SPAA 620 | DIAGNOSTIC CLINICAL PRACTICUM
FALL 2025

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COURSE INFORMATION

Catalog Course Description

Supervised clinical practice in assessment strategies, collecting clinical data, client interviewing, counseling, preparation of reports and referral procedures. A total of 4 credits may be earned, but no more than 2 in any one semester or term. Open only to SPAA graduate students.

COURSE READINGS, MATERIALS, & RESOURCES

Mandatory Clinic Trainings

Student clinicians must complete all required trainings **prior to** beginning clinic. Mrs. Kadinger (Clinic Director) will provide information related to mandatory clinic trainings at the beginning of the semester, if necessary.

Simucase

The SLP Graduate Program at Ball State University uses Simucase to supplement academic and clinical learning. Simucase costs $110 annually or $65 per semester. Clinical supervisors will assign Simucase scenarios to students individually. Simucase is designed to help students with overall clinic hours & clinical competencies. Each simulation will be prebriefed with supervisor before beginning the case using email, One Drive, or in person. Supervisors will determine the debriefing methods and due dates. Students must participate in a debriefing meeting by the assigned deadline to be able to count the hours. In most situations, students will need to obtain 90% for the case in addition to have above 70% in all skill areas to count the hours. The hours that students spend on the case must be similar to the hours listed by Simucase. If students spend significantly less time on the case than what is recommended, students will not be able to count the entire time allotted (only the time they spend on the case).

I don't anticipate using Simucase for this course unless absolutely necessary. If used (due to need), we will modify the experience and have additional tasks in addition to the sim.

***Clinic hours will be logged separately for Simucase clients.

Required Items

- Penlight
- Clipboard

Required Texts/Readings

Shipley, K.G., & McAfee, J.G. (2021). *Assessment in speech-language pathology: A resource manual* (6th ed.). Delmar Cengage Learning. ISBN13: 978-1-63550-204-6

Hedge, M.N. (2010). A coursebook on scientific & professional writing for speech-language pathology (6th ed.). Delmar Cengage Learning. ISBN: 1435469550

Flahive, L.K. & Lanza, J.R. (2012). *Linguisystems Guide to Communication Milestones: 2012 Edition; Linguisystems. ISBN: 978-0-7606-0826-5

Recommended Texts/Readings

Burrus, A.E., & Haynes, W.O. (2009) *Professional communication in speech-language pathology: How to write, talk, & act like a clinician.* Plural Publishing Incorporated. ISBN: 1597560537

Recommended Research Articles to Review

Craise, E.R., Watson, L.R. & Baranek, G.T. (2007). Use of Gestural Development in Profiling Children's Prelinguistic Communication Skills. American Journal of Speech-Language Pathology, February 2009, Vol. 18, 95-108. doi: 10.1044/1058-0360(2008/07-0041)

de Wit, E., Visser-Bochane, M.I., Steenbergen, B., van Dijk, P., van der Schans, C.P. & Luinge, M.R. (2015). Characteristics of Auditory Processing Disorders: A Systematic Review. Journal of Speech, Language, & Hearing Research, April 2016, Vol. 59, 384-413. doi: 10.1044/2015_JSLHR-H-15-0118

COURSE REQUIREMENTS & METHODS OF EVALUATING STUDENTS

Course Requirements/Procedures

It is expected that the 620 student will utilize lecture notes, handouts, previous experience, etc. throughout the semester. Procedures include planning, role/responsibilities of the interviewer, and role/responsibilities of the evaluator, proper documentation, report writing, and general expectations. Focus will be on developing these skills, refining them along the semester and increase independence, as appropriate. It is imperative that you reference notes from SPAA 624 to be successful in this course.

Evaluation Day/Time:

Group 1: Mondays 2:-30-4:30 First eval date: September 8, 2025. We will evaluate in HB 248 (eval room) and HB 245 (interview room)

Group 2: Wednesdays 8:30-10:30 am. First eval date: September 3, 2025. We will evaluate in HB 248 (eval room) and HB 245 (interview room)

Grand Rounds Planning/Debriefing Meetings: Tuesdays 12:50-1:50 in HB 261.

Everyone will attend the Grand Rounds meetings. Please respond to Outlook Calendar Invites sent. During these meetings, members will take turns presenting their evaluation plans and debriefing from recent evaluations. We begin these meetings on Tuesday August 26th with an extended meeting time: 12:00-1:45 that day.

Two diagnosticians (tester/interviewer) evaluate each week, based on a rotation. If you are unsure which group/week/rotation you have been assigned to, please see me as soon as possible. Generally, although not always, we will adhere to the diagnostic schedule until midway through the Summer then then re-evaluate the rotation after, if needed in the event of cancelations. Please be flexible should there be a need to add an evaluation. You will be given notice and consulted before an evaluation is added that isn't already an assigned time. My goal is that everyone will have 3 evaluations this semester.

