

**December 9, 2025**  
**Board Room 3**  
**10:15 a.m.**

## **Agenda**

### **Virginia Board of Audiology & Speech-Language Pathology Full Board Meeting**

---

---

**Call to Order – Melissa A. McNichol, Au.D., CCA-A, Chair**

**Page 1**

- Welcome and Introductions
- Emergency Egress
- Mission Statement

---

---

**Ordering of Agenda – Dr. McNichol**

---

---

**Public Comment – Dr. McNichol**

**Page 2-3**

The Board will receive all public comments related to agenda items at this time. The Board will not receive comments on any regulatory process for which a public comment period has closed or any pending or closed complaint or disciplinary matter.

---

---

**Approval of Minutes – Dr. McNichol**

**Pages 4-10**

- July 8, 2025, Board meeting (pp 4-8)
- July 8, 2025, Formal hearing (pp 9-10)

---

---

**Agency Director’s Report – Mr. Arne W. Owens**

---

---

**Legislative/Regulatory Report – Mr. Matt Novak**

**Pages 11-46**

Current Regulatory Actions (p 11)

- Consideration of Petition for Rulemaking (pp 12-39)
- Proposed Regulatory Language for ASLP Compact (pp 40-46)

---

---

**Discussion Items – Dr. McNichol**

**Pages 47-120**

- 2025 Healthcare Workforce Data Center Reports – **Dr. Barbara Hodgdon** (pp 47-109)
  - Audiology (pp 47-77)
  - Speech-Language Pathology (pp 78-109)
- Revised Sanctions Reference Point Manual policy document –  
**Ms. Kelli Moss/Ms. Claire Foley** (pp 110-120)

---

---

**Board Counsel’s Report – Mr. Brent Saunders**

---

---

**Chair’s Report – Dr. McNichol**

---

---

---

---

## Staff Reports

Page 121

Executive Director's Report – **Ms. Moss**

- Update on ASLP-IC Licensure Compact – **Ms. Moss**
- Conflict of interest policy acknowledgement for board members (p 121)
- Outreach
- Staff updates

Licensing report and statistics – **Ms. Laura Jackson**

Discipline report and statistics – **Ms. Foley**

---

---

## New Business – Dr. McNichol

---

---

Next Business Meeting – **Dr. McNichol/Ms. Moss**

Page 122

- April 21, 2026 – Full Board
  - 2026 Calendar (p 122)
- 
- 

## Meeting Adjournment – Dr. McNichol

---

---

This information is in **DRAFT** form and is subject to change.

# MISSION STATEMENT

---

Our mission is to ensure safe and competent patient care by licensing health professionals, enforcing standards of practice, and providing information to health care practitioners and the public.

---

## CMS/CF Guidance published

---

From Susan Adams <SAdams@asha.org>

Date Fri 9/26/2025 8:12 AM

Good morning,

I wanted to share an update related to the CMS/CF issue. CMS has [issued the long-awaited guidance](#) reinforcing that provisional licensees, such as clinical fellows (CFs), are allowed to bill for services provided to Medicare beneficiaries under Part B. The guidance—nearly identical to the guidance CMS sent to ASHA in late July via email—states:

"[CMS will] defer to state licensure requirements to determine for SLPs in each state, allowing them to determine the SLPs that are most appropriate to provide speech-language pathology services to individuals/patients, including Medicare beneficiaries... This means that to the extent that an SLP complies with the applicable state process for licensure, certification, or registration (if the state has one) necessary to practice as an SLP, which may include provisional or temporary licensure as such individual completes required supervised experience, such individual complies with the applicable licensure requirements found at section 1861(l)(a)(4)(A) of the Social Security Act, 42 CFR 410.62(a), 42 CFR 484.115(n), and Section 230.3 of Chapter 15 of the Medicare Benefit Policy Manual."

Of note, CMS:

1. **Corrects** a reference to the Claims Processing Manual made in the July email to the Benefit Policy Manual;
2. **Notes** it has issued guidance to Medicare Administrative Contractors; and
3. **Reinforces** the ability of CFs to bill for Part B services by stating: "CMS is clarifying that the state-licensed SLP may include provisional or temporary licensure as such individual completes required supervised experience and these SLPs may enroll as an SLP in Private Practice (SLPPP) and work for providers furnishing outpatient Part B speech-language pathology services, consistent with state requirements."

Thank you for your patience as ASHA advocated for this clarification. Please feel free to reach out to me if you have any questions.

Best,

~Susan

Susan Adams, Esq., CAE

Pronouns: she/her/hers

Director, State Legislative & Regulatory Affairs

American Speech-Language-Hearing Association

Direct Line: [301-296-5665](tel:301-296-5665)

Ex-officio and Legislative Liaison

ASLP Interstate Compact Commission

*“This information is based on the facts you provided to ASHA staff. ASHA has not verified the information you provided and is not responsible for the accuracy or completeness of this information. Information provided by ASHA does not supersede the clinical, legal or financial judgement of the practitioner, nor does it dictate a payer’s reimbursement policy. In all cases, practitioners remain responsible for their clinical practice and the use of correct coding procedures. ASHA’s response to your question is not and should not be construed as legal advice, which can only be provided by an attorney.”*



### Call to Order

The July 8, 2025, meeting of the Virginia Board of Audiology & Speech-Language Pathology (Board) was called to order at 9:01 a.m. at the Department of Health Professions (DHP), Perimeter Center, 9960 Mayland Drive, 2<sup>nd</sup> Floor, Board Room 3, Henrico, Virginia 23233.

### Presiding Officer

Melissa A. McNichol, AuD, CCA-A

### Members Present

Lisa G. Wallace-Davis, OD

Wayne Shaia, MD

Jennifer Radford Gay, MS, CCC-SLP

James Wells, RPh

### Members Not Present

Laura H. Vencill, MS, CCC-SLP

Bethany Rose, AuD

### Staff Present

Arne W. Owens, Director, DHP

Kelli G. Moss, Executive Director

Claire C. Foley, Deputy Executive Director

Matt Novak, Agency Regulatory Coordinator, DHP

James E. Rutkowski, Senior Assistant Attorney General, Board Counsel

Laura L. Jackson, Board Administrator

Laura D. Paasch, Senior Licensing & Operations Specialist

### Others Present

Kim Small, Vice-President, VisualResearch Inc.

Sara Blöse, Senior Assistant Attorney General (observing board counsel)

Barbara Hodgdon, Deputy Director, Healthcare Workforce Data Center (HWDC), DHP

Cherese Lampkins, Summer Intern for HWDC

Kelly Smith, Director of Communications, DHP

## **Public Present**

Melanie-Joy H. Dorn, MA, CCC-SLP, Vice President of Government & Professional Affairs, Speech-Language Hearing Association of Virginia (SHAV)

## **Establishment of Quorum**

Five out of the seven board members were present, constituting a quorum for conducting business.

## **Introduction**

Dr. McNichol welcomed Senior Assistant Attorney General, Jim Rutkowski, who was serving as board counsel for this meeting.

## **Ordering of Agenda**

Dr. McNichol opened the floor to any edits or corrections regarding the agenda. Hearing none, the agenda was accepted as presented.

## **Public Comment**

Melanie-Joy H. Dorn, SLP, addressed the Board regarding a Petition for Rulemaking she submitted in June 2025, reporting that recent changes to the Centers for Medicare and Medicaid (CMS) definition of a licensed SLP now excludes provisionally licensed SLPs from qualification to bill Medicare Part B for services. She stated this is a time-sensitive issue impacting the hiring of new graduates and the revenue of current SLP providers and urged the Board to act quickly on her petition to consider issuing full licenses to applicants upon graduation from an approved SLP program. She stated the American Speech-Language Hearing Association (ASHA) is advocating for CMS's revised policy to be reversed.

## **Approval of Minutes**

Dr. McNichol opened the floor to any edits or corrections to the draft minutes of the full board meeting held on April 8, 2025. With no additions or corrections, the minutes were approved as presented.

## **Agency Director's Report**

Mr. Owens provided an update on the agency's activities, including the dissolution of the Board of Health Professions as a policy board under DHP as a result of legislation passed during the 2025 General Assembly. As of July 1, 2025, any duties under the Board of Health Professions were transferred to the appropriate regulatory board or to his office. Mr. Owens reported DHP leadership is reviewing operations to improve efficiency measures as it develops its FY2027-2028 biennial budget.

## **Legislative/Regulatory Report**

Mr. Novak provided a report on legislative and regulatory activity, which includes one pending current regulatory action to implement the ASLP Interstate Compact. Proposed stage regulations

will be presented to the Board at a future meeting once the ASLP-IC supplies its member states with information needed to promulgate regulations.

#### Closure of Periodic Review of Chapter 11

Mr. Novak stated a periodic review was opened for 18 VAC 30-11, Public Participation Guidelines (PPG), almost two years ago and was never closed. These regulations only change when the Department of Planning and Budget has new regulations for agencies to adopt, and no updates have occurred since the Board last adopted its PPG.

A motion was made by Dr. Wallace-Davis to retain 18 VAC 30-11 without changes. The motion was seconded by Mr. Wells and carried unanimously.

#### Exempt Regulatory Action to Amend 18VAC30-21-131

Mr. Novak reported that the Board eliminated the list of approved educational programs in a previous regulatory action with a plan to place them in a policy document as part of the agency's regulatory reduction initiative. Necessary changes to Section -131 were overlooked during that action and the correction of a technical error under Virginia *Code* § 2.2-4006(A)(3), qualifies as an exempt regulatory action if the Board chooses to initiate it.

A motion was made by Dr. Wallace-Davis to initiate an exempt regulatory action to amend 18VAC30-21-131 of the regulations with the necessary changes. The motion was seconded by Dr. Shaia and carried unanimously.

#### New Policy Document - Continuing Education Providers

Mr. Novak stated that the board's regulatory reduction action effective February 13, 2025, deleted the list of board-approved continuing education providers that may be adopted within a policy document that may be amended with new education providers as they are approved by the board.

A motion was made by Dr. Shaia to approve a new policy document to document board-approved continuing education providers. The motion was seconded by Dr. Wallace-Davis and carried unanimously.

Mr. Novak provided information on the new statute § 54.1-2620 passed by the 2025 General Assembly to license speech-language pathology assistants (SLPAs). This statute has an enactment clause of July 1, 2027, which will provide ample time for the board to promulgate regulations for licensure of SLPAs.

#### **Discussion Items**

Ms. Small presented information regarding the proposed revisions to the Board's Sanctioning Reference Points worksheet and instructions. If adopted by the Board, these documents will be used to update the SRP Manual to aid the board in determining sanctions for discipline cases.

A motion was made by Dr. Wallace-Davis to adopt the SRP worksheet and instructions as presented. The motion was seconded by Dr. McNichol and carried unanimously.

Ms. Moss provided information regarding a recent change in the Centers for Medicare and Medicaid (CMS)'s definition of a qualified SLP for reimbursement of services that excludes provisional SLP licensees. She stated that financial reimbursement is beyond the board's purview and that ASHA and SHAV are advocating on behalf of SLPs. Because this is a matter of concern to its licensees and is related to the Petition for Rulemaking recently filed to change licensure requirements, board staff will keep the board informed of new developments.

Ms. Moss provided an update on the ASLP-International Compact. As of June 2025, 36 states and one territory have joined the compact. The Compact Connect data system is scheduled to launch in September 2025, and the ASLP-IC has adopted a \$50 fee per applicant, per year to purchase and maintain privileges. It has also amended its rules on criminal background checks, which will be required for privileges. This rule change reflects the difficulty some member boards are having with the Federal Bureau of Investigations issuing authorizations to conduct CBCs. Virginia may require a statutory change for the FBI to recognize the board's authority to request them. The Board cannot issue or accept privileges until regulations for the Compact are finalized. The annual business meeting is scheduled for September 20, 2025, and Ms. Gay and Dr. Rose are Virginia's delegates. Informational Compact Connect meetings will be held virtually on July 8, 2025, and July 11, 2025, to assist member boards with onboarding.

### **Board Counsel's Report**

Mr. Rutkowski informed the Board that Senior Assistant Attorney General Brent Saunders has now been assigned as counsel for this board but was unable to attend this meeting due to a scheduling conflict. Mr. Rutkowski introduced Sara Blose as the new assistant attorney general who will provide counsel to other regulatory boards under DHP, and stated she is attending board meetings and hearings with him as part of her onboarding process.

### **Chair's Report**

Dr. McNichol had no information to report to the Board.

### **Staff Reports**

Ms. Moss stated she had nothing further to add to Mr. Owens' report regarding the dissolving of BHP and the biennial budget. She provided updates regarding board outreach activities with SHAV and the implementation of an automated email "bot" to assist with CE requirements for license renewal. Ms. Moss noted she is working with Ms. Kelly Smith, DHP's director of communications, to develop a board newsletter. She announced DHP's annual board member orientation is scheduled for October 3, 2025, and invited any board members who wish to attend to contact her for more information. She provided statistics regarding the most recent monthly and total numbers of licenses issued to date.

Ms. Foley provided an update on the open and closed discipline cases.

### **New Business**

Dr. McNichol provided information from the bylaws affirming that the election of officers was required at the first organizational meeting of each year, which begins July 1. She called for nominations for the office of Chair.

#### Chair

A motion was made by Mr. Wells to nominate Dr. Wallace-Davis to serve as Chair of the Board. The motion was seconded by Dr. Shaia.

A motion was made by Dr. McNichol to nominate Ms. Gay to serve as Chair of the Board. The motion was seconded by Mr. Wells.

A roll call vote was taken resulting in three votes to two in favor of Dr. Wallace-Davis serving a one-year term as Chair of the Board effective January 1, 2026.

#### Vice Chair

A motion was made by Dr. Wallace-Davis to nominate Ms. Gay to serve as Vice-Chair of the Board. The motion was seconded by Dr. Shaia.

No other nominations were received. The motion carried unanimously for Ms. Gay to serve a one-year term as Vice-Chair of the Board with an effective date of January 1, 2026.

### **Next Meeting**

Ms. Moss stated the next full board meeting is scheduled for Tuesday, December 9, 2025.

### **Adjournment**

With no objection, Dr. McNichol adjourned the meeting at 10:22 a.m.

---

Kelli G. Moss  
Executive Director

**VIRGINIA BOARD OF AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY  
FORMAL HEARING MINUTES  
DEPARTMENT OF HEALTH PROFESSIONS  
BOARD ROOM 3  
HENRICO, VA  
July 8, 2025**

**CALL TO ORDER:** The meeting of the Virginia Board of Audiology and Speech-Language Pathology (Board) was called to order at 12:02 p.m. on July 8, 2024, at the Department of Health Professions (DHP), Perimeter Center, 9960 Mayland Drive, 2<sup>nd</sup> Floor, Board Room 3, Henrico, Virginia.

**PRESIDING OFFICER:** Melissa McNichol, Au.D., CCC-A, Chairperson

**MEMBERS PRESENT:** Jennifer Gay, MS, CCC-SLP  
Wayne Shaia, MD  
Lisa Wallace-Davis, O.D.

**QUORUM:** With four members of the Board present, a quorum was established.

**STAFF PRESENT:** Kelli Moss, Executive Director  
Claire Foley, J.D., Deputy Executive Director

**BOARD COUNSEL:** Jim Rutkowski, Senior Assistant Attorney General  
Sara Blose, Senior Assistant Attorney General

**COURT REPORTER:** Juan Ortega, Ortega International Reporting

**PARTIES ON BEHALF OF THE COMMONWEALTH:** Emily Tatum, Sr. Adjudication Specialist Administrative Proceedings Division

**COMMONWEALTH WITNESSES:** William Gorwood, Sr. Investigator, Enforcement Division

**OTHERS PRESENT:** Chris Kim, Adjudication Specialist, Administrative Proceedings Division  
Crystal Cuffley, Enforcement  
Emma Frayser, Enforcement  
Elora Grochowski, Enforcement

**MATTER SCHEDULED:** **Kiah Thompson, Provisional Speech-Language Pathology Applicant**

The Board met in accordance with a Notice of Formal Hearing dated March 4, 2025, and notice of continuance dated March 21,

2025. Ms. Thompson appeared before the Board for the Formal Hearing and was not represented by counsel.

**CLOSED SESSION:**

Dr. Wallace-Davis moved that the Board convene a closed meeting pursuant to § 2.2-3711(A)(27) of the Code of Virginia (“Code”) for the purpose of deliberation to reach a decision in the matter of **Kiah Thompson, Provisional Speech-Language Pathology Applicant**. Additionally, she moved that Ms. Moss and Ms. Foley attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Board in its deliberations. The motion was seconded by Ms. Gay and carried unanimously.

**RECONVENE:**

Dr. Wallace-Davis moved that the Board certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded by Ms. Gay and carried unanimously.

The Board reconvened in open session pursuant to § 2.2-3712(D) of the Code.

**DECISION:**

Dr. Wallace-Davis moved to grant the license to practice as a provisional speech-language pathologist to Ms. Thompson and to issue a reprimand. Dr. Wallace-Davis further moved that the basis for this decision will be set forth in a final Board Order that will be sent to Ms. Thompson at her address of record. The motion was seconded by Dr. McNichol and carried unanimously.

This decision shall be effective upon the entry by the Board of a written Order stating the findings, conclusions and decision of this quorum of the Board.

**ADJOURNMENT:**

The Formal Hearing adjourned at 1:51 p.m.

---

Kelli G. Moss, Executive Director

**Board of Audiology and Speech-Language Pathology**  
**Current Regulatory Actions**  
**As of November 20, 2025**

**In the Governor's Office**

None.

**In the Secretary's Office**

None.

**In the Department of Planning and Budget**

None.

**In the Office of the Attorney General**

VAC	Stage	Subject Matter	Submitted from agency	Time in current location	Notes
18VAC30-21	Final	Regulatory clean-up of section 131	7/10/2025	133 days	Corrects references that were not changed in a previous action.

**Recently effective or awaiting publication**

VAC	Stage	Subject Matter	Published	Comment Period Ends	Notes
18VAC30-21	NOIRA	Implementation of the ASLP Compact	5/19/2025	6/18/2025	Implements the ASLP Compact.

## **Agenda Item: Consideration of Petition for Rulemaking**

### **Included in your Agenda Package:**

- Petition for Rulemaking (Dorn) which requests the Board eliminate 18VAC30-21-60(A)(2)(c);
- Comments received on TownHall; and
- 18VAC30-21-60

**Staff Notes:** There were 34 comments provided on TownHall. 23 were in support of the petition and 6 were in opposition to the petition. Additionally, four supported removing a requirement to hold a CCC to obtain licensure and one had no discernable position.

There appears to be some confusion regarding this petition amongst several of the commenters, which are spelled out below.

- This petition is asking to eliminate the newly created pathway to licensure that is an alternative to holding a CCC, NOT to eliminate holding a CCC as a pathway to licensure. Two commenters supported elimination of CCCs as a pathway to licensure.
- Elimination of 18VAC30-21-60(A)(2)(c) would only eliminate the provisional licensure practice for one pathway, not both. Anyone obtaining their CCC would still be required to demonstrate 6 months of provisional practice after graduation. The two pathways would no longer be equivalent.

As stated during the public comment period at the Board's July meeting, this petition was filed to address CMS's new guidelines as of June 2025 which prevent provisionally licensed individuals from billing Medicare. CMS revised its guidelines in July 2025 and addressed this issue.

### **Action Needed:**

Motion to either:

- Accept the petition and initiate rulemaking; **or**
- Deny the petition, clearly stating why.



# COMMONWEALTH OF VIRGINIA

## Board of Audiology & Speech-Language Pathology

9960 Mayland Drive, Suite 300  
Richmond, Virginia 23233-1463

(804) 367-4630 (Tel)  
(804) 527-4471 (Fax)

**Note: As of June 1, 2019, the Boards phone number will change to: (804) 597-4132**

### Petition for Rule-making

*The Code of Virginia (§ 2.2-4007) and the Public Participation Guidelines of this board require a person who wishes to petition the board to develop a new regulation or amend an existing regulation to provide certain information. Within 14 days of receiving a valid petition, the board will notify the petitioner and send a notice to the Register of Regulations identifying the petitioner, the nature of the request and the plan for responding to the petition. Following publication of the petition in the Register, a 21-day comment period will begin to allow written comment on the petition. Within 90 days after the comment period, the board will issue a written decision on the petition. If the board has not met within that 90-day period, the decision will be issued no later than 14 days after it next meets.*

<b>Please provide the information requested below. (Print or Type)</b>		
Petitioner's full name (Last, First, Middle initial, Suffix,)		
Melanie-Joy H Dorn		
Street Address	Area Code and Telephone Number	
103 Harmony Dr SW	5712158564	
City	State	Zip Code
Vienna	VA	22180
Email Address (optional)	Fax (optional)	
melanie.dorn@verizon.net		
<b>Respond to the following questions:</b>		
1. What regulation are you petitioning the board to amend? Please state the title of the regulation and the section/sections you want the board to consider amending. 18VAC30-21		
2. Please summarize the substance of the change you are requesting and state the rationale or purpose for the new or amended rule. Section 60A2C should be removed. Applications should qualify for full licensure by graduating with a master's degree in speech language pathology from a Council on Academic Accreditation (CAA ) accredited university and providing an official or authenticated copy of a passing score, as established by the American Speech-Language-Hearing Association, on the Praxis II specialty examination in the area of speech-language pathology, or another examination approved by the board. Clinical experience is already part of CAA accredited programs, they require 25 observation hours and 375 supervised clinical hours.		
3. State the legal authority of the board to take the action requested. In general, the legal authority for the adoption of regulations by the board is found in § 54.1-2400 of the Code of Virginia. If there is <u>other</u> legal authority for promulgation of a regulation, please provide that Code reference. 54.1-2400		
Signature:	<i>Melanie-Joy H Dorn</i>	Date: 6/13/2025



**Agency** Department of Health Professions

**Board** Board of Audiology and Speech-Language Pathology

**Chapter** Regulations Governing the Practice of Audiology and Speech-Language Pathology [18 VAC 30 - 21]

34 comments

All comments for this forum

[Back to List of Comments](#)

**Commenter:** Anastasia M Raymer

7/14/25 12:06 pm

**Speech-Language Pathology licensure**

As the chair of the MS Speech-Language Pathology program at Old Dominion University and as a licensed speech-language pathologist, I support the proposed amendment to bring full licensure to our graduates. There is needless complication for new graduates to have two different pathways upon attempting to gain their license. They have completed all academic and professional training once the Masters degree is conferred. This has enormous implications for payors who decline to pay for services provided by a professional who is issued a provisional license.

Thank you for your attention

Anastasia Raymer, CCC-SLP

CommentID: 236954

**Commenter:** License VA SLP

7/14/25 12:14 pm

**In Support**

New graduates should be able to pursue full licensure after graduation from an accredited program and passing the praxis. No additional supervision/probationary period should be required.

CommentID: 236955

**Commenter:** Anonymous

7/15/25 10:11 am

**Opposing the Removal of CF Licensure Requirements**

As a concerned stakeholder in the field of speech-language pathology, I oppose the proposed removal of Clinical Fellowship (CF) licensure requirements for SLPs in Virginia. While recent Medicare changes have prompted discussion, dismantling CF licensure would have far-reaching and potentially harmful consequences for our profession, our clients, and our state.

**1. Threat to Virginia's Participation in the ASLP-IC (Interstate Compact):**

Virginia is a member of the Audiology and Speech-Language Pathology Interstate Compact (ASLP-IC). Removing CF licensure might jeopardize our compliance with compact requirements.

This change could isolate Virginia SLPs from national opportunities and reduce access to services for clients in underserved areas. Therefore, more information is needed to determine what, if any impact, there might be on VA's participation in the ASLP-IC.

## **2. Medicare Changes Affect a Small Subset of SLPs:**

The recent Medicare policy shift impacts only a limited number of SLPs. It is disproportionate and shortsighted to overhaul licensure requirements for all SLPs based on a federal billing issue that affects a minority.

## **3. Ongoing Advocacy and Adaptation Are Already Underway:**

Organizations like ASHA, private practices, and healthcare systems are actively working to address the Medicare changes through supervision models and policy advocacy. These efforts demonstrate that we can adapt without dismantling the CF licensure structure that ensures professional accountability and public protection.

## **4. Long-Term Risks to Workforce Development and Education:**

Eliminating CF licensure introduces significant uncertainty into the professional pipeline. It could disrupt graduate program curricula, deter students from enrolling in Virginia programs, and create confusion in the job market. Most importantly, it risks undermining the quality and readiness of new SLPs entering the field, which could ultimately harm the clients we serve.

In conclusion, while we must respond thoughtfully to federal policy changes, removing CF licensure is not the solution. I urge policymakers to preserve this critical step in professional development and maintain Virginia's commitment to high standards, workforce stability, and interstate collaboration.

CommentID: **236956**

**Commenter:** Amy Yaeger, MS, CCC/SLP

7/16/25 7:55 am

## **Move supervision requirement to renewal**

While I can appreciate the concerns related to CMS billing for provisional licensees, I am uncomfortable with removing the requirement of six months of practice and a recommendation from a supervisor under a provisional license as a path to initial licensure (18VAC30-21-60 - section c). Would it be possible to move the requirement of six months of practice and a recommendation from a supervisor to being a requirement for the initial renewal of a license? Subsequent renewals of the BASLP license would only require that SLPs meet the criteria for continuing education. This would "remove" the provisional license, but keep the requirement for supervision within at least the first year of practice.

CommentID: **236960**

**Commenter:** Phil Helman

7/17/25 2:18 pm

## **100% Support for The Pending Resolution**

As Chief Executive Officer and Owner of Adler Therapy Group, a private therapy company located in the Hampton Roads (Virginia) area which employs over 60 speech-language pathologists (SLPs) and provides speech services to close to 1,000 pediatric patients a week, I am writing in support of the petition to eliminate 18VAC30-21-60(A)(2)(c).?

Simply put, there is no reason why an SLP in the state of Virginia should not be able to gain a full, **unconditional** license from the state of Virginia upon graduation from an accredited school and having passed the Praxis. This is the standard for new physical and occupational therapy graduates and standards for speech-language pathologists should not be any different.?

As the American Speech-Language-Hearing Association (ASHA) itself says:

“The scope of practice (evaluation, diagnosis, treatment) for CFs and SLPs is the same whether an individual holds a provisional or a full license. The primary difference is the title of the license (e.g., provisional). In addition, for those who are pursuing clinical fellowship, they need to comply with the supervision standards required to obtain the CCC and state licensure. Therefore, the varied licensure title is largely a distinction without difference and fails to acknowledge that provisional licensees have earned a master’s or doctoral degree and completed supervised clock hours of clinical practicum as required by Medicare and under most state laws.”

The Virginia code follows ASHA’s supervision requirements, which boils down to only requiring a half hour of direct and a half hour of indirect supervision per week, resulting in a minimum of thirty-six hours of supervision during the entire nine-month ASHA fellowship process. While ATG has robust mentorship in place for CFs, the reality is many CFs barely interact with their supervisors and often are not even working in the same building. The simple fact is that the CF experience is never uniform and varies widely based on the structure of each work environment, and on the discretion of the supervisor involved. While some CF experiences are great, many are just going through the motion for nine months.

This issue is critical for our industry for the following reasons:

1. The standards for credentialing with most commercial and federal payers are directly related to licensure. I.e., CFs cannot see some patient populations unrestricted because both commercial and federal insurances, such as MEDICARE and TRICARE, won’t credential them with a provisional license. This causes excessive administrative and financial burdens on both the provisional licensees, and the companies which employ them.
2. Provisional licensees can do anything a fully licensed SLP can do as long as certain supervision steps are in place. Unfortunately, this creates a burden on the supervisor involved. Again, more administrative and financial burdens are created for no reason.
3. **PATIENT CARE.** The demand for speech therapy services throughout Virginia is strong. **Virginia is currently ranked 42nd in the country in the ratio of SLPs to 100,000 residents** (<https://www.asha.org/siteassets/surveys/audiologist-and-slp-to-population-ratios-report.pdf>). In fact, there are hundreds of children waiting for services across Hampton Roads alone, with some clinics on a six-month to one-year wait list. We should be doing everything possible to get these children the care they need, and eliminate obstacles such as provisional licenses and the related red tape of credentialing and supervision that cause many clinics and healthcare systems to refrain from hiring those with provisional licenses.

**Simply put, if insurance carriers won’t credential CFs, they can’t be employed and patients won’t be able to get the services they need.**

The biggest risk we face besides patient care is the risk to the speech therapy profession itself. Applicants for graduate school will likely decrease after the latest Medicare announcement because potential applicants don’t want to have to deal with the fact that after spending thousands of dollars on a graduate education, their employability is limited by a byzantine set of rules and regulations. We are already facing intense pressure to meet demand. We need to nurture this profession and avoid anything that might give someone pause as they consider this career.

Bottom line, when a new physical or occupational therapist graduate comes to work for us, they have no limitations on their work and who they can treat. That does not mean we don't mentor, coach, and support their career path. However, we can mentor them as any company in any industry does with new hires and graduates and avoid the regulatory hurdles which pop up when a practicing therapist does not have a full license.?

In closing, as listed above, it is clear that the present licensure process for SLPs is no longer practical and needs to be changed. The ultimate beneficiaries for this change would not just be new speech graduates but the ever-growing population of children and adults who need speech therapy services but whose interventions/therapy are delayed by a lack of staff who are credentialed to see them.

I can't emphasize how important it is to solve this issue now, both for our SLPs and the patients we serve. The petition involved is a common sense solution to an important issue and I encourage the board to accept it.

Sincerely,

Philip R. Helman

CEO

Adler Therapy Group

757-647-5517

CommentID: 236969

**Commenter:** Gianna Cardone

7/17/25 2:50 pm

### **Supporting Pending Resolution**

I am writing to strongly advocate for a change in the current licensure process for Speech-Language Pathologists in our state. Specifically, I urge the board to consider granting full, unrestricted licensure to SLPs immediately upon graduation and successful completion of the Praxis examination—consistent with the licensing practices for other allied health professionals such as physical therapists and occupational therapists.

The current requirement for Clinical Fellowship (CF) licensure, while well-intentioned, no longer accurately reflects the training, competence, or readiness of today's SLP graduates. By the time a clinician enters the CF year, they have completed extensive supervised clinical hours, passed a nationally standardized exam, and demonstrated their ability to provide independent, evidence-based care.

Yet, outdated regulations continue to classify CFs as needing supervision to perform tasks they are already qualified to do. This creates confusion, billing complications, and barriers to employment—especially in underserved settings where access to fully licensed SLPs is already limited.

Granting full licensure upon graduation would:

- Ensure parity with PTs and OTs, who receive unrestricted licenses immediately upon passing their exams.
- Streamline billing and credentialing processes for employers and payers.
- Reflect the high level of clinical competence and readiness our graduate programs instill.
- Support new clinicians without stigmatizing them as “in training” professionals.

Mentorship and professional support can and should continue during the first year of practice, but these supports should not be tied to an unnecessarily restricted license.

Thank you for your time and consideration. I respectfully urge the board to modernize our licensure system and align it with the realities of contemporary SLP education and practice.

Sincerely,  
Gianna Cardone, M.S., CF-SLP  
CommentID: 236970

**Commenter:** A current VA SLP Graduate Student

7/17/25 7:42 pm

### In Support

To whom it may concern,

As a current speech language pathologist graduate student, my course of study not only include a variety of classes that involve all types of age groups and disorders to be educated about for the profession; but also am required to complete 400 hours of clinical practicum. This means that I am the clinician, under a supervisor, that treats these patients for a number of disorders. I have seen a wide range of children, adults, groups, and much more that I am prepared for in my field of work. Due to this, I am in support for receiving my Certification of Clinical Competence (CCC) after graduation and eliminating the extra year of work under supervision.

Thank you for your time and consideration.

CommentID: 236972

**Commenter:** Anonymous

7/17/25 9:05 pm

### In favor

As a bilingual speech-language pathologist, Latina immigrant, and private practice owner in Virginia, I strongly support eliminating the requirement in 18VAC30-21-60(A)(2)(c) that ties licensure to holding the ASHA Certificate of Clinical Competence (CCC). While the CCC is one valuable pathway, it should not be the only one.

Many highly skilled and qualified clinicians—especially those from underrepresented, immigrant, bilingual, and internationally trained backgrounds—face systemic barriers to obtaining the CCC. These barriers are often financial, institutional, or related to accreditation access, not reflective of clinical competence or commitment to ethical, high-quality care.

The additional licensure pathway established by the Board earlier this year opens the door for these professionals to serve communities that are often overlooked, including families who need services in languages other than English or who seek therapists who reflect their cultural values and communication styles. Removing this requirement would increase access to care, support the growing demand for speech therapy across Virginia, and foster a more inclusive, culturally responsive workforce.

As someone who works directly with families who struggle to find providers who understand both language development and cultural nuance, I believe this policy change is essential. It upholds high standards while expanding access, without compromising the quality of services provided.

I urge the Board to consider the broader implications of workforce equity, client access, and community representation, and to allow this more flexible licensure pathway to remain in place.

