standards of professionalism will 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.

## 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 an ASHA (American Speech-Language-Hearing Association) Certificate of Clinical Competence (CCC) in Audiology 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 the clinical requirements for national certification 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. The clinical placements will result in the accumulation of over 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 D: scope of practice). In order to be recommended to ASHA for Clinical Certification in Audiology, a student must accumulate a minimum of 1820 hours of supervised clinical practicum sufficient in depth and breadth to achieve the knowledge and skills outcomes stipulated in the ASHA 2012 standards. Individuals who hold the Certificate of Clinical Competence in the appropriate area of practice must provide the supervision.

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 wide variety of facilities. Clinical placements are selected to provide students with experience in audiologic 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.

**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 41 clinical credits including two semesters of clinic preparation and observation, a minimum of three on-campus and three off-campus clinical rotation placements and the 4$^{th}$-year 12-month 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.

First-year AuD students observe/assist in the audiology clinic and attend clinical laboratory experiences designed to prepare students for their first clinical on-campus rotation.

Beginning in the 2nd year of the AuD program, students spend a minimum of three semesters in university-based clinical rotations at University of Colorado Hospital Family Medicine Clinic in Boulder (SLHS 5918). During the 3rd year, students continue their training in at least three approved off-campus clinical rotation placements throughout the Denver Front Range area (SLHS 5938). 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 carefully 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), which involves full-time placement for twelve months in approved regional or national facilities.

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. Additional factors for withdrawal may be considered by the clinical supervisor/preceptor in consultation with the department's Clinic Director and the Coordinator 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 in the semester prior to the desired registration through the Coordinator 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.

## 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 procedures performed at the clinic by passing an initial Practical Exam that takes place during the Spring semester of the 1st year.

### Progression of Clinical Assignments

For all students with the prerequisite courses completed, clinical practicum will begin with registration in SLHS 5918 the first semester of the program. Students will begin by observing 2nd year graduate student clinicians in the Marion Downs Hearing Center during the first semester of the Au.D program. These 1st year AuD students will assume a more active role during the latter part of the 1st semester and during the 2nd semester by assisting the 2nd year student clinicians as they gain competency in basic clinical skills (e.g., hearing aid

troubleshooting, hearing aid programming, etc.). Attendance and participation by 1st year AuD students in the weekly laboratory experiences for SLHS 5918 is required. Any unexcused absences can result in a lowering of the clinic grade.
It should be noted that when a student registers for clinical practicum (SLHS 5918/5938/6938), it is expected that the student will complete the entire semester.

Requirements for the ASHA Certificate of Clinical Competence in Audiology (CCC-A) include the completion of a minimum of 1820 hours 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.

Each approved offsite must have a formal affiliation agreement on file with CU.

**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 Mrs._____ or Dr._____ and state they are the 'supervising audiologist'. Off-campus students in placements will use "Audiology Extern" or other title if suggested 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 5918 are typically in clinic one day per week and are responsible for the service delivery and reports/chart notes for approximately four to eight patients; students registering for three credits of SLHS 5938 are typically in clinic for at 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 is a full-time externship.

**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. A doctor's note is required if you miss more than two clinic sessions due to illness during a semester.

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**. **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 the clinical hours you 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

**Check Sheets**
Several tracking documents have been developed to assist the student and the academic advisor 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 IV. 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 http://www.asha.org/Certification/2012-Audiology-Certification-Standards/ for the most current version of the 2012 Standards and Implementation Procedures for the Certificate of Clinical Competence in Audiology.

The Doctor of Audiology course schedule (Appendix I) 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 delay graduation**.** A table outlining ASHA's 2012 Standards (Appendix H) provides a summary of specific knowledge and skills required by the ASHA certification guidelines and where within the AuD curriculum these areas are covered. Students should use this table to document what courses were taken, which courses met which standards, and when these courses were taken. 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 at the Boulder 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 their hours each semester including off-campus sites and in the fourth year. At the end of each semester all clinic hours obtained need to be logged onto a clock hours form (see Appendix G clock hours form) and signed by the clinical preceptor. Duplicate copies of these signed hours sheets must be made; the student clinician keeps one; the original is to be filed with the SLHC Administrative Assistant, who tracks cumulative clock hours. **This information is necessary for graduation as well as ASHA certification. It is the student's responsibility to maintain accurate records.**

The cumulative clinic clock hours will be placed in each student's academic file at the end of the program. Upon graduation, should a student wish to obtain his/her Certificate of Clinical Competence from ASHA, the application form for the Certificate of Clinical Competence should

be completed and sent to SLHS' ASHA Program Director for signature. After this form has been signed off on, it will be returned to the graduate for submission to ASHA for certification.

## Clinical Rotation Credits

AuD students need to complete a minimum of 41 clinical credits to graduate distributed across eleven semesters as shown below:

1st year –

- Fall – observe at UCH Boulder clinic, clinical labs (SLHS 5918 – 1 credit)
- Spring – observe/assist at UCH Boulder clinic, clinical labs (SLHS 5918 – 1 credit)

2nd year –

- Summer – UCH Boulder clinic (8 hours/wk) (SLHS 5918 – 2 credits)
- Fall – UCH Boulder clinic (8 hours/wk) (SLHS 5918 – 2 credits)
- Spring – UCH Boulder clinic (8 hours/wk) (SLHS 5918 – 2 credits)

3rd year –

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

4th year –

- Externship (12 months) (SLHS 6938 – 21 credits total)

**Annual requirements**

Students are required to complete training in Universal Precautions and HIPAA annually. Presentations will be offered to meet this requirement. CPR training is required; proof of up-to-date CPR training must be provided to the SLHC Administrative Assistant (certification is typically good for two years). Prior to the commencement of the program, students are required to provide documentation of immunizations and a recently completed criminal background check. These documents should be turned into the SLHC Administrative Assistant.

**Liability Insurance**

Liability Insurance needs to be obtained by the beginning of the fall semester, prior to the beginning of practicum 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 submitted to the SLHS Administrative Assistant each fall. 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.

## Maintenance of Audiologic Equipment/Space in SLHS

It is the responsibility of all individuals who use the audiology space in SLHS to leave the audiology suites, hallway area outside the suites, and hearing aid supply room 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. 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 or drinks are allowed in the suites, labs, or hearing aid room.**

**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 Coordinator of Audiology Clinical Education who will respond to the request for equipment repair. A note should be left on the equipment, indicating the problem.

**Logbook**
First year AuD students are assigned a month in which they are responsible for ensuring the audiology teaching spaces and equipment are in good working order and clean. The students assigned each month will document in the logbook (kept in Booth 1) which tasks were finished when as well as note any problems and/or supplies that are low.

## Evaluation of Clinical Practicum

**Practical Exams**
Clinical practical exams are conducted during the Spring semester of the 1st year. The practical exam consists of the following components:

- Earmold 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 in order for the student to move on to clinical practicum in the 2nd year of the program.