Additional assignment(s) in conjunction with evals: You will create an informal assessment form to be used in your evaluation or for future evals. Also, it is my hope that you will be able to conduct a standardized assessment this semester; however, that isn't always the case. In the event you aren't able to, I will give you a scoring activity to complete.

Electronic documentation, grading and general resources:

Canvas: At the time of this syllabus, Canvas will not be used for this diagnostic experience for communication from me. One Drive folders that are shared between myself and each student for the semester for the purposes stated below. I will send all notifications and correspondence to you via e-mail and One Drive. There may be a time where I experiment with using Canvas this semester, but you will be notified and it will be more of a trial for me and my teaching methods.

One Drive Folder: We will use One Drive for supervisor feedback, student self-reflections, log sheet storage and updates, recordings for testers, chart review information (tester), interview questions (interviewer) and general resources. I will have a secure folder set up for each of you soon.

Point n Click (PnC) is a web-based electronic documentation system that we will use for all patient/client documentation. There should be some resources on the general Canvas SLP Clinic page that contains helpful information regarding this. Billing will be completed for all evaluations and I will provide you with some resources in One Drive. We will discuss appropriate billing codes after the evaluation, if time permits. You are expected to become familiar with ICD-10 and CPT codes.

Planning–All planning meetings will be an in person weekly group meeting "grand rounds style" featuring a debriefing and planning portion. Please set aside this amount of time in your schedule for this. All members of the groups will attend weekly and participate (when it is your

turn to). Outlook invitations will be created. Please respond to these. Students will take turns presenting their plan and/or delivering a debrief from their recent evaluation at these meetings.

Planning for Testers: Please use the chart review form that I have emailed you for your use. Please have this document completed and placed in One Drive in the appropriate folder labeled "Chart Reviews" prior to the planning meeting.

Planning for Interviewers: The "interviewer" should have uploaded a list of initial interview questions in the appropriate One Drive folder labeled "Interviewer questions" by the time the planning meeting occurs. After we hold the planning meeting, please update your completed interview questions two days prior to your diagnostic. I will provide you with feedback of these questions before the diagnostic via One Drive a couple of days before your evaluation.

Preparation for your Evaluation: Your diagnostic client info can be found in PnC under my schedule. We will go over how to access this at our first orientation meeting. Reception will create a blue folder for each client and place in the records room. You will have access to the records room soon where you can check out the folder as needed. Upon scheduling, Linda sends the client/patient a patient portal link to electronically complete the case history. Once this is completed successfully, the case history will appear in the Compliance Forms section in the client's chart. There will be times when we have not received a case history in time for the planning meeting. This is not ideal; however, flexibility is key and you will need to work with your partner to come up with a "general plan" and we can attempt to obtain additional information that can be crucial for planning. At times, we will be collecting a case history in the interview (via paper and pen format) when the client/patient was unable to access the case history via the patient portal. In these cases, the completed case history will be scanned into PnC after the evaluation (just give to Ms. Landis). After you are finished with the client's chart (blue folder), you will be able to place it in the return drop boxes in the clinic or documentation room. Be mindful of the correct bin to place it in and do not accidentally place in the shred bin in the documentation room.

During the evaluation:

Testers: Prior to your evaluation, please bring original protocols for me to follow along with. Please give me these before your diagnostic begins. You can place in the observation room.

Interviewers: I will view your updated interview questions via One Drive during the interview, so no need to provide me with anything during the eval. You will also want to have the client chart (blue folder) checked out for your use during the interview/evaluation. At times, the folder will not be ready yet, just let me know. Once the interview is completed, you will bring the parent (if applicable) into the observation room. Be sure to interact and continue to gather information. You are expected to take notes during the evaluation and orient the parent to the testing and explain what is transpiring.

For both evaluators: When the diagnostic is finished, please walk the client out to the waiting room and/or down to the first floor and thank them for coming. Interviewers, be sure to ask if the client needs a school note (when appropriate) before they leave. Reception may have them and I have some available as well.

Evaluation Feedback for Diagnosticians: For both testers and interviewers, I will send you feedback from the diagnostic via One Drive. This documentation may not be immediately found in your folder after the evaluation. Please do not assume that you have done something wrong or incorrect - as I take time to reflect on your clinical skills and make edits to my live feedback that I took during the evaluation session. During the eval, I may be assisting, answering questions of clients as well as supervising with little time to prepare your feedback "in the moment". You can expect your feedback within 24 hours. Please refrain from asking me about your performance after the evaluation, especially in front of your partner as this is not professional. After the evaluation, I will take a few minutes to discuss pertinent points with you and your partner about the experience (typically with regard to the client's behavior, parent interaction, general findings, billing info/codes etc.). At times, I will give you immediate feedback, when I can, and when appropriate (as this is typically not a private encounter).