CommentID: 236973

**Commenter:** Louise Chamberlin, Get Talking Speech Therapy

7/17/25 10:17 pm

### **Public Comment in Support**

As a clinician, private practice owner, and advocate for positive change in our field, I strongly support the petition to eliminate the requirement in 18VAC30-21-60(A)(2)(c) that ties licensure to holding the ASHA Certificate of Clinical Competence (CCC). While the CCC is a respected credential, it should not be the sole path to licensure in our state.

This requirement creates unnecessary barriers for highly qualified clinicians who may face challenges accessing the CCC due to financial, institutional, or systemic limitations. The additional pathway established by the Board earlier this year is an equitable step toward meeting Virginia's growing demand for speech-language services. It broadens access for professionals who are uniquely positioned to serve our communities, and especially reduces bureaucratic barriers contributing to a "funnel effect" for new, but perfectly competent, clinicians entering the field.

This change does not lower standards; it modernizes them. It recognizes that competence, ethical practice, and professional excellence are not limited to those holding one specific credential.

I respectfully urge the Board to retain this licensure flexibility and eliminate the requirement in 18VAC30-21-60(A)(2)(c), allowing our profession to move forward in a more inclusive, responsive, and accessible direction.

Sincerely,

Louise Chamberlin

CommentID: **236974**

**Commenter:** Courtney Judson

7/17/25 11:28 pm

### **Support of Removing the Provisional License Requirement**

As a CF Mentor and Lead Therapist, I fully support the resolution to eliminate the provisional license for Clinical Fellows in Virginia. In my role mentoring new graduates, I've consistently seen how this extra step—though well-intended—creates more confusion than clarity. Families are often uncertain about what a provisional license means and whether their child is being treated by a "real" speech therapist. I've had to explain the CF process multiple times to reassure parents that their child is receiving the same level of care. This confusion can erode trust and create unnecessary barriers between families and therapists.

On the administrative side, the provisional license creates complications with insurance billing, credentialing, and approvals. Each insurance company treats CFs differently, and keeping track of what is and isn't allowed for each payer adds to the workload of our administrative team. It also leads to delays in getting services started, which ultimately impacts patients.

Our Clinical Fellows are competent and well-prepared. Once they've graduated and passed the Praxis, they are fully capable of delivering high-quality care. Aligning our licensure process with other allied health professions would reduce barriers, streamline access to services, and relieve unnecessary burdens from both clinicians and families. Thank you for considering this important step forward for our profession.

Sincerely,

Courtney Judson, M.A., CCC-SLP

CommentID: **236976**

**Commenter:** Morgan Murphy

7/18/25 1:33 pm

### **In Support**

As a lead early intervention provider, I supervise and support a variety of clinician, including clinical fellows. In early intervention, our CFs are unable to treat patients with certain insurance types (like Tricare) due to the nature of the provisional license and the nature of travel therapy in early intervention. As clinical fellows have passed all necessary examinations and have a Master's degree, there is no reason that they should not be able to treat any patients who are in need of services. This makes it more difficult for those therapist's to build up their caseloads, especially in certain regions (like Virginia Beach and Norfolk) that have a high population of patients with Tricare insurance. And, ultimately, it give patients less availability of providers in their area. I am in 100% support of new clinicians being able to apply for full licensure upon their graduation.

CommentID: **236977**

**Commenter:** Madeline Appleyard

7/18/25 3:53 pm

### **Supporting the Pending Resolution**

As a speech-language pathologist serving children and families in Virginia, I strongly support the proposal to eliminate the six-month wait period for obtaining a full, unrestricted license after graduation and passing the Praxis. This unnecessary delay creates significant barriers that negatively impact patient care. Families already face long waitlists for speech therapy, and requiring an additional six-month restriction prolongs access during critical developmental windows, especially for infants and toddlers who need early intervention.

The impact is even greater in rural and underserved areas, such as the Northern Neck, where SLP shortages are already a challenge. This rule discourages new graduates from accepting positions in these communities, further limiting access to essential services. Additionally, the policy places speech-language pathologists at a disadvantage compared to other rehabilitation professionals, such as occupational and physical therapists, who do not face a similar barrier. It also creates a financial burden for families and providers when insurance cannot be billed for CF-SLP services, leaving families to pay out of pocket or forgo therapy altogether.

Removing the six-month waiting period ensures that patients across Virginia receive timely, uninterrupted care from qualified professionals. I urge the Virginia Board to approve this proposal in the best interest of the patients and families we serve.

Sincerely,

Madeline Appleyard, M.S., CCC-SLP

CommentID: **236978**

**Commenter:** Lindsay Hadel

7/21/25 2:48 pm

### **Petition for Removal of Clinical Fellowship Requirments**

I am writing to strongly advocate for a change in the current licensure process for Speech-Language Pathologists in our state. Specifically, I urge the board to consider granting full, unrestricted licensure to SLPs immediately upon graduation and successful completion of the Praxis examination—consistent with the licensing practices for other allied health professionals such as physical therapists and occupational therapists.

The current requirement for Clinical Fellowship (CF) licensure, while well-intentioned, no longer accurately reflects the training, competence, or readiness of today's SLP graduates. By the time a clinician enters the CF year, they have completed extensive supervised clinical hours, passed a nationally standardized exam, and demonstrated their ability to provide independent, evidence-based care.

Yet, outdated regulations continue to classify CFs as needing supervision to perform tasks they are already qualified to do. This creates confusion, billing complications, and barriers to employment—especially in underserved settings where access to fully licensed SLPs is already limited.

Granting full licensure upon graduation would:

- Ensure parity with PTs and OTs, who receive unrestricted licenses immediately upon passing their exams.
- Streamline billing and credentialing processes for employers and payers.
- Reflect the high level of clinical competence and readiness our graduate programs instill.
- Support new clinicians without stigmatizing them as “in training” professionals.

Mentorship and professional support can and should continue during the first year of practice, but these supports should not be tied to an unnecessarily restricted license.

Thank you for your time and consideration. I respectfully urge the board to modernize our licensure system and align it with the realities of contemporary SLP education and practice.

Sincerely,

Lindsay Hadel, M.S., CCC-SLP  
CommentID: **236983**

**Commenter:** Olivia Hampton

7/21/25 2:54 pm

### **In Support**

As a pediatric speech-language pathologist in Virginia I strongly support the proposal to eliminate the six-month wait period for obtaining a full, unrestricted license after graduation and passing the Praxis.

This policy imposes unnecessary delays for professionals who are already highly qualified to begin providing care. By the time we graduate from accredited programs, we have completed over **400 supervised clinical hours** across a variety of settings and populations. In addition, we have passed **two rigorous national exams** — the Praxis in Speech-Language Pathology and the comprehensive assessments required by our graduate programs. These experiences thoroughly prepare us to deliver evidence-based services to clients from day one.

The current six-month restriction limits our ability to practice independently, bill insurance, or be fully credentialed, even though we have already met the standards of competency. This delay directly impacts access to care, particularly for families with young children during critical periods of development. Early intervention is time-sensitive, and unnecessary barriers such as this can affect long-term outcomes.

I respectfully urge the Board to approve this change in the best interest of the patients and families we serve.

Sincerely,  
Olivia Hampton MS, CCC-SLP

CommentID: 236984

**Commenter:** Seijra A Toogood

7/22/25 9:51 am

### **Support**

I am in support of eliminating 18VAC30-21-60(A)(2)(c) and allow an applicant to qualify for licensure without holding a Certificate of Clinical Competence from the American Speech-Language-Hearing Association (ASHA).

CommentID: 236985

**Commenter:** Shannon Williams

7/22/25 6:57 pm

### **Support for alternative licensing**

I strongly support the amendment to create an additional pathway for speech-language pathology licensure that does not require completion of the Clinical Fellowship (CF). This important change will expand access to the profession, help address persistent workforce shortages, and make it more feasible for highly qualified professionals to serve in Virginia—especially in rural and underserved communities where access to care is limited.

By removing the CF requirement while still maintaining rigorous academic and clinical training standards through accredited graduate programs, the Board is recognizing the evolving nature of professional preparation in our field. Many states have already modernized their licensure requirements to reflect these trends without compromising public safety or professional quality.

I commend the Board for taking this thoughtful and forward-looking step and urge continued support for licensure pathways that expand opportunity while maintaining the integrity of the profession

CommentID: 236986

**Commenter:** Alison King

7/28/25 7:01 pm

### **Support Changes to Licensure Regulations**

I am an SLP licensed in Virginia and have supervised SLP graduate students, recent graduates, and those seeking advanced certifications over the last 25 years. I fully support the proposed changes to licensure. Our graduates finish 6 years of advanced education meeting a complicated list of competencies, both academic and clinical, as well as completing 400 supervised clinical hours. They have also passed the Praxis exam. These professionals have proven their ability to safely practice. State license is about public protection. The extra hurdle of additional supervision is not necessary and not needed to accomplish the mission of the Board.

I believe it is necessary to reflect on some of the comments that are opposed to these proposed changes. Yes, this issue only affects only a small number of professionals. I wholeheartedly disagree with the notion that if it only effects a few, then we do not need to consider changes as every one of our fully licensed professionals was once on a provisional license. I may not have had the issues with reimbursement since I was licensed well before the 2015 changes to Medicaid; however, we cannot ignore that the supervision period is an antiquated system without data from the Board as to the impact on public protection. Cited data on various message boards are provided by our professional association - ASHA. I understand and appreciate that ASHA is

"working on it" in reference to billing and the enforcement of guidelines approved 10 years ago, but we can work on it also by eliminating the unnecessary delay in licensure.

Additionally, I do not believe that considering the impact on the ASLP-IC is warranted at this time. We cannot delay our own interests in Virginia, as our commitment is to our licensed professionals, when there is nothing that is stated in the ASLP-IC that our membership would be impacted by eliminating this requirement. Finally, thank you for your time and consideration to this important matter.

CommentID: **236993**

**Commenter:** Ed M. Bice

7/29/25 10:22 am

### **SLP License**

I am writing in strong support of the proposed changes to speech-language pathology licensure in Virginia.

Although graduates of speech-language pathology programs complete rigorous academic and clinical training comparable to other allied health professionals (e.g., physical therapists and occupational therapists) current licensure requirements impose additional burdens that are not aligned with these peer professions. The unnecessary barriers may delay the attainment of full licensure and, more importantly, limit access to care for individuals who need speech and language services. Given that the primary purpose of licensure is to protect the public, policies that inadvertently reduce access to qualified clinicians run counter to that mission.

Some comments have suggested that recent CMS changes will have a minimal impact. However, these assertions are speculative. To date, no formal assessment has been conducted within Virginia to evaluate how these changes affect consumers or the workforce. Without state-level data, we cannot accurately determine the scope of the impact. National data from the American Speech-Language-Hearing Association (ASHA) indicate that approximately 44% of speech-language pathologists work in medical settings, suggesting nearly half of recent graduates may be directly affected by the CMS changes.

While I acknowledge and appreciate ASHA's national advocacy efforts, it is imperative that Virginia independently evaluate and address the needs of its own residents. Consumer protection and workforce sustainability in our state should not be contingent upon national organizations.

Additionally, I urge the Board to defer consideration of the Audiology & Speech-Language Pathology Interstate Compact (ASLP-IC) until its policies regarding postgraduate supervision are clearly defined. An inquiry to the ASLP-IC Committee confirmed that these regulations are still under development. When finalized, the needs of both consumers and clinicians must take precedence over political or financial motivations.

Thank you for your attention to this important issue. I respectfully encourage the Board to move forward with the proposed licensure changes in support of improved access to care and workforce development in Virginia.

CommentID: **236994**

**Commenter:** Maureen Brand

7/29/25 9:45 pm

### **Support CFs having full licensure**

As a licensed speech-language pathologist, I support the proposed amendment to bring full licensure to those who have graduated with a Masters degree and passed the praxis. They have completed all academic and professional training once the Masters degree is conferred, and

**P023**

should have full licensure as occupational therapists and physical therapists do. The current restricted license prevents Virginia patients from accessing a larger pool of qualified SLPs due to certain insurance companies' credentialing requirements, and should be changed

CommentID: 236995

**Commenter:** Josh Adler

8/7/25 3:12 pm

### **In Support of Licensure Changes**

I want to address some of the concerns brought up around this resolution:

1. Threat to the Interstate Compact (ASLP-IC). The proposed resolution would have absolutely no impact on the Interstate Compact. In fact, it would provide more opportunities for speech language pathologists as presently CFs/SLPs with provisional licenses are limited in what they can do under the ASLP-IC. **Hopefully, more states will follow suit.**
2. **TRICARE, which services military members and their families, does not allow SLPs with provisional licenses to treat their beneficiaries. With a large military population in Northern Virginia and Hampton Roads (Southeastern Virginia), this has a huge impact for our state.**

This leads to long waitlists for service members and their families, who are already more likely to slip through the cracks due to needing to navigate through new health systems to find care each time they relocate. This issue impacts both pediatric and adult populations, and with Medicare having put the idea out that provisional licenses/CFs are bad, other insurances may follow suit. **If commercial carriers adopt similar language and don't allow CFs/SLPs with provisional licenses to see patients, CFs/SLPs with provisional licenses will essentially become unemployable.**

3. The fact that ASHA continues to perpetuate a CF process model which causes confusion and additional administrative burdens shows how out of touch they are with the profession. Most CFs are just getting the bare minimum experience during their CCC process without true mentorship and guidance. A combination of ASHA's processes and lack of success advocating for our profession create the reasons why stakeholders are now having to navigate these threats on the state level. **Virginia was on the right track when updating state regulations back in February to allow SLPs with provisional licenses to get their full license after 6 months (with recommendation from their supervisor). However, this is not enough. We need to remove the supervision requirements altogether, giving the SLP a full license at graduation to ensure patients have access to what they need, *qualified and quality care*, no matter the insurance that is paying for the services.**

**Simply put, the state of Virginia has the opportunity to set an example for all states that can simplify the licensure process for new speech language pathologists. As ASHA itself says:**

"The scope of practice (evaluation, diagnosis, treatment) for CFs and SLPs is the same whether an individual holds a provisional or a full license. The primary difference is the title of the license (e.g., provisional). In addition, for those who are pursuing clinical fellowship, they need to comply with the supervision standards required to obtain the CCC and state licensure. Therefore, the varied licensure title is largely a distinction without difference and fails to acknowledge that provisional licensees have earned a

master's or doctoral degree and completed supervised clock hours of clinical practicum as required by Medicare and under most state laws.”

4. Some make the argument that the reason that PT and OT graduates receive a full, unrestricted license is that they are required to perform more clinical hours than speech pathology students. While this may or may not be true depending upon the graduate program in question, the truth is that the design of the ASHA CF process (and the more recent 6-month Virginia update) hardly addresses this. SLPs with provisional licenses in Virginia are only required to have 24 hours of supervision over 6 months. In reality, most receive a lot less. In any case, an additional 24 hours over six months won't bridge any clinical gap between PT/OT and speech language pathologists. Justifying supervision requirements of newly graduated SLPs to make up for supposedly less clinical hours does not make sense.

The proposed petition would make the speech-language pathologist career a better one while providing a licensing process that is in line with that of physical and occupational therapists. Most importantly, it would ensure that patients who need care, can get it consistently.

Josh Adler, OTR/L  
Owner, Chief Clinical Officer  
Adler Therapy Group  
CommentID: **237002**

**Commenter:** A.B. Mayfield-Clarke

8/7/25 5:07 pm

### **Oppose Petition to Remove SPE**

August 7, 2025

Kelli Moss, Executive Director  
Board of Audiology and Speech-Language Pathology  
9960 Mayland Drive  
Suite 300  
Henrico, VA 23233

RE: Petition for Rulemaking to Remove Supervised Professional Experience

Dear Ms. Moss:

On behalf of the American Speech-Language-Hearing Association (ASHA), I write to oppose the petition to remove the supervised professional experience required by the Board of Audiology and Speech-Language Pathology to qualify for a speech-language pathologist (SLP) license.

ASHA is the national professional, scientific, and credentialing association for 241,000 members, certificate holders, and affiliates who are audiologists; SLPs; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students. SLPs identify, assess, and treat speech, language, swallowing, and cognitive disorders. Over 5,170 ASHA members reside in Virginia. [\[1\]](#)

Recently, the Centers for Medicare & Medicaid Services (CMS) updated Chapter 15 of the Medicare Benefit Policy Manual to revise the definition of a qualified SLP for Part B (outpatient) services. This update recognized only fully licensed SLPs and excluded those with provisional license from enrolling

and billing Medicare for outpatient services, which could have threatened access to care for Medicare patients. However, last week CMS notified ASHA it is reversing its previous interpretation<sup>[ii]</sup>:

“After further review of our prior statement about ‘provisional’ licenses for clinical fellows as well as the CY 2015 Home Health final rule (79 FR 66107), for Part B outpatient services furnished by speech-language pathologists, we now believe that deferring to the state licensure requirements for SLPs in each state would allow them to determine the SLPs that are most appropriate to provide speech-language pathology services to individuals/patients, including Medicare beneficiaries. In other words, to the extent that an SLP complies with the applicable state process for licensure, certification, or registration (if the state has one) necessary to practice as an SLP, which may include provisional or temporary licensure as such individual completes required supervised experience, such individual complies with the applicable licensure requirements found at 1861(II)(a)(4)(A) of the Social Security Act and 42 CFR 410.62(a), 42 CFR 484.115(n) and Section 230.3 of Ch. 15 of the Medicare Claims Processing Manual.”

The reversal of CMS’ previous interpretation eliminates the need to move forward with this petition for rulemaking.

Additionally, removal of the requirement for a supervised professional experience would put the Commonwealth out of compliance with HB 2033 (2023), which adopted the Audiology & Speech-Language Pathology Interstate Compact (ASLP-IC). Section 54.1-2608 requires that participation in the compact include a “supervised postgraduate professional experience as required by the Commission.” If Virginia were to remove the supervised professional experience, the Commonwealth would likely be found out of compliance and unable to participate in the ASLP-IC.

Thank you for your consideration of ASHA’s position. If you or your staff have any questions, please contact Susan Adams, ASHA’s director of state legislative and regulatory affairs, at [sadams@asha.org](mailto:sadams@asha.org).

Sincerely,

A. B. Mayfield-Clarke, PhD, CCC-SLP  
2025 ASHA President?

---

<sup>[i]</sup> American Speech-Language-Hearing Association. (2024). *Virginia* [Quick Facts]. <https://www.asha.org/siteassets/advocacy/state-flyers/virginia-state-flyer.pdf>

<sup>[ii]</sup> American Speech-Language-Hearing Association. (2025, Jul 29). *CMS Reverses Its Interpretation of a Qualified SLP: Clinical Fellows Cleared to Bill Medicare*. <https://www.asha.org/news/2025/cms-reverses-its-interpretation-of-a-qualified-slp-clinical-fellows-cleared-to-bill-medicare/>

CommentID: 237003

**Commenter:** Laura Purcell Verdun

8/8/25 5:32 pm

**OPPOSE petition**

August 8, 2025

Melissa A. McNichol, Au.D., CCC-A, Chair

And the Virginia Board of Audiology & Speech-Language Pathology

c/o Kelli Moss, Executive Director

**P026**

**RE:** Opposition to Petition to Eliminate 18VAC30-21-60(A)(2)(c)

Dear Dr. McNichol and Members of the VABASLP,

I write to you as a licensee and resident of the Commonwealth of Virginia, and as a member of the Speech & Hearing Association of Virginia (SHAV). I am submitting these comments in my individual capacity, not as a representative of any volunteer leadership roles I may currently hold.

Provisional licensure in the Commonwealth was implemented in 2016. This was a landmark accomplishment during my second term serving on the VABASLP. The provisional license was designed to ensure that pre-licensed clinicians could gain additional clinical training while being able to practice and bill under supervision.

I am writing in strong opposition to the petition submitted by the SHAV and Ms. Dorn to eliminate 18VAC30-21-60(A)(2)(c) from the Regulations Governing the Practice of Audiology and Speech-Language Pathology, which currently states:

**18VAC30-21-60. Qualifications for initial licensure.**

**A. The board may grant an initial license to an applicant for licensure in audiology or speech-language pathology who:**

1. Holds a current and unrestricted Certificate of Clinical Competence issued by ASHA; or

**2. Submits evidence of the following:**

a. Documentation of graduation from a program accredited by the Council on Academic Accreditation of ASHA or an equivalent accrediting body recognized by the board;

b. Passage of the qualifying examination from an accrediting body recognized by the board; and

**c. Evidence of six months of practice pursuant to a provisional license as described in [18VAC30-21-70](#) and submission of recommendation for licensure from the applicant's supervisor during practice as a provisional licensee.**

This petition by SHAV is short-sighted, unjustified, and detrimental to public protection. The petition was prompted in response to CMS (Centers for Medicare & Medicaid Services) clarification of language disseminated in June 2025, indicating that individuals with provisional licensure, such as Clinical Fellows, would no longer be able to engage with Medicare enrollees, bill for services or be reimbursed. This was disappointing and frustrating. However, CMS since reversed course on July 29, 2025.

[https://www.asha.org/news/2025/cms-reverses-its-interpretation-of-a-qualified-slp-clinical-fellows-cleared-to-bill-medicare/?srsId=AfmBOopwFXglaboznqfSvV\\_BNXSrWoWxsn-8DP8fasY\\_4Lf7Ov6f72P0](https://www.asha.org/news/2025/cms-reverses-its-interpretation-of-a-qualified-slp-clinical-fellows-cleared-to-bill-medicare/?srsId=AfmBOopwFXglaboznqfSvV_BNXSrWoWxsn-8DP8fasY_4Lf7Ov6f72P0)

“In direct correspondence with ASHA, CMS clarified that its **updated interpretation aligns with state licensing requirements and allows individuals holding provisional or temporary licenses, such as CFs, to provide services to Medicare beneficiaries**—provided they meet their respective state’s licensure requirements.”

With this reversal, the original impetus for the petition is no longer valid.

More concerning, however, is that the petition offers no compelling rationale for lowering the threshold for full licensure. Licensure exists to protect the constituents of the Commonwealth, providing for public safety and consumer protection. It provides the minimal standards for practice in the state and sets legal recourse for individuals who have been harmed by those who have misrepresented their credentials or who have not provided services that meet the standards imposed by licensing bodies. It is a public-safety measure. Weakening these standards undermines public trust in licensed healthcare professionals. Licensing is mandatory.

The fundamental education and training for licensed and certified Speech-Language Pathologists requires completion of the mentored post-graduate clinical experience following graduation from a CAA accredited program. This is a critical, structured, mentored professional experience to transition between being a

student enrolled in a communication sciences and disorders (CSD) program and being an independent provider of speech-language pathology clinical services. The purpose of this experience is to integrate and apply the knowledge from academic education and clinical training, evaluate strengths and identify limitations, develop and refine clinical skills consistent with the *Scope of Practice in Speech-Language Pathology*, strengthen clinical reasoning and decision making, and advance the clinician from needing constant supervision to being an independent practitioner. The petition disregards the significance of this supervised transition and effectively proposes its elimination—without addressing the impact on quality of care, patient outcomes, or professional readiness.

Moreover, the petition fails to consider other categories of professionals who benefit from provisional licensure, including those:

- Seeking licensure by endorsement (18VAC30-21-80);
- Reactivating an inactive license (18VAC30-21-110); or
- Reinstating a lapsed license (18VAC30-21-120).

The mentored post-graduate clinical experience is an integral part of preparing entry-level clinicians for full licensure, certification and a successful career of competence. The clinical experience of the graduate training programs is insufficient currently for an individual to graduate and expect to be practicing without additional guidance. Eliminating this step would risk placing inadequately prepared clinicians into unsupervised roles, weakening the foundation of consumer protections imbedded in Virginia licensure laws.

Furthermore, any proposal to eliminate provisional licensure must be evaluated in the broader context of educational reform. Graduate training programs would need guidance and time to adjust. Efforts are currently underway at the national level to transition to emphasis on competency-based training v. hour-based requirements, but that will take time, collaboration and systemic adjustment. Premature regulatory changes would jeopardize the readiness of new clinicians and compromise care delivery.

Eliminating provisional licensure would also increase the administrative burden on the Virginia Board of Audiology and Speech-Language Pathology (VABASLP), as staff would need to verify all credentialing elements for every applicant—likely requiring additional budget and staffing with no added benefit to patients or consumers. Also, would want to consider impacts to participation with Medicaid, of which I am less knowledgeable.

In conclusion, the removal of 18VAC30-21-60(A)(2)(c) is ill-advised, unjustified, and risky. The current standard ensures adequate preparation, supervision, and public protection. I respectfully urge the Board to reject this petition.

Most sincerely,

Laura Purcell Verdun, M.A., CCC/SLP, ASHA Fellow

VABASLP 2010-2014, 2014-2018

VABHP 2014-2015, 2015-2019

CommentID: **237005**

**Commenter:** Janet Bunnell, MS CCC/SLP, LNHA

8/10/25 4:51 pm

### **Support of Petition to Remove Clinical Fellowship Requirements**

As a licensee and member of SHAV and ASHA who has been in practice for over fifteen years as both an SLP and a Nursing Home Administrator I am writing in strong support of the petition to remove the Clinical Fellowship Year requirement for licensure for Speech-Language Pathologists in Virginia and in so doing provide them with the same full and unrestricted licensure status which is immediately accorded to new graduate colleagues in the fields of Occupational and Physical Therapy. The current requirement for the clinical fellowship year unnecessarily restricts new graduates who have successfully completed their graduate level studies, earned at minimum the

required 400 clinical clock hours to obtain their competencies, and have successfully passed the PRAXIS examination. The CFY requirement further reduces their earning potential as well as their ability to secure employment if a supervisor is not available.

Additionally, I have had the pleasure of being a graduate clinician externship supervisor and a CFY supervisor and have been consistently impressed at the degree of knowledge, critical thinking skills, experience and integrity which the students have acquired during their program of study. I believe that there remains an opportunity for seasoned SLPs to mentor newly licensed SLPs, but the Clinical Fellowship requirement itself has been shown to be unnecessarily limiting and should be removed. For those reasons I fully support this petition.

Respectfully,

Janet C. Bunnell, MS CCC/SLP, LNHA

CommentID: **237006**

**Commenter:** Nahale Kalfas

8/11/25 10:24 am

### **Effect of Rulemaking on Compact Participation**

Kelli Moss, Executive Director  
Board of Audiology and Speech-Language Pathology  
9960 Mayland Drive  
Suite 300  
Henrico, VA 23233

RE: Removal of Supervised Professional Experience

Dear Ms. Moss:

I am reaching out on behalf of the Audiology and Speech-Language Pathology Interstate Compact (ASLP-IC) Commission. It has come to our attention that Virginia is engaging in rulemaking in consideration of removing the requirement for the supervised professional experience as required by Section 3 (F)(3) of the Model Legislation, as adopted in Virginia through HB 2033 (2023). As compacts are contracts between states, all compact member states must agree to and adopt the same material terms for compact participation.

The removal of the requirement for supervised professional experience would render Virginia non-compliant with the requirements of member state participation in the ASLP-IC. In turn, practitioners who have not undergone post-graduate supervised professional experience would not have a license that rendered them eligible to participate in the Compact.

If you or your staff have any questions, please contact me at [nkalfas@compactlegalcounsel.org](mailto:nkalfas@compactlegalcounsel.org).

Sincerely,

Nahale Kalfas, Esq.  
General Counsel  
Audiology and Speech-Language Pathology Interstate Compact Commission  
CommentID: **237007**

## OPPOSE petition

### Subject: Opposition to Petition to Eliminate Provisional Licensure Requirement (18VAC30-21-60(A)(2)(c))

Dear Dr. McNichol and Members of the Virginia Board of Audiology and Speech-Language Pathology,

I write as a licensed speech-language pathologist and Virginia resident, submitting these comments in my individual capacity and not representing any leadership roles I may hold.

I strongly oppose the petition submitted to eliminate section 18VAC30-21-60(A)(2)(c) of the licensure regulations, which requires six months of supervised practice under a provisional license and a supervisor's recommendation for full licensure.

My reasons for opposing the petition are that:

- Provisional licensure, implemented by this board in 2016, was a landmark achievement [1]. It ensures that pre-licensed clinicians receive supervised clinical training while being able to practice and bill for services. It is also in alignment with 48 other state licensing boards.
- This petition was prompted by CMS's June 2025 interpretation that excluded Clinical Fellows from billing Medicare. However, CMS reversed this decision on July 29, 2025, affirming that provisional licensees may bill Medicare if they meet state licensure requirements[2]. Thus, the petition's rationale is no longer valid.
- The petition fails to justify lowering licensure standards. Licensure protects public safety by ensuring clinicians meet minimum competency standards. The mentored post-graduate clinical experience is essential for transitioning from student to independent practitioner. It strengthens clinical reasoning, refines skills, and ensures readiness to deliver quality care. Eliminating this requirement risks placing underprepared clinicians in unsupervised roles, compromising patient outcomes and public trust[3].
- Provisional licensure supports other pathways, including licensure by endorsement, reactivation of inactive licenses, and reinstatement of lapsed licenses. Removing it would disrupt these processes and increase administrative burdens on the Board without improving consumer protection.
- Any changes to provisional licensure should be considered within broader educational reforms, such as the shift toward competency-based training. Premature regulatory changes would undermine clinician preparedness and care delivery.
- Changes would likely disqualify Virginia from participating in the interstate compact unable to participate in the ASLP-IC.

In conclusion, I urge the Board to reject the petition. Maintaining 18VAC30-21-60(A)(2)(c) is essential for ensuring adequate training, supervision, and public protection.

Respectfully,  
Carol C Dudding, PhD CCC-SLP

James Madison University

---

## References

[1] [18VAC30-21-60. Qualifications for initial licensure. - Virginia Law](#)

[2] [CMS Reverses Its Interpretation of a Qualified SLP: Clinical Fellows ...](#)

[3] [Virginia Regulatory Town Hall View Comments](#)

CommentID: 237012

**Commenter:** Rebecca Saur

8/12/25 1:11 pm

**In support**

I am in support of eliminating 18VAC30-21-60(A)(2)(c) and allow an applicant to qualify for licensure without holding a Certificate of Clinical Competence from the American Speech-Language-Hearing Association (ASHA). SLPs deserve a full, unrestricted license following graduation from graduate school and passing the praxis. The clinical fellowship only restricts employment opportunities and hinders children from receiving speech therapy services.

CommentID: 237013

**Commenter:** Rachel Weir, MS, CCC-SLP

8/12/25 5:57 pm

**Support for full licensure of SLP graduates**

There is no reason why an SLP in the state of Virginia should not be able to gain a full, unconditional license from the state of Virginia upon graduation from an accredited school and a passing score on the Praxis. This is the standard for new physical therapy and occupational therapy graduates. Standards for speech-language pathologists should not be any different. The provisional license given to SLP graduates puts our profession at a disadvantage and causes issues for healthcare businesses in the Commonwealth. It is costly to provide CF supervision, CFs are now limited in what insurances they can treat and bill, and there is already a shortage of SLPs in the state and nation.

Please do away with the provisional license for SLP graduates and allow full licensure!

CommentID: 237015

**Commenter:** Anonymous

8/12/25 6:44 pm

**In support**

I am a licensed SLP in VA with 20 years experience working in pediatrics. I am in full support of the petition to eliminate 18VAC30-21-60(A)(2)(c). This requirement creates barriers that are unnecessary and negatively impact not only new graduates, but the children and families we serve. Something that no one has mentioned it that often times, recent graduates are given a lower wage during this supervisory period. It's hard enough to make ends meet with prices for every day essentials on the rise. This also negatively impacts insurance reimbursement, which then limits job opportunities. With fewer therapists available who can bill insurance, wait-lists are created that can be long. Additionally, this proposal does not impact the Interstate Compact.

CommentID: 237016

**Commenter:** Jeanette Benigas, Ph.D., SLP

8/13/25 1:01 am

**Support with Targeted Amendments: Full Licensure + Mentored Professional Development Hours (MPDH)**

To the Virginia Board of Audiology and Speech-Language Pathology:

My name is Jeanette Benigas, PhD, SLP, founder and CEO of Fix SLP, a national grassroots advocacy organization advancing evidence-based reforms that improve access to care, build sustainable career pathways, and expand professional autonomy for speech-language pathologists. My advocacy and leadership have helped modernize licensure and credentialing policies in multiple states, balancing public protection while empowering clinicians to make informed choices about licensure and third-party certifications. I am a former full professor with two decades of experience as a clinician, academic, national public speaker, author, continuing education provider, and business owner. That cross-sector experience lets me see how licensure rules land on patients, payers, employers, and early-career clinicians, and it informs the practical, Compact-compliant amendments I'm urging the Board to adopt.