**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 written and verbal 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 using CU's evaluation form (Appendix J) at midterm and the final of the semester. Clinical preceptors complete the appropriate sections of the form at mid-term and at the conclusion of the semester that reflects the independence and competence of the student clinician during the practicum experience.

At the midterm and final evaluations the student and preceptor will meet and discuss the semester and the completed evaluation form. This is a mechanism for 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 form. The Coordinator for 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.

Any grade below B- in any enrolled practicum is considered below satisfactory performance and results in the student being placed on clinical probation. Individualized remediation plans will specify the behaviors or skills that the student must demonstrate, the context in which the skills must be performed, and a deadline for remediation. The remediation plan will include specific goals, suggested resources, and a reasonable time frame for completion. If the student demonstrates skills within expected levels in the indicated time

frame, his/her clinical practicum privileges continue. Two consecutive semesters of below satisfactory performance will result in termination from the program.

**Lines of Communication**

In the event that a student has a concern regarding the supervisory support and/or clinical performance, the student should directly discuss the concern with the Coordinator for Audiology Clinical Education and/or the Director of Clinical Education and Services in SLHS/ASHA . Students are encouraged to discuss with the Coordinator for Audiology Clinical Education/clinical preceptor their learning style and suggestions about the most beneficial clinical education style for the individual as a student clinician.

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

At the successful completion of the 4 year AuD program, students are eligible to apply for ASHA certification (CCC-A). The Praxis II exam in Audiology is required for ASHA certification. Information about the exam is available at http://www.asha.org/students/praxis/. The Praxis II exam is administered by the Educational Testing Service. The website is 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 the SLHS Department. It is recommended that students print and keep a copy of their results for their records after completing the exam.

The application for ASHA membership and certification is available online at http://www.asha.org. (Also located in Appendix F) Students applying for ASHA certification must complete these forms and turn them in to the Center's Administration Assistant in electronic form. Students can contact the ASHA Action Center at 800-498-2071 for assistance.

Certification is also available through the American Board of Audiology (ABA). Information about ABA certification can be found at http://www.americanboardofaudiology.org/about/about.html. Board Certification in Audiology requires a minimum of 2000 hours of direct patient care supervised by a licensed audiologist. A handbook containing application information and materials can be found at http://www.americanboardofaudiology.org/pdf/BCHandbook201303.pdf.

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 http://cdn.colorado.gov/cs/Satellite/DORA-Reg/CBON/DORA/1251632508562. Check individual state requirements if you are applying for jobs elsewhere.

**Note: The process of review within the SLHS department of this submitted paperwork can take 2-4 weeks. Signed paperwork will be returned to the student who can then send to ASHA for review.**

# Appendix A: 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 trans-mission. 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

### 1. Hand hygiene[1]

**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[2]

**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.

[2] The SIGN Alliance at: 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, 3rd 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, 3rd 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 Clinic**

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

1. Insert earphones

**Non-Disposable Items in Clinic**

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 B: The Health Insurance Portability and Accountability Act (HIPAA)

## 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 C: 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

**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.

**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/

## Appendix D: Clock Hours Form

**University of Colorado at Boulder**
**Department of Speech, Language, & Hearing**

2501 Kittredge Loop Road
SLHS 409 UCB
Boulder, Colorado 80309-0409
(303) 492-5375 FAX: (303) 492-3274

Clinician_____

Semester_____Year_____

**SUMMARY OF SUPERVISED CLINICAL EXPERIENCE IN AUDIOLOGY**

| CLOCK HOURS BY CATEGORY: | | PREVENTION & IDENTIFICATION | EVALUATION | TREATMENT |
|---|---|---|---|---|
| ADULT | | | | |
| PEDIATRIC | | | | |

TOTAL HOURS AUDIOLOGY :_____

SUPERVISOR SIGNATURE_____

ASHA CCC-A NUMBER_____

FACILITY NAME_____

ADDRESS/PHONE_____

_____

STUDENT SIGNATURE_____ DATE_____

## Appendix E: Audiology Certification Standards (2012)

Audiology Certification Standards (2012) Knowledge & Skill Requirements:

| Description of requirement | Course(s) | Semester(s) |
|---|---|---|
| **A. Foundations of Practice** | | |
| A1. Embryology and development of the auditory and vestibular systems, anatomy and physiology, neuroanatomy and neurophysiology and pathophysiology | | |
| A2. Genetics and associated syndromes related to hearing and balance | | |
| A3. Normal aspects of auditory physiology and behavior over the life span | | |
| A4. Normal development of speech and language | | |
| A5. Language and speech characteristics and their development across the life span | | |
| A6. Phonologic, morphologic, syntactic, and pragmatic aspects of human communication associated with hearing impairment | | |
| A7. Effects of hearing loss on communication and educational, vocational, social, and psychological functioning | | |
| A8. Effects of pharmacologic and teratogenic agents on the auditory and vestibular systems | | |
| A9. Patient characteristics (e.g., age, demographics, cultural and linguistic diversity, medical history and status, cognitive status, and physical and sensory abilities) and how they relate to clinical services | | |
| A10. Pathologies related to hearing and balance and their medical diagnosis and treatment | | |
| A11. Principles, methods, and applications of psychometrics | | |
| A12. Principles, methods, and applications of psychoacoustics | | |
| A13. Instrumentation and bioelectrical hazards | | |
| A14. Physical characteristics and measurement of electric and other non-acoustic stimuli | | |
| A15. Assistive technology | | |
| A16. Effects of cultural diversity and family systems on professional practice | | |
| A17. American Sign Language and other visual communication systems | | |

| | | |
|---|---|---|
| A18. Principles and practices of research, including experimental design, statistical methods, and application to clinical populations | | |
| A19. Legal and ethical practices (e.g., standards for professional conduct, patients rights, credentialing, and legislative and regulatory mandates) | | |
| A20. Health care and educational delivery systems | | |
| A21. Universal precautions and infectious/contagious diseases | | |
| A22. Oral and written forms of communication | | |
| A23. Principles, methods, and applications of acoustics (e.g., basic parameters of sound, principles of acoustics as related to speech sounds, sound/noise measurements and analysis, and calibration of audiometric equipment), as applicable to:<br>a. occupational and industrial environments<br>b. community noise<br>c. classroom and other educational environments<br>d. workplace environments | | |
| A24. The use of instrumentation according to manufacturer's specifications and recommendations | | |
| A25. Determining whether instrumentation is in calibration according to accepted standards | | |
| A26. Principles and applications of counseling | | |
| A27. Use of interpreters and translators for both spoken and visual communication | | |
| A28. Management and business practices, including but not limited to cost analysis, budgeting, coding and reimbursement, and patient management | | |
| A29. Consultation with professional in related and/or allied service areas | | |

| Description of requirement | Course(s) | Semester(s) |
|---|---|---|
| **B. Prevention and Identification** | | |
| B1. Implement activities that prevent and identify dysfunction in hearing and communication, balance, and other auditory-related systems | | |
| B2. Promote hearing wellness, as well as the prevention of hearing loss and protection of hearing function by designing, implementing, and coordinating universal newborn hearing screening, school screening, community hearing, and occupational conservation and identification programs | | |

