



South Carolina Department of Labor, Licensing and Regulation

**South Carolina Board of Examiners in
Speech-Language Pathology and Audiology**

110 Centerview Dr. • Columbia • SC • 29210

P.O. Box 11329 • Columbia • SC 29211-1329

Phone: 803-896-4655 • Contact.Speech@llr.sc.gov • Fax: 803-896-4719

www.llr.sc.gov/POL/Speech/



**SPEECH-LANGUAGE PATHOLOGY ASSISTANT (SLPA)
REQUIREMENTS AND INSTRUCTIONS**

EDUCATION

- Applicant must have earned a bachelor's degree in Speech-Language Pathology from a regionally accredited institution that must include as a minimum core curriculum of 36 semester hours and not less than 100 clock hours of direct client contact/clinical practicum excluding observation hours. Official transcripts should be submitted directly to the SC SLP/A Board from the issuing institution.

SUPERVISION

- A Board approved Supervisor Agreement and On-the-Job Training Plan must be in place before a SLPA may begin working in direct contact with clients/patients.
- A SLPA may work part-time for more than one supervising speech-language pathologist if the board has approved the supervisor agreements and OJT Plans for each supervising speech-language pathologist.
- If you need to change or add a supervisor after you are approved for licensure, you must remit the Supervisor Agreement and OJT Plan along with a \$25 fee. The Supervisor Agreement and OJT Plan along with the fee should be mailed to the SC SLP/A Board at the above address.

Submit the following with your application:

- To transmit your application, submit the fee in the amount of \$50. Application fee is non-refundable. A returned check fee of up to \$30, or an amount specified by law, may be assessed on all returned funds.
- Upload a legible copy of your valid Driver's License, State Issued ID, Passport or Military ID
- Upload a legible copy of social security card
- Upload a 2x2 Passport Photo taken less than 6 months prior to the application
- Upload a legible copy of the signed Supervisor Agreement
- Upload a legible copy of the On-the-Job-Training Form

Have submitted directly from the issuing institution to the SC SLP/A Board at the above address:

- Official College Transcripts
- Clinical Clock Hour Report with school seal
- Out-of-State License Verification Form, if applicable



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**Summary of Clinical Clock Hours
Speech-Language Pathology Assistant - Undergraduate**

This document should be completed by the school, contain the school seal and be mailed directly to the SC SLP/A Board at the above address. Supporting documentation may be sent to the Board; however it must be attached to this completed form.

Student Name: _____

Date: _____

Observation Hours Completed: _____

Subtotal Speech Clinical Hours at Undergraduate Level: _____

Date of Undergraduate Practicum Completion: _____

EVALUATION

Semester:	1st	2nd	3rd	4th	5th	6th
Speech-Child						
Speech-Adult						
Language-Child						
Language Adult						
Related Disorders						

TREATMENT

Speech-Child						
Speech-Adult						
Language-Child						
Language Adult						
Related Disorders						

AUDIOLOGY						
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TOTAL HOURS						
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Clinical Supervisor Signature: _____

ASHA Number: _____

Program Director Signature: _____

ASHA Number: _____

School Seal (Required)



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**NOTARIZED SIGNATURE / PASSPORT PHOTO AFFIDAVIT
THIS FORM IS FOR USE WITH ELECTRONIC APPLICATIONS ONLY.**

I, _____, am the person described and identified and the person named in all documents presented in support of this application. I certify that I have never been convicted of violating any Federal, State, Municipal or other law, statute or ordinance, other than as disclosed as required within this application.

I have carefully read the questions within this application and have answered them completely, without reservations of any kind, and I declare that all statements made by me herein are true and correct to the best of my knowledge and belief.

Should I furnish any false, incomplete, or misleading information in this application, I hereby agree that such act shall constitute the cause for denial or revocation of my license in South Carolina.

Applicant's Signature: _____

Date: _____

Sworn to and subscribed me this _____ day of _____, 20__.