**I support the petition, only with targeted amendments that preserve patient protection, prevent payer denials, and keep Virginia compliant with the Audiology & Speech-Language Pathology Interstate Compact (ASLP-IC). Approval of the petition with these amendments grants full licensure at graduation, replaces supervision with structured first-year mentored CE, and keeps Virginia ASLP-IC compliant.**

While CMS has reversed its June 2025 interpretation, systemic payer barriers remain. TRICARE has a longstanding practice of not credentialing or reimbursing conditionally licensed SLPs, and employers report that Palmetto GBA, Virginia's Medicare Administrative Contractor (MAC), has inconsistently refused to credential conditionally licensed providers over the last several years. These gaps create denials and delays despite state licensure. Without explicit state action, full licensure at graduation paired with a Board-defined, Compact-compliant first-year mentored CE requirement, payers will continue to treat early-career clinicians as "conditional." Absent clarity, similar tactics may spread to commercial plans (e.g., Blue Cross Blue Shield plans, UnitedHealth Group) to avoid reimbursement.

**Note on PT/OT comparisons:** While some commenters cite physical therapy and occupational therapy models, those professions follow clinical-doctorate pathways with substantially longer training timelines and supervised hours. Virginia does not need to import those frameworks to protect the public. An SLP-specific solution, full licensure at graduation paired with a Board-defined, Compact-compliant first-year mentored CE requirement (MPDH), better fits our current education model, workforce needs, and ASLP-IC obligations.

I propose the following targeted amendments as a starting point for the Board to refine and adopt:

**1. Eliminate 18VAC30-21-60(A)(2)(c)**

Eliminate 18VAC30-21-60(A)(2)(c), as proposed, to enable the Board to issue a full, unrestricted license upon graduation/exam, so that employers and payers do not misclassify new clinicians as "conditional," a practice that can depress wages, trigger billing/credentialing denials, and delay access to care.

**2. Restructure the required post-graduate support period to a mentored CE model**

**a. Timeline and substitution for first-year CE:** Extend the current six-month format to allow as few as nine months (to accommodate school SLPs), but up to twelve months to complete a Board-defined mentored continuing education/professional development program, required instead of the first-year 10 hours of CE per year. Name the hours Mentored Professional Development Hours (MPDH) (alternates: Applied Clinical Education Hours, Skill Advancement Education Hours, Structured Continuing Education Hours).

**b. CE credit and documentation:** Award Board-approved CE to mentees for documented mentored contact hours and completed activities, and to mentors for providing structured mentorship; both report using a Board template (learning plan, session logs, artifacts) retained for audit, or require all first years to report via the method in place for the current six-month model. For mentors, allow up to five hours per mentee (aligned with some OT models).

**c. Mentor structure:** The mentee can designate one mentor for primary accountability, but encourage multiple mentors of record with complementary skills; this reduces dependency, risk of abuse of power, and broadens clinical judgment.

d. **Interaction standards:** Define interaction standards (face-to-face/synchronous) to prevent employers from substituting telephone or web-only check-ins as a cost-saving measure.

i. **Months 1-3:** At least two mentored meetings per month; at least three face-to-face meetings across Q1 and at least three direct observations (live or synchronous video).

ii. **Months 4+:** Six monthly mentored meetings (in-person; allow a limited number of virtual meetings), with at least three additional direct observations across the year.

iii. Encounters may include live observation, case conference, documentation review, payer policy coaching, ethics consults, and interprofessional coordination.

e. **Qualifications and safeguards:** Mentor need not be the employer and may not condition sign-off on employment terms. The Board may reassign a mentor if concerns arise without penalizing the mentee's progress. Define clear progress criteria and a remediation plan when the mentee does not meet competencies.

f. **Competency-based completion:** Core domains include clinical decision making, documentation and compliance, payer requirements, ethics, safety/quality, culturally responsive care, and specialty-specific skills. Completion requires concurrence from at least two mentors (where available) to mitigate a single-person veto/approval.

### 3. Provide administrative clarity to prevent lower wages and payer denials.

a. The license is full and unrestricted from day one. The mentored CE is post-licensure and does not create a conditional status.

b. Issue written guidance to payers and employers clarifying that first-year mentored CE is post-licensure and does not create a conditional status.

## ASLP-IC Compliance

### To maintain participation in the ASLP-IC:

1. Codify the mentored CE year as Virginia's post-graduate supervised professional experience (SPE) equivalent, delivered in a structured, Board-regulated mentorship format (Mentored Professional Development Hours).
2. Make explicit in regulation that successful completion of this mentored CE satisfies the Compact's post-graduate supervision requirement for Virginia licensees.
3. With these amendments, approval of the petition maintains Virginia's ASLP-IC compliance while modernizing oversight and strengthening support.

## Implementation Considerations

1. **Transition:** Individuals currently in Virginia's six-month pathway may roll those months into the new mentored CE requirement.
2. **Access and Equity:** Permit tele-mentoring statewide, provided minimum in-person thresholds are met; create an optional mentor registry to expand availability in rural/underserved areas.
3. **Audit and Quality:** The Board may audit artifacts and logs and establish a non-punitive feedback loop to improve the program continually.

In closing, this amended approach maintains the elimination of 18VAC30-21-60(A)(2)(c), as proposed, protects patients, improves early-career support, avoids payer confusion, may increase early-career compensation, and preserves interstate mobility. I respectfully urge the Board to approve the petition with these or similar amendments and adopt Mentored Professional Development Hours (MPDH) as Virginia's first-year, structured, competency-based CE requirement.

If you or the Board have any questions, I can be reached at [team@fixslp.com](mailto:team@fixslp.com).

Respectfully submitted,  
Jeanette Benigas, PhD, SLP

**Commenter:** Tiffany Rhodes

8/13/25 8:35 am

### In Support

As a licensed speech-language pathologist, I am in support of the proposed amendment to bring full licensure to recent SLP graduates in Virginia. SLPs complete at least 375 hours of supervised, direct patient care during graduate school, hold a Master's degree, and pass a Praxis exam. Occupational therapists require a Master's degree and do not require a provisional license to treat upon graduation and the standards for SLPs should not be different. A provisional license limits what insurances that SLP can bill and reduces the options that families have regarding their care.

CommentID: 237018

**Commenter:** Jane Hilton

8/13/25 9:40 am

### Opposition to Eliminate Provisional Licensure (18VAC30-21-60(A)(2)(c))

Dear Dr. McNichol and Members of the Virginia Board of Audiology and Speech-Language Pathology,

I write as a licensed speech-language pathologist and Virginia resident, submitting these comments in my individual capacity and not representing any leadership roles I may hold.

I strongly oppose the petition submitted to eliminate section 18VAC30-21-60(A)(2)(c) of the licensure regulations, requiring six months of supervised practice under a provisional license and a supervisor's recommendation for full licensure.

My reasons for opposing the petition are that:

- Provisional licensure, implemented by this board in 2016, was a landmark achievement [1]. It ensures that pre-licensed clinicians receive much needed supervised clinical training while being able to practice and bill for services. It is also in alignment with 48 other state licensing boards.
- This petition was prompted by CMS's June 2025 interpretation that excluded Clinical Fellows from billing Medicare. However, CMS reversed this decision on July 29, 2025, affirming that provisional licensees may bill Medicare if they meet state licensure requirements. Thus, the petition's rationale is no longer valid.
- The petition fails to justify lowering licensure standards. Licensure protects public safety by ensuring clinicians meet minimum competency standards. The mentored post-graduate clinical experience is essential for transitioning from student to independent practitioner. It strengthens clinical reasoning, refines skills, and ensures readiness to deliver quality care. Eliminating this requirement risks placing underprepared clinicians in unsupervised roles, compromising patient outcomes and public trust.
- Provisional licensure supports other pathways, including licensure by endorsement, reactivation of inactive licenses, and reinstatement of lapsed licenses. Removing it would disrupt these processes and increase administrative burdens on the Board without improving consumer protection.
- Any changes to provisional licensure should be considered within broader educational reforms, such as the shift toward competency-based training. Premature regulatory changes would undermine clinician preparedness and care delivery.
- Changes would likely disqualify Virginia from participating in the interstate compact unable to participate in the ASLP-IC.

In conclusion, please reject the petition. Maintaining 18VAC30-21-60(A)(2)(c) is essential for ensuring adequate training, supervision, and public protection.

Respectfully,  
Jane C. Hilton, Ph.D., CCC-SLP  
CommentID: 237019

**Commenter:** Philip Helman

8/13/25 5:40 pm

## **CMS REVERSAL HAS NO EFFECT ON THE PROPOSED RESOLUTION**

CMS's recent reversal of its interpretation of Clinical Fellows (CFs) should have no effect on the pending resolution for the following reasons:

1. The reversal is contingent on speech-language pathologists meeting their state licensure requirements. Thus, the CMS reversal explicitly leaves it up to the State of Virginia to decide on the criteria for who receives a full, unconditional license in our state, and who can therefore treat Medicare patients.
2. The CMS reversal does not address the questions front and center in our industry....why is there a CF requirement process in place for speech-language pathology graduates who have passed the Praxis exam, and is this process still relevant in today's various practice settings.

Here is the issue in a nutshell:

In its own words, ASHA has said this about CFs: "The scope of practice (evaluation, diagnosis, treatment) for CFs and SLPs is the same whether an individual holds a provisional or a full license.....Therefore, the varied licensure title is largely a distinction without difference...."

Thus, we have to ask the question if a CF (Provisional License) and someone with their CCCs (Full License) in the State of Virginia all can do the same things as practitioners, why don't they have the same license??? The answer is that they should.

Pro CF provisional license advocates claim that SLP graduates need more clinical hours to augment their training. However, the current CF process as outlined by ASHA only requires one hour a week (a total of 36 hours over nine months) of supervision, with only 30 minutes per week (a total of 18 hours over 9 months) requiring actual observation of therapy. Up to 6 hours can be completed in one day, with some CFs going months without seeing or hearing from their CF supervisor. Simply put, 36 hours over nine months is not worth the administrative burden involved and has minimal impact on the new graduate's development.

We can all speculate about the reasons why ASHA and other legacy advocates are holding onto this outdated model, but the bottom line is that the ones who suffer are the patients who can't receive timely care.

- Here are the facts:

- Virginia is currently ranked 42 in the country in the ratio of SLPs to 100,000 residents. This means that citizens are going without or receiving delayed care. I encourage the board to do a simple survey of children's hospitals and private practices in our state. They will find there are up to 400-500 children on a waitlist at some facilities. We desperately need more SLPs with full, unconditional licenses.
- SHAV is on record as supporting the proposed resolution.

- Many insurance companies will not reimburse for services performed by CFs.

Here is a note from ASHA itself: "Please note. Some private payers and state Medicaid programs do not recognize provisional licensure as meeting their personnel standards for billing purposes. ASHA members should always verify billing and supervision requirements with each payer individually." I can't think of any other national medical organization with such a disclaimer about a class of professionals.

For Virginia, and our large military population, TRICARE does not allow CFs to see active military members or their beneficiaries, thus these patients can only be seen by those with their CCCs. This has a huge impact on our day-to-day operation with the Norfolk Naval Base being the largest in our country along with numerous other military institutions in our area and state.

Virginia Medicaid considers CFs to be "assistants", and the supervision requirements are much stricter than the state code. This means that if a CF has 50 Medicaid patients on their caseload, I have to pay a CF SUPERVISOR to jointly see each patient with the CF once a month. Thus, I am paying two therapists to do one job.....our margins are small, and reimbursements are decreasing. This makes no sense, but we have to comply with Medicaid's rules.

- The administrative and clinical burdens are overwhelming for any therapy company trying to do things the right way and follow the rules. In my above example, the CF SUPERVISOR could be seeing an extra 50 patients a month, but can't because they have to shadow the CF's Medicaid patients.
- When a physical or occupational therapist graduates and passes the necessary examinations, they receive full, unconditional licenses. Speech-language pathologists should do the same. There is no logical financial, clinical, or administrative reason to make SLPs go through more steps for full licensure.

Here are some other myths that I have read from opposition to the resolution:

- Myth #1. Public Safety??? By state code, CFs can do whatever a fully licensed SLP can do. As ASHA said, "licensure title is largely a distinction without difference." Public safety is not a relevant issue here.
- Myth #2. The CF is a structured/mentored experience. I have to disagree. While not true at our clinics, CF Supervisors are often in separate physical buildings than the CFs they are overseeing. There is no audit or checking regarding hours submitted or progress made by any national association. Supervision in most settings is minimal, and most folks are just going through the motion for nine months to check the box to get their CCCs.
- Myth #3. The resolution would increase administrative burden on the state board. The board does a tremendous job, and this would actually decrease the board's tasks by only having to issue licensure one time, not two. Presently, the board is issuing both provisional licenses and six/nine months later, full licenses. The process would go from two steps to one.
- Myth #4. The resolution threatens the Audiology and Speech-Language Pathology Interstate Compact for Virginia. The Virginia State Board needs to do what is best for the state of Virginia, not other states. Since our state is now ranked 42 in terms of SLP ratio, Virginia is not really benefiting from the compact as-is. By taking the lead on a commonsense idea to improve the industry, we are going to get a flock of new speech graduates from all over the country ready to come to Virginia to work as SLPs. They will benefit from living in an amazing state, reduced administrative hurdles, and higher wages as they are able to start their career with full licenses as opposed to provisional ones. I am also confident that most other states

will follow Virginia's lead once this resolution is enacted. The compact should have to adjust to Virginia, not the other way around.

The ironic thing about ASHA's opposition to this resolution is that they are resisting a solution to a problem they created....creating a class of professionals (CFs) whose ability to practice is interpreted and defined differently amongst every national regulatory agency (e.g., Medicare vs. TRICARE), state insurances such as Medicaid, private insurance companies, state boards, private practice, etc. Simply put, this process no longer makes sense, and the Virginia Board of Audiology and Speech-Language Pathology can provide a solution for our state and others to follow.

The board identified licensure issues when it implemented the new six-month window to apply for full licensure earlier this year. I urge it to now go all the way and implement this common sense resolution to eliminate 18VAC30-21-60(A)(2)(c) so that the patients in Virginia in need of care can get it in a timely manner.

Philip Helman  
CEO  
Adler Therapy Group  
CommentID: **237024**

**Commenter:** Kathleen Wido, MS Ed., CCC-SLP

8/13/25 9:12 pm

### **In Support of Removing 18VAC30-21-60(A)(2)(c)**

I am a licensed SLP and resident in Virginia, and I am writing in support of the removal of 18VAC30-21-60(A)(2)(c). Moving forward with conveying full SLP licensure in Virginia to those who earn a Master's degree in speech-language pathology/communication disorders and pass the Praxis is the next step in aligning the profession with current needs.

SLPs who have surpassed these two hurdles (which include acquiring a multitude of clinical care hours with a diverse patient base) are well-prepared for the next step of entering the workforce to provide quality care to patients in need. Requiring an on-paper mentorship, the way it is set up now, is not conducive to improving quality of care, nor growth of the clinician's skills. Removing mandated mentorship will allow for a better balance between providing quality patient care, and encouraging the seeking out of new information for the purpose of providing quality care.

To ensure this, I support extending the current continuing education requirements that exist for all license renewals after the initial renewal, to also include SLPs within their first year of licensure/first renewal. **This is a win-win solution to increase quality and availability of care for patients overall.**

Virginia must not be afraid to do something *different*, and instead must be willing to turn the tide when the time is right.

Thank you,

Kathleen Wido, MS Ed., CCC-SLP

CommentID: **237025**

**Commenter:** Pamela Roberts

8/13/25 11:45 pm

### **Eliminate the 6-Month Waiting Period!**

I am a speech-language pathologist providing speech therapy services in an outpatient clinic in the state of Virginia, and am in favor of revoking Virginia 18VAC30-21-60(A)(2)(c), adopted by the Virginia State Board in earlier this year.

**P037**

I believe that graduates of Speech-Language Pathology/Communication Science Disorders programs who have passed the PRAXIS examination in Virginia have attained an appropriate level of study and clinical experience to competently provide therapy services across a wide range of communication disorders.

Requiring CFs to wait six months before they can receive full licensure hinders their ability to provide speech therapy services to patients waiting for treatment. While timely diagnosis and treatment correlates with more favorable patient outcomes, those forced to remain on waitlists due to the shortage of SLPs are surely at a disadvantage.

Therefore, I fully support the pending resolution being considered by the Virginia Board of Audiology and Speech-Language Pathology to eliminate the six-month waiting period for Clinical Fellows to obtain full, unrestricted licensure in the state of Virginia.

CommentID: **237026**

18VAC30-21-60. Qualifications for initial licensure.

A. The board may grant an initial license to an applicant for licensure in audiology or speech-language pathology who:

1. Holds a current and unrestricted Certificate of Clinical Competence issued by ASHA;  
or
2. Submits evidence of the following:
  - a. Documentation of graduation from a program accredited by the Council on Academic Accreditation of ASHA or an equivalent accrediting body recognized by the board;
  - b. Passage of the qualifying examination from an accrediting body recognized by the board; and
  - c. Evidence of six months of practice pursuant to a provisional license as described in 18VAC30-21-70 and submission of recommendation for licensure from the applicant's supervisor during practice as a provisional licensee.

B. The board may grant a license to an applicant as a school speech-language pathologist who holds a master's degree in speech-language-pathology.

C. The board may refuse to issue a license to any applicant who has been determined to have committed an act in violation of 18VAC30-21-160.

## **Agenda Item: Consideration of Proposed Stage Language to Implement the ASLP Compact**

### **Included in your Agenda Package:**

- Draft changes to 18VAC30-21 to implement the ASLP compact

**Staff Note:** These changes are standard changes made across all licensing boards who implement a compact. If the compact commission changes their rules in a way that requires a change to this language, it can be made at the final stage.

### **Action Needed:**

- Motion to adopt proposed stage regulations to implement the ASLP Compact.

## Project 7660 - Proposed

### Board of Audiology And Speech-Language Pathology

#### Implementation of the ASLP Compact

##### 18VAC30-21-10. Definitions.

A. The words and terms "audiologist," "board," "practice of audiology," "practice of speech-language pathology," "speech-language disorders," and "speech-language pathologist" when used in this chapter shall have the meanings ascribed to them in § 54.1-2600 of the Code of Virginia.

B. The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"ABA" means the American Board of Audiology.

"Active practice" means a minimum of 160 hours of professional practice as an audiologist or speech-language pathologist for each 12-month period immediately preceding application for licensure. Active practice may include supervisory, administrative, educational, research, or consultative activities or responsibilities for the delivery of such services.

"ASHA" means the American Speech-Language-Hearing Association.

"Client" means a patient or person receiving services in audiology or speech-language pathology.

"Compact" means the Audiology and Speech-Language Pathology Interstate Compact.

"Compact privilege" means the authorization granted by a remote state to allow a licensee from another member state to practice as an audiologist or speech-language pathologist in the remote state under its laws and rules.

"Audiology and Speech-Language Pathology Compact Commission" or "commission" means the national administrative body whose membership consists of all states that have entered the compact.

"Home state" means the member state that is the licensee's primary state of residence.

"Limited cerumen management" means the identification and removal of cerumen from the cartilaginous outer one-third portion of the external auditory canal in accordance with minimum standards and procedures set forth in this chapter.

"Member state" means a state that has entered the Compact.

"Practitioner" means an individual who holds a license to practice as an audiologist, license to practice as a speech-language pathologist, or a compact privilege to practice as an audiologist or a speech-language pathologist in Virginia.

"Remote state" means a member state other than the home state where a licensee in exercising or seeking to exercise the compact privilege.

"School speech-language pathologist" means a person licensed pursuant to § 54.1-2603 of the Code of Virginia to provide speech-language pathology services solely in public school divisions.

"Supervision" means that the audiologist or speech-language pathologist is responsible for the entire service being rendered or activity being performed, is available for consultation, and is providing regular monitoring and documentation of clinical activities and competencies of the person being supervised.

**18VAC30-21-20. Required licenses.**

A. There shall be separate licenses for the practices of audiology and speech-language pathology. It is prohibited for any person to practice as an audiologist or a speech-language pathologist unless the person has been issued the appropriate license or compact privilege to practice in Virginia.

B. A licensee practitioner shall provide a copy of his license upon request.

**18VAC30-21-30. Records; accuracy of information.**

A. All changes of name, address of record, or public address, if different from the address of record, shall be furnished to the board within 30 days after the change occurs.

B. A licensee practitioner who has changed his name shall submit as legal proof to the board a copy of the marriage certificate, a certificate of naturalization, or a court order evidencing the change. A duplicate license with the changed name shall be issued by the board upon receipt of such evidence and the required fee.

C. All notices required by law and by this chapter to be mailed by the board to any licensee practitioner shall be validly served when mailed to the latest address of record on file with the board.

**18VAC30-21-40. Fees required.**

A. The following fees shall be paid as applicable for licensure:

1. Application for audiology or speech-language pathology license	\$135
2. Application for school speech-language pathology license	\$70
<u>3. Application for compact privilege</u>	<u>\$60</u>
<u>4. Annual renewal of compact privilege</u>	<u>\$60</u>
<del>3.</del> <u>5. Verification of licensure requests from other states</u>	\$20
<del>4.</del> <u>6. Annual renewal of audiology or speech-language pathology license</u>	\$75
<del>5.</del> <u>7. Late renewal of audiology or speech-language pathology license</u>	\$25
<del>6.</del> <u>8. Annual renewal of school speech-language pathology license</u>	\$40
<del>7.</del> <u>9. Late renewal of school speech-language pathology license</u>	\$15
<del>8.</del> <u>10. Reinstatement of audiology or speech-language pathology license</u>	\$135
<del>9.</del> <u>11. Reinstatement of school speech-language pathology license</u>	\$70
<del>10.</del> <u>12. Duplicate wall certificate</u>	\$25

11. <del>13.</del> Duplicate license	\$5
12. <del>14.</del> Handling fee for returned check or dishonored credit card or debit card	\$50
13. <del>15.</del> Inactive license renewal for audiology or speech-language pathology	\$40
14. <del>16.</del> Inactive license renewal for school speech-language pathology	\$20
15. <del>17.</del> Application for provisional license	\$50
16. <del>18.</del> Renewal of provisional license	\$25

B. Fees shall be nonrefundable.

**18VAC30-21-61. Compact privilege to practice in Virginia.**

To obtain a compact privilege to practice as an audiologist or speech-language pathologist in Virginia, a licensee in a member state shall comply with the rules adopted by the Audiology and Speech-Language Pathology Compact Commission at the time of application.

**18VAC30-21-90. Renewal requirements.**

A. A person who desires to renew his license shall, not later than June 30 of each year, submit the renewal notice and applicable renewal fee. A licensee who fails to renew his license by the expiration date shall have a lapsed license, and practice with a lapsed license may constitute grounds for disciplinary action by the board.

B. In order to renew a compact privilege to practice in Virginia, the compact privilege holder shall comply with the rules adopted by the commission in effect at the time of the renewal.

~~B.~~ C. A person who fails to renew his license by the expiration date may renew at any time within one year of expiration by submission of a renewal notice, the renewal fee and late fee, and an attestation of compliance with continuing education requirements.

**18VAC30-21-140. Supervisory responsibilities; supervision of unlicensed assistants.**

A. Responsibility of a ~~licensee~~ practitioners.

1. A licensed audiologist who supervises unlicensed assistants shall document such supervision, shall be held fully responsible for their performance and activities, and shall ensure that they perform only those activities that do not constitute the practice of audiology and that are commensurate with their level of training.

2. A licensed speech-language pathologist who supervises unlicensed assistants shall document such supervision, shall be held fully responsible for their performance and activities, and shall ensure that they perform only those activities that do not constitute the practice of speech-language pathology and that are commensurate with their level of training.

a. A speech-language pathologist shall not supervise an assistant without the speech-language pathologist's knowledge and consent by the assistant and the licensee documented prior to assumption of supervisory responsibilities.

b. The frequency in which the speech-language pathologist personally delivers treatment or services to a client who is receiving some services from an assistant shall be up to the professional judgment of the speech-language pathologist and shall be

determined by the treatment needs of the client, the type of services being provided, and the setting in which the client is being served, but shall occur at least every 30 days.

3. The identity of the unlicensed assistant shall be disclosed to the client prior to treatment and shall be made a part of the client's file.

B. Qualifications of a speech-language pathologist assistant.

1. A person acting as a speech-language pathologist assistant shall have:

- a. A bachelor's degree or associate's degree and documented training by a licensed speech-language pathologist in topics related to the client population to be served; or
- b. Employment as a speech-language pathologist assistant in a United States jurisdiction within the last five years preceding July 27, 2016.

2. A speech-language pathologist supervising an assistant shall be responsible for determining that the knowledge, skills, and clinical experience of the assistant are sufficient to ensure competency to perform all tasks to which the assistant is assigned. The speech-language pathologist shall document competency after training and direct observation of the assistant's performance of such tasks, and a record of skills and competencies shall be maintained.

C. Scope of practice of a speech-language pathologist assistant. After demonstration and documentation of competency for the duties to be assigned, an assistant shall only engage in those duties planned, designed, and supervised by a licensed speech-language pathologist, to include the following:

1. Assist with speech, language, and hearing screenings without clinical interpretation of results.
2. Assist during assessment of a client exclusive of administration or interpretation.
3. Perform activities for each session that are routine and do not require professional judgment, in accordance with a plan developed and directed by the speech-language pathologist who retains the professional responsibility for the client.
4. Document a client's performance and report information to the supervising speech-language pathologist.
5. Assist with programming augmentative and alternative communication devices and assist the client in repetitive use of such devices.
6. Sign or initial informal treatment notes and, upon request, co-sign formal documents with the supervising speech-language pathologist.
7. Engage in the following activities:
  - a. Preparing materials;
  - b. Scheduling appointments and activities;
  - c. Preparing charts, records, or graphs and performing other clerical duties;
  - d. Performing checks and maintenance of equipment; and
  - e. Assisting a client with transitioning to and from therapy sessions.
8. Perform duties not otherwise restricted to the practice of speech-language pathology.

D. A speech-language pathologist assistant shall not engage in the practice of speech-language pathology, including the following:

1. Represent himself as a speech-language pathologist.
2. Perform standardized or nonstandardized diagnostic tests or formal or informal evaluations.

3. Perform procedures that require a professional level of clinical acumen and technical skill.
4. Tabulate or interpret results and observations of feeding and swallowing evaluations or screenings performed by a speech-language pathologist.
5. Participate in formal conferences or meetings without the presence of the supervising speech-language pathologist.
6. Provide interpretative information to the client, the family of the client, or others regarding the client's status or service.
7. Write, develop, or modify a client's treatment plan.
8. Assist in or provide services as specified in subsection C of this section unless directed by the supervising speech-language pathologist.
9. Sign any formal documents in lieu of the supervising speech-language pathologist.
10. Select a client for service or discharge a client from service.
11. Make a decision on the need for additional services or make referrals for service.
12. Disclose clinical or confidential information either orally or in writing to anyone other than the supervising speech-language pathologist, unless mandated by law or authorized by the supervising speech-language pathologist.
13. Develop or determine the swallowing or feeding strategies or precautions for a client or provide feeding or swallowing treatment.

E. Supervision of an assistant in speech-language pathology.

1. The practice of an assistant shall only be supervised by a speech-language pathologist who retains full legal and ethical responsibility for the client. A speech-language pathologist shall only supervise the equivalent of two full-time assistants.
2. The speech-language pathologist shall provide the level of supervision to the speech-language pathologist assistant necessary to ensure quality of care to include onsite supervision of at least two client sessions for each assistant being supervised every 30 days to directly observe and evaluate the performance of the assistant. The speech-language pathologist shall document such onsite observation and evaluation in the client record for each session.

**18VAC30-21-141. Recordkeeping.**

A ~~licensee~~ practitioner shall properly manage and keep timely, accurate, legible, and complete client records, to include the following:

1. For ~~licensees~~ practitioners who are employed by a health care institution, school system, or other entity in which the individual practitioner does not own or maintain the practitioner's own records, maintain client records in accordance with the policies and procedures of the employing entity; or
2. For ~~licensees~~ practitioners who are self-employed or employed by an entity in which the individual practitioner does own and is responsible for client records, maintain a client record for a minimum of six years following the last client encounter with the following exceptions:
  - a. For records of a minor child, the minimum time is six years from the last client encounter or until the child reaches 18 years of age or becomes emancipated, whichever is longer; or
  - b. Records that have previously been transferred to another practitioner or health care provider or provided to the client or the client's personal representative as documented in a record or database maintained for a minimum of six years.

### **18VAC30-21-160. Unprofessional conduct.**

The board may refuse to issue a license or compact privilege to any applicant, suspend a license or compact privilege for a stated period of time or indefinitely, reprimand a licensee or compact privilege or place his license or compact privilege on probation with such terms and conditions and for such time as it may designate, impose a monetary penalty, or revoke a license or compact privilege for any of the following:

1. Guarantee of the results of any speech, voice, language, or hearing consultative or therapeutic procedure or exploitation of clients by accepting them for treatment when benefit cannot reasonably be expected to occur or by continuing treatment unnecessarily;
2. Diagnosis or treatment of speech, voice, language, and hearing disorders solely by written correspondence, provided this shall not preclude:
  - a. Follow-up by written correspondence or electronic communication concerning individuals previously seen; or
  - b. Providing clients with general information of an educational nature;
3. Failure to comply with provisions of § 32.1-127.1:03 of the Code of Virginia related to the confidentiality and disclosure of client records or related to provision of client records to another practitioner or to the client or his personal representative;
4. Engaging or attempting to engage in a relationship with a client that constitutes a professional boundary violation in which the practitioner uses his professional position to take advantage of the vulnerability of a client or a client's family, including sexual misconduct with a client or a member of the client's family or other conduct that results or could result in personal gain at the expense of the client;
5. Incompetence or negligence in the practice of the profession;
6. Failure to comply with applicable state and federal statutes or regulations specifying the consultations and examinations required prior to the fitting of a new or replacement prosthetic aid for any communicatively impaired person;
7. Failure to refer a client to an appropriate health care practitioner when there is evidence of an impairment for which assessment, evaluation, care, or treatment might be necessary;
8. Failure to supervise persons who assist in the practice of audiology or speech-language pathology as well as failure to disclose the use and identity of unlicensed assistants;
9. Conviction of a felony or a misdemeanor involving moral turpitude;
10. Violating or cooperating with others in violating any of the provisions of Chapter 1 (§ 54.1-100 et seq.), 24 (§ 54.1-2400 et seq.), or 26 (§ 54.1-2600 et seq.) of Title 54 of the Code of Virginia or the regulations of the board;
11. Publishing or causing to be published in any manner an advertisement relating to his professional practice that is false, deceptive, or misleading;
12. Inability to practice with skill and safety;
13. Fraud, deceit, or misrepresentation in provision of documentation or information to the board or in the practice of audiology or speech-language pathology;
14. Aiding and abetting unlicensed activity; or
15. Revocation, suspension, restriction, or any other discipline of a license, or certificate to practice, compact privilege, or surrender of license, or certificate, or compact privilege while an investigation or administrative proceedings are pending in another regulatory agency in Virginia or another jurisdiction.

