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
llr.sc.gov/aud

SPEECH-LANGUAGE PATHOLOGY ASSISTANT (SLPA) REQUIREMENTS AND INSTRUCTIONS

EDUCATION

An 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 as set forth in SC Regulation 115-2(B). Official transcripts should be submitted directly to the Board from the issuing institution.

SUPERVISED CLINICAL EXPERIENCE

An applicant must have supervised clinical experience consisting of 100 hours of clinical fieldwork before a speech-language pathology assistant license can be issued by the Board. There are four ways to meet this requirement in accordance with SC Regulation 115-2(C):

1. **Academic program**
   The 100 hours supervised clinical experience may be obtained as part of an academic program that is acceptable to the Board. You must have the educational institution submit directly to the Board an official transcript along with a completed Summary of Clinical Clock Hours (Academic Program) form.

2. **On-the-job training/work program completed in another state**
   The 100 hours supervised clinical experience may be obtained through an on-the-job training/work program completed in another state in accordance with that state's law. You must have the appropriate state licensing authority verify with the Board that this requirement has been met, or have your former employer submit directly to the Board a completed Summary of Clinical Clock Hours (OJT/Work Program Completed in Another State) form.

3. **ASHA Speech-Language Pathology Assistant Certification**
   The 100 hours supervised clinical experience may be obtained in conjunction with obtaining an ASHA Speech-Language Pathology Assistant Certification. You must have ASHA provide the Board with your ASHA Speech-Language Pathology Assistant Certification as proof that this requirement has been met.

4. **Complete a Board-approved Supervised Clinical Experience**
   If you have not completed 100 hours supervised clinical experience in accordance with #1 or #2 above, you may apply to the Board to obtain the 100 hours under the supervision of a South Carolina licensed speech language pathologist ("SLP"). The 100 hours of supervised clinical fieldwork must be completed as part of this plan and cannot be combined with any other clinical clock hours that may have been obtained as part of an academic program or in compliance with the law of another state. The supervised clinical experience must be completed in four consecutive months from the date that the registration is issued indicating that the Board has approved the plan. If not completed within four months, the SCER must submit a new plan to be approved by the Board.

   To apply for the Board-approved Supervised Clinical Experience, you must submit a completed **SCER Supervisor Agreement and SCER On-the-Job Training Plan Form** (These forms are not the same Supervisor Agreement and OJT Plan that is required for licensure as an SLPA.) These forms should be submitted along with the completed SLPA application. **Please note however that you are not authorized to begin the Supervised Clinical Experience until you receive approval from the Board**. Please see instruction for the "SCER Process" (Applicants that do not have the 100 clinical practice hours in accordance with SC Reg 115-2).

SUPERVISION FOR ASSISANT LICENSE

- A Board approved **Supervisor Agreement** and **On-the-Job Training Plan (SLPA Supervisor Agreement & On-the-Job-Training Form)** 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.

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APPLICATION FOR SPEECH-LANGUAGE PATHOLOGY ASSISTANT LICENSE

Submit the following with your application to the above address:

- Check or Money Order in the amount of $40 made payable to SCBSLP/A. 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.
- Copy of your valid Driver's License, State Issued ID, Passport or Military ID
- Copy of social security card
- 2x2 Passport Photo taken less than 6 months prior to the application
- SLPA Supervisor Agreement & On-the-Job-Training Form (required, attached)
- Notarized Verification of Lawful Presence

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

- Official College Transcripts
- Summary of Clinical Clock Hour (Academic Program) with school seal, if applicable
- Summary of OJT/Work Program Completed in Another State, if applicable
- Out-of-State License Verification Form, if applicable
- ASHA Speech-Language Pathology Assistant Certification, if applicable

APPLICANT INFORMATION:

Full Name: _____ Maiden/Prior: _____

Have you ever legally changed your name? ☐ Yes ☐ No If yes, submit legal documentation supporting the change.

Home Address: _____ City:_____ State:____ Zip:_____

Mailing Address: _____ City:_____ State:____ Zip:_____
(If different than above)

Phone: _____ Social Security No.: _____

Date of Birth: _____ Email Address (Required): _____

Race (for statistical purposes only): _____ Gender: ☐ Female ☐ Male

SLPA EMPLOYMENT (if known):

Company Name: _____ Start Date: _____

Position Title: _____ Telephone: _____ Setting: _____

Location (Site) Address: _____
(Must be physical location – no PO BOX)

EMPLOYMENT SETTINGS

Type	Description	Type	Description	Type	Description
1	Private Practice	7	Habilitation Facility	13	Out-Patient Facility
2	Physician's Office	8	Home Health	14	Academic Setting
3	Hospital	9	Nursing Home	15	Military Setting
4	Public School	10	Other Government Facility	16	Hearing Aid Dealer or Franchiser
5	Private School	11	Other Private Facility		
6	Rehabilitation Facility	12	Unknown	17	Industrial Setting

EMPLOYMENT HISTORY:
List your previous SLPA employment history; attach additional sheet if necessary.