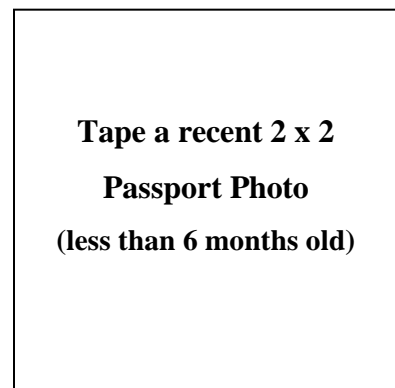
Notary Signature: _____

Print Notary Signature: _____

Notary Public for the State of: _____

Commission Expiration Date: _____

{Seal}



You can submit this page by either attaching it to the online application under the "Uploads" section OR by mailing this page to the Board.

Please note that any illegible documents will not be accepted. If your upload is found to be illegible you will be asked to mail in the supporting document.

SOUTH CAROLINA DEPARTMENT OF LABOR, LICENSING AND REGULATION
Board of Examiners in Speech-Language Pathology and Audiology

**SUPERVISORY AGREEMENT
 SPEECH-LANGUAGE PATHOLOGY ASSISTANT**

Applicant/Licensee Name	Social Security #	License #

Speech-Language Pathology Assistant

When applying for a license as an assistant, renewing that license or with a change in supervision, the licensed speech-language pathologist must submit a notarized statement accepting supervisory responsibilities. To be licensed and to practice as a speech-language pathology assistant, the speech-language pathology assistant must have a licensed supervisor. A speech-language pathology assistant may renew a license even though the assistant does not have a supervisor. However the assistant may not practice until a supervisor is obtained and a supervisory agreement is approved by the board office. Practice without a supervisor may result in disciplinary action. Assistants who are not supervised by a licensed speech-language pathologist must inform the board office immediately. When another supervisor and a completed, notarized supervisory agreement is accepted by the board office, a letter authorizing the resumption of practice will be sent to the licensee.

Supervisor

The following information and statement must be completed by each licensed supervisor on a separate form and submitted to the board office with application, renewal or change of supervision.

Supervisor Name	Title	Lic. #	Location	Soc. Security #
Company		Location		Setting
Mailing Address		City State Zip Code		Telephone

If supervisory responsibility is shared, please provide us with the name(s) of the other supervisor(s).

I UNDERSTAND THAT I AM RESPONSIBLE FOR THE SERVICES TO THE CLIENT THAT MAY BE PERFORMED BY THIS ASSISTANT AND THAT I MUST ENSURE THAT ALL SERVICES ARE IN COMPLIANCE WITH THE PRACTICE ACT. I ALSO UNDERSTAND THAT I MUST KEEP CURRENT JOB DESCRIPTIONS, ON-THE-JOB TRAINING, QUARTERLY REVIEW AND PERFORMANCE RECORDS. THESE RECORDS MUST BE MADE AVAILABLE TO THE BOARD WITHIN 15 DAYS OF THE DATE OF THE BOARD'S REQUEST FOR SUCH RECORDS. IF THIS SUPERVISORY RELATIONSHIP CHANGES, I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO IMMEDIATELY NOTIFY THE BOARD OFFICE IN WRITING.

 Supervisor's Signature

 Date

SWORN AND SUBSCRIBED BEFORE ME THIS _____ DAY OF _____, 200_____.

