BOARD OF SPEECH-LANGUAGE PATHOLOGISTS AND AUDIOLOGISTS
301 SOUTH PARK, 4TH FLOOR
PO BOX 200513
HELENA MONTANA 59620-0513
(406) 841-2385 or 2369 FAX: (406) 841-2305
Email: dlibsdslp@mt.gov
Website: www.slpaud.mt.gov

AIDE REGISTRATION REQUIREMENTS AND APPLICATION INSTRUCTIONS

Incomplete applications will be returned with a statement regarding incomplete portions. Once an application is complete, estimated time for issuance of registration is 7 days.

AUDIOLOGIST AIDE or SPEECH-LANGUAGE PATHOLOGIST AIDE REGISTRATION

Qualifications for Registration: Applicants for aide registration must:

- ✓ Be supervised by a current Montana licensed speech-language pathologist or audiologist.
- ✓ Must annually register with the board on or before October 31.
- ✓ Applicants must submit a fully completed and signed aide registration form.

Fees:
- ✓ $30.00 Application fee

Make check or money order payable to the Board of Speech-Language Pathologists and Audiologists. All fees are non-refundable. Do not send cash**.**

REGISTRATION APPLICATION PROCEDURES: A fully-completed, signed application for registration shall be submitted with the following:

- Aide 1 applicants must submit proof of enrollment in a graduate program.
- Aide 2 applicants must identify date and major of BA degree.
- Aide 3 applicants do not require a degree.
- Signature of the aide applicant, the current Montana licensed speech-language pathologist or audiologist supervisor and the representative of the hiring agency.
- The supervisor is also required to fill out sections of the registration form.
- Aides must register annually.
- Registered aides are not licensed practitioners.

- Supervision Requirements:
  Aide 1 = 30% while preforming diagnostic and interpretive functions in the first year of activities.
  5% client contact time of which 2% shall be direct contact
  Aide 2 = 10% of client contact time of which 5% shall be direct contact
  Aide 3 = 20% of client contact time of which 10% shall be direct contact

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ANNUAL AIDE/ASSISTANT REGISTRATION FORM

REGISTRATION #:_____ (for Board use only)

(Please allow an average of 10 days for processing from the date that the Board has a completed application)

APPLICANT INFORMATION: PLEASE TYPE OR PRINT IN INK.

1. FULL NAME: _____
   Last First Middle

2. MAILING ADDRESS: _____
   Street or PO Box # City and State Zip

3. TELEPHONE _____ EMAIL ADDRESS _____

4. SOCIAL SECURITY NUMBER _____

5. DATE OF BIRTH _____ PLACE OF BIRTH _____ ☐ MALE ☐ FEMALE

6. NAME FOR REGISTRATION CARD: _____
   (State your name, as it should appear on the registration card if approved.)

EMPLOYMENT INFORMATION:

7. NAME OF EMPLOYER: _____ PHONE: _____

8. EMPLOYER ADDRESS: _____
   Street or PO Box # City and State Zip

9. ANTICIPATED DATES OF EMPLOYMENT: FROM _____ TO _____
   MONTH/DAY/YEAR MONTH/DAY/YEAR

AIDE/ASSISTANT LEVEL: ☐ SLP AIDE 1 ☐ SLP AIDE 2 ☐ SLP AIDE 3 ☐ AUD AIDE

AIDE/ASSISTANT 1: **Attach current proof of enrollment in a graduate program.**
24.222.301 "a person who holds an undergraduate degree in communication sciences and disorders or its equivalent, and is currently enrolled in an accredited graduate program for the purpose of completing licensure requirements".

SUPERVISION
The aide/assistant must be supervised a minimum of 30% while performing diagnostic and interpretive functions in the first year. During the first year, the supervision requirement will be 5% client contact time, of which 2% shall be direct supervision after the first year, at the discretion of the supervising speech/language pathologist.

Is this the first year you have been **registered** as Aide/Assistant 1? ☐ Yes ☐ No
If yes, total number of hours per month with clients _____ x 5% = _____
If no, total number of hours per month with clients _____ x 2% = _____

AIDE/ASSISTANT 2: _____ **Type of Degree** _____ **Graduation Date** _____
24.222.301 "a person who holds an undergraduate degree in communication disorders, or its equivalent, but is not currently enrolled in an accredited graduate program".

