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 the above address:

- Check or Money Order in the amount of $50 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
- Supervisor Agreement
- 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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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 $50 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
- Supervisor Agreement
- 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

Note for SC Residents: To find your Congressional District you may go to: http://www.scstatehouse.gov/legislatorssearch.php

APPLICANT INFORMATION:

Full Name: _____ Maiden: _____

Home Address: _____ District: _____
(Street, City, State & Zip) Congressional District (SC Residents Only)

Mailing Address: _____
(If different than above)

County:_____ Date of Birth_____ Social Security # _____

Email address: _____Telephone: _____

EMPLOYMENT:

Company Name: _____ Start Date: _____

Position Title: _____ Telephone: _____ Setting: _____

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

Mailing Address (if different): _____

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	Title	Dates

EDUCATION:

Contact your College /University and have your official transcripts submitted directly to the SC SLP/A Board at the address on the front of this application. Your transcripts must list out the minimum required courses outlined for licensure as a SC Speech-Language Pathology Assistant.

College:

School: _____ Location (city/state or country): _____

Degree: _____ Date of Attendance/ Date Degree Awarded: _____

School: _____ Location (city/state or country): _____

Degree: _____ Date of Attendance/ Date Degree Awarded: _____

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 at the above listed address. We will accept a state board issued form. Attach additional sheet if necessary.

State	Type of License	License No.	Date of Initial Licensure	Expiration Date	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 an arrest or 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 been notified to appear or appeared before any professional or occupational licensing jurisdiction/agency for a hearing or complaint? **YES** ☐ **NO** ☐

2. Have you ever had a license denied, suspended, revoked, disciplined or restricted by any professional or occupational licensing agency for any reason? **YES** ☐ **NO** ☐

3. Have you ever resigned from employment or surrendered a professional or occupational license in lieu of disciplinary action? **YES** ☐ **NO** ☐

4. Are you a habitual user of alcohol or any other drug to a degree which prohibits you from safely practicing as a Speech Pathologist or Audiologist? **YES** ☐ **NO** ☐

5. Is your ability to practice speech pathology or audiology presently impaired by any disease, physical, mental or emotional condition? **YES** ☐ **NO** ☐

6. Have you ever been convicted of or plead guilty or nolo contendere to a felony of any kind, or to a non-felony crime involving drugs, alcohol or moral turpitude? You do not need to disclose juvenile crimes or crimes that have been expunged or pardoned. **YES** ☐ **NO** ☐

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.

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

Signature of Notary Public: _____ **(Seal here)**

Print Name of Notary: _____

Notary Public for the State of: _____

My Commission Expires: _____

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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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						

TOTAL HOURS						

Clinical Supervisor Signature: _____ ASHA Number: _____

Program Director Signature: _____ ASHA Number: _____

School Seal (Required)

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	___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 clients 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.	

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:**_____