| | | |
|---|---|---|
| B3. Screen individuals for hearing impairment and disability/handicap using clinically appropriate, culturally sensitive, and age-and site-specific screening measures. | | |
| B4. Screen individuals for speech and language impairments and other factors affecting communication function using clinically appropriate, culturally sensitive, and age- and site-specific screening measures | | |
| B5. Educate individuals on potential causes and effects of vestibular loss | | |
| B6. Identify individuals at risk for balance problems and falls who require further vestibular assessment and/or referral for other professional services | | |

| Description of requirement | Course(s) | Semester(s) |
|---|---|---|
| **C. Assessment** | | |
| C1. Measuring and interpreting sensory and motor evoked potentials, electromyography, and other electrodiagnostic tests for purposes of neurophysiologic intraoperative monitoring and cranial nerve assessment | | |
| C2. Assessing individuals with suspected disorders of hearing, communication, balance, and related systems | | |
| C3. Evaluating information from appropriate sources and obtaining a case history to facilitate assessment planning | | |
| C4. Performing otoscopy for appropriate audiological assessment/management decisions, determining the need for cerumen removal, and providing a basis for medical referral | | |
| C5. Conducting and interpreting behavioral and/or electrophysiologic methods to assess hearing thresholds and auditory neural function | | |
| C6. Conducting and interpreting behavioral and/or electrophysiologic methods to assess balance and related systems | | |
| C7. Conducting and interpreting otoacoustic emissions and acoustic immittance (reflexes) | | |
| C8. Evaluating auditory-related processing disorders | | |
| C9. Evaluating functional use of hearing | | |
| C10. Preparing a report, including interpreting data, summarizing findings, generating recommendations, and developing an audiologic treatment/management plan | | |

| | | |
|---|---|---|
| C11. Referring to other professionals, agencies, and/or consumer organizations | | |

| Description of requirement | Course(s) | Semester(s) |
|---|---|---|
| **D. Intervention (Treatment)** | | |
| D1. The provision of intervention services (treatment) to individuals with hearing loss, balance disorders, and other auditory dysfunction that compromises receptive and expressive communication | | |
| D2. Development of a culturally appropriate audiologic rehabilitative management plan that includes, when appropriate, the following:<br>a. evaluation, selection, verification, validation, and dispensing of hearing aids, sensory aids, hearing assistive devices, alerting systems, and captioning devices, and educating consumer and family/caregivers in the use of and adjustment to such technology<br>b. determining of candidacy of persons with hearing loss for cochlear implants and other implantable sensory devices and provision of fitting, mapping, and audiologic rehabilitation to optimize device use<br>c. counseling relating to psychosocial aspects of hearing loss and other auditory dysfunction, and process to enhance communication competence<br>d. provision of comprehensive audiologic treatment for persons with hearing loss or other auditory dysfunction including but not exclusive to communication strategies, auditory training, speech reading, and visual communication systems | | |
| D3. Determination of candidacy for vestibular and balance rehabilitation therapy to persons with vestibular and balance impairments | | |
| D4. Treatment and audiologic management of tinnitus | | |
| D5. Provision of treatment services for infants and children with hearing loss; collaboration/consultation with early interventionists, school based professionals, and other service providers regarding development of intervention plans (i.e., individualized education programs and/or individualized family service plans) | | |
| D6. Management of the selection, purchase, installation, and evaluation of large-area amplification systems | | |
| D7. Evaluation of the efficacy of intervention (treatment) services | | |

| Description of requirement | Course(s) | Semester(s) |
|---|---|---|
| **E. Advocacy/Consultation** | | |
| E1. Educating and advocating for communication needs of all individuals that may include advocating for the programmatic needs, rights and funding of services for those with hearing loss, other auditory dysfunction, or vestibular disorders | | |
| E2. Consulting about accessibility for persons with hearing loss and other auditory dysfunctions in public and private buildings, programs, and services | | |
| E3. Identifying underserved populations and promoting access to care | | |

| Description of requirement | Course(s) | Semester(s) |
|---|---|---|
| **F. Education/Research/Administration** | | |
| F1. Measuring functional outcomes, consumer satisfaction, efficacy, effectiveness, and efficiency of practices and programs to maintain and improve the quality of audiologic services | | |
| F2. Applying research findings in the provision of patient care (evidence based practice) | | |
| F3. Critically evaluating and appropriately implementing new techniques and technologies supported by research based evidence | | |
| F4. Administering clinical programs and providing supervision of professionals as well as support personnel | | |
| F5. Identifying internal programmatic needs and developing new programs | | |
| F6. Maintaining or establishing links with external programs, including but not limited to education programs, government programs, and philanthropic agencies | | |

## Appendix F: Course Schedule

Course Schedule: The following is a typical course schedule for the AuD program.

*Year 1 Fall:*

| *Course #* | *Course Title* | *Credit Hours* |
|---|---|---|
| SLHS 5576 | Communication Neuroscience | 3 |
| SLHS 5918 | Audiology Clinical Practica: Level 1 | 1 |
| SLHS 6544 | Auditory Processes: Adult Assessment | 3 |
| SLHS 6614 | Fundamentals of Amplification | 3 |
| SLHS 6564 | Auditory Processes: Neurodiagnostics | 3 |

*Year 1 Spring:*

| *Course #* | *Course Title* | *Credit Hours* |
|---|---|---|
| SLHS 5918 | Audiology Clinical Practica: Level 1 | 1 |
| SLHS 6006 | Advanced Hearing Science | 3 |
| SLHS 6554 | Auditory Processes: Child Assessment | 3 |
| SLHS 7000 | Research Designs in Human Communication Sciences and Disorders | 3 |

*Year 2 Summer:*

| *Course #* | *Course Title* | *Credit Hours* |
|---|---|---|
| SLHS 5918 | Audiology Clinical Practica: Level 1 | 1 |

*Year 2&3 Fall (Even Years: 2012-13, 2014-15, 2016-17):*

| *Course #* | *Course Title* | *Credit Hours* |
|---|---|---|
| SLHS 5674 | Signals and Systems | 3 |
| SLHS 6670 | Adult Aural Rehabilitation | 3 |
| SLHS 7614 | Implantable Devices: Technology and Clinical Application | 3 |
| SLHS 5918 | Audiology Clinical Practica: Level 1 (2nd year students) | 2 |
| SLHS 5938 | Audiology Clinical Practica: Level 2 (3rd year students) | 4 |

*Year 2&3 Spring (Even Years: 2012-13, 2014-15, 2016-17):*

| *Course #* | *Course Title* | *Credit Hours* |
|---|---|---|
| SLHS 7540 | Auditory Processes: Physiology, Assessment, and Management of the Vestibular System | 3 |
| SLHS 7714 | Advanced Topics in Amplification | 3 |
| SLHS 5918 | Audiology Clinical Practica: Level 1 (second year students) | 2 |
| SLHS 5938 | Audiology Clinical Practica: Level 2 (third year students) | 4 |
| SLHS 7450 | Audiology Capstone Project (all students) | 3 |