---

# *Virginia's Audiologist Workforce: 2025*

---

Healthcare Workforce Data Center

August 2025

Virginia Department of Health Professions  
Healthcare Workforce Data Center  
Perimeter Center  
9960 Mayland Drive, Suite 300  
Henrico, VA 23233  
804-597-4213, 804-527-4434 (fax)  
E-mail: [HWDC@dhp.virginia.gov](mailto:HWDC@dhp.virginia.gov)

Follow us on Tumblr: [www.vahwdc.tumblr.com](http://www.vahwdc.tumblr.com)

Get a copy of this report from:

<http://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/ProfessionReports/>

*More than 500 Audiologists voluntarily participated in this survey. Without their efforts, the work of the center would not be possible. The Department of Health Professions, the Healthcare Workforce Data Center, and the Board of Audiology & Speech-Language Pathology express our sincerest appreciation for their ongoing cooperation.*

***Thank You!***

***Virginia Department of Health Professions***

**Arne E. Owens, MS**  
*Director*

*Healthcare Workforce Data Center Staff:*

Yetty Shobo, PhD  
*Director*

Barbara Hodgdon, PhD  
*Deputy Director*

Rajana Siva, MBA  
*Data Analyst*

Christopher Coyle, BA  
*Research Assistant*

# The Board of Audiology & Speech-Language Pathology

## ***Chair***

Melissa A. McNichol, AuD, CCC-A  
*Charlottesville*

## ***Vice-Chair***

Lisa G. Wallace-Davis, OD  
*Hampton*

## ***Members***

Jennifer Radford Gay, MS, CCC-SLP  
*Danville*

Bethany Rose, AuD  
*Richmond*

Wayne Shaia, MD  
*Richmond*

Laura H. Vencill, MS, CCC-SLP  
*Rosedale*

James Wells, RPh  
*Front Royal*

## ***Executive Director***

Kelli Moss

# Contents

---

Results in Brief.....	2
Summary of Trends .....	2
Survey Response Rates .....	3
The Workforce.....	4
Demographics.....	5
Background .....	6
Education .....	8
Specializations & Credentials.....	9
Current Employment Situation .....	10
Employment Quality.....	11
2025 Labor Market .....	12
Work Site Distribution .....	13
Establishment Type .....	14
Languages.....	16
Time Allocation .....	17
Patient Workload .....	18
Retirement & Future Plans .....	19
Full-Time Equivalency Units.....	21
Maps .....	22
Virginia Performs Regions .....	22
Area Health Education Center Regions .....	22
Workforce Investment Areas .....	24
Health Services Areas .....	25
Planning Districts.....	26
Appendix .....	27
Weights .....	27

# The Audiologist Workforce At a Glance:

## The Workforce

Licensees:	640
Virginia's Workforce:	474
FTEs:	419

## Background

Rural Childhood:	27%
HS Degree in VA:	38%
Prof. Degree in VA:	29%

## Current Employment

Employed in Prof.:	96%
Hold 1 Full-Time Job:	79%
Satisfied?:	96%

## Survey Response Rate

All Licensees:	82%
Renewing Practitioners:	97%

## Education

AuD:	83%
Masters:	12%

## Job Turnover

Switched Jobs:	4%
Employed Over 2 Yrs.:	66%

## Demographics

Female:	89%
Diversity Index:	24%
Median Age:	45

## Finances

Median Inc.:	\$90k-\$100k
Health Benefits:	62%
Under 40 w/ Ed Debt:	56%

## Time Allocation

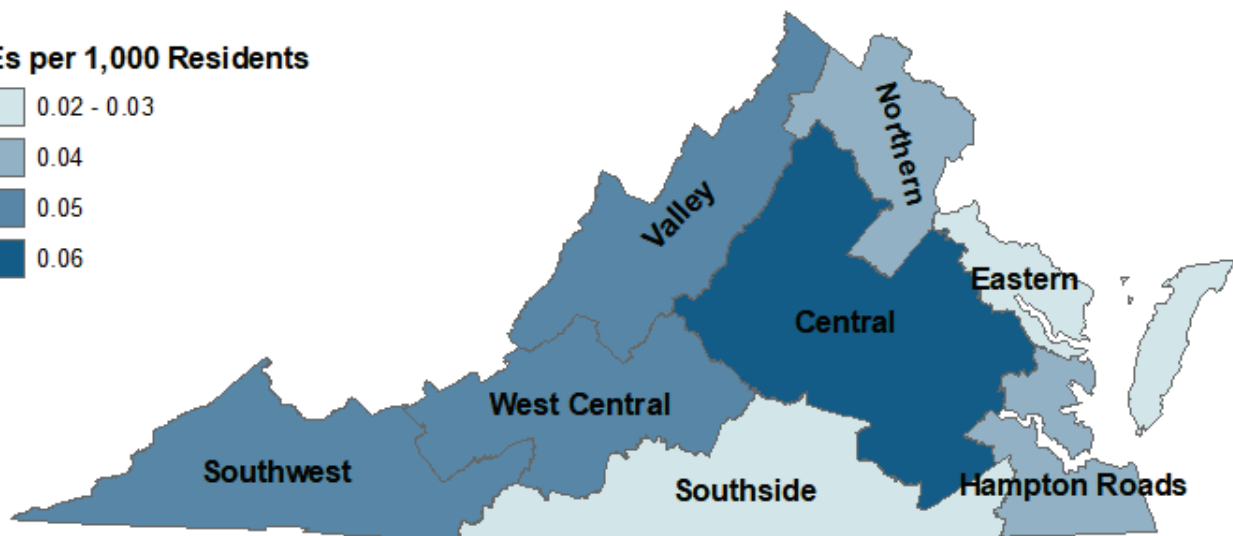
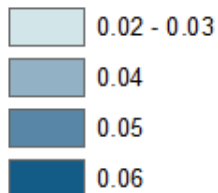
Client Care:	70%-79%
Administration:	10%-19%
Client Care Role:	77%

Source: Va. Healthcare Workforce Data Center

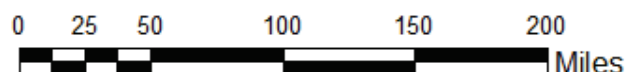
## Full-Time Equivalency Units Provided by Audiologists per 1,000 Residents by Virginia Performs Region

Source: Va Healthcare Work force Data Center

### FTEs per 1,000 Residents



Annual Estimates of the Resident Population: July 1, 2023  
Source: U.S. Census Bureau, Population Division



P051

This report contains the results of the 2025 Audiologist Workforce Survey. In total, 527 audiologists voluntarily participated in this survey. The Virginia Department of Health Professions' Healthcare Workforce Data Center (HWDC) administers the survey during the license renewal process, which takes place every June for audiologists. These survey respondents represent 82% of the 640 audiologists licensed in the state and 97% of renewing practitioners.

The HWDC estimates that 474 audiologists participated in Virginia's workforce during the survey period, which is defined as those audiologists who worked at least a portion of the year in the state or who live in the state and intend to work as an audiologist at some point in the future. Over the past year, Virginia's audiologist workforce provided 419 "full-time equivalency units," which the HWDC defines simply as working 2,000 hours per year.

Nearly nine out of every ten audiologists are female, and the median age of this workforce is 45. In a random encounter between two audiologists, there is a 24% chance that they would be of different races or ethnicities, a measure known as the diversity index. This diversity index increases to 29% among those audiologists who are under the age of 40. The comparable diversity index for Virginia's overall population is 60%. More than one out of every four audiologists grew up in a rural area, and 13% of audiologists who grew up in a rural area currently work in a non-metro area of Virginia. In total, 6% of all audiologists work in a non-metro area of the state.

Among all audiologists, 96% are currently employed in the profession, 79% hold one full-time job, and 56% work between 40 and 49 hours per week. More than four out of every five audiologists are employed in the private sector, including 61% who work in the for-profit sector. The median annual income of Virginia's audiologist workforce is between \$90,000 and \$100,000, and 72% of audiologists receive this income in the form of a salary. In addition, 88% of wage and salaried audiologists receive at least one employer-sponsored benefit, including 62% who have access to health insurance. Among all audiologists, 96% indicated that they are satisfied with their current work situation, including 69% of audiologists who indicated that they are "very satisfied."

## Summary of Trends

---

In this section, all statistics for the current year are compared to the 2015 audiologist workforce. The number of licensed audiologists in Virginia has increased by 23% (640 vs. 522). In addition, the size of Virginia's audiologist workforce has increased by 19% (474 vs. 397), and the number of FTEs provided by this workforce has increased by 24% (419 vs. 338). Virginia's renewing audiologists are more likely to respond to this survey (97% vs. 86%).

The percentage of Virginia's audiologists who are female has increased (89% vs. 88%), although the opposite is true among audiologists who are under the age of 40 (91% vs. 96%). At the same time, the diversity index of Virginia's audiologist workforce has increased (24% vs. 18%), a trend that has also occurred among those audiologists who are under the age of 40 (29% vs. 20%). While there has been no change in the percentage of audiologists who grew up in a rural area (27%), audiologists who grew up in a rural area are less likely to work in a non-metro area of Virginia (13% vs. 14%). In total, the percentage of all audiologists who work in a non-metro area of the state has also fallen (6% vs. 7%).

Audiologists are more likely to carry a Doctorate of Audiology (AuD) (83% vs. 68%) than a master's degree (12% vs. 23%) as their highest professional degree. While there has been no change in the percentage of audiologists who carry education debt (32%), the median outstanding balance among those audiologists with education debt has increased (\$80k-\$90k vs. \$30k-\$40k). The median annual income of Virginia's audiologists has also increased (\$90k-\$100k vs. \$70k-\$80k), and wage and salaried audiologists are more likely to receive at least one employer-sponsored benefit (88% vs. 85%).

Audiologists are more likely to hold one full-time job (79% vs. 75%) and work between 40 and 49 hours per week (56% vs. 51%). Audiologists are relatively more likely to work in the non-profit sector (19% vs. 9%) than in the for-profit sector (61% vs. 72%). Audiologists are less likely to indicate that they are satisfied with their current work situation (96% vs. 98%), including those audiologists who indicated that they are "very satisfied" (69% vs. 70%).

**A Closer Look:**

Licensee Counts		
License Status	#	%
Renewing Practitioners	529	83%
New Licensees	55	9%
Non-Renewals	56	9%
<b>All Licensees</b>	<b>640</b>	<b>100%</b>

Source: Va. Healthcare Workforce Data Center

*HWDC surveys tend to achieve very high response rates. Among all renewing audiologists, 97% submitted a survey. These represent 82% of the 640 audiologists who held a license at some point in the past year.*

Response Rates			
Statistic	Non Respondents	Respondents	Response Rate
<b>By Age</b>			
Under 30	27	33	55%
30 to 34	24	86	78%
35 to 39	10	60	86%
40 to 44	13	58	82%
45 to 49	9	77	90%
50 to 54	11	58	84%
55 to 59	4	43	92%
60 and Over	15	112	88%
<b>Total</b>	<b>113</b>	<b>527</b>	<b>82%</b>
<b>New Licenses</b>			
Issued in Past Year	41	14	25%
<b>Metro Status</b>			
Non-Metro	8	27	77%
Metro	57	342	86%
Not in Virginia	48	158	77%

Source: Va. Healthcare Workforce Data Center

**Definitions**

- 1. The Survey Period:** The survey was conducted in June 2025.
- 2. Target Population:** All audiologists who held a Virginia license at some point between July 2024 and June 2025.
- 3. Survey Population:** The survey was available to those who renewed their licenses online. It was not available to those who did not renew, including some audiologists newly licensed in 2025.

Response Rates	
Completed Surveys	527
Response Rate, All Licensees	82%
Response Rate, Renewals	97%

Source: Va. Healthcare Workforce Data Center

**At a Glance:**

Licensed Audiologists

Number: 640  
 New: 9%  
 Not Renewed: 9%

Survey Response Rates

All Licensees: 82%  
 Renewing Practitioners: 97%

Source: Va. Healthcare Workforce Data Center

## At a Glance:

### Workforce

2025 Audiologist Workforce: 474  
 FTEs: 419

### Utilization Ratios

Licensees in VA Workforce: 74%  
 Licensees per FTE: 1.53  
 Workers per FTE: 1.13

Source: Va. Healthcare Workforce Data Center

## Definitions

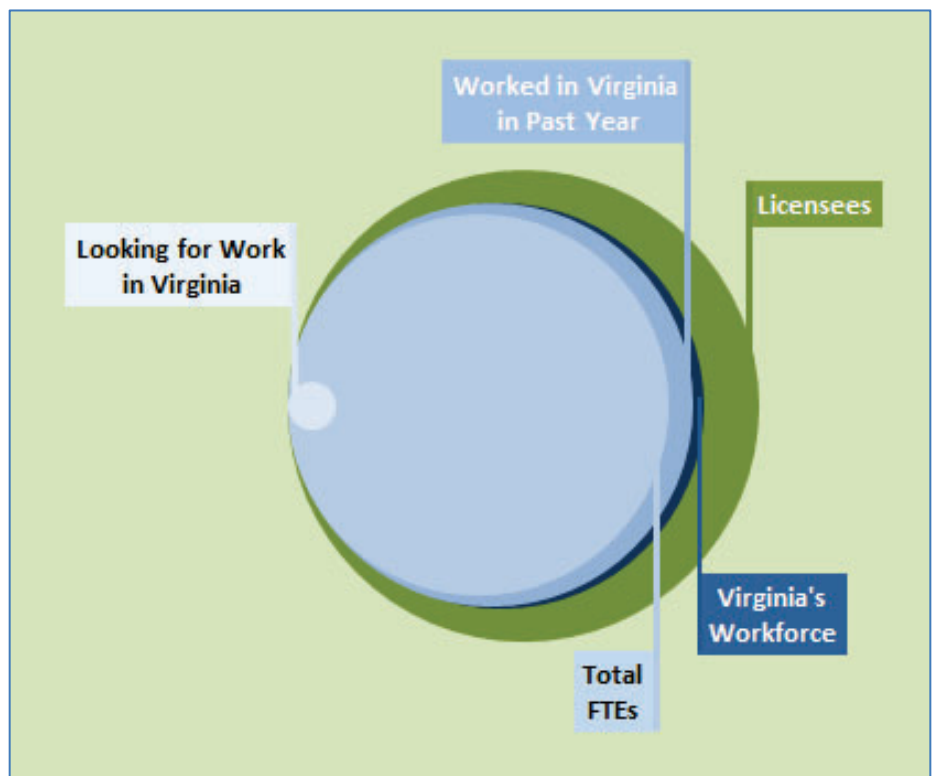
- 1. Virginia’s Workforce:** A licensee with a primary or secondary work site in Virginia at any time in the past year or who indicated intent to return to Virginia’s workforce at any point in the future.
- 2. Full-Time Equivalency Unit (FTE):** The HWDC uses 2,000 (40 hours for 50 weeks) as its baseline measure for FTEs.
- 3. Licensees in VA Workforce:** The proportion of licensees in Virginia’s Workforce.
- 4. Licensees per FTE:** An indication of the number of licensees needed to create 1 FTE. Higher numbers indicate lower licensee participation.
- 5. Workers per FTE:** An indication of the number of workers in Virginia’s workforce needed to create 1 FTE. Higher numbers indicate lower utilization of available workers.

## Audiologist Workforce

Status	#	%
Worked in Virginia in Past Year	468	99%
Looking for Work in Virginia	7	1%
Virginia's Workforce	474	100%
Total FTEs	419	
Licensees	640	

Source: Va. Healthcare Workforce Data Center

*Weighting is used to estimate the figures in this report. Unless otherwise noted, figures refer to the Virginia Workforce only. For more information on the HWDC’s methodology, visit: <https://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/>*



Source: Va. Healthcare Workforce Data Center

**A Closer Look:**

Age & Gender						
Age	Male		Female		Total	
	#	% Male	#	% Female	#	% in Age Group
Under 30	4	8%	43	92%	47	12%
30 to 34	8	11%	61	89%	69	18%
35 to 39	2	5%	41	95%	43	11%
40 to 44	4	10%	32	90%	36	9%
45 to 49	3	8%	40	93%	44	12%
50 to 54	1	3%	36	97%	37	10%
55 to 59	3	11%	25	89%	29	8%
60 and Over	18	23%	60	77%	78	20%
<b>Total</b>	<b>43</b>	<b>11%</b>	<b>339</b>	<b>89%</b>	<b>382</b>	<b>100%</b>

Source: Va. Healthcare Workforce Data Center

Race & Ethnicity					
Race/ Ethnicity	Virginia*	Audiologists		Audiologists Under 40	
	%	#	%	#	%
White	59%	336	87%	136	84%
Black	19%	16	4%	9	6%
Asian	7%	10	3%	6	4%
Other Race	0%	5	1%	2	1%
Two or More Races	3%	9	2%	5	3%
Hispanic	11%	10	3%	4	2%
<b>Total</b>	<b>100%</b>	<b>386</b>	<b>100%</b>	<b>162</b>	<b>100%</b>

\*Population data in this chart is from the U.S. Census, Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for the United States, States, and Counties: July 1, 2023.

Source: Va. Healthcare Workforce Data Center

**At a Glance:**

**Gender**

% Female: 89%  
% Under 40 Female: 91%

**Age**

Median Age: 45  
% Under 40: 42%  
% 55 and Over: 28%

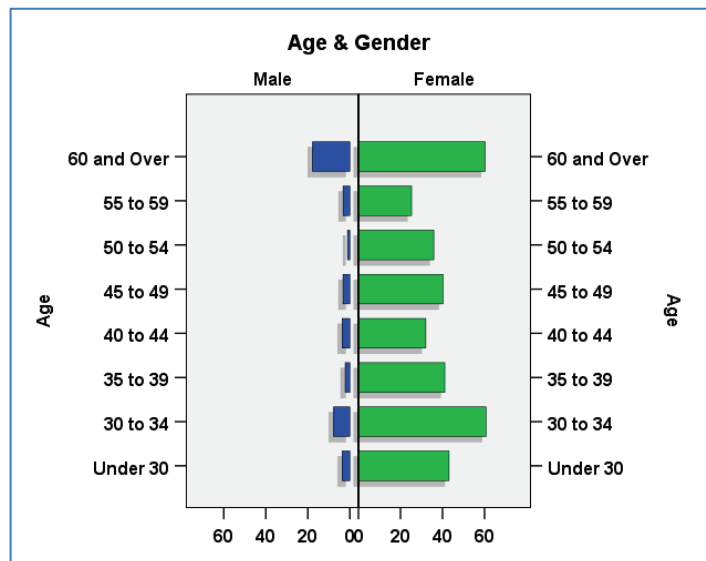
**Diversity**

Diversity Index: 24%  
Under 40 Div. Index: 29%

Source: Va. Healthcare Workforce Data Center

*In a chance encounter between two audiologists, there is a 24% chance that they would be of different races or ethnicities (a measure known as the Diversity Index). For Virginia's population as a whole, the comparable number is 60%.*

*Among all audiologists, 42% are under the age of 40, and 91% of audiologists who are under the age of 40 are female. In addition, the diversity index among audiologists who are under the age of 40 is 29%.*



Source: Va. Healthcare Workforce Data Center

## At a Glance:

### Childhood

Urban Childhood: 10%  
 Rural Childhood: 27%

### Virginia Background

HS in Virginia: 38%  
 Prof. Education in VA: 29%  
 HS/Prof. Edu. in VA: 44%

### Location Choice

% Rural to Non-Metro: 13%  
 % Urban/Suburban to Non-Metro: 4%

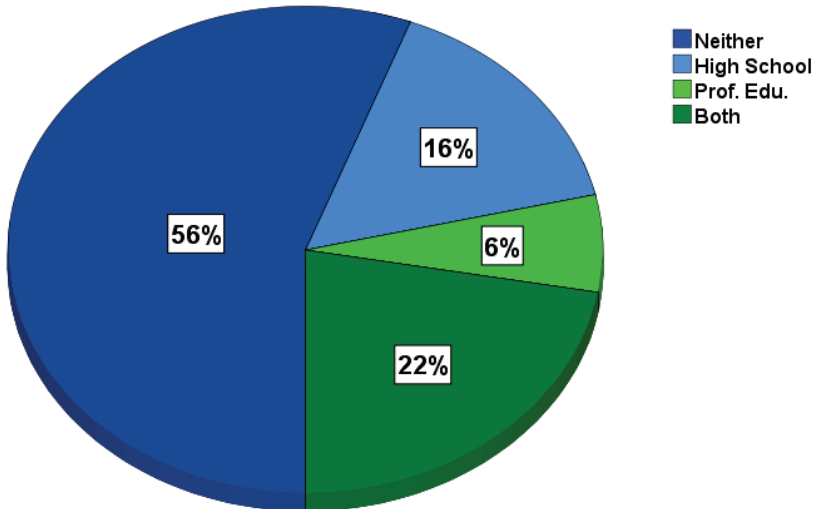
Source: Va. Healthcare Workforce Data Center

## A Closer Look:

Primary Location: USDA Rural Urban Continuum		Rural Status of Childhood Location		
Code	Description	Rural	Suburban	Urban
<b>Metro Counties</b>				
1	Metro, 1 Million+	21%	68%	11%
2	Metro, 250,000 to 1 Million	39%	58%	3%
3	Metro, 250,000 or Less	38%	55%	8%
<b>Non-Metro Counties</b>				
4	Urban, Pop. 20,000+, Metro Adjacent	67%	33%	0%
6	Urban, Pop. 2,500-19,999, Metro Adjacent	67%	0%	33%
7	Urban, Pop. 2,500-19,999, Non-Adjacent	33%	67%	0%
8	Rural, Metro Adjacent	-	-	-
9	Rural, Non-Adjacent	67%	17%	17%
<b>Overall</b>		<b>27%</b>	<b>63%</b>	<b>10%</b>

Source: Va. Healthcare Workforce Data Center

Educational Background in Virginia



Source: Va. Healthcare Workforce Data Center

*More than one-quarter of all audiologists grew up in a self-described rural area, and 13% of audiologists who grew up in a rural area currently work in a non-metro county. In total, 6% of all audiologists currently work in a non-metro county.*

## Top Ten States for Audiologist Recruitment

Rank	All Professionals			
	High School	#	Professional School	#
1	Virginia	150	Virginia	110
2	Maryland	31	Tennessee	37
3	Pennsylvania	21	Maryland	27
4	New York	18	Pennsylvania	26
5	West Virginia	18	Washington, D.C.	20
6	Ohio	14	West Virginia	18
7	New Jersey	13	Ohio	17
8	Michigan	12	New York	15
9	Illinois	12	Illinois	14
10	Outside U.S./Canada	10	Florida	11

Source: Va. Healthcare Workforce Data Center

Among all audiologists, 38% received their high school degree in Virginia, and 29% received their initial professional degree in the state.

Rank	Licensed in the Past Five Years			
	High School	#	Professional School	#
1	Virginia	34	Maryland	15
2	Maryland	13	Tennessee	12
3	Pennsylvania	8	Virginia	11
4	Louisiana	6	Illinois	11
5	Wisconsin	5	Pennsylvania	10
6	North Carolina	4	New York	8
7	Illinois	4	Ohio	5
8	New York	4	Washington, D.C.	5
9	New Jersey	4	West Virginia	4
10	Alabama	3	Missouri	3

Source: Va. Healthcare Workforce Data Center

Among audiologists who obtained their license in the past five years, 31% received their high school degree in Virginia, and 14% received their initial professional degree in the state.

More than one out of every four of Virginia's licensed audiologists did not participate in the state's workforce in the past year. Among these audiologists, 90% worked at some point in the past year, including 84% who are currently employed as audiologists.

### At a Glance:

#### Not in VA Workforce

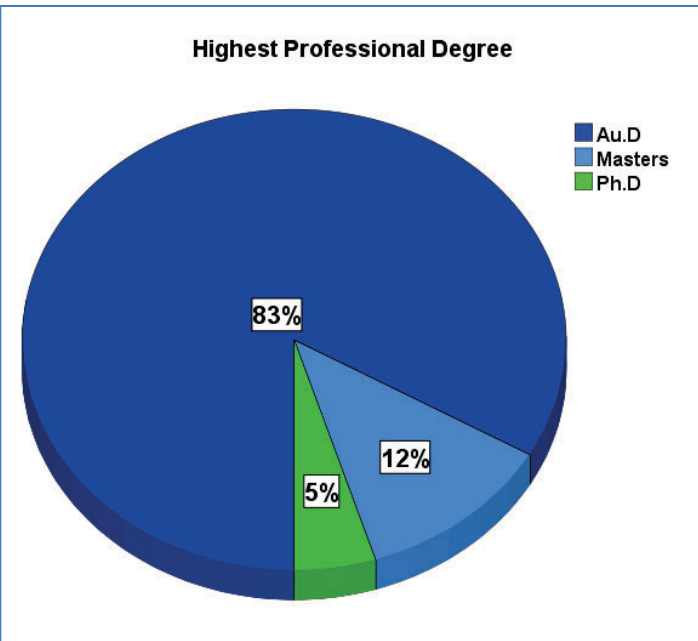
Total:	166
% of Licensees:	26%
Federal/Military:	16%
Va. Border State/DC:	25%

Source: Va. Healthcare Workforce Data Center

**A Closer Look:**

Highest Professional Degree		
Degree	#	%
Master's Degree	45	12%
AuD	320	83%
PhD	19	5%
Other Doctorate Degree	0	0%
<b>Total</b>	<b>384</b>	<b>100%</b>

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

*Nearly one out of every three audiologists currently have education debt, including 56% of those audiologists who are under the age of 40. For those with education debt, the median outstanding balance on their education debt is between \$80,000 and \$90,000.*

## At a Glance:

**Education**  
 Doctor of Audiology (AuD): 83%  
 Master's Degree: 12%

**Education Debt**  
 Carry Debt: 32%  
 Under Age 40 w/ Debt: 56%  
 Median Debt: \$80k-\$90k

Source: Va. Healthcare Workforce Data Center

*More than four out of every five audiologists hold a Doctorate of Audiology (AuD) as their highest professional degree.*

Amount Carried	All Audiologists		Audiologists Under 40	
	#	%	#	%
None	224	68%	58	43%
Less than \$10,000	6	2%	3	2%
\$10,000-\$19,999	5	2%	3	2%
\$20,000-\$29,999	8	2%	5	4%
\$30,000-\$39,999	6	2%	5	4%
\$40,000-\$49,999	1	0%	0	0%
\$50,000-\$59,999	10	3%	9	7%
\$60,000-\$69,999	3	1%	3	2%
\$70,000-\$79,999	3	1%	3	2%
\$80,000-\$89,999	10	3%	10	7%
\$90,000-\$99,999	3	1%	1	1%
\$100,000 or More	50	15%	33	25%
<b>Total</b>	<b>329</b>	<b>100%</b>	<b>133</b>	<b>99%</b>

Source: Va. Healthcare Workforce Data Center

## At a Glance:

### Top Specialties

Hearing Aids/Devices:	58%
Geriatrics:	31%
Pediatrics:	26%

### Top Credentials

CCC-A Audiology:	60%
Hearing Aid Disp. License:	47%
F-AAA Fellow:	23%

Source: Va. Healthcare Workforce Data Center

## A Closer Look:

Self-Designated Specialties		
Specialty	#	% of Workforce
Hearing Aids/Devices	275	58%
Geriatrics	147	31%
Pediatrics	124	26%
Vestibular	84	18%
Cochlear Implants	69	15%
Educational	56	12%
Occupational Hearing Conservation	43	9%
Intraoperative Monitoring	5	1%
Other	36	8%
<b>At Least One Specialty</b>	<b>335</b>	<b>71%</b>

Source: Va. Healthcare Workforce Data Center

Credentials		
Credential	#	% of Workforce
CCC-A: Audiology	286	60%
Hearing Aid Dispenser License	224	47%
F-AAA Fellow	109	23%
ABA Certification	29	6%
CCC-SLP: Speech-Language Pathology	6	1%
PASC: Pediatric Audiology	6	1%
CI: Cochlear Implants	1	0%
Other	14	3%
<b>At Least One Credential</b>	<b>366</b>	<b>77%</b>

Source: Va. Healthcare Workforce Data Center

*Among all audiologists, 71% have at least one self-designated specialty, and 77% have at least one credential.*

## At a Glance:

### Employment

Employed in Profession: 96%  
 Involuntarily Unemployed: < 1%

### Positions Held

1 Full-Time: 79%  
 2 or More Positions: 5%

### Weekly Hours:

40 to 49: 56%  
 60 or More: 3%  
 Less Than 30: 12%

Source: Va. Healthcare Workforce Data Center

## A Closer Look:

Current Work Status		
Status	#	%
Employed, Capacity Unknown	0	0%
Employed in an Audiologist-Related Capacity	371	96%
Employed, NOT in an Audiologist-Related Capacity	6	2%
Not Working, Reason Unknown	0	0%
Involuntarily Unemployed	1	< 1%
Voluntarily Unemployed	5	1%
Retired	3	1%
<b>Total</b>	<b>386</b>	<b>100%</b>

Source: Va. Healthcare Workforce Data Center

Current Positions		
Positions	#	%
No Positions	9	2%
One Part-Time Position	52	14%
Two Part-Time Positions	3	1%
One Full-Time Position	302	79%
One Full-Time Position & One Part-Time Position	15	4%
Two Full-Time Positions	0	0%
More than Two Positions	1	0%
<b>Total</b>	<b>382</b>	<b>100%</b>

Source: Va. Healthcare Workforce Data Center

*Among all audiologists, 96% are currently employed in the profession, 79% have one full-time job, and 56% work between 40 and 49 hours per week.*

Current Weekly Hours		
Hours	#	%
0 Hours	9	2%
1 to 9 Hours	9	2%
10 to 19 Hours	11	3%
20 to 29 Hours	23	6%
30 to 39 Hours	79	21%
40 to 49 Hours	210	56%
50 to 59 Hours	20	5%
60 to 69 Hours	11	3%
70 to 79 Hours	0	0%
80 or More Hours	1	0%
<b>Total</b>	<b>373</b>	<b>100%</b>

Source: Va. Healthcare Workforce Data Center

**A Closer Look:**

Annual Income		
Income Level	#	%
Volunteer Work Only	1	0%
Less Than \$50,000	21	7%
\$50,000-\$59,999	9	3%
\$60,000-\$69,999	14	5%
\$70,000-\$79,999	33	11%
\$80,000-\$89,999	40	13%
\$90,000-\$99,999	36	12%
\$100,000-\$109,999	43	14%
\$110,000-\$119,999	34	11%
\$120,000-\$129,999	17	6%
\$130,000-\$139,999	22	7%
\$140,000-\$149,999	3	1%
\$150,000 or More	26	9%
<b>Total</b>	<b>301</b>	<b>100%</b>

Source: Va. Healthcare Workforce Data Center

**At a Glance:**

**Annual Earnings**

Median Income: \$90k-\$100k

**Benefits**

**(Salary/Wage Employees Only)**

Health Insurance: 62%

Retirement: 76%

**Satisfaction**

Satisfied: 96%

Very Satisfied: 69%

Source: Va. Healthcare Workforce Data Center

*The typical audiologist earns between \$90,000 and \$100,000 per year. In addition, 88% of wage and salaried audiologists receive at least one employer-sponsored benefit, including 62% who have access to health insurance.*

Job Satisfaction		
Level	#	%
Very Satisfied	255	69%
Somewhat Satisfied	100	27%
Somewhat Dissatisfied	11	3%
Very Dissatisfied	5	1%
<b>Total</b>	<b>370</b>	<b>100%</b>

Source: Va. Healthcare Workforce Data Center

Employer-Sponsored Benefits			
Benefit	#	%	% of Wage/Salary Employees
Paid Vacation	271	73%	85%
Retirement	240	65%	76%
Paid Sick Leave	220	59%	68%
Health Insurance	195	53%	62%
Dental Insurance	173	47%	57%
Group Life Insurance	126	34%	40%
Signing/Retention Bonus	34	9%	12%
<b>At Least One Benefit</b>	<b>283</b>	<b>76%</b>	<b>88%</b>

\*From any employer at time of survey.

Source: Va. Healthcare Workforce Data Center

**A Closer Look:**

Employment Instability in the Past Year		
In The Past Year, Did You . . . ?	#	%
Experience Involuntary Unemployment?	5	1%
Experience Voluntary Unemployment?	19	4%
Work Part-Time or Temporary Positions, but Would Have Preferred a Full-Time/Permanent Position?	4	1%
Work Two or More Positions at the Same Time?	27	6%
Switch Employers or Practices?	17	4%
Experience At Least One?	<b>59</b>	<b>12%</b>

Source: Va. Healthcare Workforce Data Center

*In total, 1% of Virginia’s audiologists experienced involuntary unemployment at some point over the past year. For comparison, Virginia’s average monthly unemployment rate was 3.2%.<sup>1</sup>*

Location Tenure				
Tenure	Primary		Secondary	
	#	%	#	%
Not Currently Working at This Location	3	1%	4	7%
Less than 6 Months	17	5%	2	4%
6 Months to 1 Year	41	11%	7	12%
1 to 2 Years	58	16%	5	9%
3 to 5 Years	55	15%	10	18%
6 to 10 Years	64	18%	8	14%
More than 10 Years	119	33%	20	35%
Subtotal	<b>358</b>	<b>100%</b>	<b>57</b>	<b>100%</b>
Did Not Have Location	12		413	
Item Missing	104		4	
Total	<b>474</b>		<b>474</b>	

Source: Va. Healthcare Workforce Data Center

*More than seven out of every ten audiologists receive a salary at their primary work location, while 16% receive an hourly wage.*

## At a Glance:

**Unemployment Experience**  
 Involuntarily Unemployed: 1%  
 Underemployed: 1%

**Turnover & Tenure**  
 Switched: 4%  
 New Location: 19%  
 Over 2 Years: 66%  
 Over 2 Yrs., 2<sup>nd</sup> Location: 67%

**Employment Type**  
 Salary/Commission: 72%  
 Hourly Wage: 16%

Source: Va. Healthcare Workforce Data Center

*Two out of every three audiologists have worked at their primary work location for more than two years.*

Employment Type		
Primary Work Site	#	%
Salary/Commission	185	72%
Hourly Wage	40	16%
By Contract/Per Diem	7	3%
Business/Practice Income	25	10%
Unpaid	0	0%
Subtotal	<b>257</b>	<b>100%</b>

Source: Va. Healthcare Workforce Data Center

<sup>1</sup> As reported by the U.S. Bureau of Labor Statistics. Over the past year, the non-seasonally adjusted monthly unemployment rate fluctuated between a low of 2.5% and a high of 3.9%. At the time of publication, the unemployment rate for June 2025 was still preliminary.

