South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of Examiners in Speech-Language Pathology and Audiology
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SPEECH-LANGUAGE PATHOLOGY ASSISTANT QUARTERLY EVALUATION REPORT

This form is in a fillable pdf format. The form should be downloaded and saved before completion.

If audited, this completed evaluation report along with Audit form should be uploaded to Document Submission: https://eservice.llr.sc.gov/DocumentSubmission/.

QUARTERLY REVIEWS

In addition to direct and indirect supervision, the supervising speech-language pathologist must conduct quarterly performance reviews of each service or task conducted by the speech-language pathology assistant and directly observed by the supervising speech-language pathologist. A quarterly review must be completed for each quarter of supervision through the last date of employment.

SPEECH-LANGUAGE PATHOLOGIST ASSISTANT INFORMATION

Name: _____ License Number: _____
Please Print

Employment Status:

☐ Full-time (minimum of 30 hours per week) ☐ Part-time (less than 30 hours per week.)

Quarter for this report:

If supervision did not occur for the full quarter, please note below the start and end date of supervision during this quarter. Note that if any supervision occurred during the quarter, a Quarterly Evaluation Report must be completed (e.g. A supervision start date of March 28th – a report must be completed for Q1).

Please select the quarter for which this report is applicable:

☐ **1st Qtr** (01/01- 03/31) ☐ **2nd Qtr** (04/01- 06/30) ☐ **3rd Qtr** (07/01 – 09/30) ☐ **4th Qtr** (10/01 – 12/31)

Date supervision for this quarter began: _____ Date supervision for this quarter ended: _____

Practice Setting: (Check one)

☐ 01 Private Practice	☐ 07 Habilitation Facility	☐ 13 Outpatient Facility
☐ 02 Physician's Office	☐ 08 Home Health	☐ 14 Academic Facility
☐ 03 Hospital	☐ 09 Nursing Home	☐ 15 Military Setting
☐ 04 Public School	☐ 10 Other Government Facility	☐ 16 Hearing Aid Dealer or Franchise
☐ 05 Private School	☐ 11 Other Private Facility	☐ 17 Industrial Setting
☐ 06 Rehabilitation Facility	☐ 12 Unknown	☐ 18 Other: _____

SUPERVISOR INFORMATION

Name: _____ License Number: _____
Please Print

EMPLOYMENT INFORMATION

Name of Business: _____ Phone: _____

Business Address (No PO Box): _____

EVALUATION DATA

Rate the assistant on the following activities directly observed during this quarter, indicating if the performance was Below Standard, Achieves, Exceeds. Select N/A for each task not directly observed during this quarter.

Activities	**Rating** Below Standard, Achieves or Exceeds
Conducts speech-language screenings	Select One
Conducts hearing screenings	Select One
Implements evaluative or management programs or procedures planned/designed by the supervisor	Select One
Records/charts/graphs information relative to client performance	Select One
Maintains clinical records	Select One
Reports changes in client performance to supervisor	Select One
Prepares clinical materials	Select One
Tests equipment for performance	Select One
Participates in projects planned and directed by the supervisor	Select One

Signature of Supervisor: _____ Date: _____

Signature of Assistant: _____ Date: _____

Quarterly Evaluation Reports must be signed by both the supervising speech-language pathologist and the speech-language pathology assistant, must be maintained by the supervising speech-language pathologist for a period of four (4) years, and must be made available to the Board upon request.