Tester and Interviewer Self-Reflection: Each team member will submit a written self-evaluation within 8 hours of each diagnostic evaluation. Please reflect on your strengths and weaknesses, as appropriate. Please place this information in the One Drive folder "Self-Reflections" utilizing the strict confidentiality measures. This task can be completed off-site being mindful of confidentiality parameters. I will correspond with you on this document.

Protocols: Testers should place all protocols from the evaluation (including parent checklists that the tester analyzed and the interviewer facilitated) in a campus mail envelope and place in my clinic mailbox **after** your 1st draft has been submitted in PnC. Please include *your* name, the client's DOB and testing date on ALL protocols as well as the envelope.

Important Forms that the Interviewer completes or manages:

Release of Information: A release of information does not have to be completed by the client/patient in order for the evaluation report to be sent to the ordering physician. However, if the client/parent requests the report to be sent to a school, this must be completed in PnC via the consent or "special iPad" from the Records Room. This form is also used when the parent allows us to obtain records from an outside source from an evaluation, IEP, etc. I will orient each student to this software. In the event technology fails us, the interviewer can provide this form (green release form) to the client/parent in a paper/pen format for them to sign. Mrs. Landis will have the paper scanned into PnC afterwards. The scanned form would then be found in PnC under "Scanned Documents" in the client's chart in PnC. The interviewer would view this in PnC to complete the work order, as appropriate. Clinical graduate students will have access to the records room momentarily.

Hard copy Tracking Form: The interviewer is responsible for the completion of this form. It should be given to me after the diagnostic or within one business day. This is a medical record and should never leave the clinic or the client's folder before you turn it in. If you are unable to complete it the day of the diagnostic, please do so the next day ASAP and place in my clinic supervisor mailbox (place in a campus mail envelope. Tracking forms are populated regardless of therapy being recommended or not. Please **do not** create a tracking form in PnC, I will create one once I have received the hard copy form.

Take home letter: We will explain "next steps" to the client/family after every evaluation. However, much of this information can be misunderstood or not processed in the moment for

various reasons. To help remedy this, a take home letter is given to every patient/client after the evaluation. Please make yourself comfortable with the information.

Work orders: The interviewer will also be responsible for completing the work order once the report is close to being finalized. You may place the work order inside a campus mail envelope and place in my clinic mailbox located in the materials/equipment room. This is completed towards the end of the report writing process of an evaluation. The client/parent is always the first person listed to receive the report per FERPA. There is room to include the referring physician's information for the report to be sent (faxed) as well. If there were records that need to be obtained from somewhere else, there is a place to indicate that.

Team Responsibility Sheet: I will share a checklist that should be utilized throughout the evaluation process with your partner for each particular diagnostic. It outlines specific responsibilities and keeps everyone on track. Please turn this in completed to me along with the work order once you are instructed to sign the report. Only one form per team, per eval is needed.

Diagnostic Binder: This is found in the Records Room. The interviewer completes this after the evaluation typically but more importantly once we fully have solidified a decision to recommend therapy or not. There will be some evaluations where we will hold a phone conference after test results have been analyzed. However, most evaluations will provide sufficient information to be able to come to a decision at the end of the evaluation. Exceptions include language processing evaluations secondary to APD/Audiology testing.

Case History: As mentioned, in the event the client/family did not complete a case history online, a hard copy form will need to be completed by the family and this will take place in the interview, typically at the end. After the evaluation, place this form in the blue folder and once you have written the report, please turn the case history into Mrs. Landis. Again, this will eventually be scanned into PnC and the document can be found under "Scanned Documents".

PnC Documentation: The interviewer is responsible for the following documents to be created in PnC: 1) documenting of the reminder phone call (phone note) made to the client; and 2) ongoing documentation (documenting the evaluation occurred and the outcome). Please do not sign the phone note (undersignatures) until I have instructed you to.

The following areas in the **SLP Eval visit note** (the report associated with the evaluation appointment) **are to be completed by the appropriate evaluator:**

Tester: All testing areas, summary, prognosis statement, diagnosis code(s) (ICD-10 code).

Interviewer: All background information, recommendations, conference statement with date, and charge slip code (CPT code).

Follow the attached *Dx Practicum Procedure Outline* for specific responsibilities. Remember, you are working in teams and each team member should perform their specific duties, as well as function as a team. Refer to the Diagnostic Report Format when writing your Dx report. You received this in Dr. McMillan's graduate diagnostic class (SPAA 624).

Please regularly check PnC for the most current information regarding clients scheduled in your particular time slot.

Failure to complete required documentation and all paperwork in a timely manner will result in performance improvement plan/remediation goals. Please see me if you have questions regarding the required paperwork that needs to be done at the end of the diagnostic session.

If you do not have a copy of the Diagnostic Practicum Procedures Outline, please see me as soon as possible.

You should familiarize yourself with the current ICD-10 codes as well as CPT codes: https://www.asha.org/siteassets/uploadedfiles/icd-10-codes-slp.pdf More information is provided in the DX Resources folder in your One Drive folder that we will share.