## At a Glance:

### Concentration

Top Region:	33%
Top 3 Regions:	76%
Lowest Region:	2%

### Locations

2 or More (Past Year):	17%
2 or More (Now*):	16%

Source: Va. Healthcare Workforce Data Center

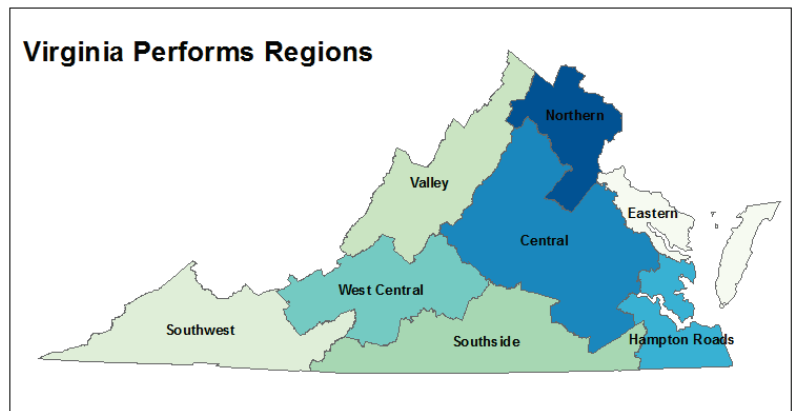
More than three out of every four audiologists in the state work in Northern Virginia, Central Virginia, or Hampton Roads.

## A Closer Look:

Regional Distribution of Work Locations				
Virginia Performs Region	Primary Location		Secondary Location	
	#	%	#	%
Central	92	25%	9	15%
Eastern	6	2%	1	2%
Hampton Roads	62	17%	11	19%
Northern	120	33%	21	36%
Southside	10	3%	1	2%
Southwest	14	4%	1	2%
Valley	20	6%	6	10%
West Central	31	9%	2	3%
Virginia Border State/D.C.	4	1%	1	2%
Other U.S. State	2	1%	6	10%
Outside of the U.S.	0	0%	0	0%
<b>Total</b>	<b>361</b>	<b>100%</b>	<b>59</b>	<b>100%</b>
Item Missing	100		2	

Source: Va. Healthcare Workforce Data Center

### Virginia Performs Regions



Source: Va. Healthcare Workforce Data Center

Among all audiologists, 16% currently have multiple work locations, while 17% have had multiple work location over the past year.

Locations	Number of Work Locations			
	Work Locations in Past Year		Work Locations Now*	
	#	%	#	%
0	7	2%	9	2%
1	296	81%	298	82%
2	39	11%	42	12%
3	18	5%	13	4%
4	1	0%	0	0%
5	1	0%	1	0%
6 or More	1	0%	1	0%
<b>Total</b>	<b>363</b>	<b>100%</b>	<b>364</b>	<b>100%</b>

\*At the time of survey completion, June 2025.

Source: Va. Healthcare Workforce Data Center

**A Closer Look:**

Sector	Location Sector			
	Primary Location		Secondary Location	
	#	%	#	%
<b>For-Profit</b>	202	61%	42	74%
<b>Non-Profit</b>	63	19%	13	23%
<b>State/Local Government</b>	32	10%	1	2%
<b>Veterans Administration</b>	19	6%	1	2%
<b>U.S. Military</b>	9	3%	0	0%
<b>Other Federal Gov't</b>	4	1%	0	0%
<b>Total</b>	<b>329</b>	<b>100%</b>	<b>57</b>	<b>100%</b>
<b>Did Not Have Location</b>	12		413	
<b>Item Missing</b>	132		4	

Source: Va. Healthcare Workforce Data Center

## At a Glance: (Primary Locations)

**Sector**

For Profit:	61%
Federal:	10%

**Top Establishments**

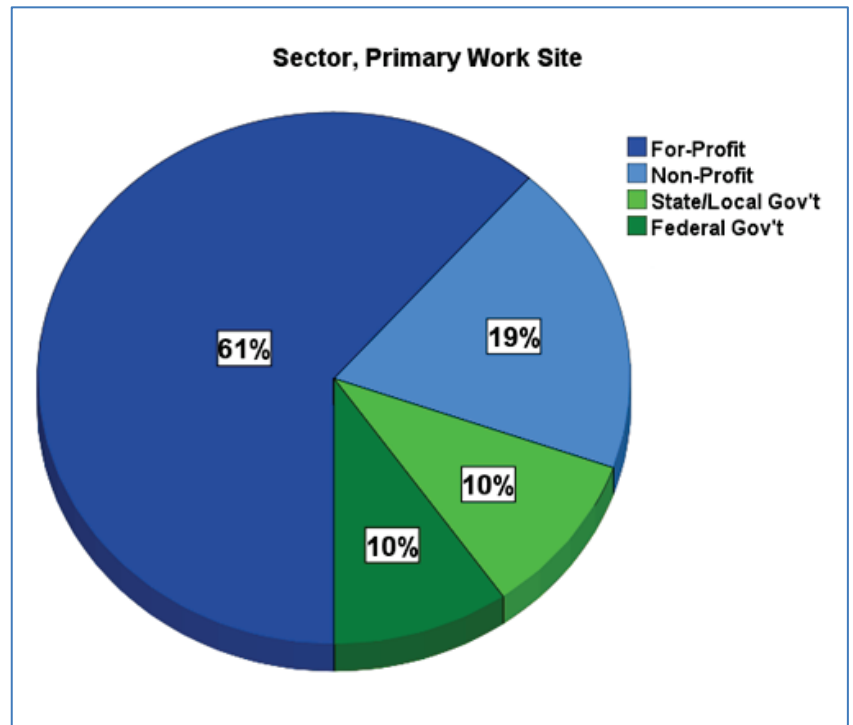
Private Practice (Group):	27%
Hospital (Outpatient):	22%
Physician Office:	15%

**Payment Method**

Cash/Self-Pay:	55%
Private Insurance:	55%

Source: Va. Healthcare Workforce Data Center

More than four out of every five audiologists work in the private sector, including 61% who work in the for-profit sector. In addition, 10% of Virginia's audiologists work for the federal government.



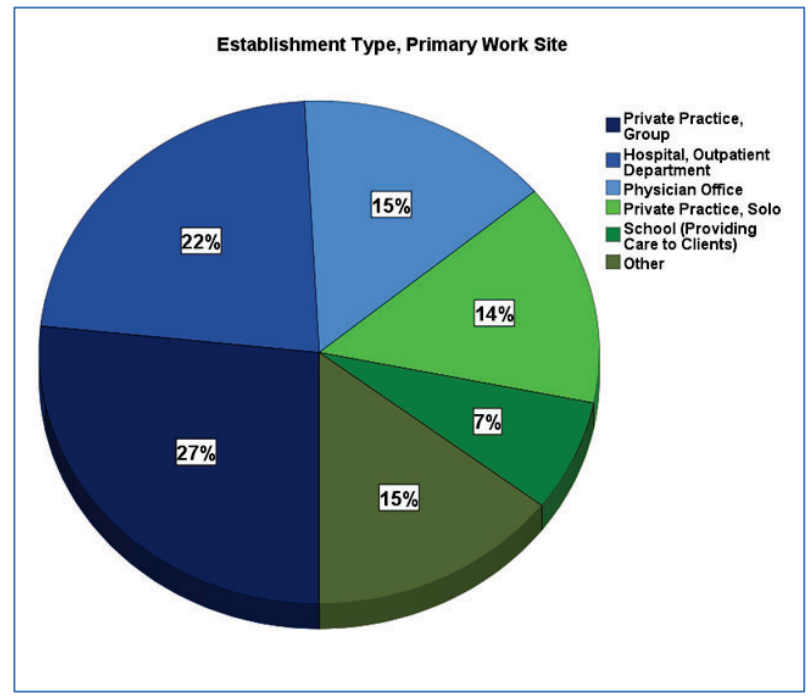
Source: Va. Healthcare Workforce Data Center

Establishment Type	Location Type			
	Primary Location		Secondary Location	
	#	%	#	%
Private Practice, Group	87	27%	14	25%
Hospital, Outpatient Department	73	22%	13	23%
Physician Office	48	15%	6	11%
Private Practice, Solo	47	14%	12	21%
School (Providing Care to Clients)	23	7%	1	2%
Community-Based Clinic or Health Center	14	4%	1	2%
Administrative/Business Organization	7	2%	1	2%
Academic Institution (Teaching Health Professions Students or Research)	6	2%	2	4%
Hospital, Inpatient Department	3	1%	0	0%
Outpatient Surgical Center	1	0%	0	0%
Rehabilitation Facility	1	0%	0	0%
Home Health Care	0	0%	1	2%
Other	16	5%	5	9%
<b>Total</b>	<b>326</b>	<b>100%</b>	<b>56</b>	<b>100%</b>
<b>Did Not Have a Location</b>	12		413	

Source: Va. Healthcare Workforce Data Center

*In total, 27% of all audiologists are employed by group private practices, while another 22% work in the outpatient department of hospitals.*

*Among those audiologists who also have a secondary work location, 25% are employed in group private practices, and 23% work in the outpatient department of hospitals. Cash or self-pay is the most commonly accepted form of payment among Virginia's audiologists.*



Source: Va. Healthcare Workforce Data Center

Accepted Forms of Payment		
Payment Type	#	% of Workforce
Cash or Self-Pay	263	55%
Private Insurance	260	55%
Medicare	236	50%
Medicaid	179	38%

Source: Va. Healthcare Workforce Data Center

## At a Glance: (Primary Locations)

### Languages Offered

Spanish:	27%
Arabic:	17%
French:	16%

### Means of Communication

Virtual Translation:	64%
Onsite Translation:	32%
Other Staff Member:	28%

Source: Va. Healthcare Workforce Data Center

## A Closer Look:

Languages Offered		
Language	#	% of Workforce
Spanish	126	27%
Arabic	79	17%
French	77	16%
Korean	77	16%
Hindi	76	16%
Chinese	75	16%
Tagalog/Filipino	73	15%
Vietnamese	72	15%
Urdu	70	15%
Pashto	66	14%
Persian	65	14%
Amharic, Somali, or Other Afro-Asiatic Languages	64	14%
Others	54	11%
<b>At Least One Language</b>	<b>146</b>	<b>31%</b>

Source: Va. Healthcare Workforce Data Center

*Among all audiologists, 27% are employed at a primary work location that offers Spanish language services for patients.*

## Means of Language Communication

Provision	#	% of Workforce with Language Services
Virtual Translation Service	93	64%
Onsite Translation Service	47	32%
Other Staff Member is Proficient	41	28%
Respondent is Proficient	28	19%
Other	7	5%

Source: Va. Healthcare Workforce Data Center

*Among audiologists who are employed at a primary work location that offers language services, nearly two out of every three provide those services by means of a virtual translation service.*

## At a Glance: (Primary Locations)

### Typical Time Allocation

Client Care: 70%-79%  
Administration: 10%-19%

### Roles

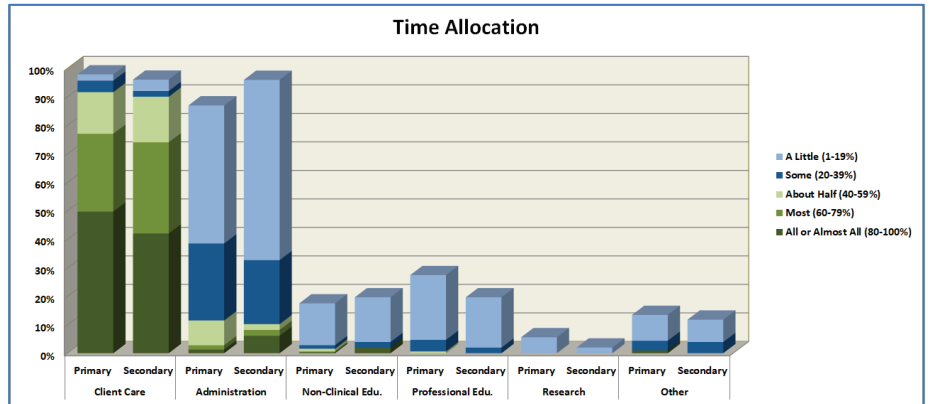
Client Care: 77%  
Administration: 3%

### Client Care Audiologists

Median Admin. Time: 10%-19%  
Avg. Admin. Time: 10%-19%

Source: Va. Healthcare Workforce Data Center

## A Closer Look:



Source: Va. Healthcare Workforce Data Center

*Audiologists spend approximately 75% of their time in client care activities. In fact, 77% of audiologists fill a client care role, defined as spending at least 60% of their time in that activity.*

## Time Allocation

Time Spent	Client Care		Admin.		Non-Clinical Education		Professional Education		Research		Other	
	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site
<b>All or Almost All (80-100%)</b>	50%	42%	1%	6%	0%	2%	0%	0%	0%	0%	1%	0%
<b>Most (60-79%)</b>	27%	32%	2%	2%	0%	0%	0%	0%	0%	0%	0%	0%
<b>About Half (40-59%)</b>	15%	16%	9%	2%	1%	0%	1%	0%	0%	0%	0%	0%
<b>Some (20-39%)</b>	4%	2%	27%	22%	1%	2%	4%	2%	0%	0%	3%	4%
<b>A Little (1-19%)</b>	2%	4%	48%	62%	15%	16%	23%	18%	6%	2%	9%	8%
<b>None (0%)</b>	2%	4%	13%	4%	82%	82%	72%	82%	94%	98%	86%	90%

Source: Va. Healthcare Workforce Data Center

## At a Glance:

### Weekly Patient Totals

(Median)

Primary Location: 30-39

Secondary Location: 10-19

Total: 30-39

### % with Group Sessions

Primary Location: 6%

Secondary Location: 0%

Source: Va. Healthcare Workforce Data Center

## A Closer Look:

Weekly Patients Totals						
Number of Patients	Primary Work Location		Secondary Work Location		Total <sup>2</sup>	
	#	%	#	%	#	%
None	14	4%	8	14%	13	4%
1-9	33	10%	13	22%	27	8%
10-19	35	11%	17	29%	28	9%
20-29	59	18%	8	14%	56	17%
30-39	67	20%	7	12%	62	19%
40-49	58	18%	4	7%	59	18%
50-59	37	11%	1	2%	42	13%
60-69	11	3%	0	0%	17	5%
70-79	7	2%	0	0%	15	5%
80 or More	7	2%	0	0%	10	3%
<b>Total</b>	<b>328</b>	<b>100%</b>	<b>58</b>	<b>100%</b>	<b>329</b>	<b>100%</b>

Source: Va. Healthcare Workforce Data Center

*Audiologists typically treat between 30 and 39 patients per week at their primary work location. In addition, audiologists who also have a secondary work location treat an additional 10 to 19 patients per week.*

Weekly Patient Sessions								
Number of Sessions	Primary Work Location				Secondary Work Location			
	Individual Sessions		Group Sessions		Individual Sessions		Group Sessions	
	#	%	#	%	#	%	#	%
None	11	3%	303	94%	8	14%	57	100%
1-9	37	11%	17	5%	13	23%	0	0%
10-19	39	12%	0	0%	17	30%	0	0%
20-29	57	18%	1	0%	8	14%	0	0%
30-39	64	20%	1	0%	7	12%	0	0%
40-49	58	18%	0	0%	4	7%	0	0%
50-59	38	12%	0	0%	1	2%	0	0%
60-69	9	3%	1	0%	0	0%	0	0%
70-79	6	2%	0	0%	0	0%	0	0%
80 or More	6	2%	0	0%	0	0%	0	0%
<b>Total</b>	<b>325</b>	<b>100%</b>	<b>323</b>	<b>100%</b>	<b>57</b>	<b>100%</b>	<b>57</b>	<b>100%</b>

Source: Va. Healthcare Workforce Data Center

<sup>2</sup> This column estimates the total number of patients treated per week across both primary and secondary work locations.

**A Closer Look:**

Retirement Expectations				
Expected Retirement Age	All		50 and Over	
	#	%	#	%
<b>Under Age 50</b>	1	0%	-	-
<b>50 to 54</b>	6	2%	1	1%
<b>55 to 59</b>	28	9%	5	5%
<b>60 to 64</b>	93	30%	29	26%
<b>65 to 69</b>	130	42%	47	42%
<b>70 to 74</b>	27	9%	15	14%
<b>75 to 79</b>	7	2%	4	4%
<b>80 or Over</b>	5	2%	2	2%
<b>I Do Not Intend to Retire</b>	10	3%	8	7%
<b>Total</b>	<b>306</b>	<b>100%</b>	<b>111</b>	<b>100%</b>

Source: Va. Healthcare Workforce Data Center

**At a Glance:**

**Retirement Expectations**

**All Audiologists**

Under 65: 42%  
Under 60: 11%

**Audiologists 50 and Over**

Under 65: 32%  
Under 60: 5%

**Time Until Retirement**

Within 2 Years: 7%  
Within 10 Years: 24%  
Half the Workforce: By 2050

Source: Va. Healthcare Workforce Data Center

*More than two out of every five audiologists expect to retire by the age of 65. Among those audiologists who are age 50 or over, 32% expect to retire by the age of 65.*

*Within the next two years, 3% of audiologists expect to increase their client care hours. In addition, 3% of audiologists also expect to pursue additional educational opportunities.*

**Future Plans**

Two-Year Plans:	#	%
<b>Decrease Participation</b>		
<b>Leave Profession</b>	6	1%
<b>Leave Virginia</b>	11	2%
<b>Decrease Client Care Hours</b>	30	6%
<b>Decrease Teaching Hours</b>	1	0%
<b>Increase Participation</b>		
<b>Increase Client Care Hours</b>	16	3%
<b>Increase Teaching Hours</b>	8	2%
<b>Pursue Additional Education</b>	16	3%
<b>Return to Virginia's Workforce</b>	4	1%

Source: Va. Healthcare Workforce Data Center

By comparing retirement expectation to age, we can estimate the maximum years to retirement for audiologists. While 7% of audiologists expect to retire in the next two years, 24% plan to retire in the next ten years. Half of the current audiology workforce expect to retire by 2050.

Time to Retirement			
Expect to Retire Within . . .	#	%	Cumulative %
2 Years	20	7%	7%
5 Years	19	6%	13%
10 Years	34	11%	24%
15 Years	30	10%	34%
20 Years	33	11%	44%
25 Years	21	7%	51%
30 Years	40	13%	64%
35 Years	41	13%	78%
40 Years	42	14%	92%
45 Years	12	4%	95%
50 Years	1	0%	96%
55 Years	1	0%	96%
In More than 55 Years	0	0%	96%
Do Not Intend to Retire	10	3%	99%
<b>Total</b>	<b>306</b>	<b>100%</b>	

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Using these estimates, retirement will begin to reach 10% of the current workforce every five years starting in 2035. Retirement will peak at 14% of the current workforce around 2065 before declining to under 10% of the current workforce again around 2070.

## At a Glance:

### FTEs

Total: 419  
 FTEs/1,000 Residents<sup>3</sup>: 0.048  
 Average: 0.91

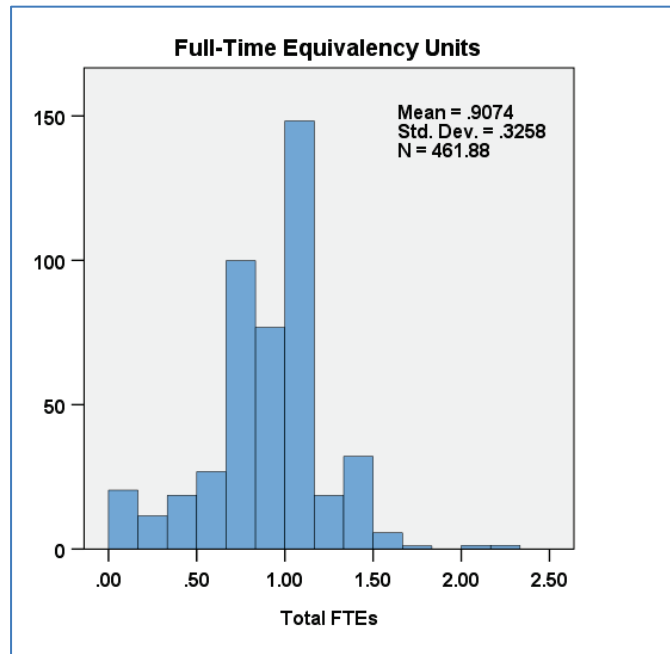
### Age & Gender Effect

Age, *Partial Eta*<sup>2</sup>: Small  
 Gender, *Partial Eta*<sup>2</sup>: Small

*Partial Eta*<sup>2</sup> Explained:  
*Partial Eta*<sup>2</sup> is a statistical  
 measure of effect size.

Source: Va. Healthcare Workforce Data Center

## A Closer Look:

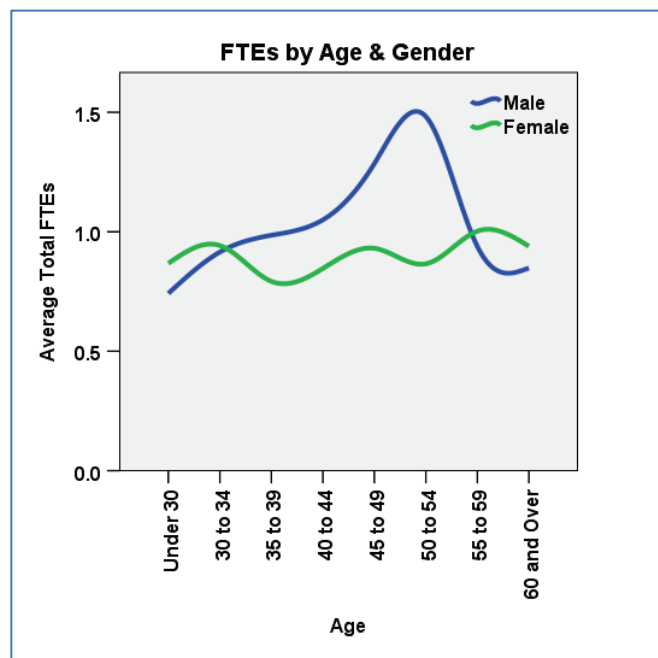


Source: Va. Healthcare Workforce Data Center

*The typical audiologist provided 0.96 FTEs in the past year, or about 38 hours per week for 50 weeks. Statistical tests did not indicate that FTEs vary by either age or gender.*

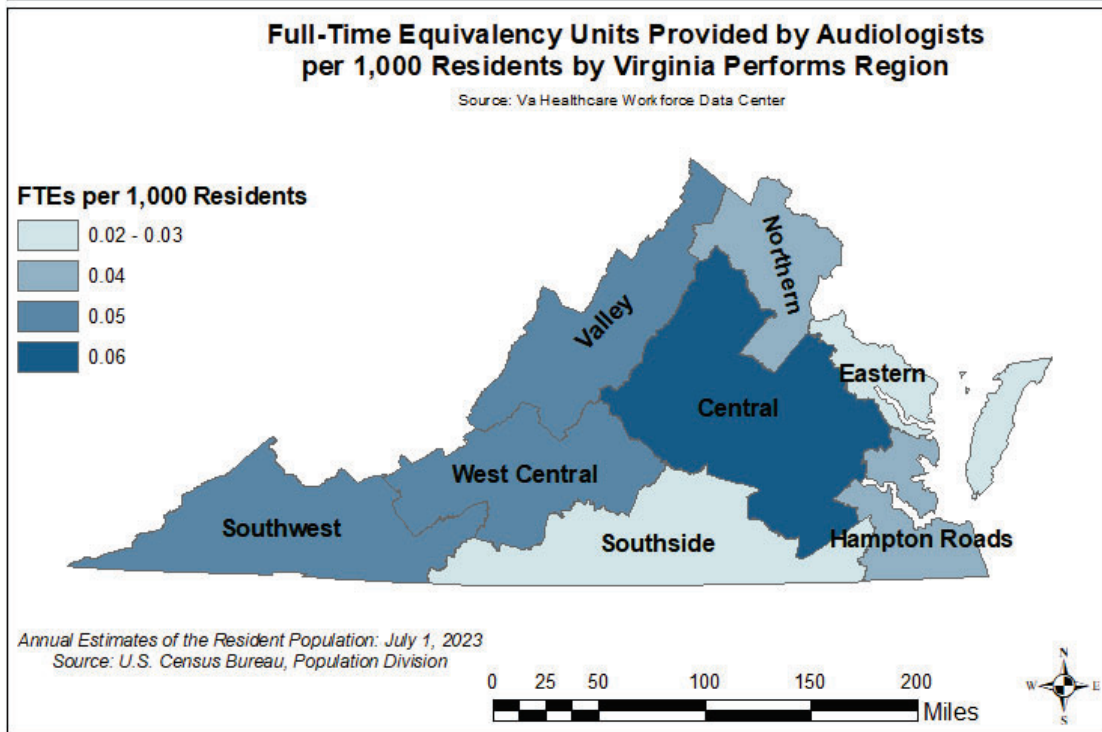
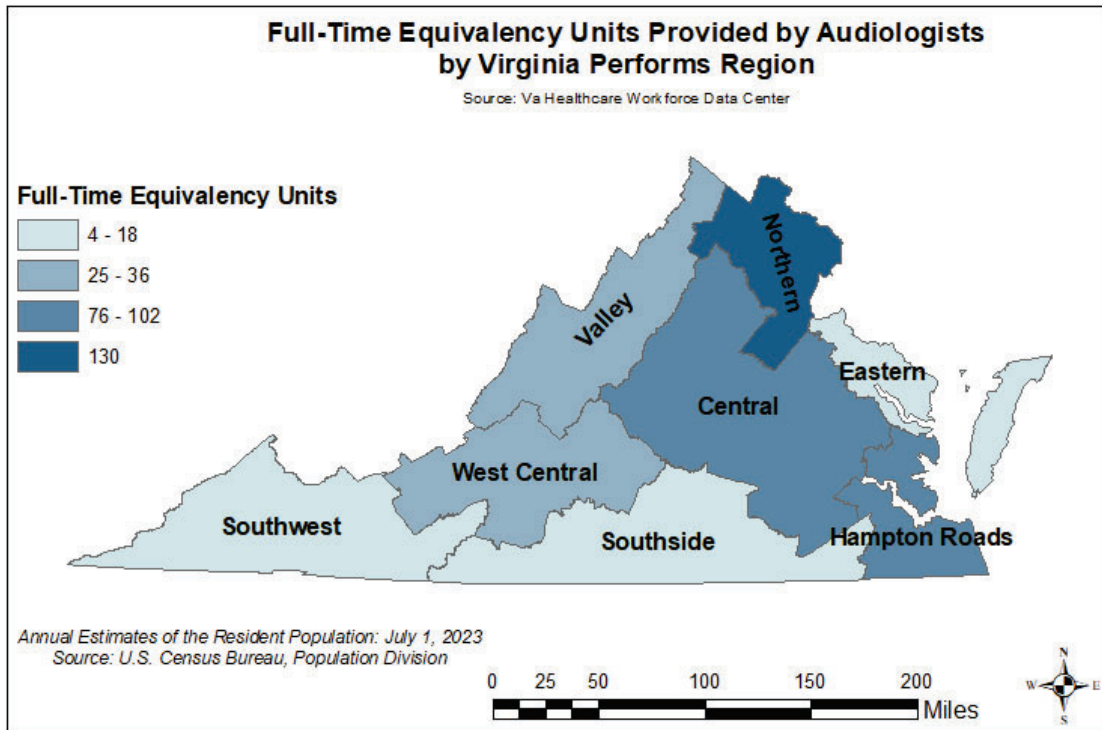
Full-Time Equivalency Units		
Age	Average	Median
Under 30	0.77	0.88
30 to 34	0.93	0.93
35 to 39	0.81	0.83
40 to 44	0.87	0.89
45 to 49	1.07	1.09
50 to 54	0.87	0.83
55 to 59	0.98	0.93
60 and Over	0.93	1.01
Gender		
Male	0.93	0.96
Female	0.90	0.96

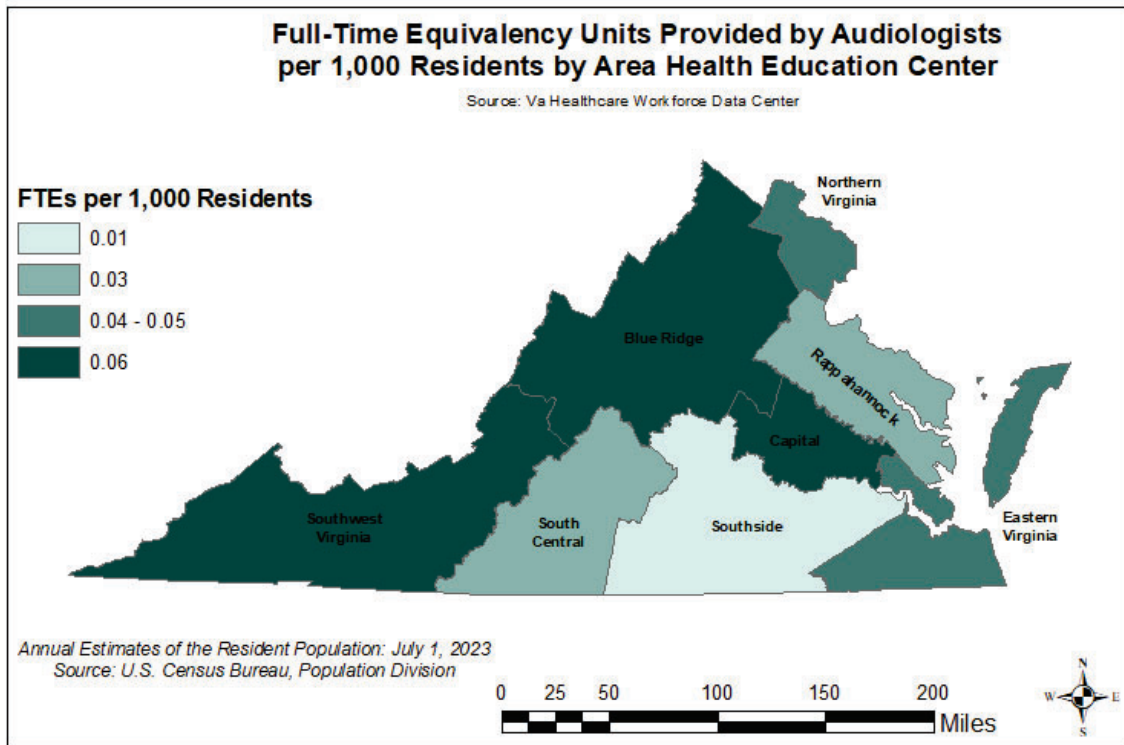
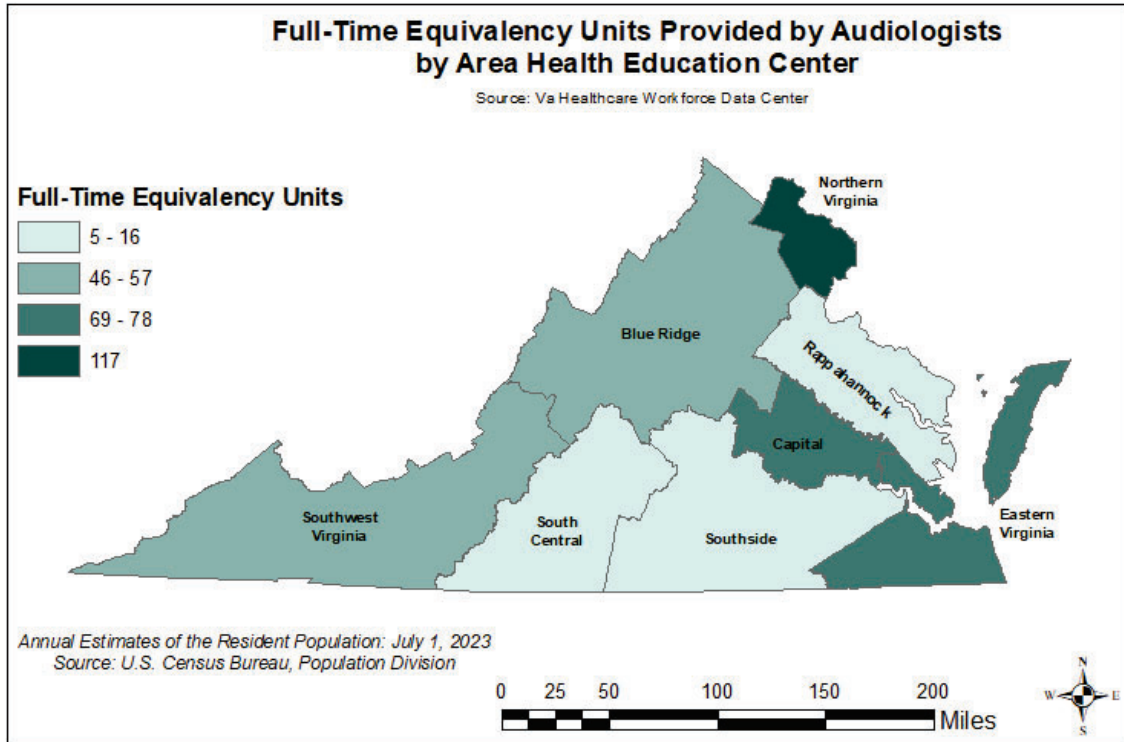
Source: Va. Healthcare Workforce Data Center

