**Kent State University**

**Department of Speech Pathology and Audiology Record of Guided UNDERGRADUATE 25 Observation Hours**

*In order to log your observation hours, the following information is* ***REQUIRED Hours will only be counted if both sides of this form are completed and signed.***

|  |  |  |
| --- | --- | --- |
| **Name:** |  | **Date:** |
| **Banner ID:** |  | **E-mail:** |

**Name & City of Observation Site:**

**Please answer the following questions:**

1. **What information was provided prior to the session by the treating clinician?**
2. **What skills were being worked on?**
3. **How were the skills taught?**
4. **Did you see any cueing/modeling?**

Record your observations by notating how many hours/minutes observed in each of the specific “Big 9” categories. Please note:

* “Adult” = 18 years or older
* Document hours and minutes in decimals to the nearest 15-min interval (e.g. 1.0 = 1 hour; 2.25 = 2 hours and 15 min; 3.5 = 3 ½ hours; 4.75 = 4 hours and 45 min)
* If you are unsure of the categories, please discuss this with the treating clinician.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Category*** | ***Pediatric Hours/Minutes (Screening &***  ***Assessment)*** | ***Pediatric Hours/Minutes (Treatment)*** | ***Adult Hours/Minutes (Screening &***  ***Assessment)*** | ***Adult Hours/Minutes (Treatment)*** |
| Articulation/Speech Sound Production |  |  |  |  |
| Receptive/Expressive language |  |  |  |  |
| Voice and resonance |  |  |  |  |
| Fluency and fluency disorders |  |  |  |  |
| Hearing (Screenings **and**  Aural Rehab) |  |  |  |  |
| Swallowing/Feeding |  |  |  |  |
| Cognitive aspects of communication |  |  |  |  |
| Social aspects of communication |  |  |  |  |
| Augmentative and alternative communication  modalities |  |  |  |  |
| ***Total Hours/Minutes***  ***Observed*** |  |  |  |  |

**To be completed by the on-site clinical educator:**

By signing below I certify that the above observations were guided per ASHA’s standards and there was communication/discussion regarding the observations between the student and the clinical educator.

Supervisor’s Signature and Date of Observation

|  |  |  |
| --- | --- | --- |
| Supervisor’s Name: |  | ASHA Number: |
| Ohio License Number: |  |  |