_____ MY COMMISSION EXPIRES _____.

(Affix Seal Here)

South Carolina Department of Labor, Licensing and Regulation
 Board of Examiner in Speech-Language Pathology and Audiology
Speech Language –Pathology Assistant (only)
 Projected On-The-Job-Training (OJT) Plan

Print clearly in black ink only or type the following information:

Applicant's Name: _____

Check one: Full time Part time

SUPERVISOR DATA: Name: _____ License Number: _____

Site Address: (Physical Location, P O. Box not acceptable)

Business Phone: _____

ACTIVITY/SUPERVISORY DATA:

(Note: The activity plan must comply with S.C. Ann Code 115-3(H)(I)

Activity to be Performed by Assistant	How Activity will be Taught/Supervised
1. Conduct speech-language or hearing screenings	___ Supervisor will model procedures/techniques for appropriate speech language and/or hearing screenings ___ Assistant will observe Supervisor and implement techniques learned ___ Supervisor will review and monitor and give feedback related to skills
2. Implements plan of care designed by the supervisor	___ Supervisor and Assistant will meet to review evaluate Plan of care for each client prior to start of services ___ Assistant will provide direct implementation as supervisor observes and provides feedback during weekly meetings ___ Co-treat and observe with clients to analyze progress as needed
3. Records information relative to clients performance	___ Supervisor will provide examples of adequate documentation for assistant to follow and monitor and observe weekly ___ Assistant will complete session record to document client performance for every session ___ Supervisor and Assistant will review and critique documentation for client performance and progress

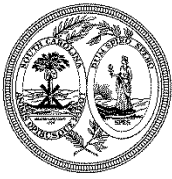
4. Maintain clinical records	<p>___ Supervisor will provide sample clinical records for assistant and provide feedback for proper procedure to meet internal and external compliance.</p> <p>___ Supervisor and Assistant will conduct periodic internal file audit.</p> <p>___ Supervisor and Assistant will review and critique documentation for compliance on a regular scheduled basis.</p>
5. Report changes in client performance to supervisor	<p>___ Supervisor and Assistant will conduct weekly conferences to discuss client changes in performance and progress.</p> <p>___ Assistant will contact Supervisor immediately following any change/s in client status</p>
6. Prepare clinical materials	<p>___ Assistant will observe Supervisor and assist the Supervisor in choosing clinical materials.</p> <p>___ Prepare materials as outlined in clients plan of care</p> <p>___ Assistant will review with Supervisor specific materials to be used with each client.</p>
7. Test equipment for performance	<p>___ Supervisor will provide appropriate in-service regarding all testing equipment.</p> <p>___ Assistant will independently test equipment as Supervisor observes and provides feedback.</p>
8. Participate in projects planned and directed by the supervisor	<p>___ Supervisor will review any planned projects with Assistant.</p> <p>___ Assistant will complete any duties related to project as Supervisor provides ongoing review and feedback</p> <p>___ Weekly, Monthly and Quarterly meetings will be held to review progress</p>
9. Other: Please list any additional plans you may wish to include.	

I affirm that the Assistant and Supervisor have reviewed the plan together and the South Carolina Ann. Code 115-3. I fully understand my responsibilities to the Assistant and to the Board as a Supervisor of the Speech Assistant.

I UNDERSTAND THAT I AM RESPONSIBLE FOR THE SERVICES TO THE CLIENT THAT MAY BE PERFORMED BY THE ASSISTANT AND THAT I MUST ENSURE THAT ALL SERVICES ARE IN COMPLIANCE WITH THE PRACTICE ACT. I ALSO UNDERSTAND THAT I MUST KEEP CURRENT TRAINING AND PERFORMANCE RECORDS. THESE RECORDS MUST BE MADE AVAILABLE TO THE BOARD WITHIN 15 DAYS OF THE DATE OF THE BOARD REQUEST FOR RECORDS. IF THIS SUPERVISORY RELATIONSHIP CHANGES, I UNDERSTAND THAT I MUST IMMEDIATELY NOTIFY THE BOARD OFFICE IN WRITING.

Supervisor Signature: _____ **Date:** _____

Applicant Signature: _____ **Date:** _____



STATE OF SOUTH CAROLINA
DEPARTMENT OF LABOR, LICENSING AND REGULATION
VERIFICATION OF LAWFUL PRESENCE IN THE UNITED STATES
AFFIDAVIT OF ELIGIBILITY



Pursuant to Section 8-29-10, *et seq.* of the South Carolina Code of Laws (1976, as amended), the Department of Labor, Licensing and Regulation must verify that any person who applies for a South Carolina license is lawfully present in the United States. Complete and sign this affidavit of eligibility. The information provided is subject to verification.