Use of workroom/documentation room (HB 123): Please only use this room for documentation or meeting with your partner and do not walk in the hallway to the right of this room as it is a confidential area for Counseling Psychology. HPB 123 can be used for all report writing and to make reminder phone calls as there are rooms with phones and plenty of space to meet with your partner, as well.

CONFIDENTIALITY: All confidential information must be omitted from any information placed in One Drive and information must exclude the 18 identifiers (see DX Resources folder in One Drive).

Log sheets/Clinic hours: Please keep track of your hours for each live diagnostic and update this in One Drive. Make sure you are logging your hours after each Dx. Do not wait until the end of the semester to compile hours. I will review your hours periodically. You will be expected to compile your Dx hours on the Semester Hours Summary form (which is found in the materials room and clinic handbook) at the end of the semester. You will need to divide minutes between yourself and your partner for each diagnostic. The hours log sheet may be obtained on the Canvas 620/628 page. Students should maintain an additional record of hours as a "back-up." Students should keep **track of the minutes** of each session-time in & time out. Students should count time in minutes for each session (be exact). At the conclusion of the semester, a clinic hours' summary sheets will be completed, converting minutes earned into hours in **.25 increments**. Separate clinic hours log sheets will be kept for on-campus clinic, off-campus clinical assignments, Simucase simulations, teletherapy and observations.

Grading: Each team member will be graded individually based upon performance within the diagnostic session and the writing of the diagnostic report per the Diagnostic Competency Form Guidelines. For the iI grade the tester's portion of the report first, then the interviewer's.

Report Due Dates: For Group 1, initial evaluation reports are due Thursday at 5:00 pm. For Group 2, initial evaluation reports are due Fridays at noon. Please take turns writing your OWN areas of the report. Coordinate with your partner on times as you won't be able to work on the report at the same time. Revisions are due within 24-36 hours. Please do not sign the report or any documentation until instructed to.

Deductions will occur for the following:

-misspelled words

-grammatical errors/punctuation errors

-unprofessional language/awkward wording

-incorrect recommendations

-incorrect scoring/reporting/interpretation

-incorrect /incomplete summary sheet entry

-failure to include client name and date on ALL forms

-blank phonetic transcription symbols (//)

-missed corrections of revisions

-incorrect/inaccurate information

-poor proofreading

Occasionally, written feedback will be provided on a revision where it did not occur on a previous draft. It should be expected that not all issues will be noticed on the first draft.

General policies:

If a report is late, your report will be reduced by half a letter grade for each late day. You will be allowed two revisions in addition to your initial draft. Your grade will be reduced by half a letter grade for each additional revision needed.

You could receive a 0 for the diagnostic if any of the following occurs during the evaluation process:

- you do not make written notes during the interview/assessment
- you do not do live transcription during the assessment
- you do not record responses/data on the test protocol during the assessment
- You "no-show" to either the planning meeting or the diagnostic session

Student Conferences: You will receive a cumulative grade at the end of the semester based on your episodic performance over 3 evals for the semester via a student/supervisor conference. However, after you have been the tester and interviewer, you will be provided with a written summary (midterm) of your performance as both tester and interviewer. Alternatively, face-to-face midterm conferences may be held at supervisor discretion, or by student request. Also, meetings will occur as needed, to ensure your success.

Miscellaneous, yet important reminders:

Record all portions of the testing portion of the evaluation and listen to your recording to verify information. Cell phones are not permitted to be used for recording. All recordings should occur on Ball State iPads that can be checked out in the materials room. All recordings are to be uploaded into One Drive under the folder titled "Recordings". Please log out of One Drive when you have finished uploading the recording and remember to erase the recording in the appropriate recording app.

Always report on all communication domains appropriate for the client. For example, you will always report on a child's language skills even if you have not completed a formal language assessment. In this case, you will use a dynamic assessment approach with an informal language sample, or screen and comment on the child's language abilities. Be ready for informal/dynamic assessment always in pediatric evaluations. I can not stress this enough! Think – "What will I use if I am unable to give a GFTA-3 or a CELF-P:3?" Be creative and intuitive! Know the milestones, use and comb resources and make a form to keep data or use an already established/published one. I will expect to see your data and form.

When assessing language, always be sure to include assessments for receptive, expressive and pragmatic/social language. For addressing social language/communication, be sure to always have something the parent can complete with regard to this area. We are only evaluating the child in a short amount of time and are considered strangers. The interviewer should provide the parent something to complete and then later, the tester will analyze and report findings. The tester will also use their own tool to observe and keep data but we must have the parent's perspective to fully be able to analyze social communication.

For articulation testing:

Transcribe Live
Do sentence/conversational levels
Report on stimulability levels and how they were achieved
Important: Raw scores, age equivalents and the sole recommendation of Ball State University by name **are not permitted** within reports. Inclusion of either will result in lowering of your grade for the evaluation.

