

**UNIVERSITY OF MASSACHUSETTS - AMHERST  
DEPARTMENT OF COMMUNICATION DISORDERS**

**PRACTICUM REPORT - SPECIALIST TEACHER IN SPEECH, LANGUAGE AND HEARING  
DISORDERS (All Levels)**

THIS FORM MUST BE COMPLETED AND FILED WITH THE MASSACHUSETTS DEPARTMENT OF ELEMENTARY AND  
SECONDARY EDUCATION FOR TEACHER CERTIFICATION.

This form is issued pursuant to regulations adopted under M.G.L.c. 71, and it, or a form containing the same information, must be completed and filed with  
the Certification and Credentialing Service by all applicants for certification.

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**Part I. To be completed by the applicant.**

Legal Name: (print) \_\_\_\_\_ Social Security: \_\_\_\_\_

Address: \_\_\_\_\_

Sponsoring Organization: University of Massachusetts-Amherst Program & Level: MA degree in Spch-Lang Patholgy

Other MA Certification Held: Field \_\_\_\_\_ Level \_\_\_\_\_

Have any components of the approved program been waived?: Yes \_\_\_\_\_ No \_\_\_\_\_

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**Part II. To be completed by the Graduate Program Supervisor.**

Name: (print) \_\_\_\_\_ Position/Title: Director of Clinical Program

(sign) \_\_\_\_\_

The applicant completed a practicum/equivalent designed by the sponsoring organization as partial preparation for the following  
license:

Title of License: Specialist Teacher in Speech, Language and Hearing Disorders (All Levels).

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**Part III. To be completed by the Supervising Practitioner.**

Course Title: **CLINICAL PRACTICUM** Course #: **698B**

Credit Hours: **3 per Semester**

**OTHER SETTING**

Semester: \_\_\_\_\_ Practitioner's Name: (print) \_\_\_\_\_

Practicum Site: \_\_\_\_\_ ASHA Certification #: \_\_\_\_\_

Type(s) of clients: \_\_\_\_\_

Number of clock hours as assistant: \_\_\_\_\_ MA State License #: \_\_\_\_\_

Assumed full responsibility in role: \_\_\_\_\_

**SCHOOL SETTING (must complete Part V.)**

Semester: \_\_\_\_\_ Practitioner's Name: (print) \_\_\_\_\_

School System: \_\_\_\_\_ Mass Teachers Certification #: \_\_\_\_\_

\_\_\_\_\_ NA \_\_\_\_\_

Grade level of students: \_\_\_\_\_ Certification Field: \_\_\_\_\_

Number of clock hours as assistant: \_\_\_\_\_ Three years of experience in Role: \_\_\_yes\_\_\_ no

Assumed full responsibility in role: \_\_\_\_\_ Has a waiver for either the certification field or experience been  
approved? \_\_\_yes\_\_\_ no

ASHA Certification #: \_\_\_\_\_

MA State License #: \_\_\_\_\_

**OTHER SETTING**

Semester: \_\_\_\_\_ Practitioner's Name: (print) \_\_\_\_\_  
Practicum Site: \_\_\_\_\_ ASHA Certification #: \_\_\_\_\_  
Type(s) of clients: \_\_\_\_\_  
Number of clock hours as assistant: \_\_\_\_\_ MA State License #: \_\_\_\_\_  
Assumed full responsibility in role: \_\_\_\_\_

**OTHER SETTING (if indicated)**

Semester: \_\_\_\_\_ Practitioner's Name: (print) \_\_\_\_\_  
Practicum Site: \_\_\_\_\_ ASHA Certification #: \_\_\_\_\_  
Type(s) of clients: \_\_\_\_\_  
Number of clock hours as assistant: \_\_\_\_\_ MA State License #: \_\_\_\_\_  
Assumed full responsibility in role: \_\_\_\_\_

**Part IV. Conference Record**

A. Initial meeting held at which the Professional Standards and the procedures for evaluation were explained to the Applicant.

Applicant: \_\_\_\_\_ Date: \_\_\_\_\_  
Program Supervisor: \_\_\_\_\_ Supervising Practitioner: \_\_\_\_\_

B. Meeting held midway through the practicum program at which the Applicant's progress toward meeting the Professional Standards was discussed.

Applicant: \_\_\_\_\_ Date: \_\_\_\_\_  
Program Supervisor: \_\_\_\_\_ Supervising Practitioner: \_\_\_\_\_

C. Final meeting held to complete evaluation and to allow Applicant an opportunity to raise questions and make comments.

Applicant: \_\_\_\_\_ Date: \_\_\_\_\_  
Program Supervisor: \_\_\_\_\_ Supervising Practitioner: \_\_\_\_\_

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**Part V. To be completed by Program Supervisor and Supervising Practitioner in School Setting.**

Candidate has successfully completed a clinical practicum consisting of 100 on-site hours in a public school or an approved private school setting.

Yes \_\_\_\_\_ No \_\_\_\_\_

Supervising Practitioner (sign): \_\_\_\_\_ Date: \_\_\_\_\_

Program Supervisor (sign): \_\_\_\_\_ Date: \_\_\_\_\_

Mediator (if necessary: see 7.07 (4)) (sign): \_\_\_\_\_ Date: \_\_\_\_\_