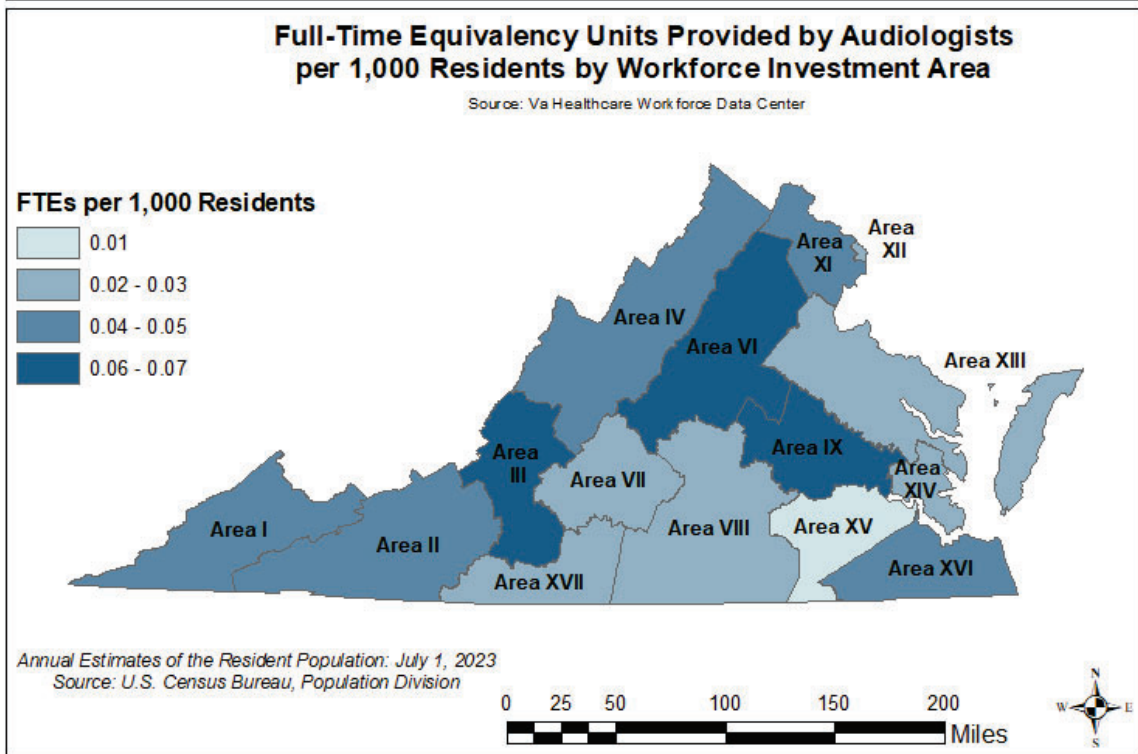
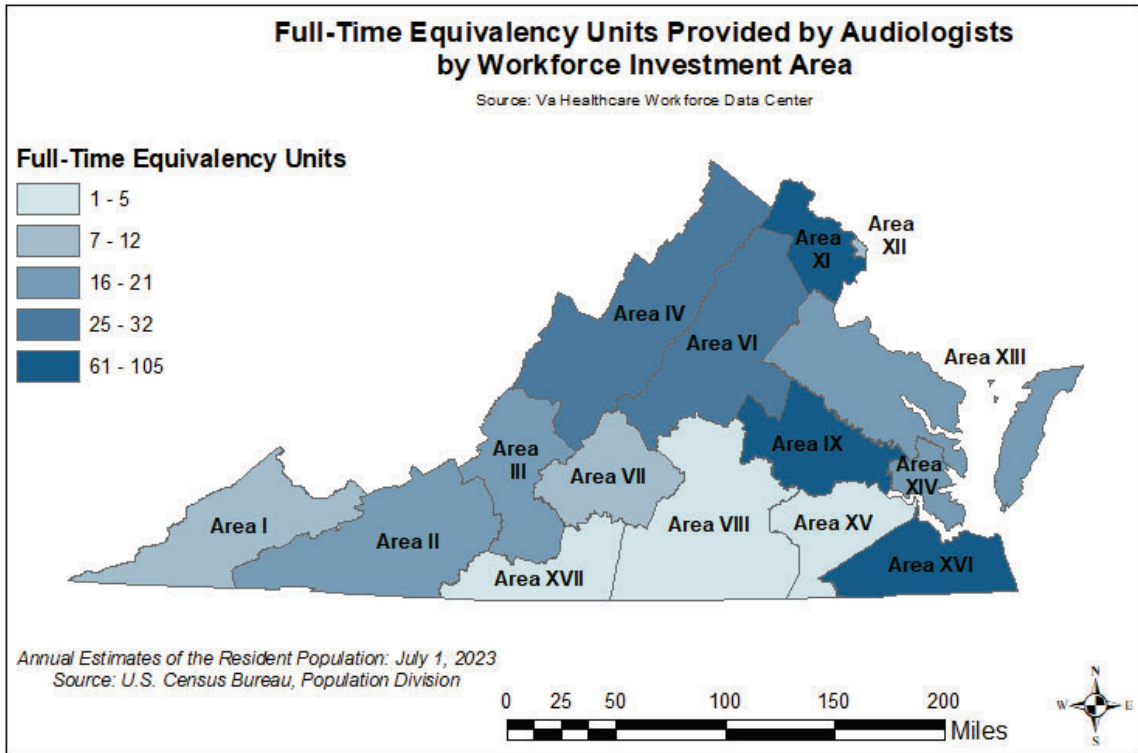


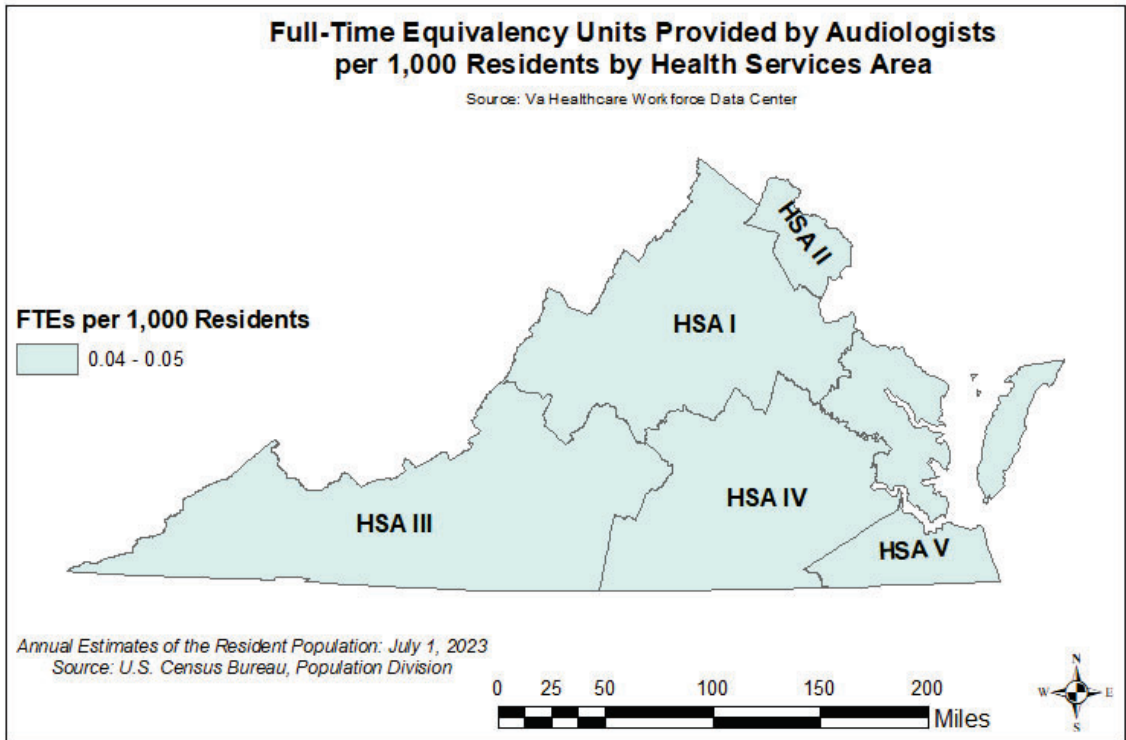
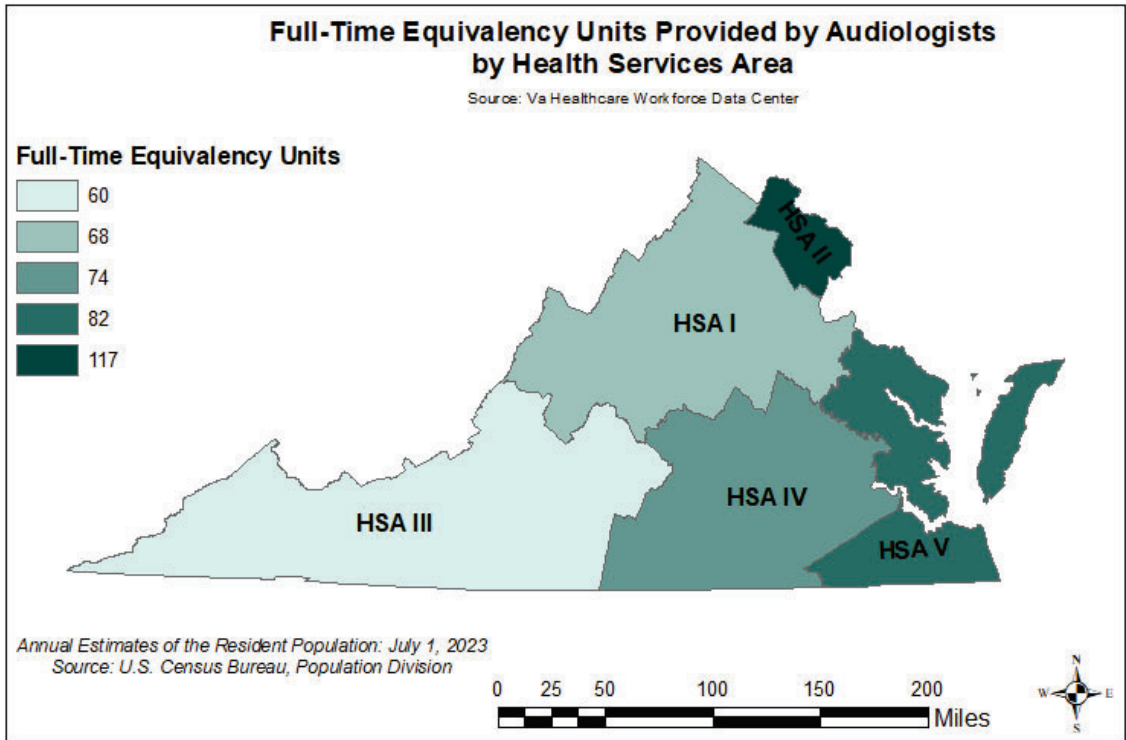
Source: Va. Healthcare Workforce Data Center

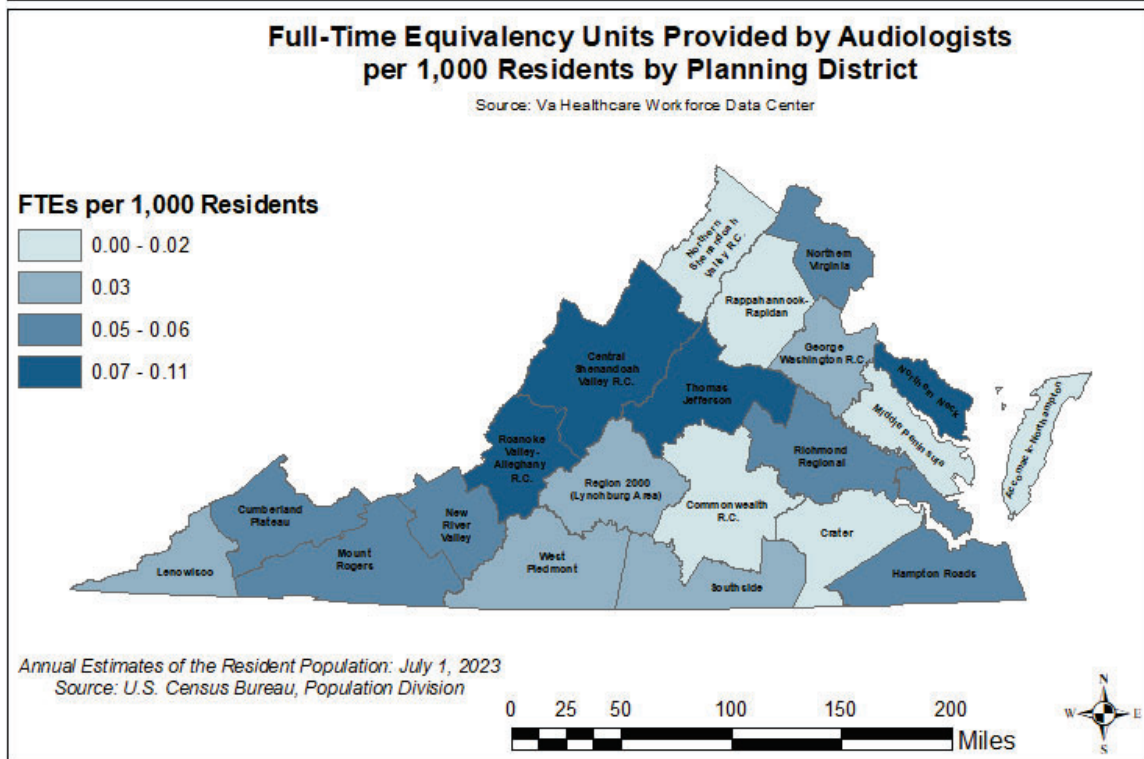
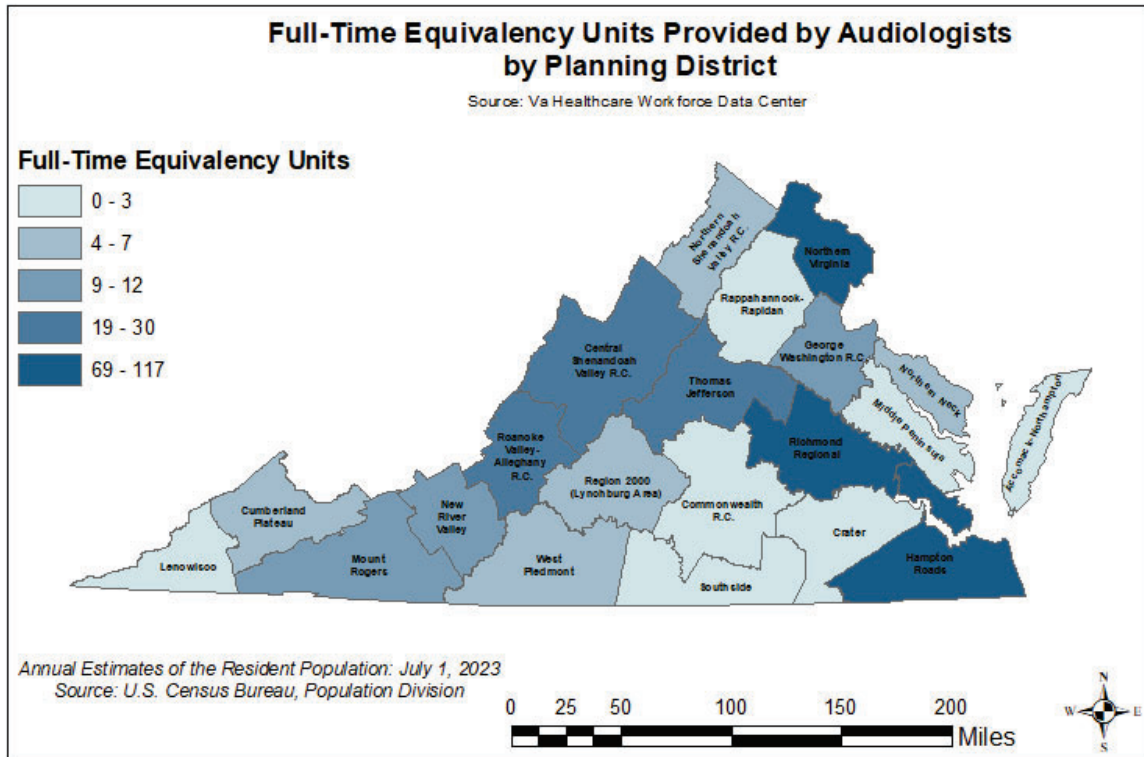
<sup>3</sup> Number of residents in 2023 was used as the denominator.











## Appendix

### Weights

Rural Status	Location Weight			Total Weight	
	#	Rate	Weight	Min.	Max.
<b>Metro, 1 Million+</b>	304	84.87%	1.178	1.061	1.764
<b>Metro, 250,000 to 1 Million</b>	35	88.57%	1.129	1.016	1.690
<b>Metro, 250,000 or Less</b>	60	88.33%	1.132	1.019	1.695
<b>Urban, Pop. 20,000+, Metro Adj.</b>	9	44.44%	2.250	2.025	2.268
<b>Urban, Pop. 20,000+, Non-Adj.</b>	0	NA	NA	NA	NA
<b>Urban, Pop. 2,500-19,999, Metro Adj.</b>	10	90.00%	1.111	1.037	1.664
<b>Urban, Pop. 2,500-19,999, Non-Adj.</b>	8	75.00%	1.333	1.226	1.245
<b>Rural, Metro Adj.</b>	4	100.00%	1.000	0.920	1.008
<b>Rural, Non-Adj.</b>	4	100.00%	1.000	0.934	1.053
<b>Virginia Border State/D.C.</b>	111	74.77%	1.337	1.204	2.002
<b>Other U.S. State</b>	95	78.95%	1.267	1.140	1.896

Source: Va. Healthcare Workforce Data Center

Age	Age Weight			Total Weight	
	#	Rate	Weight	Min.	Max.
<b>Under 30</b>	60	55.00%	1.818	1.664	2.002
<b>30 to 34</b>	110	78.18%	1.279	1.053	1.409
<b>35 to 39</b>	70	85.71%	1.167	0.961	1.285
<b>40 to 44</b>	71	81.69%	1.224	1.008	2.268
<b>45 to 49</b>	86	89.53%	1.117	0.920	1.230
<b>50 to 54</b>	69	84.06%	1.190	0.980	2.204
<b>55 to 59</b>	47	91.49%	1.093	1.016	2.025
<b>60 and Over</b>	127	88.19%	1.134	0.934	2.101

Source: Va. Healthcare Workforce Data Center

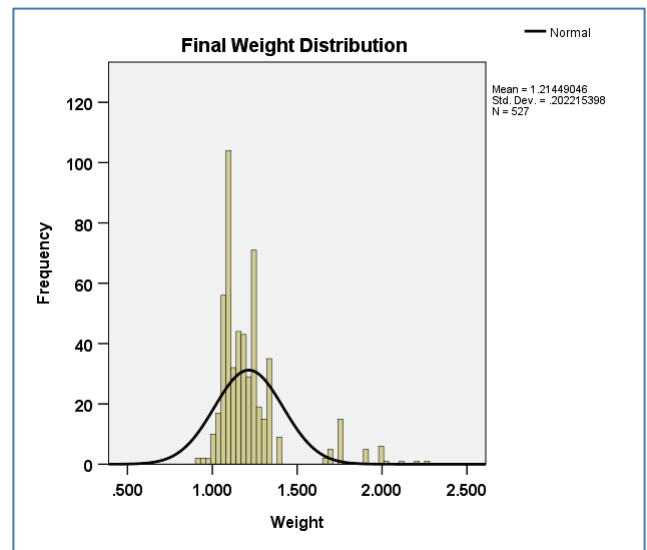
See the Methods section on the HWDC website for details on HWDC methods:

<https://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/>

Final weights are calculated by multiplying the two weights and the overall response rate:

$$\text{Age Weight} \times \text{Rural Weight} \times \text{Response Rate} = \text{Final Weight}$$

**Overall Response Rate: 0.823438**



Source: Va. Healthcare Workforce Data Center

---

# *Virginia's Speech-Language Pathology Workforce: 2025*

---

Healthcare Workforce Data Center

August 2025

Virginia Department of Health Professions  
Healthcare Workforce Data Center  
Perimeter Center  
9960 Mayland Drive, Suite 300  
Henrico, VA 23233  
804-597-4213, 804-527-4434 (fax)  
E-mail: [HWDC@dhp.virginia.gov](mailto:HWDC@dhp.virginia.gov)

Follow us on Tumblr: [www.vahwdc.tumblr.com](http://www.vahwdc.tumblr.com)

Get a copy of this report from:

<https://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/ProfessionReports/>

*More than 4,600 Speech-Language Pathologists voluntarily participated in this survey. Without their efforts, the work of the center would not be possible. The Department of Health Professions, the Healthcare Workforce Data Center, and the Board of Audiology & Speech-Language Pathology express our sincerest appreciation for their ongoing cooperation.*

***Thank You!***

***Virginia Department of Health Professions***

**Arne E. Owens, MS**

*Director*

*Healthcare Workforce Data Center Staff:*

**Yetty Shobo, PhD**  
*Director*

**Barbara Hodgdon, PhD**  
*Deputy Director*

**Rajana Siva, MBA**  
*Data Analyst*

**Christopher Coyle, BA**  
*Research Assistant*

**The Board of Audiology & Speech-Language Pathology**

***Chair***

Melissa A. McNichol, AuD, CCC-A  
*Charlottesville*

***Vice Chair***

Lisa G. Wallace-Davis, O.D.  
*Hampton*

***Members***

Jennifer Radford Gay, MS, CCC-SLP  
*Danville*

Bethany Rose, AuD  
*Richmond*

Wayne Shaia, M.D.  
*Richmond*

Laura H. Vencill, MS, CCC-SLP  
*Rosedale*

James Wells, RPh  
*Charlottesville*

***Executive Director***

Kelli Moss

<b>Results in Brief</b> .....	<b>2</b>
<b>Summary of Trends</b> .....	<b>2</b>
<b>Survey Response Rates</b> .....	<b>3</b>
<b>The Workforce</b> .....	<b>4</b>
<b>Demographics</b> .....	<b>5</b>
<b>Background</b> .....	<b>6</b>
<b>Education</b> .....	<b>8</b>
<b>Specializations &amp; Credentials</b> .....	<b>9</b>
<b>Current Employment Situation</b> .....	<b>10</b>
<b>Employment Quality</b> .....	<b>11</b>
<b>2025 Labor Market</b> .....	<b>12</b>
<b>Work Site Distribution</b> .....	<b>13</b>
<b>Establishment Type</b> .....	<b>14</b>
<b>Languages</b> .....	<b>16</b>
<b>Supervision</b> .....	<b>17</b>
<b>Time Allocation</b> .....	<b>18</b>
<b>Patient Workload</b> .....	<b>19</b>
<b>Retirement &amp; Future Plans</b> .....	<b>20</b>
<b>Full-Time Equivalency Units</b> .....	<b>22</b>
<b>Maps</b> .....	<b>23</b>
Virginia Performs Regions .....	23
Area Health Education Center Regions .....	24
Workforce Investment Areas .....	25
Health Services Areas .....	26
Planning Districts.....	27
<b>Appendix</b> .....	<b>28</b>
Weights .....	28

# The Speech-Language Pathology Workforce At a Glance:

## The Workforce

Licensees:	5,631
Virginia's Workforce:	4,669
FTEs:	3,576

## Background

Rural Childhood:	28%
HS Degree in VA:	47%
Prof. Degree in VA:	47%

## Current Employment

Employed in Prof.:	94%
Hold 1 Full-Time Job:	60%
Satisfied?:	94%

## Survey Response Rate

All Licensees:	83%
Renewing Practitioners:	97%

## Education

Masters:	98%
Doctorate:	2%

## Job Turnover

Switched Jobs:	6%
Employed Over 2 Yrs.:	65%

## Demographics

Female:	97%
Diversity Index:	29%
Median Age:	41

## Finances

Median Income:	\$70k-\$80k
Health Insurance:	61%
Under 40 w/ Ed. Debt:	54%

## Time Allocation

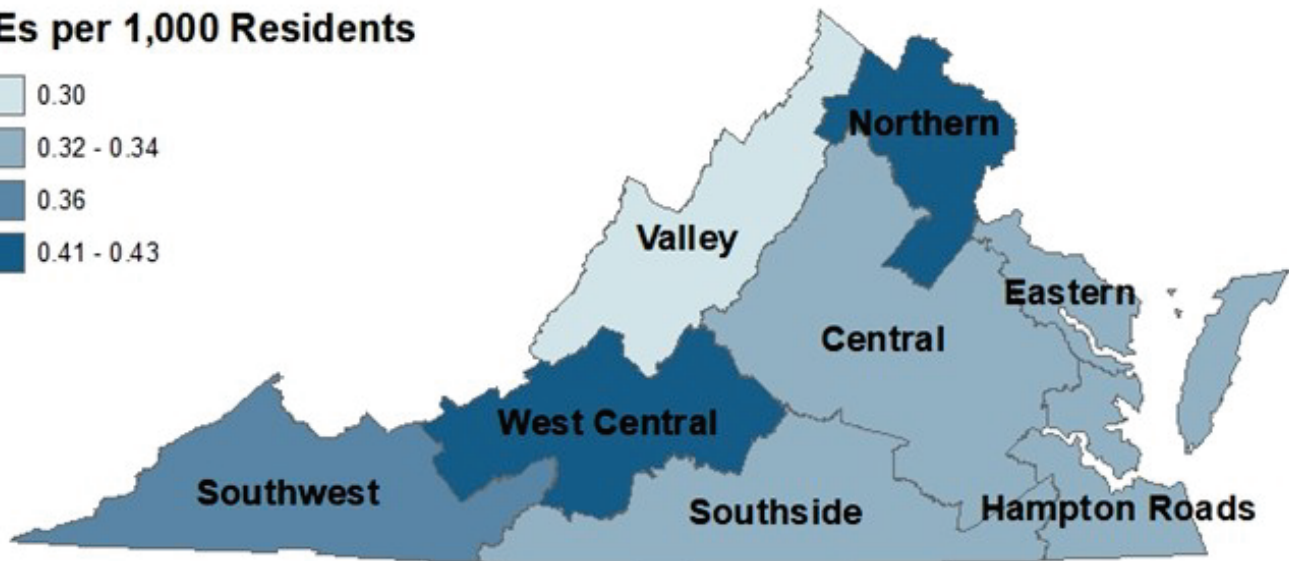
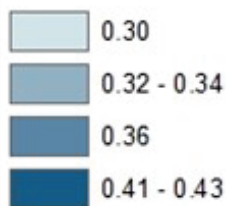
Client Care:	70%-79%
Administration:	10%-19%
Client Care Role:	72%

Source: Va. Healthcare Workforce Data Center

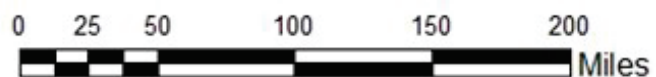
## Full Time Equivalency Units Provided by Speech-Language Pathologists per 1,000 Residents by Virginia Performs Regions

Source: Va Healthcare Work force Data Center

### FTEs per 1,000 Residents



Annual Estimates of the Resident Population: July 1, 2023  
Source: U.S. Census Bureau, Population Division



This report contains the results of the 2025 Speech-Language Pathology (SLP) Workforce Survey. More than 4,600 SLPs voluntarily participated in this survey. The Virginia Department of Health Professions' Healthcare Workforce Data Center (HWDC) administers the survey during the license renewal process, which takes place every June for SLPs. These survey respondents represent 83% of the 5,631 SLPs who are licensed in the state and 97% of renewing practitioners.

The HWDC estimates that 4,669 SLPs participated in Virginia's workforce during the survey period, which is defined as those SLPs who worked at least a portion of the year in the state or who live in the state and intend to return to work as a SLP at some point in the future. Over the past year, Virginia's SLP workforce provided 3,576 "full-time equivalency units," which the HWDC defines simply as working 2,000 hours per year.

The vast majority of SLPs are female, who constitute 97% of the SLP workforce. The median age of the SLP workforce is 41. In a random encounter between two SLPs, there is a 29% chance that they would be of different races or ethnicities, a measure known as the diversity index. This is well below the comparable diversity index of 60% for Virginia's population as a whole. Approximately 28% of all SLPs grew up in a rural area, and 24% of SLPs who grew up in a rural area currently work in a non-metro area of Virginia. In total, 9% of all SLPs work in a non-metro area of the state.

Among all SLPs, 94% are currently employed in the profession, 60% hold one full-time job, and 43% work between 40 and 49 hours per week. About three out of every five SLPs work in the private sector, including 40% who work at a for-profit organization, while another 38% of SLPs work for a state or local government. The median annual income of Virginia's SLP workforce is between \$70,000 and \$80,000. In addition, 79% of wage and salaried SLPs receive at least one employer-sponsored benefit, including 61% who have access to health insurance. More than nine out of every ten SLPs are satisfied with their current work situation, including 52% who indicated that they are "very satisfied."

## Summary of Trends

---

In this section, all statistics are compared to the 2013 SLP workforce. The number of licensed SLPs in Virginia has increased by 62% (5,631 vs. 3,468). In addition, the size of Virginia's SLP workforce has increased by 56% (4,669 vs. 2,993), and the number of FTEs provided by this workforce has increased by 52% (3,576 vs. 2,358). Virginia's renewing SLPs are more likely to respond to this survey (97% vs. 85%).

Virginia's SLP workforce has become more diverse (29% vs. 24%), following a similar trend as the state's overall population (60% vs. 54%). SLPs are less likely to have grown up in a rural area (28% vs. 31%), but SLPs who grew up in a rural area are more likely to work in a non-metro area of the state (24% vs. 21%). The percentage of all SLPs who carry education debt has fallen (36% vs. 40%). Among SLPs who are under the age of 40, the percentage holding education debt has fallen even further (54% vs. 66%). However, the median outstanding balance among those SLPs with education debt has increased (\$50k-\$60k vs. \$30k-\$40k).

SLPs are more likely to hold one-full time job (60% vs. 55%) instead of two or more positions simultaneously (20% vs. 21%). SLP employment has shifted away from the for-profit sector (40% vs. 45%) in favor of state and local governments (38% vs. 34%). With respect to establishment types, schools that provide care to clients are employing a greater share of Virginia's SLP workforce (40% vs. 33%), and this shift has mainly come at the expense of employment in skilled nursing facilities (7% vs. 15%). The typical SLP has seen their median patient workload increase at their primary work location (30-39 vs. 20-29). In addition, the percentage of SLPs who hold group sessions at their primary work location has increased as well (49% vs. 42%).

The median annual income of Virginia's SLP workforce has increased (\$70k-\$80k vs. \$50k-\$60k), and SLPs are more likely to receive this income in the form of a salary (54% vs. 46%) instead of an hourly wage (35% vs. 40%). The percentage of SLPs who indicated that they are satisfied with their current employment situation has fallen slightly (94% vs. 95%). This decline is even greater among those SLPs who indicated that they were "very satisfied" with their current employment situation (52% vs. 60%).

**A Closer Look:**

Licensee Counts		
License Status	#	%
Renewing Practitioners	4,566	81%
New Licensees	524	9%
Non-Renewals	541	10%
<b>All Licensees</b>	<b>5,631</b>	<b>100%</b>

Source: Va. Healthcare Workforce Data Center

*HWDC surveys tend to achieve very high response rates. Among all renewing SLPs, 97% submitted a survey. These represent 83% of the 5,631 SLPs who held a license at some point in the past year.*

**Definitions**

- 1. The Survey Period:** The survey was conducted in June 2025.
- 2. Target Population:** All SLPs who held a Virginia license at some point between July 2024 and June 2025.
- 3. Survey Population:** The survey was available to those who renewed their licenses online. It was not available to those who did not renew, including some SLPs newly licensed in the past year.