Remember to reserve tests the day prior to your diagnostic session.

A reminder that you are in a professional clinic setting and your behavior should reflect that. Make sure you are dressed professionally and avoid perfume or cologne due to many of our clients having allergies. Please do not be late for your diagnostic.

Prepare as much as you can ahead of time. Good preparation will help your Dx run more smoothly. Remember, be flexible.

Dress Code: Please be in sync with your evaluating partner. If one wears scrubs, the other wears scrubs. I have no preference on your choice, just as long as you look in sync with your partner.

Please be reminded this is a learning experience. My role as a supervisor/clinical educator is to teach and guide you, not to let you struggle or be lost in the process. Please also remember that you are not expected to know everything, particularly with diagnostics. My objective is to help you become more familiar, comfortable, and competent with all aspects of this process. Communicate any concerns or questions about this diagnostic experience to me and we will work together to resolve them. The best way to reach me about most issues or questions, is by email. I check it often.

Required Resources to be utilized: Please refer to the 9 appendices/templates for your reference and utilization (many of these resources will be placed in One Drive).

Release form in PnC (I will orient you)

Hard copy Yellow Work Order

Hard copy Tracking Form

Hard Copy green Release form (only use when PnC copy not available)

Hard copy Team Responsibility Sheet

Chart Review Form in One Drive

Linguisystems pdf (Communication Milestones)

ASHA's Social Communication Milestones – www.asha.org

Test Materials List

Dr. McMillan's Doe Boy from SPAA 624

Clinic Handbook - You should be able to find this on the 620/628 Canvas course that Mrs. Kadinger manages.

Professional Writing Resource:

The Learning Center offers free tutoring for many courses on campus, including science and humanities, modern languages, math and business, help with any writing task, and study strategies such as time management, test taking, note taking, and effective textbook reading. To make an appointment, call 765-285-3780 or Live Chat online at www.bsu.edu/learningcenter

Lockers: Zephyr lockers are available for your use in both the documentation room hallway (the room on the left) or in our SPAA clinic. See One Drive for instructions.

Assessment Methods & Criterion

The Ball State University Clinical Evaluation of Speech-Language Pathology Student Competencies form will be used to determine & document student performance on course objectives. Documentation of performance on the competency form will be used at midterm & at the end of the semester. Performance ratings on the competency form will be based on the following:

5 = Demonstrated independence by taking initiative & making appropriate changes. Displayed superior competencies. Independent.
4 = Needed general direction from supervisor
3 = Needed general & some specific direction from supervisor
2 = Required modeling & specific direction from supervisor. Remediation required. Below average performance.
1 = Unable to change performance despite specific direction from supervisor. Remediation required.

Grade Distribution

The student must pass the clinical competency **and** receive a passing grade in order to pass this clinical enrollment. Graduate students must have a "B" or better to pass. Totaling **all** items & dividing by the total number will determine the grade/score on the clinical competency form. The grading scale is as follows:

4.5 +	**A**	**3.49 – 3.25**	**C+**
4.49 – 4.25	**A-**	**3.24 – 3.00**	**C**
4.24 – 4.00	**A-**	**2.99 – 2.75**	**C-**
3.99 – 3.75	**B+**		
3.74 – 3.50	**B-**		

Opportunities for Remediation

Any item on the competency form with a score of "2" or below requires remediation. The student must have no more than three items with a score of "2" in order to demonstrate competency by the end of the semester. In addition, each section of the competency form should be averaged for a "section score." The student must have an average of "3" or more on each section in order to demonstrate competency by the end of the semester.
If the student requires remediation, a remediation plan will be developed with the clinical faculty who are currently supervising a student clinician. The remediation plan must include:

1. Description of knowledge/skills which are not being demonstrated by the clinician, based on the competencies described in the Clinical Evaluation of Speech-Language Pathology Student Competencies form.
2. Goals & behaviors which must be demonstrated to indicate knowledge & skills appropriate for current practicum level.
3. Semester of remediation plan implementation, date of initiation, & date of anticipated completion.

It is possible that remediation may be required, although the student has a passing grade in the practicum. Remediation plans may be developed and/or extended for no more than two consecutive semesters during the student's graduate experience. Graduate students may appeal adverse decisions impacting their progress toward a graduate degree. Appeals should be conducted according to the process outlined in the Ball State University Code of Student Rights & Responsibilities.

ASHA Standards for Certification

The course objectives relate to the following Standards for Clinical Certification (2020) from the Council for Clinical Certification in Audiology and Speech-Language Pathology.