*Year 2&3 Summer (Even Years: 2012-13, 2014-15, 2016-17):*

| *Course #* | *Course Title* | *Credit Hours* |
|---|---|---|
| SLHS 5938 | Audiology Clinical Practica: Level 1 (third year students) | 4 |
| SLHS 6938 | Audiology Clinical Externship | 4 |

*Year 2&3 Fall (Odd Years: 2013-14, 2015-16, 2017-2018):*

| *Course #* | *Course Title* | *Credit Hours* |
|---|---|---|
| SLHS 7640 | Communication Processes and Hearing Loss: Birth through Six | 3 |
| SLHS 7530 | Auditory Processes: Theory and Application in School Environment | 3 |
| SLHS 7520 | Auditory Processes: Medical and Genetic Bases | 3 |
| SLHS 5918 | Audiology Clinical Practica: Level 1 (second year students) | 2 |
| SLHS 5938 | Audiology Clinical Practica: Level 2 (third year students) | 4 |

*Year 2&3 Spring (Odd Years: 2013-14, 2015-16, 2017-2018):*

| *Course #* | *Course Title* | *Credit Hours* |
|---|---|---|
| SLHS 7550 | Management and Prevention of Noise and Noise Induced Hearing Loss | 2 |
| SLHS 7200 | Business, Management & Ethics in Audiology | 3 |
| SLHS 5918 | Audiology Clinical Practica: Level 1 (second year students) | 2 |
| SLHS 5938 | Audiology Clinical Practica: Level 2 (third year students) | 4 |
| SLHS 7554 | Instrumentation and Calibration in Audiology | 1 |
| SLHS 6650 | Counseling and Professional Ethics | 2 |
| SLHS 6660 | Multicultural Issues in SLHS and its Disorders | 1 |

*Year 2&3 Summer (Odd Years: 2013-14, 2015-16, 2017-2018):*

| | | |
|---|---|---|
| SLHS 5938 | Audiology Clinical Practica: Level 1 (third year students) | 4 |
| SLHS 6938 | Audiology Clinical Externship | 4 |

*Year 4:*

*Fall:*

| *Course #* | *Course Title* | *Credit Hours* |
|---|---|---|
| *SLHS 6938* | *Audiology Clinical Externship* | *8* |

*Spring:*

| *Course #* | *Course Title* | *Credit Hours* |
|---|---|---|
| *SLHS 6938* | *Audiology Clinical Externship* | *9* |

## Appendix G: Clinical Evaluation form

### UNIVERSITY OF COLORADO - BOULDER

#### EVALUATION OF CLINICAL PRACTICUM

**Student's name:** _____ **Evaluation Date:** _____

**Supervisor's name:** _____ **Facility Name:** _____

**Grade:** _____

**Grading Scale:**
**A:** Overall, student's skills are consistently above the expected level.
**A-/B+:** Overall, student's skills are at the expected level.
**B:** Some of the student's skills are at the expected level, but others are below expectations. "B" is a passing grade, but also indicates that the student is somewhat below the expected level and needs to improve his/her clinical skills.
**B-/C+:** Not a passing grade. The student's performance is below the expected level.
**C or below:** Significant problems with professionalism and/or clinical skills.

Your feedback regarding student performance is important! Please complete this form by evaluating the student's clinical and professional skills. Honest, constructive feedback is useful not only in determining student performance, but also in developing goals for the student to work on in the upcoming semester(s). The codes in parentheses that follow some of the items being evaluated are there to help the student track the knowledge and skill requirements, per ASHA. As a supervisor, you need not worry about the codes!

Thank you for taking the time to work with our students. Please do not hesitate to contact CU's Coordinator of Audiology Clinical Education (tammy.fredrickson@colorado.edu) should you have any questions or concerns!

**CONSEQUENCES OF UNACCEPTABLE PROFESSIONALISM*:*** If any item under "professional responsibility and skills" is unacceptable, the student's grade may be lowered at the supervisor's discretion, ***even if other clinical skills are acceptable.***

*Please rank the following skills as satisfactory (S), unsatisfactory (U), or inconsistent (I).*

| PROFESSIONAL RESPONSIBILITY & SKILLS | S | U | I |
|---|---|---|---|
| 1. Punctuality | ☐ | ☐ | ☐ |
| 2. Appropriate Communication with Supervisor (A29) | ☐ | ☐ | ☐ |
| 3. Responsiveness to supervisor | ☐ | ☐ | ☐ |
| 4. Projects a professional attitude & demeanor | ☐ | ☐ | ☐ |
| 5. Professional appearance and conduct | ☐ | ☐ | ☐ |

| | | | |
|---|---|---|---|
| 6. Listening ability | ☐ | ☐ | ☐ |
| 7. Interest in Practicum | ☐ | ☐ | ☐ |
| 8. Demonstration of initiative | ☐ | ☐ | ☐ |
| 9. Interacts effectively with patients, parents, professionals, from all backgrounds (A29) | ☐ | ☐ | ☐ |
| 10. Promptness in submitting written reports | ☐ | ☐ | ☐ |
| 11. Independence in learning | ☐ | ☐ | ☐ |
| 12. Performs task on own initiative | ☐ | ☐ | ☐ |
| 13. Cleans and straighten clinic | ☐ | ☐ | ☐ |
| 14. Demonstrates awareness of safety issues/infection control in clinic (A21) | ☐ | ☐ | ☐ |
| 15. Adheres to facility policy & procedure and ASHA code of ethics (A19) | ☐ | ☐ | ☐ |
| 16. Maintains records in manner consistent with legal/professional standards (A19) | ☐ | ☐ | ☐ |

Comments:

| **Legend:** | |
|---|---|
| **1 = Not Evident** | Competency/skill not evident; Requires constant supervisory modeling/ intervention (Operates independently <30% of the time) |
| **2 = Emerging** | Competency/skill emerging; Requires frequent supervisory instruction (Operates independently 30-50% of the time) |
| **3 = Developing** | Competency/skill present but needs further development; Requires frequent supervisory monitoring (Operates independently 50-70% of the time) |
| **4 = Refining** | Competency/skill developed but needs refinement and/or consistency; Requires infrequent supervisory monitoring (Operates independently 70-80% of the time) |
| **5 = Independent** | Competency/skill well-developed and consistent; Requires guidance and/or consultation only (Operates independently 80-100% of the time) |
| **N/A = not applicable** | |

**EXPECTED SKILL LEVELS FOR EACH YEAR:**

For the first 3 years, if a skill has not yet been covered in class, the expected level will be 1-2. For skills that *have* been covered in class, below are the expected levels by the end of the term.

**2nd Year (begins Summer after 1st year):** 3 for adult audiometric evaluations, 3 for report writing/documentation, 3 for others.3/ 4 should be achieved for adult audiometric evaluations and report writing by the end of the 2nd year clinical rotations (Spring).

