BOARD OF SPEECH-LANGUAGE PATHOLOGISTS AND AUDIOLOGISTS
301 SOUTH PARK, 4TH FLOOR
PO BOX 200513
HELENA MONTANA 59620-0513
(406) 841-2202 FAX: (406) 841-2305
Email: dlibsdlicensingunitB@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 I applicants must submit proof of enrollment in a graduate program.
- Aide II applicants must identify date and major of BA degree.
- Aide III 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 I = 30% while performing diagnostic and interpretive functions.
  10% client contact time (with the option to reduce to 2% after the first year at the discretion of the supervisor for subsequent years)
  Aide II = 10% of client contact time
  Aide III = 20% of client contact time
  Audiology Aide/Assistant = 10% of client contact time

For the purpose of this form one month is equal to four consecutive weeks without holidays, vacation days or other leave.

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ANNUAL AIDE/ASSISTANT REGISTRATION FORM

REGISTRATION #:_____ (for Board use only)

(Please allow an average of 7 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 _____ ☐ MALE ☐ FEMALE

EMPLOYMENT INFORMATION:

6. NAME OF EMPLOYER: _____ PHONE: _____
7. EMPLOYER ADDRESS: _____
   Street or PO Box # City and State Zip
8. ANTICIPATED DATES OF EMPLOYMENT: FROM _____ TO _____
   MONTH/DAY/YEAR MONTH/DAY/YEAR

AIDE/ASSISTANT LEVEL: ☐ **SLP AIDE I** ☐ **SLP AIDE II** ☐ **SLP AIDE III** ☐ **AUD AIDE**

AIDE/ASSISTANT I: **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. During the first year, the supervision requirement will be 10% client contact time, with the option to reduce to 2% after the first year at the discretion of the supervisor for subsequent years.

Is this the first year you have been **registered** as Aide/Assistant I? ☐ Yes ☐ No
If yes, total number of hours per month with clients _____ x 10%= _____
If no, total number of hours per month with clients _____ x 2% = _____

AIDE/ASSISTANT II: _____ **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.

Total number of hours of direct client contact time per month _____ X 10% = _____

AIDE/ASSISTANT III:
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.

Total number of hours of direct client contact time per month _____ X 20% = _____

AUDIOLOGY AIDE/ASSISTANT:
24.222.301 "a person meeting 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. (Minimum requirements)

Total number of hours of direct client contact time per month _____ X 10% = _____

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

Aide/Assistant I shall complete 20 units of continuing education annually. Aide/Assistant II and III will submit verification of 10 continuing education hours annually and must be completed by February 1.

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

List continuing education completed in the past year. Attach Verification:

Plan for meeting the CE requirement for the current year:

S**UPERVISOR INFORMATION**

The Supervisor Information must accompany all AIDE/ASSISTANT Registration Forms

SUPERVISOR NAME: _____

License #: _____ ☐ SLP ☐ AUD ☐ DUAL Year License Obtained _____

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

TELEPHONE _____
Business Home

EMAIL ADDRESS: _____

EMPLOYING AGENCY: _____

MAILING ADDRESS: _____

PLEASE LIST LOCATION(S) TO WHICH YOU PROVIDE SERVICE FOR THIS EMPLOYER:

Number of client contact hours monthly _____

Number of hours monthly travel _____

Caseload Total with Aides _____

Caseload Total with no Aides _____

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

MID-YEAR VERIFICATION OF SUPERVISION: To be submitted by February 25 of each year. The undersigned must verify the plan of supervision for this aide has been met as written with the following exception:

☐ met as written ☐ with the following exceptions _____

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 (SLP, AUD OR SA)

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

DATE _____ _____
SIGNATURE OF REPRESENTATIVE OF HIRING AGENCY

If more than three (3) aides are supervised, board review and approval is required. ARM 24.222.702(5)

AIDE'S NAME	SITE AND CITY OF SERVICE (list separately)	CASELOAD	CLIENT CONTACT TIME PER MONTH BY SLP/AUD	CLIENT CONTACT TIME PER MONTH BY AIDE	TRAVEL TIME PER MONTH	TOTAL SUPERVISION PER MONTH

TOTALS

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 (SLP, AUD OR SA)

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

DATE _____ _____
SIGNATURE OF REPRESENTATIVE OF HIRING AGENCY

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 _____

GLOSSARY OF TERMS

Caseload Total:	This is the total number of clients the supervisor is responsible for, both those that are served in conjunction with the aide and those only seen by the supervisor.
Caseload served jointly with aides:	This is the number of clients that receive services from the aide.
Caseload not jointly served with aides:	These are the clients who receive services only from the supervisor and not the aide.
Hours spent with aides and clients per month:	This is the total for all aides from 24.222.702 AIDE SUPERVISION REQUIREMENT.
Supervisor caseload	Hours spent with clients per month when the aide is not physically present.
Supervisor travel time	Travel time between work sites.
Aide caseload	This is the total number of clients the aide has.
Mid-year Verification:	**This** must be submitted by February 25 along with the Aide/Assistant information submitted at the beginning of the period. Send a duplicate copy with the mid-year signature update.