**Response Rates**

Statistic	Non Respondents	Respondents	Response Rate
<b>By Age</b>			
Under 30	257	531	67%
30 to 34	187	791	81%
35 to 39	131	735	85%
40 to 44	96	618	87%
45 to 49	77	545	88%
50 to 54	74	516	88%
55 to 59	50	388	89%
60 and Over	108	527	83%
<b>Total</b>	<b>980</b>	<b>4,651</b>	<b>83%</b>
<b>New Licenses</b>			
Issued in Past Year	347	177	34%
<b>Metro Status</b>			
Non-Metro	44	336	88%
Metro	493	3,290	87%
Not in Virginia	443	1,025	70%

Source: Va. Healthcare Workforce Data Center

**Response Rates**

Completed Surveys	4,651
Response Rate, All Licensees	83%
Response Rate, Renewals	97%

Source: Va. Healthcare Workforce Data Center

**At a Glance:**

**Licensed SLPs**

Number:	5,631
New:	9%
Not Renewed:	10%

**Survey Response Rates**

All Licensees:	83%
Renewing Practitioners:	97%

Source: Va. Healthcare Workforce Data Center

## At a Glance:

### Workforce

SLP Workforce: 4,669  
 FTEs: 3,576

### Utilization Ratios

Licensees in VA Workforce: 83%  
 Licensees per FTE: 1.57  
 Workers per FTE: 1.31

Source: Va. Healthcare Workforce Data Center

## Definitions

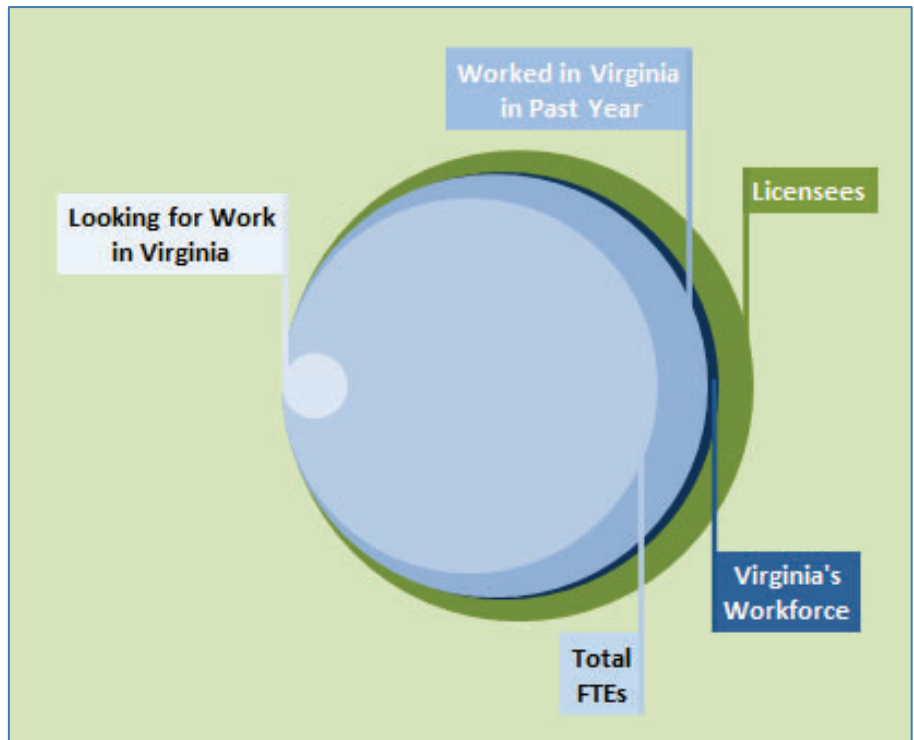
- 1. Virginia’s Workforce:** A licensee with a primary or secondary work site in Virginia at any time in the past year or who indicated intent to return to Virginia’s workforce at any point in the future.
- 2. Full-Time Equivalency Unit (FTE):** The HWDC uses 2,000 (40 hours for 50 weeks) as its baseline measure for FTEs.
- 3. Licensees in VA Workforce:** The proportion of licensees in Virginia’s workforce.
- 4. Licensees per FTE:** An indication of the number of licensees needed to create 1 FTE. Higher numbers indicate lower licensee participation.
- 5. Workers per FTE:** An indication of the number of workers in Virginia’s workforce needed to create 1 FTE. Higher numbers indicate lower utilization of available workers.

### Virginia's SLP Workforce

Status	#	%
Worked in Virginia in Past Year	4,582	98%
Looking for Work in Virginia	87	2%
Virginia's Workforce	4,669	100%
Total FTEs	3,576	
Licensees	5,631	

Source: Va. Healthcare Workforce Data Center

*Weighting is used to estimate the figures in this report. Unless otherwise noted, figures refer to the Virginia Workforce only. For more information on the HWDC’s methodology, visit: <https://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/>*



Source: Va. Healthcare Workforce Data Center

**A Closer Look:**

Age & Gender						
Age	Male		Female		Total	
	#	% Male	#	% Female	#	% in Age Group
Under 30	9	1%	594	99%	603	16%
30 to 34	28	4%	653	96%	681	18%
35 to 39	15	3%	573	97%	588	15%
40 to 44	14	3%	476	97%	490	13%
45 to 49	9	2%	403	98%	413	11%
50 to 54	11	3%	397	97%	408	11%
55 to 59	7	2%	286	98%	293	8%
60 and Over	13	3%	361	97%	374	10%
<b>Total</b>	<b>106</b>	<b>3%</b>	<b>3,744</b>	<b>97%</b>	<b>3,850</b>	<b>100%</b>

Source: Va. Healthcare Workforce Data Center

Race & Ethnicity					
Race/ Ethnicity	Virginia*	SLPs		SLPs Under 40	
	%	#	%	#	%
White	59%	3,242	84%	1,553	83%
Black	19%	256	7%	119	6%
Asian	7%	113	3%	57	3%
Other Race	0%	27	1%	10	1%
Two or More Races	3%	87	2%	54	3%
Hispanic	11%	140	4%	83	4%
<b>Total</b>	<b>100%</b>	<b>3,865</b>	<b>100%</b>	<b>1,876</b>	<b>100%</b>

\*Population data in this chart is from the U.S. Census, Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for the United States, States, and Counties: July 1, 2023.

Source: Va. Healthcare Workforce Data Center

**At a Glance:**

**Gender**

% Female: 97%  
% Under 40 Female: 97%

**Age**

Median Age: 41  
% Under 40: 49%  
% 55 and Over: 17%

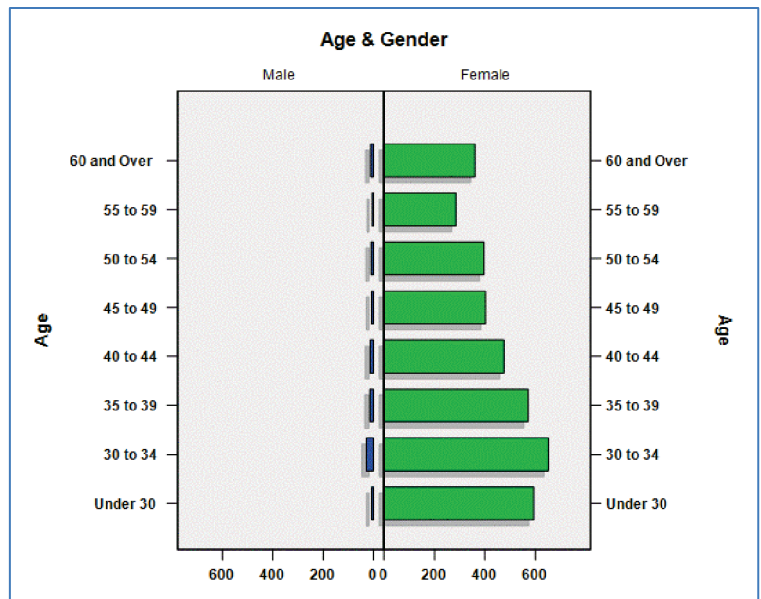
**Diversity**

Diversity Index: 29%  
Under 40 Div. Index: 31%

Source: Va. Healthcare Workforce Data Center

*In a chance encounter between two SLPs, there is a 29% chance that they would be of different races or ethnicities (a measure known as the diversity index). For Virginia's population as a whole, the comparable diversity index is 60%.*

*Close to half of all SLPs are under the age of 40, and 97% of SLPs who are under the age of 40 are female. In addition, the diversity index among SLPs who are under the age of 40 is 31%.*



Source: Va. Healthcare Workforce Data Center

## At a Glance:

### Childhood

Urban Childhood: 7%  
 Rural Childhood: 28%

### Virginia Background

HS in Virginia: 47%  
 Prof. Education in VA: 47%  
 HS/Prof. Edu. in VA: 57%

### Location Choice

% Rural to Non-Metro: 24%  
 % Urban/Suburban to Non-Metro: 4%

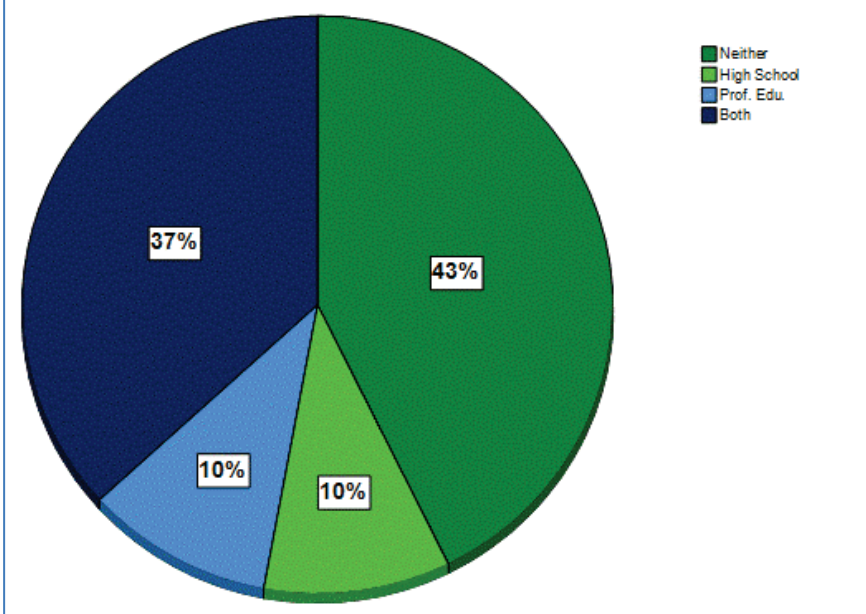
Source: Va. Healthcare Workforce Data Center

## A Closer Look:

Primary Location: USDA Rural Urban Continuum		Rural Status of Childhood Location		
Code	Description	Rural	Suburban	Urban
<b>Metro Counties</b>				
1	Metro, 1 Million+	19%	73%	8%
2	Metro, 250,000 to 1 Million	48%	49%	3%
3	Metro, 250,000 or Less	35%	57%	8%
<b>Non-Metro Counties</b>				
4	Urban, Pop. 20,000+, Metro Adjacent	61%	34%	5%
6	Urban, Pop. 2,500-19,999, Metro Adjacent	66%	29%	5%
7	Urban, Pop. 2,500-19,999, Non-Adjacent	91%	8%	1%
8	Rural, Metro Adjacent	75%	26%	n/a
9	Rural, Non-Adjacent	70%	25%	5%
<b>Overall</b>		28%	65%	7%

Source: Va. Healthcare Workforce Data Center

Educational Background in Virginia



Source: Va. Healthcare Workforce Data Center

Nearly three out of every ten SLPs grew up in a self-described rural area, and 24% of SLPs who grew up in a rural area currently work in a non-metro county. In total, 9% of all SLPs currently work in a non-metro county.

## Top Ten States for Speech-Language Pathologist Recruitment

Rank	All Speech-Language Pathologists			
	High School	#	Professional School	#
1	Virginia	1,797	Virginia	1,783
2	Pennsylvania	270	Washington, D.C.	246
3	New York	229	New York	193
4	Maryland	158	Pennsylvania	168
5	New Jersey	141	North Carolina	162
6	North Carolina	117	Florida	134
7	Florida	113	Maryland	122
8	Ohio	80	Tennessee	111
9	Illinois	77	Ohio	77
10	West Virginia	74	Massachusetts	71

Source: Va. Healthcare Workforce Data Center

*Among all SLPs, 47% received their high school degree in Virginia, and 47% received their initial professional degree in the state.*

Rank	Licensed in the Past Five Years			
	High School	#	Professional School	#
1	Virginia	638	Virginia	605
2	Pennsylvania	139	Washington, D.C.	110
3	New York	80	Pennsylvania	85
4	Maryland	65	New York	82
5	New Jersey	64	Florida	69
6	Florida	61	North Carolina	62
7	North Carolina	54	Maryland	50
8	Illinois	41	Texas	41
9	Texas	40	Massachusetts	39
10	Ohio	36	West Virginia	32

Source: Va. Healthcare Workforce Data Center

*Among SLPs licensed in the past five years, 42% received their high school degree in Virginia, and 40% also received their initial professional degree in the state.*

*Among all licensed SLPs, 17% did not participate in Virginia's workforce in the past year. Nearly nine out of every ten of these professionals worked at some point in the past year, including 82% who currently work as SLPs.*

### At a Glance:

#### Not in VA Workforce

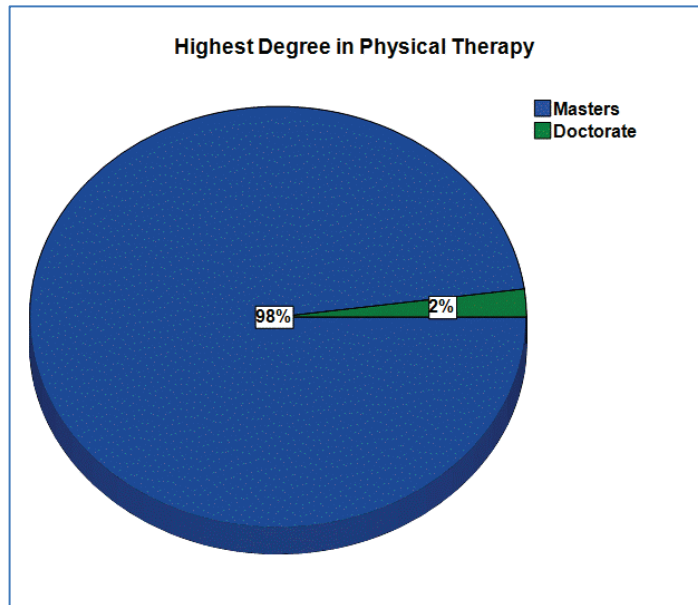
Total:	964
% of Licensees:	17%
Federal/Military:	2%
VA Border State/DC:	28%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Highest Professional Degree		
Degree	#	%
Master's Degree	3,667	98%
Doctorate - SLP	54	2%
Other Doctorate	26	1%
<b>Total</b>	<b>3,747</b>	<b>100%</b>

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

## At a Glance:

**Education**  
Masters: 98%  
Doctorate: 2%

**Education Debt**  
Carry Debt: 36%  
Under Age 40 w/ Debt: 54%  
Median Debt: \$50k-\$60k

Source: Va. Healthcare Workforce Data Center

Nearly all SLPs hold a master's degree as their highest professional degree.

Approximately 36% of all SLPs carry education debt, including 54% of those SLPs who are under the age of 40. For those SLPs with education debt, the median outstanding balance is between \$50,000 and \$60,000.

Amount Carried	All SLPs		SLPs Under 40	
	#	%	#	%
None	2,107	64%	731	46%
Less than \$10,000	97	3%	51	3%
\$10,000-\$19,999	89	3%	45	3%
\$20,000-\$29,999	121	4%	78	5%
\$30,000-\$39,999	107	3%	84	5%
\$40,000-\$49,999	90	3%	71	4%
\$50,000-\$59,999	89	3%	71	4%
\$60,000-\$69,999	104	3%	91	6%
\$70,000-\$79,999	91	3%	77	5%
\$80,000-\$89,999	88	3%	78	5%
\$90,000-\$99,999	52	2%	46	3%
\$100,000 or More	236	7%	168	11%
<b>Total</b>	<b>3,272</b>	<b>100%</b>	<b>1,592</b>	<b>100%</b>

Source: Va. Healthcare Workforce Data Center

## At a Glance:

### Top Specialties

School/Pediatrics:	27%
Child Language:	27%
Autism:	25%

### Top Credentials

CCC-SLP:	72%
VitalStim Certified:	6%
DOE Endorsement:	1%

Source: Va. Healthcare Workforce Data Center

## A Closer Look:

Self-Designated Specialties		
Specialty	#	% of Workforce
School/Pediatrics	1,248	27%
Child Language	1,247	26%
Autism	1,155	24%
Swallowing & Swallowing Disorders	1,003	23%
Child/Infant	779	17%
Medical	582	13%
Geriatrics	578	13%
Brain Injury	430	9%
Fluency Disorders	370	7%
Voice	294	6%
Deaf and Hard of Hearing	163	4%
Other	363	8%
<b>At Least One Specialization</b>	<b>2,779</b>	<b>60%</b>

Source: Va. Healthcare Workforce Data Center

Three out of every five SLPs hold at least one self-designated specialty, including 27% who have a specialization in school/pediatrics.

## Credentials

Credential	#	% of Workforce
CCC-SLP: Speech-Language Pathology	3,362	72%
VitalStim Certified	294	6%
CBIS: Certified Brain Injury Specialist	39	1%
DOE Endorsement	34	1%
CF-SLP: Fellowship	20	<1%
BRS-S: Swallowing	10	<1%
BRS-FD: Fluency Disorders	4	<1%
BRS-CL: Child Language	2	<1%
CCC-A: Audiology	2	<1%
Other	155	3%
<b>At Least One Credential</b>	<b>3,417</b>	<b>73%</b>

Source: Va. Healthcare Workforce Data Center

Nearly three out of every four SLPs hold at least one credential, including 72% who hold a CCC-SLP credential.

## At a Glance:

### Employment

Employed in Profession: 94%  
 Involuntarily Unemployed: 0%

### Positions Held

1 Full-Time: 60%  
 2 or More Positions: 20%

### Weekly Hours

40 to 49: 43%  
 60 or More: 2%  
 Less than 30: 17%

Source: Va. Healthcare Workforce Data Center

## A Closer Look:

Current Work Status		
Status	#	%
Employed, Capacity Unknown	0	0%
Employed in a SLP-Related Capacity	3,569	94%
Employed, NOT in a SLP-Related Capacity	106	3%
Not Working, Reason Unknown	0	0%
Involuntarily Unemployed	0	0%
Voluntarily Unemployed	88	2%
Retired	34	1%
<b>Total</b>	<b>3,798</b>	<b>100%</b>

Source: Va. Healthcare Workforce Data Center

*Among all SLPs, 94% are currently employed in the profession, 60% have one full-time job, and 43% work between 40 and 49 hours per week.*

Current Positions		
Positions	#	%
No Positions	122	3%
One Part-Time Position	623	17%
Two Part-Time Positions	209	6%
One Full-Time Position	2,256	60%
One Full-Time Position & One Part-Time Position	417	11%
Two Full-Time Positions	4	0%
More than Two Positions	108	3%
<b>Total</b>	<b>3,739</b>	<b>100%</b>

Source: Va. Healthcare Workforce Data Center

Current Weekly Hours		
Hours	#	%
0 Hours	122	3%
1 to 9 Hours	129	4%
10 to 19 Hours	221	6%
20 to 29 Hours	288	8%
30 to 39 Hours	1,071	29%
40 to 49 Hours	1,568	43%
50 to 59 Hours	210	6%
60 to 69 Hours	53	1%
70 to 79 Hours	7	0%
80 or More Hours	15	0%
<b>Total</b>	<b>3,684</b>	<b>100%</b>

Source: Va. Healthcare Workforce Data Center

**A Closer Look:**

Annual Income		
Income Level	#	%
Volunteer Work Only	20	1%
Less than \$20,000	144	5%
\$20,000-\$29,999	82	3%
\$30,000-\$39,999	128	4%
\$40,000-\$49,999	150	5%
\$50,000-\$59,999	254	8%
\$60,000-\$69,999	472	15%
\$70,000-\$79,999	526	17%
\$80,000-\$89,999	463	15%
\$90,000-\$99,999	338	11%
\$100,000-\$109,999	201	7%
\$110,000-\$119,999	127	4%
\$120,000 or More	178	6%
<b>Total</b>	<b>3,083</b>	<b>100%</b>

Source: Va. Healthcare Workforce Data Center

Job Satisfaction		
Level	#	%
Very Satisfied	1,899	52%
Somewhat Satisfied	1,527	42%
Somewhat Dissatisfied	178	5%
Very Dissatisfied	47	1%
<b>Total</b>	<b>3,650</b>	<b>100%</b>

Source: Va. Healthcare Workforce Data Center

**At a Glance:**

**Annual Earnings**

Median Income: \$70k-\$80k

**Benefits**

Health Insurance: 61%

Retirement: 67%

**Satisfaction**

Satisfied: 94%

Very Satisfied: 52%

Source: Va. Healthcare Workforce Data Center

The typical SLP earns between \$70,000 and \$80,000 per year. In addition, 79% of wage and salaried SLPs receive at least one employer-sponsored benefit, including 61% who have access to a health insurance plan.

Employer-Sponsored Benefits			
Benefit	#	%	% of Wage/Salary Employees
Retirement	2,110	59%	67%
Health Insurance	1,968	55%	61%
Paid Sick Leave	1,850	52%	58%
Paid Vacation	1,891	53%	60%
Dental Insurance	1,877	53%	59%
Group Life Insurance	1,110	31%	36%
Signing/Retention Bonus	317	9%	10%
<b>At Least One Benefit</b>	<b>2,547</b>	<b>71%</b>	<b>79%</b>

\*From any employer at time of survey.

Source: Va. Healthcare Workforce Data Center

**A Closer Look:**

Employment Instability in the Past Year		
In The Past Year, Did You . . . ?	#	%
Experience Involuntary Unemployment?	17	<1%
Experience Voluntary Unemployment?	216	5%
Work Part-Time or Temporary Positions, but Would Have Preferred a Full-Time/Permanent Position?	100	2%
Work Two or More Positions at the Same Time?	821	18%
Switch Employers or Practices?	292	6%
<b>Experience at Least One?</b>	<b>1,198</b>	<b>26%</b>

Source: Va. Healthcare Workforce Data Center

*Among all SLPs in Virginia, less than 1% experienced involuntary unemployment at some point in the past year. For comparison, Virginia's average monthly unemployment rate was 3.1%.<sup>1</sup>*

Location Tenure				
Tenure	Primary		Secondary	
	#	%	#	%
Not Currently Working at This Location	57	2%	42	6%
Less than 6 Months	134	4%	107	14%
6 Months to 1 Year	383	11%	114	15%
1 to 2 Years	671	19%	187	25%
3 to 5 Years	938	26%	156	21%
6 to 10 Years	566	16%	68	9%
More than 10 Years	799	23%	78	10%
<b>Subtotal</b>	<b>3,549</b>	<b>100%</b>	<b>752</b>	<b>100%</b>
Did Not Have Location	137		3,891	
Item Missing	983		27	
<b>Total</b>	<b>4,669</b>		<b>4,669</b>	

Source: Va. Healthcare Workforce Data Center

*More than half of SLPs receive a salary or work on commission at their primary work location, while 35% of SLPs receive an hourly wage.*

**At a Glance:**

**Unemployment Experience**

Involuntarily Unemployed: <1%  
Underemployed: 2%

**Turnover & Tenure**

Switched: 6%  
New Location: 21%  
Over 2 Years: 65%  
Over 2 Yrs., 2<sup>nd</sup> Location: 40%

**Employment Type**

Salary/Commission: 54%  
Hourly Wage: 35%

Source: Va. Healthcare Workforce Data Center

*More than three in five SLPs have worked at their primary work location for more than two years.*

Employment Type		
Primary Work Site	#	%
Salary/Commission	1,237	54%
Hourly Wage	808	35%
By Contract/Per Diem	192	8%
Business/Practice Income	61	3%
Unpaid	8	<1%
<b>Subtotal</b>	<b>2,306</b>	<b>100%</b>

Source: Va. Healthcare Workforce Data Center

<sup>1</sup> As reported by the U.S. Bureau of Labor Statistics. Over the past year, the non-seasonally adjusted monthly unemployment rate has fluctuated between a low of 2.5% and a high of 3.5%. At the time of publication, the unemployment rate for May 2025 was still preliminary, and the unemployment rate for June 2025 had not yet been released.

## At a Glance:

### Concentration

Top Region:	34%
Top 3 Regions:	75%
Lowest Region:	1%

### Locations

2 or More (Past Year):	21%
2 or More (Now*):	20%

Source: Va. Healthcare Workforce Data Center

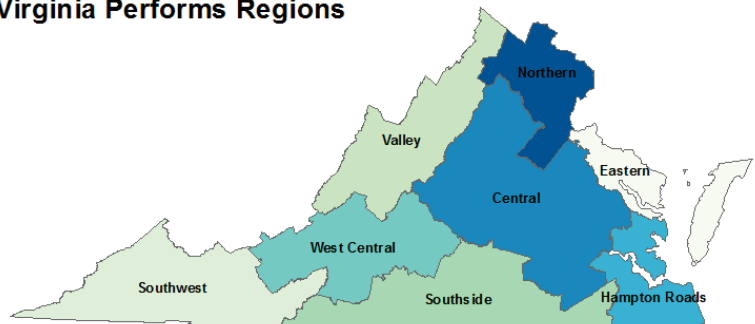
Three out of every four SLPs work in Northern Virginia, Central Virginia, or Hampton Roads.

## A Closer Look:

Regional Distribution of Work Locations				
Virginia Performs Region	Primary Location		Secondary Location	
	#	%	#	%
Central	793	22%	136	18%
Eastern	48	1%	10	1%
Hampton Roads	666	19%	140	19%
Northern	1,199	34%	214	28%
Southside	118	3%	31	4%
Southwest	145	4%	31	4%
Valley	197	6%	37	5%
West Central	320	9%	57	8%
Virginia Border State/D.C.	24	1%	25	3%
Other U.S. State	34	1%	72	10%
Outside of the U.S.	0	0%	1	<1%
<b>Total</b>	<b>3,544</b>	<b>100%</b>	<b>754</b>	<b>100%</b>
Item Missing	988		24	

Source: Va. Healthcare Workforce Data Center

### Virginia Performs Regions



Source: Va. Healthcare Workforce Data Center

Among all SLPs, 20% currently have multiple work locations, while 21% have had multiple work locations over the past year.

Number of Work Locations				
Locations	Work Locations in Past Year		Work Locations Now*	
	#	%	#	%
0	87	2%	123	3%
1	2,764	76%	2,785	77%
2	510	14%	493	14%
3	178	5%	164	5%
4	46	1%	31	1%
5	14	0%	10	0%
6 or More	24	1%	17	0%
<b>Total</b>	<b>3,623</b>	<b>100%</b>	<b>3,623</b>	<b>100%</b>

\*At the time of survey completion, June 2024.

Source: Va. Healthcare Workforce Data Center

**A Closer Look:**

Sector	Location Sector			
	Primary Location		Secondary Location	
	#	%	#	%
<b>For-Profit</b>	1,336	40%	529	73%
<b>Non-Profit</b>	674	20%	102	14%
<b>State/Local Government</b>	1,284	38%	86	12%
<b>Veterans Administration</b>	16	0%	2	0%
<b>U.S. Military</b>	13	0%	1	0%
<b>Other Federal Gov't</b>	27	1%	7	1%
<b>Total</b>	<b>3,350</b>	<b>100%</b>	<b>727</b>	<b>100%</b>
<b>Did Not Have Location</b>	137		3,891	
<b>Item Missing</b>	1,182		50	

Source: Va. Healthcare Workforce Data Center

## At a Glance: (Primary Locations)

**Sector**

For-Profit:	40%
Federal:	2%

**Top Establishments**

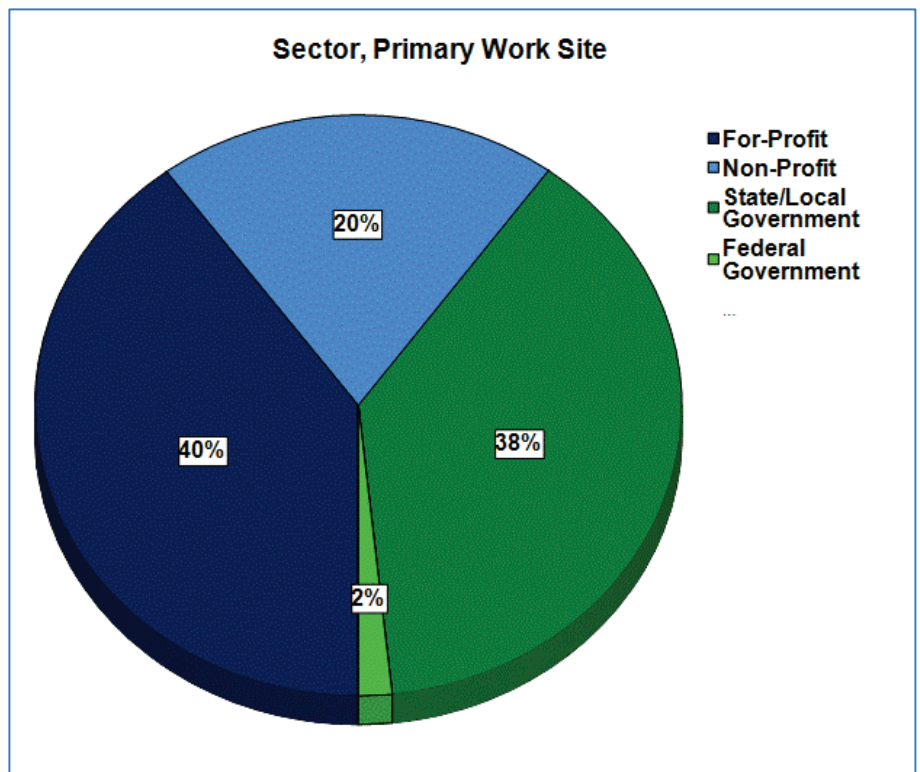
School (Providing Care To Clients):	40%
Private Practice, Group:	11%
Hospital, Inpatient:	8%

**Payment Method**

Cash/Self-Pay:	29%
Medicaid:	30%

Source: Va. Healthcare Workforce Data Center

Approximately 60% of all SLPs work in the private sector, including 40% who work in the for-profit sector. Another 38% of SLPs work in a state or local government.



Source: Va. Healthcare Workforce Data Center

Location Type				
Establishment Type	Primary Location		Secondary Location	
	#	%	#	%
School (Providing Care to Clients)	1,309	40%	61	9%
Private Practice, Group	370	11%	109	15%
Hospital, Inpatient Department	279	8%	90	13%
Skilled Nursing Facility	237	7%	113	16%
Hospital, Outpatient Department	234	7%	27	4%
Private Practice, Solo	189	6%	99	14%
Home Health Care	185	6%	72	10%
Rehabilitation Facility	112	3%	43	6%
Academic Institution (Teaching Health Professions Students or Research)	77	2%	23	3%
Community-Based Clinic or Health Center	57	2%	14	2%
Residential Facility/Group Home	26	1%	11	2%
Administrative/Business Organization	25	1%	6	1%
Child Day Care	8	0%	6	1%
Physician Office	6	0%	0	0%
Outpatient Surgical Center	4	0%	1	0%
Other	170	5%	33	5%
<b>Total</b>	<b>3,288</b>	<b>100%</b>	<b>708</b>	<b>100%</b>
Did Not Have a Location	137		3,891	

Source: Va. Healthcare Workforce Data Center

*Schools that provide care to clients employ 40% of all SLPs in Virginia. Another 11% of SLPs work at group private practices.*

*Approximately three out of every ten SLPs work at establishments that accept cash/self-pay as a form of payment for services rendered. This makes cash/self-pay the most commonly accepted form of payment among Virginia's SLP workforce.*

Accepted Forms of Payment		
Payment	#	% of Workforce
Cash/Self-Pay	1,374	29%
Medicaid	1,403	30%
Private Insurance	1,257	27%
Medicare	849	18%

Source: Va. Healthcare Workforce Data Center

## At a Glance: (Primary Locations)

### Languages Offered

Spanish:	21%
Arabic:	9%
Chinese:	8%

### Means of Communication

Virtual Translation:	63%
Onsite Translation:	43%
Other Staff Member:	34%

Source: Va. Healthcare Workforce Data Center

## A Closer Look:

Languages Offered		
Language	#	% of Workforce
Spanish	995	21%
Arabic	435	9%
Chinese	383	8%
French	373	8%
Korean	358	8%
Vietnamese	353	8%
Urdu	341	7%
Hindi	338	7%
Tagalog/Filipino	327	7%
Amharic, Somali, or Other Afro-Asiatic Languages	303	6%
Persian	294	6%
Pashto	287	6%
Others	224	5%
<b>At Least One Language</b>	<b>1,098</b>	<b>24%</b>

Source: Va. Healthcare Workforce Data Center

Among all SLPs, 21% are employed at a primary work location that offers Spanish language services for patients.

More than three out of every five SLPs who are employed at a primary work location that offers language services for patients provide it by means of a virtual translation service.

## Means of Language Communication

Provision	#	% of Workforce with Language Services
Virtual Translation Service	696	63%
Onsite Translation Service	469	43%
Other Staff Member is Proficient	369	34%
Respondent is Proficient	208	19%
Other	43	4%

Source: Va. Healthcare Workforce Data Center

## At a Glance:

### Supervision

% Supervisor:	7%
% Additional Supervision by Other SLPs:	65%

### Supervisee Count

One:	83%
Two:	14%
Three or More:	2%

Source: Va. Healthcare Workforce Data Center

## A Closer Look:

Supervision of SLP Assistants		
Supervisor?	#	%
Yes	246	7%
No	3,116	93%
<b>Total</b>	<b>3,362</b>	<b>100%</b>

Source: Va. Healthcare Workforce Data Center

Among all SLPs, 7% supervise SLP assistants at their primary work location.

Among SLPs who supervise SLP assistants at their primary work location, more than eight out of every ten supervise one SLP assistant.

Number of SLP Assistants Supervised		
Count	#	%
One	188	83%
Two	31	14%
Three	4	2%
Four or More	1	<1%
<b>Total</b>	<b>226</b>	<b>100%</b>

Source: Va. Healthcare Workforce Data Center

Among SLPs who supervise SLP assistants at their primary work location, approximately one out of three supervise SLP assistants who are also supervised by other SLPs.