**3rd Year (begins Summer after 2nd year):** 4 for most skills, 3 for skills that *have* been covered in class, but with which the student has little or no prior clinical experience. 4/5 should be achieved for most skills (except for those with which the student has little clinical experience) by the end of 3rd year clinical rotations (Spring).

**4th Year:** 4/5 for most skills, some possible 3's early in the year for skills with which the student has little or no prior clinical experience

| CASE HISTORY | 5 | 4 | 3 | 2 | 1 | N/A |
|---|---|---|---|---|---|---|
| 1. Obtains history with appropriate questions (C3) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Utilizes time efficiently | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Relates case history to test results (A9) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Evaluates referral information for assessment plan (A9,C3) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Comments:

| CONVENTIONAL AUDIOMETRY | 5 | 4 | 3 | 2 | 1 | N/A |
|---|---|---|---|---|---|---|
| 1. Demonstrates appropriate otoscopic evaluation (C4) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Determines the need for cerumen management (C4) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Familiarity with equipment | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Gives appropriate instructions | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Appropriate techniques in the following diagnostic areas (C5,C9): | | | | | | |
| a. Air conduction | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| b. Bone conduction | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| c. Speech testing | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| d. Soundfield testing | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| e. Masking | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6. Knowledge and use of the following tests (C5,C9): | | | | | | |
| a. Conditioned Play Audiometry (CPA) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| b. Visual Reinforcement Audiometry (VRA) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 7. Conducts and understands results of (C7): | | | | | | |
| a. Tympanometry | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| b. High frequency tympanometry | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| c. Acoustic reflex testing | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| d. Acoustic reflex decay testing | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8. Utilizes time efficiently | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 9. Modifies techniques for special populations (A9) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 10. Ability to interpret test results (C6,C7,C10) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Comments:

| COUNSELING | 5 | 4 | 3 | 2 | 1 | N/A |
|---|---|---|---|---|---|---|
| 1. Interprets results to establish type and severity of loss (C6,C7,C10) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Develops and implements treatment using appropriate data (A9.B6) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Develops culturally sensitive/age appropriate management (A9,D2) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Effectively explains audiogram to patient (A29) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Communicates results, recommendations, | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| & progress (A26,C10,C11,D2) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6. Effectively counsels patient/family on results and treatment (A29,D2) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 7. Establishes a trusting relationship with clients & families (A26) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8. Understands emotional reactions to diagnosis of hearing impairment & uses counseling techniques to support personal/family growth & acceptance (A9,A26,E1,E2) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 9. Demonstrates understanding of cultural/linguistic diversity (A9) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 10. Discusses prognosis and tx with appropriate individuals(B3,E3) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 11. Makes appropriate referrals (C11) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 12. Collaborates with relevant professionals as necessary (A29,D5) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 13. Serves as a patient/family advocate (E1,E2,E3) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Comments:

| SCREENING & CONSERVATION | 5 | 4 | 3 | 2 | 1 | N/A |
|---|---|---|---|---|---|---|
| 1. Identifies and screens at risk for hearing impairment (B1) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Screens for speech/language/communication function (B4) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Ability to perform pure tone screening (B1) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Ability to perform tympanometry screening (B1) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Administers conservation program (B1) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Comments:

| AMPLIFICATION/HEARING AIDS (D1) | 5 | 4 | 3 | 2 | 1 | N/A |
|---|---|---|---|---|---|---|
| 1. Conducts hearing aid evaluation (D2) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Selects and recommends appropriate amplification (D2) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Ability to make an earmold impression | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Orders appropriate earmolds | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Earmold fitting and modifications | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6. Correctly programs and fits amplification | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 7. Provides amplification orientation (D2) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8. Hearing aid troubleshooting skills | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 9. Electroacoustical analysis of hearing aids | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 10. Conducts real-ear measures (D7,F1,F2,F3) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 11. Hearing aid sound field measures (D7,F1) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 12. Assess amplification system – | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| subjective/behavioral (F1) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Comments:

| AUDIOLOGIC REHABILITATION (C10) | 5 | 4 | 3 | 2 | 1 | N/A |
|---|---|---|---|---|---|---|

***Pediatric***

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. Counsels parents on effects of child's hearing loss on academic, communication, and social development | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Assesses functional auditory skills using formal/informal procedures (C9 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Plans and conducts appropriate auditory -linguistic intervention (C9) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Applies knowledge of auditory development & speech acoustics | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Conducts family-centered intervention program (C9) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6. Administers & interprets formal/informal communication Assessments (C9) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 7. Determines child's potential use of residual hearing (C9) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8. Determines the benefit afforded by a sensory device | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

***Adults***

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. Administration and interpretation of: APHAB, COSI, HHIE, HHIA, Glasgow, SAC | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Plans and conducts a program in auditory training (C9) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Counsel adult and significant other on facts of hearing loss (A7) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Refers patients to the appropriate support organizations (C11) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Evaluates and documents effectiveness of AR services (C9,D6) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Comments:

| CALIBRATION/INSTUMENTATION | 5 | 4 | 3 | 2 | 1 | N/A |
|---|---|---|---|---|---|---|
| 1. Assesses and maintains equipment calibration (A25) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Uses instruments according to specs and recommendations (A24) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Comments:

| REPORT WRITING/DOCUMENTATION (A22) | 5 | 4 | 3 | 2 | 1 | N/A |
|---|---|---|---|---|---|---|
| 1. Pertinent history in concise and organized form (A9) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Uses appropriate format and grammar | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Accurately documents procedures, treatment and results (C10) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Documentation is culturally sensitive, understandable and professional | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Completes patient care documentation (C10) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6. Correctly completes billing forms | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Comments:

| ELECTROPHYSIOLOGIC TESTING | 5 | 4 | 3 | 2 | 1 | N/A |
|---|---|---|---|---|---|---|
| 1. Familiarity with equipment | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Instructions for OAEs | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Administration of OAEs (C7) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Interpretation of OAEs (C7) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Counseling/recommendations from results (A26,C11) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Instructions for ABR | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6. Administration of ABR (C5) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 7. Interpretation of ABR (C5) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8. Counseling/recommendation from results (A26,C11) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Comments:

| VESTIBULAR ASSESSMENT | 5 | 4 | 3 | 2 | 1 | N/A |
|---|---|---|---|---|---|---|
| 1. Familiarity with equipment | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. ENG/VNG testing techniques (C6) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Interpretation of ENG/VNG (C6) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Knowledge of all other vestibular measures and treatment | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Determines appropriate vestibular rehabilitation (D3) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6. Utilizes time efficiently | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 7. Appropriate counseling (A26,C11) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Comments:

| COCHLEAR IMPLANTS | 5 | 4 | 3 | 2 | 1 | N/A |
|---|---|---|---|---|---|---|
| 1. Knowledge of candidacy guidelines (D2) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Explanation of device, surgery and follow-up (D2) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 3. Professional relationship with the implant team (A29) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Choosing processing strategy | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Creating a MAP (D2) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6. Adjusting a MAP (D2) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 7. Explaining the proper use and care (D2) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8. Troubleshoot device failures | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 9. Appropriate counseling (A26,D2) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Comments:

| AUDITORY PROCESSING | 5 | 4 | 3 | 2 | 1 | N/A |
|---|---|---|---|---|---|---|
| 1. Instructions and selects appropriate tests (C8) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Administration (C8) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Interpretation (C8) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Counseling and recommendations (A26) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Comments:

**ADDITIONAL COMMENTS (please attach a separate sheet if necessary):**

_____ _____

Supervisor Signature/Date Student Extern Signature/Date

## Appendix H: ASHA Code of Ethics

(Please refer to http://www.asha.org/uploadedFiles/ET2010-00309.pdf for the most current version of the Code of Ethics.)