Employer	Site Location City, State	Dates

EDUCATION:

Contact your college and have your official transcripts submitted directly to the SC SLP/A Board at the address on the front of this application or via email: contact.speech@llr.sc.gov . Your transcripts must list out the minimum required courses outlined for licensure as a SC Speech-Language Pathology Assistant.

College:

School: _____ Degree: _____ Date Degree Awarded: _____

School: _____ Degree: _____ Date Degree Awarded: _____

SUPERVISED CLINICAL EXPERIENCE:
Have you completed a supervised clinical experience consisting of 100 hours of clinical fieldwork? (check the appropriate answer)

☐ Yes, I have completed the supervised clinical experience as part of an academic program. Provide the name of the academic program: _____

☐ Yes, I have completed the supervised clinical experience as part of on-the-job training work program in another state in accordance with that state's laws. Provide the name of the state and the former employer.

State: _____ Former Employer: _____

☐ Yes, I have completed the supervised clinical experience in conjunction with obtaining an ASHA Speech-Language Pathology Assistant Certification. Provide date of certification: _____

☐ No, I do not yet have supervised clinical experience and am applying to the Board to complete a Board-approved Supervised Clinical Experience.

OTHER PROFESSIONAL LICENSES:

List all states in which you have been licensed in; regardless of status: Active, Inactive, Expired, etc. You are required to contact each State Board and request a license verification to be sent directly to our Board via mail or email to: contact.speech@llr.sc.gov. We will accept a state board issued form. Attach additional sheet if necessary.

State	License Type	License No.	Status of License (Active, Lapsed, Disciplined, etc)

PERSONAL HISTORY:

Answer all the questions below; you are required to include a written statement with your application for any questions marked "Yes". If you answer "Yes" to a conviction, you will need to have the court mail directly to our office the disposition and you will need to have a Statewide Background check mailed in directly from the law enforcement agency.

1. Have you ever had any application for any professional license, certification, or registration refused or denied by any licensing authority? ☐ YES ☐ NO

2. Have you ever had any written complaint, formal accusation, final order, disciplinary action, sanction or consent order filed against you by any person, jurisdiction, licensing authority, or professional association? ☐ YES ☐ NO

3. Is any complaint currently pending or under investigation or has any action been taken against your license in any jurisdiction? ☐ YES ☐ NO

4. Have you ever resigned from professional employment or voluntarily surrendered your license in lieu of disciplinary action in any jurisdiction? ☐ YES ☐ NO

5. Currently or within the last two years, have you developed or been treated for any physical, mental, or emotional condition or drug or alcohol addiction that might interfere with your ability to competently and safely perform the essential functions of the practice of speech pathology or audiology? ☐ YES ☐ NO

6. Have you ever been convicted, pled guilty or pled nolo contendere for violation of any federal, state, or local law (you may exclude minor traffic violations, juvenile and/or expunged violations)? If yes, you will need to submit a court disposition and any other legal documentation. ☐ YES ☐ NO

CERTIFYING STATEMENT:

I, _____, am the person described and identified, of good moral character, 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 statue 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 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 and subscribed before me this _____ day of _____ , 20_____.

Notary Signature: _____ *(SEAL)*

Print Notary Name: _____

Notary Public for the State of: _____

Commission Expiration Date: _____

Attach a recent full-face 2" x 2" color photo

No copies

Do not staple

PRIVACY DISCLOSURE:

South Carolina Law requires that every individual who applies for an occupational or professional license provide a social security number for use in the establishment, enforcement and collection of child support obligations and for reporting to certain databanks established by law. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Social security numbers may also be disclosed to other governmental regulatory agencies and for identification purposes to testing providers and organizations involved in professional regulation. Your social security number will not be released for any other purpose not provided for by law.

Other personal information collected by the Department for the licensing boards it administers is limited to such personal information as is necessary to fulfill a legitimate public purpose. The South Carolina Freedom of Information Act ensures that the public has a right to access appropriate records and information possessed by a government agency. Therefore, some personal information on the application may be subject to public scrutiny or release. The Department collects and disseminates personal information in compliance with The South Carolina Freedom of Information Act, the South Carolina Family Privacy Protection Act, and other applicable privacy laws and regulations. Additionally, the Department shares certain information on the application with other governmental agencies for various governmental purposes, including research and statistical services.

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: _____

Rev: 02-02-2015

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)

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SUPERVISOR AGREEMENT AND PROJECTED ON-THE-JOB-TRAINING FOR SPEECH-LANGUAGE PATHOLOGY ASSISTANTS (Required Form)

If submitting this form with an initial application, no additional fee is needed.

If submitting this form after licensure in order to add or change your supervisor, log into https://eservice.llr.sc.gov/DocumentSubmission, upload form, and pay the $25 fee.