Course Objective	ASHA Standards of Certification 2020
1. The student will demonstrate, through supervised practicum, application of knowledge in evaluation and/or treatment of various	**Standard IV-B** The applicant must have demonstrated knowledge of basic human communication and swallowing processes, including the appropriate biological, neurological, acoustic, psychological, developmental, and linguistic and cultural bases. The applicant must have demonstrated

client populations that vary in types and severities of communication/swallowing disorders or communication differences, which are across the life span, and are culturally/linguistically diverse; including articulation/phonology, voice, fluency, language, cognitive communication, swallowing, hearing, social aspects, and/or communication modalities.	the ability to integrate information pertaining to normal and abnormal human development across the life span. **Standard IV-C** The applicant must have demonstrated knowledge of communication and swallowing disorders and differences, including the appropriate etiologies, characteristics, and anatomical/physiological, acoustic, psychological, developmental, and linguistic and cultural correlates in the following areas: • Speech sound production, to encompass articulation, motor planning and execution, phonology, and accent modification • Fluency and fluency disorders • Voice and resonance, including respiration and phonation • Receptive and expressive language, including phonology, morphology, syntax, semantics, pragmatics (language use and social aspects of communication), prelinguistic communication, paralinguistic communication (e.g., gestures, signs, body language), and literacy in speaking, listening, reading, and writing • Hearing, including the impact on speech and language • Swallowing/feeding, including (a) structure and function of orofacial myology and (b) oral, pharyngeal, laryngeal, pulmonary, esophageal, gastrointestinal, and related functions across the life span • Cognitive aspects of communication, including attention, memory, sequencing, problem solving, and executive functioning • Social aspects of communication, including challenging behavior, ineffective social skills, and lack of communication opportunities • Augmentative and alternative communication modalities **Standard IV-D:** For each of the areas specified in Standard IV-C, the applicant must have demonstrated current knowledge of the principles and methods of prevention, assessment, and intervention for persons with communication and swallowing disorders, including consideration of anatomical/physiological, psychological, developmental, and linguistic and cultural correlates.
2. The student will demonstrate application of ethical conduct standards to clinical decisions.	**Standard IV-E:** The applicant must have demonstrated knowledge of standards of ethical conduct.
3. The student will complete a thorough chart review, develop a complete diagnostic plan, and write a full diagnostic evaluation	**Standard V-A:** The applicant must possess skill in oral and written or other forms of communication sufficient for entry into professional practice.

report that is accurate in style, format and grammar.	
4. The student will consistently meet levels of performance as expected for each sequential semester of clinical work as measured through the use of the Ball State University Clinical Competence Form in the following areas: • Evaluation • Intervention • Personal & professional qualities • Professional report writing	**Standard V-B** The applicant must have completed a program of study that included experiences sufficient in breadth and depth to achieve the following skills outcomes: 1. Evaluation a. Conduct screening and prevention procedures, including prevention activities. b. Collect case history information and integrate information from clients/patients, family, caregivers, teachers, and relevant others, including other professionals. c. Select and administer appropriate evaluation procedures, such as behavioral observations, nonstandardized and standardized tests, and instrumental procedures. d. Adapt evaluation procedures to meet the needs of individuals receiving services. e. Interpret, integrate, and synthesize all information to develop diagnoses and make appropriate recommendations for intervention. f. Complete administrative and reporting functions necessary to support evaluation. g. Refer clients/patients for appropriate services. 2. Intervention a. Develop setting-appropriate intervention plans with measurable and achievable goals that meet clients'/patients' needs. Collaborate with clients/patients and relevant others in the planning process. b. Implement intervention plans that involve clients/patients and relevant others in the intervention process. c. Select or develop and use appropriate materials and instrumentation for prevention and intervention. d. Measure and evaluate clients'/patients' performance and progress. e. Modify intervention plans, strategies, materials, or instrumentation as appropriate to meet the needs of clients/patients. f. Complete administrative and reporting functions necessary to support intervention. g. Identify and refer clients/patients for services, as appropriate. 3. Interaction and Personal Qualities

	a. Communicate effectively, recognizing the needs, values, preferred mode of communication, and cultural/linguistic background of the individual(s) receiving services, family, caregivers, and relevant others. b. Manage the care of individuals receiving services to ensure an interprofessional, team-based collaborative practice. c. Provide counseling regarding communication and swallowing disorders to clients/patients, family, caregivers, and relevant others. d. Adhere to the ASHA Code of Ethics and behave professionally.

COURSE STATEMENTS & POLICIES

Attendance

Students are responsible for notifying clinical supervisors prior to scheduled clinic time when they will be absent from clinic for any reason, including illness, quarantine, bereavement and jury duty. Documentation will be required for absences (for example, a doctor's note or jury duty notice.)

Explore Ball State course attendance policies.

Client Cancellation Policy

If the assigned client cancels in advance, students should notify their clinical supervisor as soon as possible to ensure the appointment cancellation is recorded in the electronic medical record system (PNC). Students should check PNC for cancellations prior to setting up for their session (Students should not call the office to inquire if their patient has cancelled.) **All cancellations should be documented in PNC.** Students should keep in mind the interprofessional clinics will operate AS USUAL when area schools are delayed. Students may be asked to find another colleague to cover their client or see another clinician's client with minimal notice. A student's One Drive folders & PNC notes should be complete, and the information should be "reader friendly" for the next clinician.