American Speech-Language-Hearing Association. (2010). *Code of Ethics* [Ethics].

Available from www.asha.org/policy.
Index terms: ethics
doi:10.1044/policy.ET2010-00309
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**Preamble** The preservation of the highest standards of integrity and ethical principles is vital to the responsible discharge of obligations by speech-language pathologists, audiologists, and speech, language, and hearing scientists. This Code of Ethics sets forth the fundamental principles and rules considered essential to this purpose. Every individual who is (a) a member of the American Speech-Language-Hearing Association, whether certified or not, (b) a nonmember holding the Certificate of Clinical Competence from the Association, (c) an applicant for membership or certification, or (d) a Clinical Fellow seeking to fulfill standards for certification shall abide by this Code of Ethics. Any violation of the spirit and purpose of this Code shall be considered unethical. Failure to specify any particular responsibility or practice in this Code of Ethics shall not be construed as denial of the existence of such responsibilities or practices. The fundamentals of ethical conduct are described by Principles of Ethics and by Rules of Ethics as they relate to the responsibility to persons served, the public, speech-language pathologists, audiologists, and speech, language, and hearing scientists, and to the conduct of research and scholarly activities. Principles of Ethics, aspirational and inspirational in nature, form the underlying moral basis for the Code of Ethics. Individuals shall observe these principles as affirmative obligations under all conditions of professional activity. Rules of Ethics are specific statements of minimally acceptable professional conduct or of prohibitions and are applicable to all individuals.

## 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, and they shall treat animals involved in research in a humane manner.

## Rules of Ethics

A. Individuals shall provide all services competently.
B. Individuals shall use every resource, including referral when appropriate, to ensure that high-quality service is provided.
C. Individuals shall not discriminate in the delivery of professional services or the conduct of research and scholarly activities on the basis of race or ethnicity, gender, gender identity/gender expression, age, religion, national origin, sexual orientation, or disability.

D. Individuals shall not misrepresent the credentials of assistants, technicians, support personnel, students, Clinical Fellows, or any others under their supervision, and they shall inform those they serve professionally of the name and professional credentials of persons providing services.
E. Individuals who hold the Certificate of Clinical Competence shall not delegate tasks that require the unique skills, knowledge, and judgment that are within the scope of their profession to assistants, technicians, support personnel, or any nonprofessionals over whom they have supervisory responsibility.
F. Individuals who hold the Certificate of Clinical Competence may delegate tasks related to provision of clinical services to assistants, technicians, support personnel, or any other persons only if those services are appropriately supervised, realizing that the responsibility for client welfare remains with the certified individual.
G. Individuals who hold the Certificate of Clinical Competence may delegate tasks related to provision of clinical services that require the unique skills, knowledge, and judgment that are within the scope of practice of their profession to students only if those services are appropriately supervised. The responsibility for client welfare remains with the certified individual.
H. Individuals shall fully inform the persons they serve of the nature and possible effects of services rendered and products dispensed, and they shall inform participants in research about the possible effects of their participation in research conducted.
I. Individuals shall evaluate the effectiveness of services rendered and of products dispensed, and they shall provide services or dispense products only when benefit can reasonably be expected.
J. Individuals shall not guarantee the results of any treatment or procedure, directly or by implication; however, they may make a reasonable statement of prognosis.
K. Individuals shall not provide clinical services solely by correspondence.
L. Individuals may practice by telecommunication (e.g., telehealth/e-health), where not prohibited by law.
M. Individuals shall adequately maintain and appropriately secure records of professional services rendered, research and scholarly activities conducted, and products dispensed, and they shall allow access to these records only when authorized or when required by law.
N. Individuals shall not reveal, without authorization, any professional or personal information about identified persons served professionally or identified participants involved in research and scholarly activities unless doing so is necessary to protect the welfare of the person or of the community or is otherwise required by law.
O. Individuals shall not charge for services not rendered, nor shall they misrepresent services rendered, products dispensed, or research and scholarly activities conducted.
P. Individuals shall enroll and include persons as participants in research or teaching demonstrations only if their participation is voluntary, without coercion, and with their informed consent.
Q. Individuals whose professional services are adversely affected by substance abuse or other health-related conditions shall seek professional assistance and, where appropriate, withdraw from the affected areas of practice.
R. Individuals shall not discontinue service to those they are serving without providing reasonable notice.

## 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 shall engage in the provision of clinical services only when they hold the appropriate Certificate of Clinical Competence or when they are in the certification process and are supervised by an individual who holds the appropriate Certificate of Clinical Competence.
B. Individuals shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their level of education, training, and experience.
C. Individuals shall engage in lifelong learning to maintain and enhance professional competence and performance.
D. Individuals shall not require or permit their professional staff to provide services or conduct research activities that exceed the staff member's competence, level of education, training, and experience.
E. Individuals shall ensure that all equipment used to provide services or to conduct research and scholarly activities is in proper working order and is properly calibrated.

## Principle of Ethics III

Individuals shall honor their responsibility to the public by promoting public understanding of the professions, by supporting the development of services designed to fulfill the unmet needs of the public, and by providing accurate information in all communications involving any aspect of the professions, including the dissemination of research findings and scholarly activities, and the promotion, marketing, and advertising of products and services.

## Rules of Ethics

A. Individuals shall not misrepresent their credentials, competence, education, training, experience, or scholarly or research contributions.
B. Individuals shall not participate in professional activities that constitute a conflict of interest.
C. Individuals shall refer those served professionally solely on the basis of the interest of those being referred and not on any personal interest, financial or otherwise.
D. Individuals shall not misrepresent research, diagnostic information, services rendered, results of services rendered, products dispensed, or the effects of products dispensed.
E. Individuals shall not defraud or engage in any scheme to defraud in connection with obtaining payment, reimbursement, or grants for services rendered, research conducted, or products dispensed.
F. Individuals' statements to the public shall provide accurate information about the nature and management of communication disorders, about the professions, about professional services, about products for sale, and about research and scholarly activities.
G. Individuals' statements to the public when advertising, announcing, and marketing their professional services; reporting research results; and promoting products shall adhere to professional standards and shall not contain misrepresentations.

## Principle of Ethics IV

Individuals shall honor their responsibilities to the professions and their relationships with colleagues, students, and members of other professions and disciplines.