Application Type:

☐ New Applicant (no fee needed) ☐ Add a Supervisor ($25 fee) ☐ Change a Supervisor ($25 Fee)

Employment Type:

☐ Full-Time Position ☐ Part-Time Position

APPLICANT/ ASSISTANT INFORMATION

Name: _____ Phone: _____

Last 5 digits of social: _____ License Number: _____ (If applicable)

SUPERVISOR INFORMATION

Name: _____ Title: _____

License Number (Required): _____ Phone: _____

Number of SLP Assistants Currently Supervising: **Full-Time:** _____ **Part-Time:** _____

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

Name: _____ License No.:_____ Name: _____ License No.:_____

EMPLOYMENT INFORMATION

Company: _____ Phone: _____

Physical Location (No PO Boxes, include city, state, zip): _____

Mailing Address (if different): _____ (Include City, State and Zip code)

Proposed Start Date: _____ Setting (See below): _____

Type	Description	Type	Description	Type	Description
1	Private Practice	7	Habilitation Facility	13	Out-Patient Facility
2	Physician's Office	8	Home Health	14	Academic Setting
3	Hospital	9	Nursing Home	15	Military Setting
4	Public School	10	Other Government Facility	16	Hearing Aid Dealer or Franchiser
5	Private School	11	Other Private Facility		
6	Rehabilitation Facility	12	Unknown	17	Industrial Setting

ON-THE-JOB TRAINING AND SUPERVISION:
Note: The activity plan must comply with Regulation 115-(2)(E) and (F)

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, monitor and give feedback related to skills.
2. Implements plan of care designed by the supervisor	• Supervisor and Assistant will meet to review and 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 client performance	• Supervisor will provide examples of adequate documentation for Assistant to follow, 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	• Supervisor will provide sample clinical records for Assistant and provide feedback for proper procedure to meet internal and external compliance. • Supervisor and Assistant will conduct periodic internal file audit. • Supervisor and Assistant will review and critique documentation for compliance on a regular scheduled basis.
5. Report changes in client performance to supervisor	• Supervisor and Assistant will conduct weekly conferences to discuss client changes in performance and progress. • Assistant will contact Supervisor immediately following any change/s in client status.
6. Prepare clinical materials	• Assistant will observe Supervisor and assist the Supervisor in choosing clinical materials. • Prepare materials as outlined in client's plan of care. • Assistant will review with Supervisor specific materials to be used with each client.
7. Test equipment for performance	• Supervisor will provide appropriate in-service regarding all testing equipment. • Assistant will independently test equipment as Supervisor observes and provides feedback.

8. Participate in projects planned and directed by the Supervisor	• Supervisor will review any planned projects with Assistant. • Assistant will complete any duties related to project as Supervisor provides ongoing review and feedback. • Weekly, Monthly and Quarterly meetings will be held to review progress.
9. Other: Please list any additional plans you may wish to include.	

Speech-Language Pathology Assistant:
I affirm that I have reviewed the above OJT Plan and Regulation 115-2 with the Supervisor and hereby agree to abide by all requirements and responsibilities set forth therein.

_____ _____
Speech-Language Pathology Assistant Signature Date

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

Notary Signature: _____

Print Notary name: _____ Seal

Notary Public for the State of: _____

Commission Expiration Date: _____

Speech-Language Pathology Supervisor:

I affirm that I have reviewed the above plan and Regulation 115-2 with the above-mentioned Speech-Language Pathology Assistant. I fully understand my responsibilities to the Speech-Language Pathology Assistant and to the Board of Examiners in Speech-Language Pathology and Audiology as a Supervisor of the Speech-Language Pathology Assistant. I hereby agree to abide by all requirements and responsibilities set forth in the above plan and Regulation 115-2.

I understand that in addition to direct and indirect supervision, I must conduct quarterly performance reviews of the above-mentioned Speech-Language Pathology Assistant. These performance reviews must remain on file for a period of four (4) years. I also understand that I must keep current training and performance records, which must be made available to the SC Board of Examiners in Speech-Language Pathology and Audiology within 15 days of being requested.

I acknowledge that I have full and complete responsibility for all services and tasks performed or omitted by the above-mentioned Speech-Language Pathology Assistant and must ensure that all services are in compliance with the SC Practice Act and regulations.

_____ _____
Supervisor's Signature Date

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

Notary Signature: _____

Print Notary name: _____

Notary Public for the State of: _____

Commission Expiration Date: _____

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Summary of Clinical Clock Hours (Academic Program)
Speech-Language Pathology Assistant

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: _____

Total Clinical Practice Hours Completed **Excluding Observation Hours**: _____

Date of Academic Program Clinical 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						

TOTAL HOURS						

Clinical Supervisor Signature: _____ ASHA Number: _____

Program Director Signature: _____ ASHA Number: _____

School Seal (Required)