Client Charts

The Speech-Language Clinic has transitioned to electronic documentation and billing. However, some information (e.g., assessment protocols) will still be in the client's folder (paper charts - (see Records Room). Students should make sure to check the Records Room to see if their client has a paper chart ready. Students should make sure they are adhering to the client folder check-out times if they are wanting to review past protocols. Client folders are **not permitted** to leave the building. Students are responsible for their client's folder. Students should make sure all documentation requirements are complete and filed appropriately. Client files will be reviewed by clinical supervisors periodically throughout the semester to ensure all paperwork is filed correctly. Folder orientation/etiquette will occur in Grand Rounds meetings.

Professional Behavior & Dress

Student clinicians should wear their BSU ID and be dressed professionally for all clinic services (see Clinic Handbook on Canvas for acceptable clinic attire). Students should avoid perfume or cologne as many clients have allergies. Students should not be late for clinic. Preparation & organization are key elements to a successful therapy experience for both the student clinician and the client. Students should remember to be flexible.

SLP Graduate Student Handbook

Students are responsible for reviewing all information in the SLP Graduate Student Handbook and Clinic Handbook (both are available on Canvas). Students will be held accountable for knowledge of necessary information including the number of clinical hours needed to graduate, equipment/materials rooms' procedures, dress code, etc.

Clinic Supervision Policy

It is the supervisor's responsibility to make clinical assignments and to assist students in discovering the best plan of action for assessment. The student diagnostician is responsible for spending the time to research possible assessment approaches and to review standardized tests. Student clinicians will be guided along the way by the clinical supervisor and suggestions made as appropriate.

UNIVERSITY POLICIES

University Services Statement

We are committed to ensuring that all members of the community are welcome, through valuing the various experiences and worldviews represented at Ball State and among those we serve. We promote a culture of respect and civil discourse. If you need course adaptations or accommodations because of a disability, please contact the instructor of record as soon as possible. Ball State's *Disability Services* office coordinates services for students with disabilities; documentation of a disability needs to be on file in that office before any accommodations can be provided. Disability Services can be contacted at 765-285-5293 or *dsd@bsu.edu*.

Attendance Policies

Students are expected to review course syllabi regarding absence guidelines & follow those guidelines. The University has a number of specific policies regarding student absences that are housed within different areas. Explore Ball State course attendance policies.

Ball State Student Academic Ethics Policy

Honesty, trust, and personal responsibility are fundamental attributes of the university community. Academic dishonesty and other forms of academic misconduct threaten the foundation of an institution dedicated to the pursuit of knowledge and will not be tolerated. To maintain its credibility and reputation, and to equitably assign evaluations of scholastic and creative performance, Ball State University is committed to maintaining a climate that upholds

and values the highest standards of academic integrity. Visit the VPAA's academic integrity website (Students tab) for resources on understanding academic integrity, citing sources properly, and avoiding inadvertent academic dishonesty. To learn about BSU's academic integrity expectations and students' rights, please read the University Student Academic Ethics Policy.

Academic integrity violations include giving or receiving an unfair academic advantage (cheating), presenting someone else's ideas or work as your own (plagiarism), and falsifying academic records. Unless otherwise indicated, you must work independently by yourself. Check with me if you are unsure whether something constitutes academic dishonesty. Examples of academic integrity violations include but are not limited to:

Using resources not authorized by the faculty member (including devices, AI tools, hidden notes, and open books)

Using commercial study websites to find answers to graded assignments (Chegg, Course Hero, StudyPool, OneClass, etc.).

Without the instructor's written permission, giving away, buying, or selling graded assignments class notes, exams, study guides, or other course materials to other students or to third-party vendors (Course Hero, Chegg, 24HourAnswers, etc.).

Working with another person on any assignment other than authorized group projects.

Sharing or allowing others to access your files, whether done with permission or not.

Reusing your own work from another semester, course, or section.

Sharing answers with others during exams (passing notes, texting, whispering, gesturing)

Discussing exam questions and answers with students who have not taken the exam.

Soliciting others to complete work for you.

Plagiarism Policy

Plagiarism is not acceptable, unless otherwise indicated for all assignments, you must work independently by yourself. Sharing of files is not permitted for any reason. Examples of academic integrity violations include but are not limited to:

- Working with another person on any assignment other than authorized group projects.
- Sharing or allowing others to access your files, whether done with permission or not.
- Use or possession of a file created by someone else.
- Reusing work from another semester, course, or section.
- Fraudulent submission of work.
- Using unauthorized materials during Exams.
- Impersonating someone else or having them impersonate you.
- Making fraudulent or dishonest statements regarding your work.
- Soliciting others to complete work for you.
- Posting course files & resources on study or content sharing websites.