## Rules of Ethics

A. Individuals shall uphold the dignity and autonomy of the professions, maintain harmonious interprofessional and intraprofessional relationships, and accept the professions' self-imposed standards.
B. Individuals shall prohibit anyone under their supervision from engaging in any practice that violates the Code of Ethics.

C. Individuals shall not engage in dishonesty, fraud, deceit, or misrepresentation.
D. Individuals shall not engage in any form of unlawful harassment, including sexual harassment or power abuse.
E. Individuals shall not engage in any other form of conduct that adversely reflects on the professions or on the individual's fitness to serve persons professionally.
F. Individuals shall not engage in sexual activities with clients, students, or research participants over whom they exercise professional authority or power.
G. Individuals shall assign credit only to those who have contributed to a publication, presentation, or product. Credit shall be assigned in proportion to the contribution and only with the contributor's consent.
H. Individuals shall reference the source when using other persons' ideas, research, presentations, or products in written, oral, or any other media presentation or summary.
I. Individuals' statements to colleagues about professional services, research results, and products shall adhere to prevailing professional standards and shall contain no misrepresentations.
J. Individuals shall not provide professional services without exercising independent professional judgment, regardless of referral source or prescription.
K. Individuals shall not discriminate in their relationships with colleagues, students, and members of other professions and disciplines on the basis of race or ethnicity, gender, gender identity/gender expression, age, religion, national origin, sexual orientation, or disability.
L. Individuals shall not file or encourage others to file complaints that disregard or ignore facts that would disprove the allegation, nor should the Code of Ethics be used for personal reprisal, as a means of addressing personal animosity, or as a vehicle for retaliation.
M. Individuals who have reason to believe that the Code of Ethics has been violated shall inform the Board of Ethics.
N. Individuals shall comply fully with the policies of the Board of Ethics in its consideration and adjudication of complaints of violations of the Code of Ethics.

# Appendix D: 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.
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## About This Document

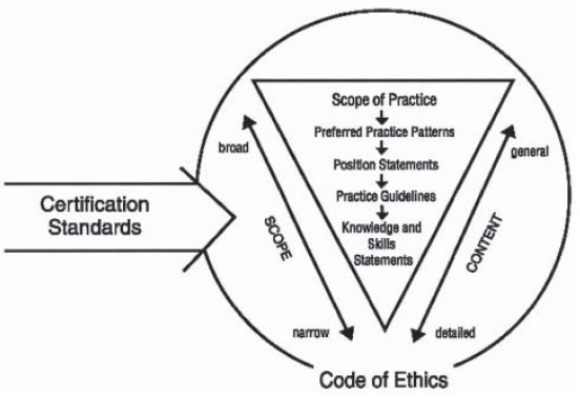
This scope of practice in audiology statement is an official policy of the American Speech-Language-Hearing Association (ASHA). The document was developed by the Coordinating Committee for the ASHA vice president for professional practices in audiology and approved in 2003 by the Legislative Council (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 access 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.

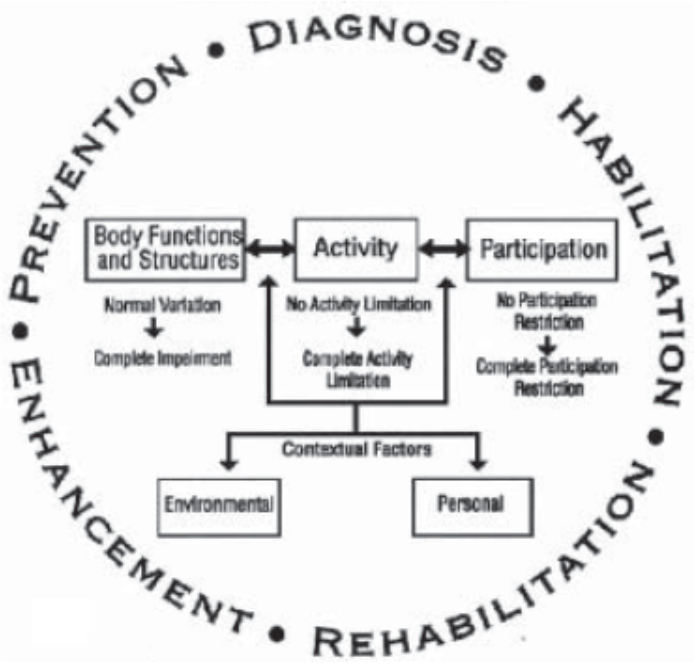
• **Personal Factors**: Personal Factors are the internal influences on an individual's functioning and disability and are not a part of the health condition. These factors may include but are not limited to age, gender, social
background, and profession.

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 psycho social 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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AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

# Appendix J: Application for the Certificate of Clinical Competence in Audiology – 2012 Standards

## APPLICATION FOR THE CERTIFICATE OF CLINICAL COMPETENCE IN AUDIOLOGY – 2012 STANDARDS

Instructions

1. Applicants applying within three years of graduation from a CAA-accredited program need to complete and submit the following:

- The four-page application form (pages 1–3 to be completed and signed by the applicant; page 4 to be completed and signed by the director of the graduate academic program, and must be the original page with the ASHA logo from the application (blank or altered copies will not be accepted). All four pages must be submitted together; partial applications will delay processing.
- An official graduate transcript which verifies the date and the doctoral degree awarded or a letter from the registrar verifying that all degree requirements have been met.
- Full payment in the form of a check or charge authorization. Charges accepted are Visa, MasterCard, or Discover.

Applicants applying more than three years after graduation from a CAA-accredited program need to complete and submit the following:

- The four-page application form (pages 1–3 to be completed and signed by the applicant; page 4 to be completed and signed by the director of the graduate academic program, and must be the original page with the ASHA logo from the application (blank or altered copies will not be accepted). All four pages must be submitted together; partial applications will delay processing.
- Official graduate and undergraduate transcripts showing all course work completed for certification and the dates and degrees awarded.
- Full payment in the form of a check or charge authorization. Charges accepted are Visa, MasterCard, or Discover.

2. Please complete the application form in black ink.

3. Applications must bear the original signatures of both the applicant and the director of the graduate academic program. Applications without original signatures are considered as incomplete and will delay the award of certification.

4. Please make and retain copies of all documents prior to submitting them to the ASHA National Office. Copies of documents are not available once certification is awarded.

5. Please carefully review the application prior to submission to be certain that all sections

have been completed. Incomplete applications will be returned to the applicant.

6. All applications and payments must be sent to the PO Box address as listed on the top of the application form.

Application processing time is approximately 4 to 6 weeks from the date all required materials are received.

AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

For Internal Use Only

Account #_____
Most Recent CCC Date___/____/____
Expiration Date_____/_____/
_____

American Speech-Language-Hearing Association
PO Box 1160 #313, Rockville, MD 20849

# APPLICATION FOR CERTIFICATION AND MEMBERSHIP 2012 AUDIOLOGY STANDARDS

Please read all application instructions before completing and submitting this form.
ALL sections must be completed and original signatures must appear on the application.
Please be sure that you are using the appropriate application for the standards under which you wish to apply.