SUPERVISION
The aide/assistant must be supervised a minimum of 10% client contact time, 5% of which must be direct supervision.
Total number of hours of direct client contact time per month _____ x10%= _____
Total number of hours of direct client contact time per month _____ x 5% = _____

AIDE/ASSISTANT 3: _____
24.222.301 "a person who holds no undergraduate degree in communication disorders, or its equivalent".

SUPERVISION
The aide/assistant must be supervised a minimum of 20% of client contact time, 10% of which must be direct supervision.
Total number of hours of direct client contact time per month _____ x20% =_____
Total number of hours of direct client contact time per month _____ x10% =_____

AUDIOLOGY AIDE/ASSISTANT:_____
24.222.301 "a person meting the minimum requirements established by the board who performs any of the activities defined under the practice of Audiology definition of 37-15-02, MCA, under the supervision of a licensed audiologist".

SUPERVISION
The aide/assistant must be supervised a minimum of 10% of client contact time.
Total number of hours of direct client contact time per month_____ x10% = _____

AIDE/ASSISTANT CONTINUING EDUCATION REQUIREMENTS 24.222.2102 (6),(7) AND (8)

Aide/Assistant 1 shall complete 20 units of continuing education annually. Aide/Assistant 2 and 3 will submit verification of 10 continuing education hours at the time of registration.

I have completed _____ hours of continuing education during the past year.

Plan for meeting the continuing education requirement for the current year:

_____

_____

SUPERVISOR INFORMATION

The Supervisor Information must accompany all AIDE/ASSISTANT Registration Forms

SUPERVISOR NAME: _____ License #: _____

MAILING ADDRESS: _____
Street or PO Box # City and State Zip

TELEPHONE _____
Business Home

EMPLOYING AGENCY: _____

Number of hours of supervision provided to aide/assistant per month: _____
Number of hours of direct client supervision per month: _____

I now supervise _____ **aides/assistants, which equals** _____ **FTE's** (24.222.702(5))

Number of client contact hours monthly _____ Number of hours monthly travel _____ Caseload _____

If more than 3 aides are supervised, board review is required (24.222.702(5))

Aide's Name	#Hours monthly/direct	#Hours monthly indirect	Aide Caseload

SUPERVISION RULES 24.222.701 through 24.222.703 are located on the web site www.slpaud.mt.gov

IF THERE IS A SIGNIFICANT CHANGE IN THE SUPERVISION PLAN OR IF THERE IS A DISAGREEMENT BETWEEN THE SUPERVISOR, AIDE OR EMPLOYING AGENCY, THE BOARD MUST BE NOTIFIED IN WRITING.

I HAVE READ, REVIEWED AND HAVE AGREED TO FOLLOW THE ABOVE PROPOSED PLAN AND THE ADMINISTRATIVE RULES OF THE BOARD 24.222.701. I UNDERSTAND THAT AS A SUPERVISOR I ASSUME FULL LEGAL AND ETHICAL RESPONSIBILITY FOR THE TASKS PERFORMED BY THE AIDE OR ASSISTANT AND FOR ANY SERVICES OR RELATED INTERACTIONS WITH A CLIENT.

DATE _____ _____
SIGNATURE OF SUPERVISOR

DATE _____ _____
SIGNATURE OF SPEECH PATHOLOGY AND/OR AUDIOLOGY AIDE

DATE _____ _____
SIGNATURE OF REPRESENTATIVE OF HIRING AGENCY

THE MID YEAR FORM WILL BE AN AFFIDAVIT ON THE LICENSEE/SUPERVISOR RENEWAL FORM

DECLARATION

I authorize the release of information concerning my education, training, record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Board of Speech-Language Pathologists and Audiologists.

I hereby declare under penalty or perjury that the information included in the aide application and supervisor information to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement may lead to denial of the aide application or subsequent revocation of annual registration on ethical grounds. I have read and will abide by the current statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

_____ _____
Signature of Licensed Supervisor **Date**

License Number _____ Expiration Date _____