Plagiarism Detection: The campus subscribes to Turnitin, a plagiarism prevention service, through Canvas. You may need to submit written assignments to Turnitin. Student work will be used for plagiarism detection & for no other purpose. The student may indicate in writing to the instructor that he/she refuses to participate in the plagiarism detection process, in which case the instructor can use other electronic means to verify the originality of their work.

Procedures for Dealing with Academic Dishonesty & Disciplinary Action

Before disciplinary action for academic dishonesty is taken against a student, the concerned faculty member must inform the student of the alleged violation & discuss it with him or her in a private conference. Based on this conference further action may be taken by both the student & faculty member. A student who has committed or attempted to commit academic fraud is subject to disciplinary action by the University. Penalties include but are not limited to one or more of the following:

- A grade of failure for the work concerned;
- A grade of failure for the course;
- Suspension from the University;
- Expulsion from the University;
- Revocation of a previously awarded degree

For a more information, find the complete Code of Student Rights & Responsibilities at https://www.bsu.edu/about/administrativeoffices/student-conduct.

Copyright Policy

Students may not reproduce, distribute, or publicly post their course materials without the course instructor's permission. Selling or distributing course materials may violate the Ball State University Code of Conduct &/or the Information Technology Users' Privileges & Responsibilities policy.

FERPA & Privacy

As a student, your educational records are considered confidential. Under FERPA (Family Educational Rights & Privacy Act), your records are confidential & protected. Under most circumstances, your records will not be released without your written & signed consent. However, some directory information may be released to third parties without your prior consent unless a written request to restrict this is on file. You can learn more about student rights to privacy by reading Ball State's FERPA & Privacy & Protection.

Video Conferencing Recording

In this class, software may be used to record live class discussions. As a student in this class, your participation in live class discussions may be recorded. These recordings typically will be made available only to students enrolled in the class, to assist those who cannot attend the live session or to serve as a resource for those who would like to review content that was presented. Students who prefer to participate via audio only will be allowed to disable their video camera so only audio will be captured. Students who prefer to listen only must disable their audio capability & visual camera. If you have concerns, please discuss these options with me.

ACADEMIC SUPPORT SERVICES

The Basic Needs Hub

If you are having difficulty affording enough food, do not have a safe & reliable place to sleep, &/or experiencing an emergency or crisis, help is available through the basic needs hub. The basic needs hub has information, resources, & provides individualized support to students. To talk with a supportive staff member about your experience, receive one on one assistance, or learn more about resources, you can submit a basic needs assistance form.

The Counseling Center

The Ball State University Counseling Center offers free & confidential services to all students. The Counseling Center is located in Lucina Hall, Room 320. To schedule an appointment, you can contact us at 765-285-1736. Ball State now also offers a 24/7 Crisis Line, which can be reached at 765-285-HOPE (4673). The Crisis Line is a mental health resource for those who are struggling with any mental health concerns, including thoughts of self-harm &/or suicide.

At the Ball State Counseling Center, we see students for a variety of reasons, some of which include homesickness, relationship concerns, anxiety, & depression. At your first appointment, you will work with a therapist to create a plan that will connect you with resources that best fit your needs. We assist students with getting connected to therapy at our Center as well as connecting students to self-help resources, other on-campus resources, & community-based resources. All Ball State students also have access to several on-demand, self-help resources through a variety of different platforms. All of these resources, including a direct link to our website, can be found here.

The Writing Center

All writers improve with practice and feedback, so as a student in this course, you are encouraged to use the Writing Center (in Robert Bell 295 during weekdays, Bracken Library First Floor West in the evenings, or online during any of our regularly scheduled hours) to get additional feedback on your writing.

The Writing Center offers free planning, feedback, and accountability sessions (in person and online) to all students composing essays, reports, reflections, research projects, web content, lesson plans, slideshows, poster presentations, resumes, and other digital or print texts. To schedule a free appointment to discuss your writing, go to *bsu.edu/writingcenter*. Online and in-person appointments are available; however, plan ahead because appointments book quickly!

The Speaking Center

The *Speaking Center* is a free resource available to all members of the BSU community wanting to improve their public speaking abilities. We offer personalized coaching designed to help you become a more confident and effective speaker. Our trained coaches provide constructive feedback and support throughout the entire speech preparation process, whether you are in the

early stages of brainstorming ideas and organizing your thoughts, or you need to practice your delivery and refine your message.

The Center is in the David Letterman Communication and Media Building, room 302. To schedule an appointment, please access us through your Navigate app or use this *direct link* to sign up for a time**.** Appointments are available both in person and on Zoom. Appointments are available in person, on Zoom, and in virtual reality (VR) for those interested in practicing in an immersive speaking environment.

General resources:

A link of BSU's student's rights and responsibilities can be found here:

https://ballstate.policytech.com/dotNet/documents/?docid=2586

SUBJECT TO CHANGE STATEMENT

This syllabus & schedule are subject to change in the event of extenuating circumstance.