## I. BACKGROUND INFORMATION (Sections 1-5) (1) Personal Information

Ms
Mrs
Miss
Dr

Name: _____

Mailing Address: _____

_____
City State Zip

Social Security Number: _____

Daytime phone number: _____ Evening phone number: _____

E-mail address: _____ Fax number: _____

(2) Application Category

I am applying for (Please [v] the appropriate category): [ ] Membership and Certification in Audiology

[ ] Certification in Audiology (without Membership)

My present affiliation with ASHA is (Please [v] the appropriate category):

[ ] None [ ] ASHA Member only

[ ] NSSLHA Member (NSSLHA Account Number _____)

[ ] ASHA Certified Member in Speech [ ] ASHA Certificate Holder in Speech

I am a former member of ASHA [ ] Yes [ ] No

I am a former ASHA certificate hold er [ ] Yes [ ] No

I am a former applicant for membership and/or certification [ ] Yes [ ] No

(3) Education – Official transcripts, or a letter from the registrar verifying the graduate degree, must be submitted by all applicants.

AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

For Internal Use Only

| Institution Code (See appendix) | Education Began Mo Yr | Education Completed Mo Yr | Institution Name | Major | Date Degree Awarded | Degre |
|---|---|---|---|---|---|---|
| Ex. R0291 | 08 2009 | 05 2012 | University, USA | Audiology | 06/12/2012 | AuD |
| | | | | | | |
| | | | | | | |
| | | | | | | |

American Speech-Language-Hearing Association
PO Box 1160 #313, Rockville, MD 20849

Name of Applicant: _____
(Please print)

(4) Examination Information

I have taken and passed the Praxis Series examination in audiology and have listed ASHA as a score recipient
(Please [v] the appropriate response): [ ] yes [ ] No Note: Only scores received

1. Have you ever been convicted; been found guilty; or entered a plea of guilty or nolo contendere to
a. any misdemeanor involving dishonesty, physical harm to the person or property of another, or a threat of physical harm to the person or property of another or
b. any felony?

Check one [ ] Yes [ ] No

If yes, explain fully, including the nature and date of the offense(s); your age at time of conviction or plea; whether incarceration, fine, or probation was imposed; rehabilitation; and any other relevant factors that you would like ASHA to consider. Please submit a certified copy of court record or docket entry of the finding, conviction, and/or plea, or, if applicable, a certified copy from a governmental agency(s) that includes the pleas and/or convictions and demonstrates remediation. If the offense has been sealed or expunged by a court or agency, submit a certified document to that effect. Please use a separate piece of paper if necessary.

_____

_____

Note: Checking yes to any of the above will not automatically preclude certification and/or membership. All relevant factors will be considered. An applicant may file with ASHA, at any time, a certificate demonstrating that the underlying finding, plea, or judgment of conviction has been modified, reversed, vacated, or set aside (on appeal).

2. Are you presently indicted on or charged with (a) one or more misdemeanors involving dishonesty, physical harm to the person or property of another, or threat of physical harm to the person or property of another; or (b) one or more felonies?

Check one [ ] Yes [ ] No

If yes, explain fully, including the nature and date of the alleged offense(s), the court of jurisdiction where the indictment(s) or charges are pending, and any other relevant factors that you would like ASHA to consider. Please use a separate piece of paper if necessary.

_____

_____

Note: Checking yes to the question above will not automatically preclude certification and/or membership. All relevant factors will be considered. An applicant may file with ASHA, at any time, a certificate demonstrating that the indictment(s) or charge(s) have been dismissed or otherwise resolved.

Name of Applicant: _____
(Please print)

3. Have you ever been disciplined or sanctioned, other than for insufficient professional or continuing education, by any professional association, professional licensing authority or board, or other professional regulatory body?

Check one [ ] Yes [ ] No

If yes, explain fully, including the nature and date of the offense(s); rehabilitation; restitution; and any other relevant factors that you would like ASHA to consider. Please submit a certified copy of documentation from the professional agency(s) that includes the discipline or sanctions imposed and demonstrates, if applicable, remediation. Please use a separate piece of paper if necessary.

_____

_____

Note: Checking yes to the question above will not automatically preclude certification and/or membership. All relevant factors will be considered. An applicant may file with ASHA, at any time, a certificate demonstrating that the underlying finding, discipline, or sanction has been modified, reversed, vacated, or set aside.

II. Affidavits (Section 6)

A. I affirm that all of the information provided on this application is true and accurate and fully responsive to the questions asked.
B. I have read and agree to abide by the Code of Ethics of the American Speech-Language-Hearing Association.
C. I agree to abide by all standards required to maintain my certification, including payment of annual fees and participation in continuing professional development activities, and I understand that, once certified, my certification status may be made available to the public.

Signature: _____ Date: _____

American Speech-Language-Hearing Association
PO Box 1160 #313, Rockville, MD 20849

Name of Applicant: _____
(Please print)

## 2012 Standards for Clinical Certification in Audiology
## Verification by Program Director

Please respond to each question. The applicant must have met each standard in order to apply for certification.

The applicant has:

| | | |
|---|---|---|
| o Yes | o No | Completed a course of study that addresses the knowledge and skills necessary to independently practice in the profession of audiology. (Std. I) |
| o Yes | o No | Been granted a doctoral degree from a program accredited by the Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA). (Std. II) |
| o Yes | o No | Completed a course of study that includes academic course work and a minimum of 1,820 hours of supervised clinical practicum sufficient in depth and breadth to achieve knowledge and skills outcomes stipulated in Standard IV. Supervision was provided by individuals who held the ASHA Certificate of Clinical Competence (CCC) in Audiology. (Std. III) |
| o Yes | o No | Knowledge delineated in Foundations of Practice (Std. IV. A1-A21) |
| o Yes | o No | Knowledge and skills delineated in Foundations of Practice (Std. IV. A22-29) |
| o Yes | o No | Knowledge and skills delineated in Prevention and Identification (Std. IV. B1-B6) |
| o Yes | o No | Knowledge delineated in Assessment (Std. IV. C1) |
| o Yes | o No | Knowledge and skills delineated in Assessment (Std. IV. C2-C11) |
| o Yes | o No | Knowledge and skills delineated in Intervention (Treatment) (Std. IV. D1-D7) |
| o Yes | o No | Knowledge and skills delineated in Advocacy/Consultation (Std. IV. E1-E3) |
| o Yes | o No | Knowledge and skills delineated in Education/Research/Administration (Std. IV. F1-F6) |
| o Yes | o No | Met the education program's requirements for demonstrating satisfactory performance through ongoing formative assessment of knowledge and skills. (Std. V-A) |

The program director or designee verifies that the student met each standard and has successfully met the education program's requirements.

Name of Program Director _____ Title _____

Signature _____ Date _____

Date coursework and clinical practicum requirements for ASHA certification were completed _____