

**College of Heath Sciences and Professions**

**Ohio University Therapy Associates**

Hearing, Speech and Language Clinic

Grover Center W174

Athens, OH 45701-2979

T: 740.593.404

F: 740.593.4433

[www.ohio.edu/chsp/hsl](http://www.ohio.edu/chsp/hsl)

**CLINICAL OBSERVATION HOURS RECORD FORM FOR MASTER CLINICIAN**

**STUDENT NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PID#** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The American Speech-Language-Hearing Association (ASHA) requires students in training to obtain 25 clock hours of observation of clinical evaluation and treatment. The 25 observation hours are a portion of the total number of clock hours that students in training must complete as part of their degree program. This Clinical Hours Observation Record Form is to be used to record all observations that have previously been described on the Clinical Hours Observation Documentation form. One Clinical Hours Observation Documentation form is to be completed for each individual observation. Each individual observation must be signed with certification/license information by the supervising professional. Students are responsible for maintaining their own documentation of all submitted forms. Both the Record Form as well as all individual Observation Documentation forms are to be submitted to the CSD 4420 course instructor or representative. A letter(s) certifying completion of all 25 observation hours will be completed by the CSD 4420 course instructor or representative, for submission to the student’s clinic file.

**Key:**

 **Age: A = Adult; C= Child**

 **Disorder: Articulation Fluency Voice Language Swallowing Cognitive**

 **Social Aspects Comm. Modality Hearing**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **DATE** | **Patient** | **DISORDER(s)** | **AGE** | **LIVE/Video** | **TIME (hr:min:sec)** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **DATE** | **Patient** | **DISORDER** | **AGE** | **LIVE/Video** | **TIME****(hr:min:sec)** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| **Supervisor Signature/Credentials (corresponding to each set of above initials)** | **ASHA Certification #** | **State of SLP****State License #** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Total time (hours: minutes: seconds):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STUDENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**