Section A: LAWFUL PRESENCE in the United States.

The undersigned _____, of _____
(Print clearly First, Middle, and Last name) (Home Address, City, State, and Zip Code)
being first duly sworn deposes and states as follows:

Check only one box:

1. I am a United States citizen; or

2. I am a Legal Permanent Resident of the United States eighteen years of age or older; or

3. I am a Qualified Alien or non-immigrant under the Federal Immigration and Nationality Act, Public Law 82-414, eighteen years of age or older, and lawfully present in the United States.

4. Other: _____ Please submit any documentation that supports this status.

Date of Birth: _____

Alien Number: _____ I-94 Number: _____

(If you checked number 2, 3, or 4 you must attach a copy of your immigration documents. See instruction sheet for a list of accepted immigration documents.)

Section B: ATTESTATION.

I understand that in accordance with section 8-29-10 of the South Carolina Code of Laws, a person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall, in addition to other sanctions imposed by this State or the United States, be guilty of a felony, and upon conviction must be fined and/or imprisoned for not more than 5 years (or both).

I understand that the representations made in this Affidavit shall apply through any license(s) or renewals issued, and that I shall have an affirmative duty to immediately advise the Department of Labor, Licensing and Regulation of any change of my immigration or citizenship status.

I swear and attest the information contained herein is true and correct to the best of my knowledge. I understand that under South Carolina law, providing false information is grounds for denial, suspension, or revocation of a license, certificate, registration or permit.

Signature of Affiant

SWORN to before me this _____ day of _____, 20____

Notary Signature

Print Name

Notary Public for _____

My Commission Expires: _____

INSTRUCTION SHEET FOR COMPLETING AFFIDAVIT OF ELIGIBILITY

CHECK box 1:

If you are a United States Citizen by birth or naturalization

CHECK box 2:

If you are a Legal Permanent Resident and you are not a U.S. Citizen, but are residing in the U.S. under legally recognized and lawfully recorded permanent residence as an immigrant.

PROVIDE A COPY OF ALL IMMIGRATION DOCUMENTS.

CHECK box 3:

If you are a Qualified Alien. You are a Qualified Alien if you are:

An alien who is lawfully admitted for residence under the INA.

An alien who is granted asylum under Section 208 of the INA.

A refugee who is admitted to the United States under Section 207 of the INA.

An alien who is paroled into the United States under Section 212(d)(5) of the INA for a period of at least 1 year.

An alien whose deportation is being withheld under Section 243(h) of the INA (as in effect prior to April 1, 1997) or whose removal has been withheld under Section 241(b)(3).

An alien who is granted conditional entry pursuant to Section 203(a)(7) of the INA as in effect prior to April 1, 1980.

An alien who is a Cuban/Haitian Entrant as defined by Section 501(e) of the Refugee Education Assistance Act of 1980.

An alien who has been battered or subjected to extreme cruelty, or whose child or parent has been battered or subject to extreme cruelty.

PROVIDE A COPY OF ALL IMMIGRATION DOCUMENTS.

ACCEPTED IMMIGRATION DOCUMENTS:

Unexpired Reentry Permit (I-327)

Permanent Resident Card or Alien Registration Receipt Card With Photograph (I-551)

Unexpired Refugee Travel Document (I-571)

Unexpired Employment Authorization Card Which Contains a Photograph (I-766)

Machine Readable Immigrant Visa (with Temporary I-551 Language)

Temporary I-551 Stamp (on passport or I-94)

I-94 (Arrival/Departure Record) in Unexpired Foreign Passport

I-20 (Certificate of Eligibility for Nonimmigrant, F-1, Student Status)

DS2019 (Certificate of Eligibility for Exchange Visitor, J-1, Status)