Supervision of SLP Assistants by Other SLPs		
Additional Supervision?	#	%
Yes	157	65%
No	81	34%
Unknown	4	2%
<b>Total</b>	<b>241</b>	<b>100%</b>

Source: Va. Healthcare Workforce Data Center

## At a Glance: (Primary Locations)

### Typical Time Allocation

Client Care: 70%-79%  
Administration: 10%-19%

### Roles

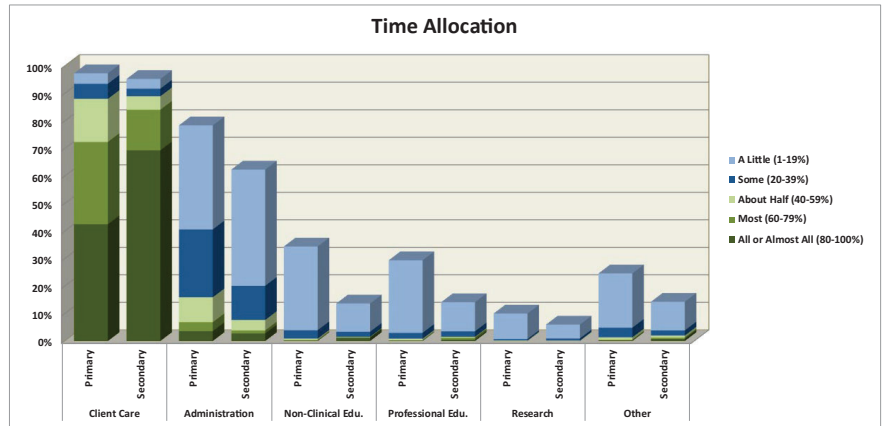
Client Care: 72%  
Administration: 7%  
Other: 1%

### Client Care SLPs

Median Admin. Time: 1%-9%  
Avg. Admin. Time: 10%-19%

Source: Va. Healthcare Workforce Data Center

## A Closer Look:



Source: Va. Healthcare Workforce Data Center

*In general, SLPs spend approximately three-quarters of their time treating patients. In fact, 72% of SLPs fill a client care role, defined as spending 60% or more of their time in that activity.*

## Time Allocation

Time Spent	Client Care		Admin.		Non-Clinical Education		Professional Education		Research		Other	
	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site
<b>All or Almost All (80-100%)</b>	42%	69%	4%	3%	0%	1%	0%	0%	0%	0%	0%	1%
<b>Most (60-79%)</b>	30%	15%	3%	1%	0%	0%	0%	1%	0%	0%	0%	0%
<b>About Half (40-59%)</b>	16%	5%	9%	4%	1%	0%	1%	0%	0%	0%	1%	1%
<b>Some (20-39%)</b>	5%	3%	25%	12%	3%	2%	2%	2%	0%	1%	4%	2%
<b>A Little (1-19%)</b>	4%	4%	38%	42%	30%	10%	26%	11%	9%	5%	20%	10%
<b>None (0%)</b>	3%	5%	22%	38%	66%	86%	71%	86%	90%	94%	75%	86%

Source: Va. Healthcare Workforce Data Center

**A Closer Look:**

**At a Glance:**

**Weekly Patient Totals**

(Median)

Primary Location: 30-39

Secondary Location: 1-9

Total: 40-49

**% with Group Sessions**

Primary Location: 49%

Secondary Location: 17%

Source: Va. Healthcare Workforce Data Center

Weekly Patient Totals						
Number of Patients	Primary Work Location		Secondary Work Location		Total <sup>2</sup>	
	#	%	#	%	#	%
<b>None</b>	166	5%	45	6%	146	4%
<b>1-9</b>	350	10%	413	57%	284	8%
<b>10-19</b>	390	12%	101	14%	347	10%
<b>20-29</b>	455	13%	76	10%	451	13%
<b>30-39</b>	406	12%	35	5%	407	12%
<b>40-49</b>	265	8%	17	2%	301	9%
<b>50-59</b>	342	10%	21	3%	348	10%
<b>60-69</b>	167	5%	4	1%	192	6%
<b>70-79</b>	92	3%	4	1%	118	3%
<b>80 or More</b>	745	22%	11	2%	790	23%
<b>Total</b>	<b>3,378</b>	<b>100%</b>	<b>727</b>	<b>100%</b>	<b>3,338</b>	<b>100%</b>

Source: Va. Healthcare Workforce Data Center

*SLPs typically treat approximately 30 to 39 patients per week at their primary work location. In addition, SLPs who also have a secondary work location treat an additional 1 to 9 patients per week.*

Weekly Patient Sessions								
Number of Sessions	Primary Work Location				Secondary Work Location			
	Individual Sessions		Group Sessions		Individual Sessions		Group Sessions	
	#	%	#	%	#	%	#	%
<b>None</b>	187	6%	1,706	51%	52	7%	599	83%
<b>1-9</b>	1,062	32%	594	18%	478	66%	105	14%
<b>10-19</b>	811	24%	406	12%	123	17%	12	2%
<b>20-29</b>	530	16%	381	11%	33	5%	4	1%
<b>30-39</b>	375	11%	157	5%	15	2%	0	0%
<b>40-49</b>	203	6%	54	2%	5	1%	3	0%
<b>50-59</b>	125	4%	42	1%	13	2%	1	0%
<b>60-69</b>	42	1%	9	0%	3	0%	1	0%
<b>70-79</b>	20	1%	4	0%	1	0%	0	0%
<b>80 or More</b>	11	0%	5	0%	2	0%	0	0%
<b>Total</b>	<b>3,366</b>	<b>100%</b>	<b>3,359</b>	<b>100%</b>	<b>727</b>	<b>100%</b>	<b>725</b>	<b>100%</b>

Source: Va. Healthcare Workforce Data Center

<sup>2</sup> This column estimates the total number of patients treated per week across both primary and secondary work locations.

**A Closer Look:**

Retirement Expectations				
Expected Retirement Age	All		50 and Over	
	#	%	#	%
<b>Under Age 50</b>	60	2%	-	-
<b>50 to 54</b>	118	4%	10	1%
<b>55 to 59</b>	400	13%	71	8%
<b>60 to 64</b>	892	29%	223	26%
<b>65 to 69</b>	1,069	35%	340	40%
<b>70 to 74</b>	313	10%	115	14%
<b>75 to 79</b>	69	2%	30	4%
<b>80 or Over</b>	30	1%	16	2%
<b>I Do Not Intend to Retire</b>	96	3%	37	4%
<b>Total</b>	<b>3,048</b>	<b>100%</b>	<b>842</b>	<b>100%</b>

Source: Va. Healthcare Workforce Data Center

**At a Glance:**

**Retirement Expectations**

**All SLPs**

Under 65: 48%

Under 60: 19%

**SLPs 50 and Over**

Under 65: 36%

Under 60: 10%

**Time Until Retirement**

Within 2 Years: 5%

Within 10 Years: 16%

Half the Workforce: By 2050

Source: Va. Healthcare Workforce Data Center

*Close to one-half of all SLPs expect to retire before the age of 65. Among SLPs who are age 50 and over, 36% expect to retire by the age of 65.*

*Within the next two years, 8% of SLPs expect to pursue additional educational opportunities, and 8% also expect to increase their client care hours.*

**Future Plans**

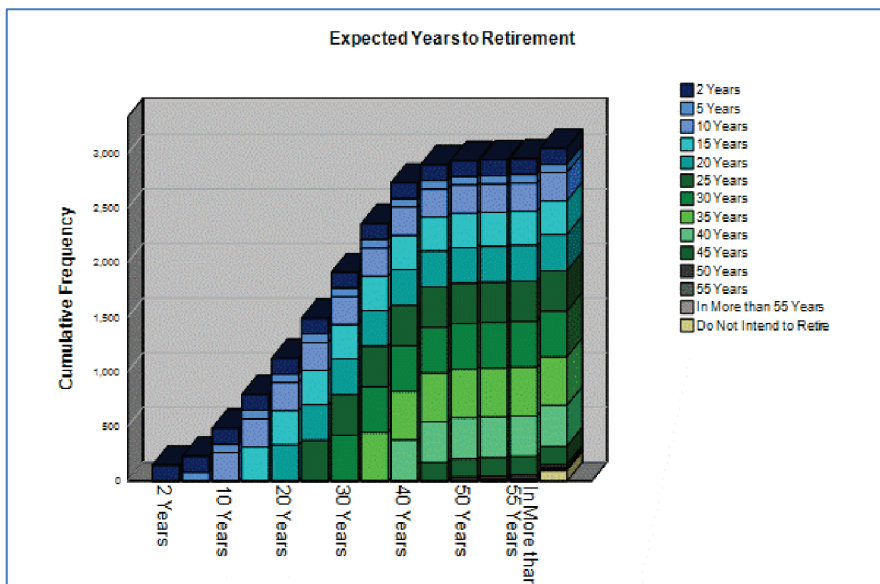
Two-Year Plans:	#	%
<b>Decrease Participation</b>		
<b>Leave Profession</b>	72	2%
<b>Leave Virginia</b>	163	3%
<b>Decrease Client Care Hours</b>	276	6%
<b>Decrease Teaching Hours</b>	19	<1%
<b>Increase Participation</b>		
<b>Increase Client Care Hours</b>	358	8%
<b>Increase Teaching Hours</b>	138	3%
<b>Pursue Additional Education</b>	368	8%
<b>Return to the Workforce</b>	39	1%

Source: Va. Healthcare Workforce Data Center

By comparing retirement expectation to age, we can estimate the maximum years to retirement for SLPs. Only 5% of SLPs expect to retire in the next two years, while 16% expect to retire in the next ten years. About half of the current workforce expect to retire by 2050.

Time to Retirement			
Expect to Retire Within . . .	#	%	Cumulative %
2 Years	147	5%	5%
5 Years	79	3%	7%
10 Years	258	8%	16%
15 Years	311	10%	26%
20 Years	330	11%	37%
25 Years	368	12%	49%
30 Years	420	14%	63%
35 Years	445	15%	77%
40 Years	375	12%	90%
45 Years	167	5%	95%
50 Years	35	1%	96%
55 Years	10	<1%	97%
In More than 55 Years	9	<1%	97%
Do Not Intend to Retire	96	3%	100%
<b>Total</b>	<b>3,048</b>	<b>100%</b>	

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Using these estimates, retirement will begin to reach 10% of the current workforce starting in 2040. Retirement will peak at 15% of the current workforce around 2060 before declining to under 10% of the current workforce again around 2070.

## At a Glance:

### FTEs

Total: 3,576  
 FTEs/1,000 Residents<sup>3</sup>: 0.414  
 Average: 0.79

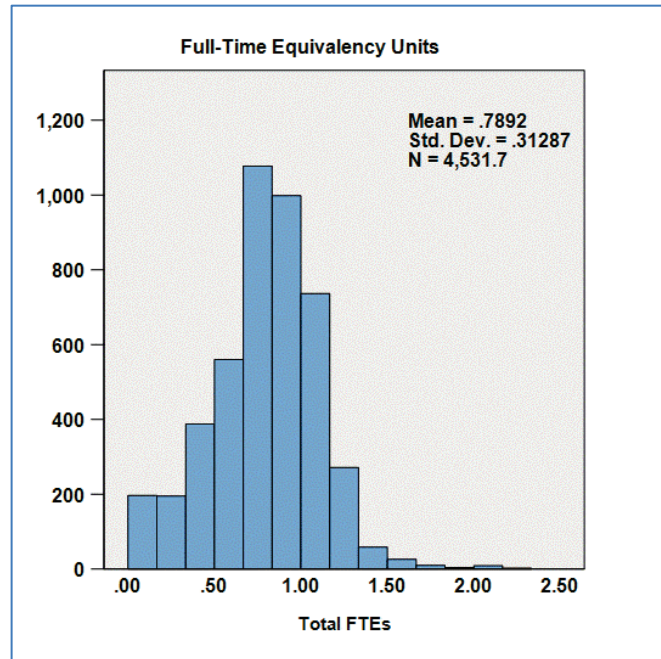
### Age & Gender Effect

Age, *Partial Eta*<sup>2</sup>: Negligible  
 Gender, *Partial Eta*<sup>2</sup>: Negligible

*Partial Eta*<sup>2</sup> Explained:  
*Partial Eta*<sup>2</sup> is a statistical  
 measure of effect size.

Source: Va. Healthcare Workforce Data Center

## A Closer Look:

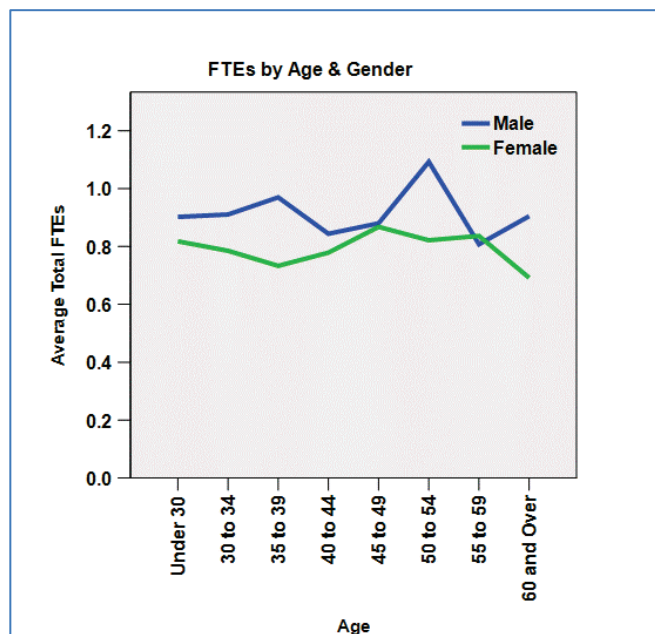


Source: Va. Healthcare Workforce Data Center

The typical SLP provided 0.79 FTEs in the past year, or approximately 32 hours per week for 50 weeks. Although FTEs appear to vary by gender, statistical tests did not verify that a difference exists.<sup>4</sup>

Full-Time Equivalency Units		
	Average	Median
<b>Age</b>		
Under 30	0.81	0.83
30 to 34	0.76	0.76
35 to 39	0.68	0.70
40 to 44	0.78	0.77
45 to 49	0.94	0.96
50 to 54	0.85	0.94
55 to 59	0.84	0.85
60 and Over	0.72	0.80
<b>Gender</b>		
Male	0.92	0.96
Female	0.79	0.83

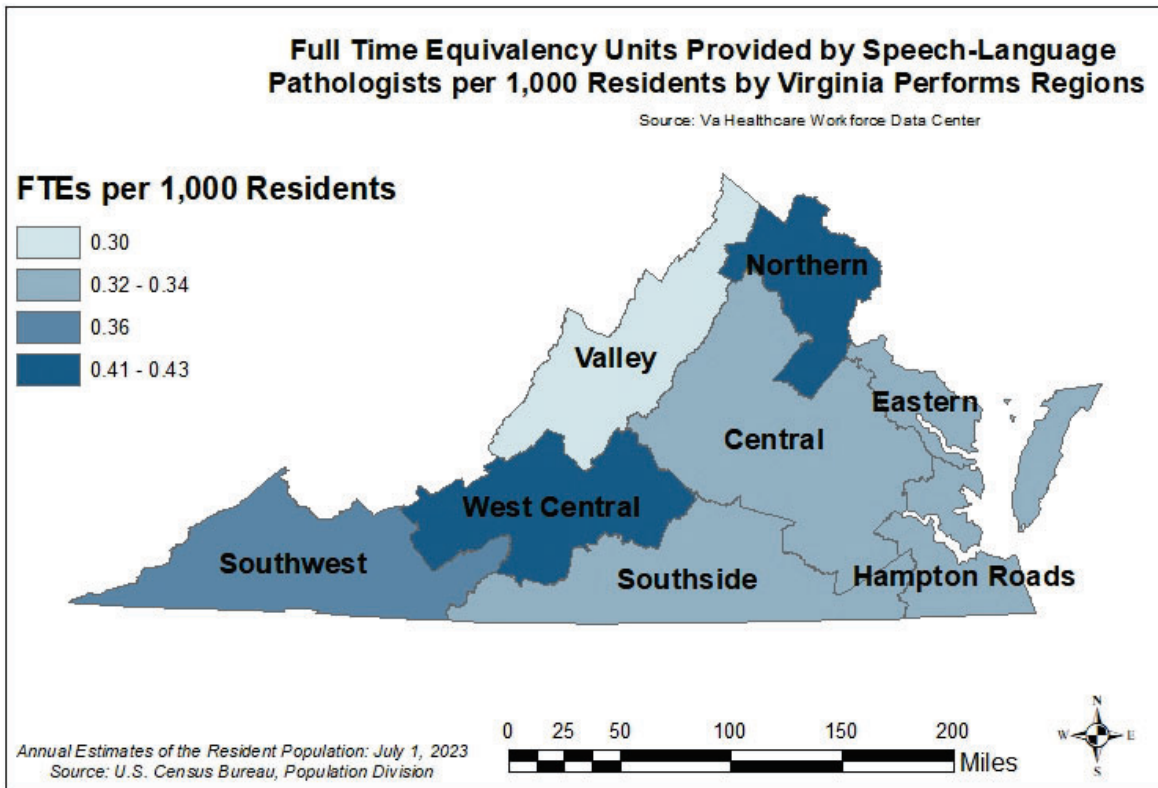
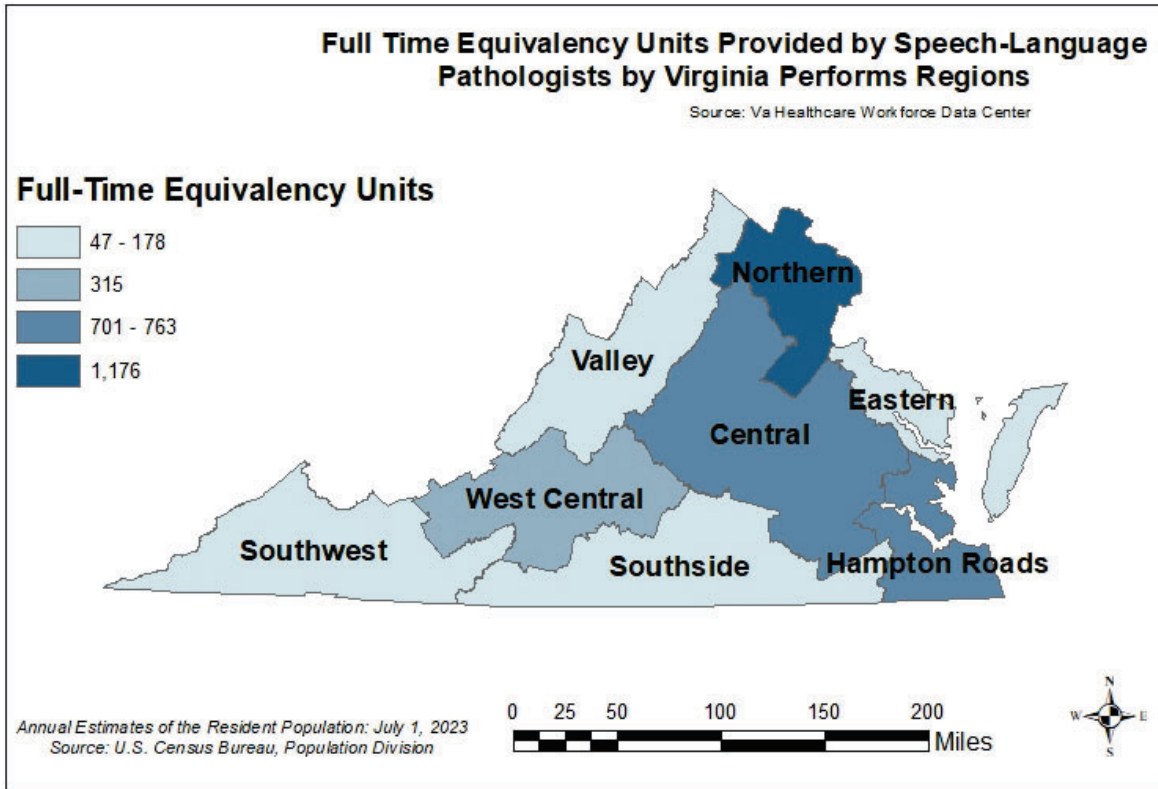
Source: Va. Healthcare Workforce Data Center

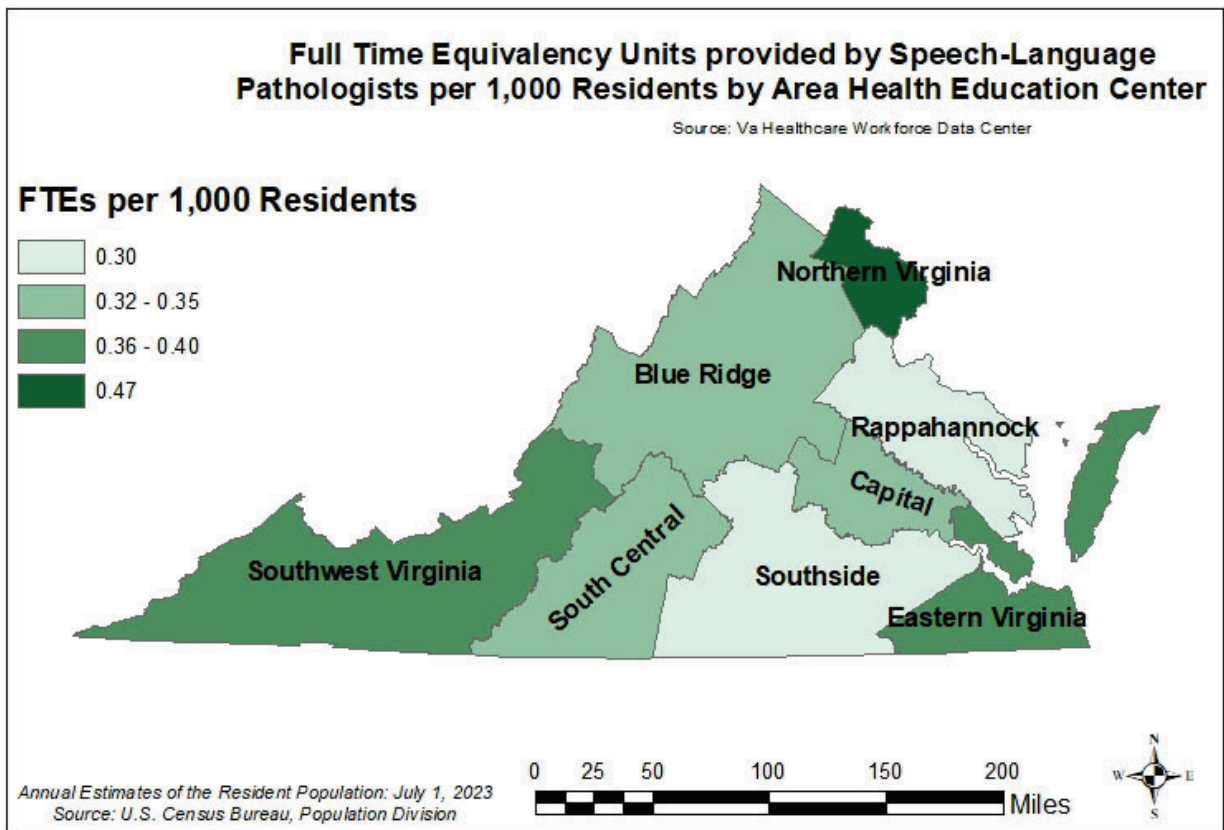
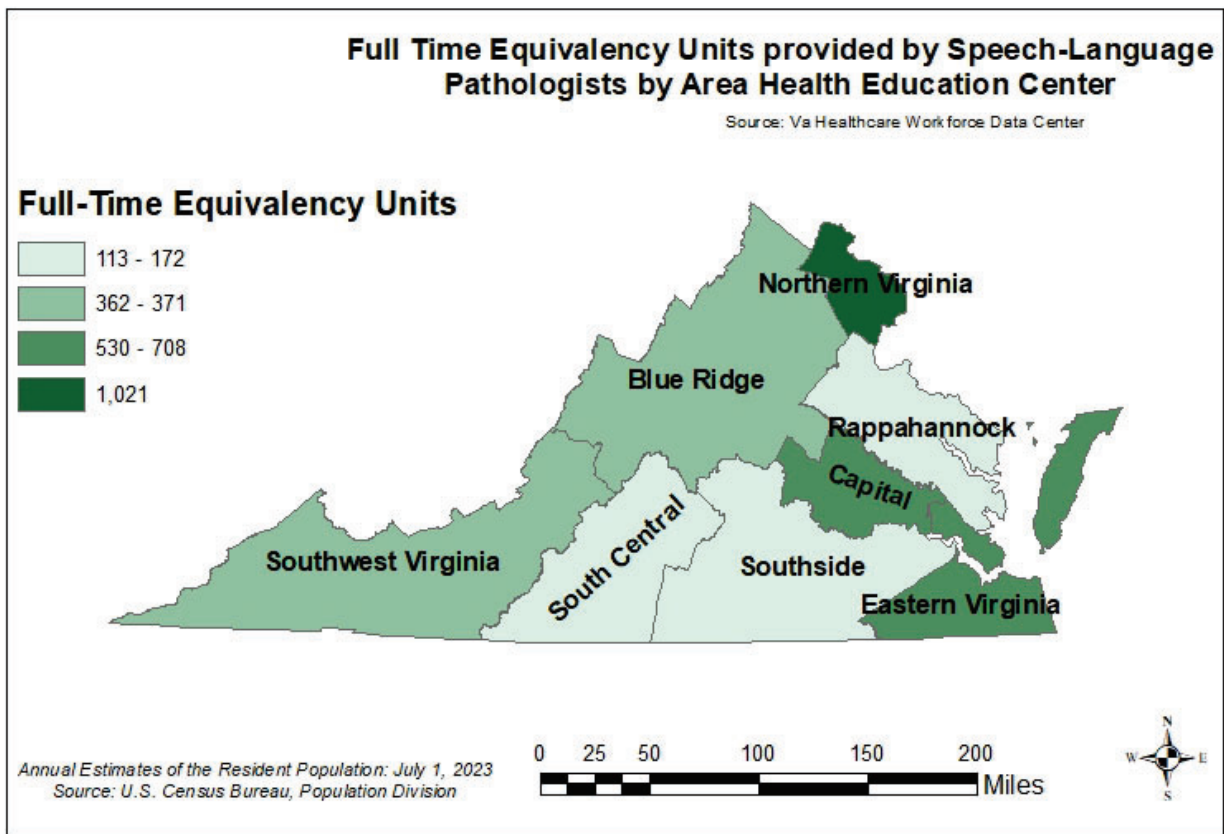


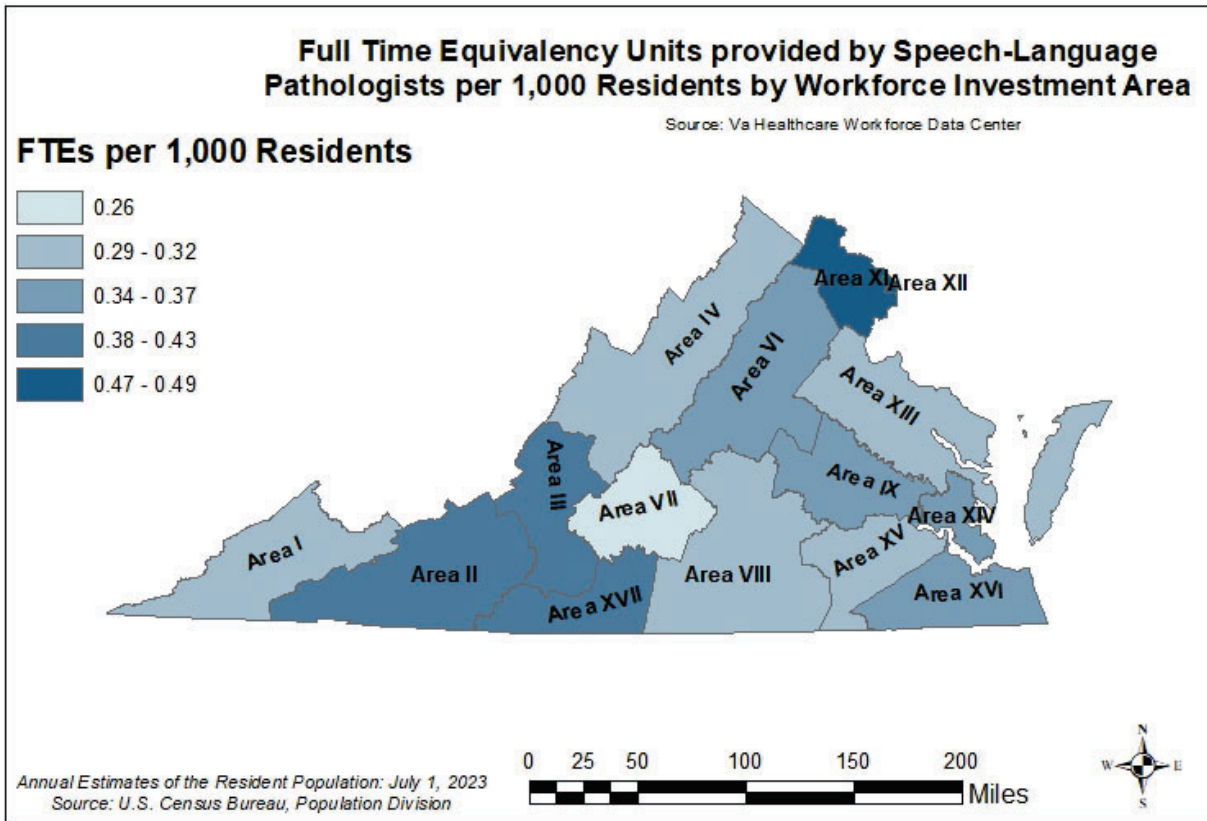
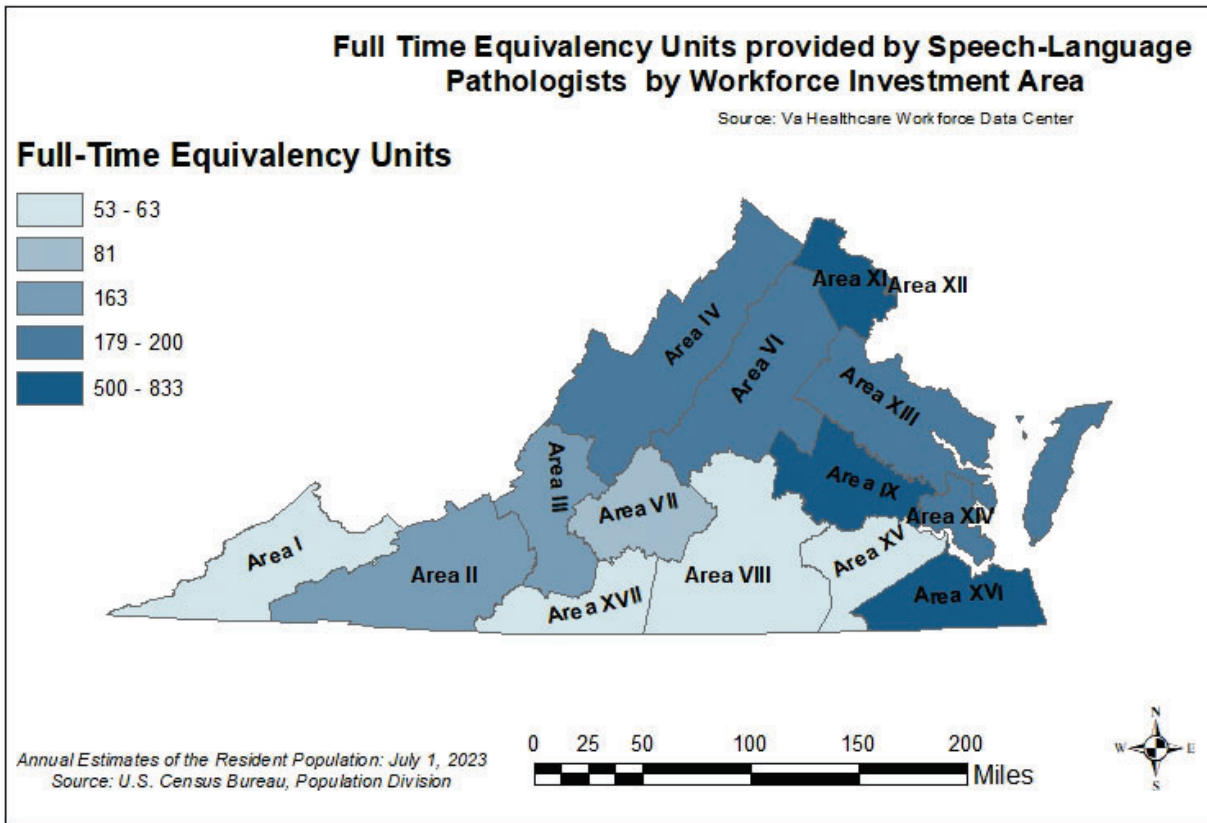
Source: Va. Healthcare Workforce Data Center

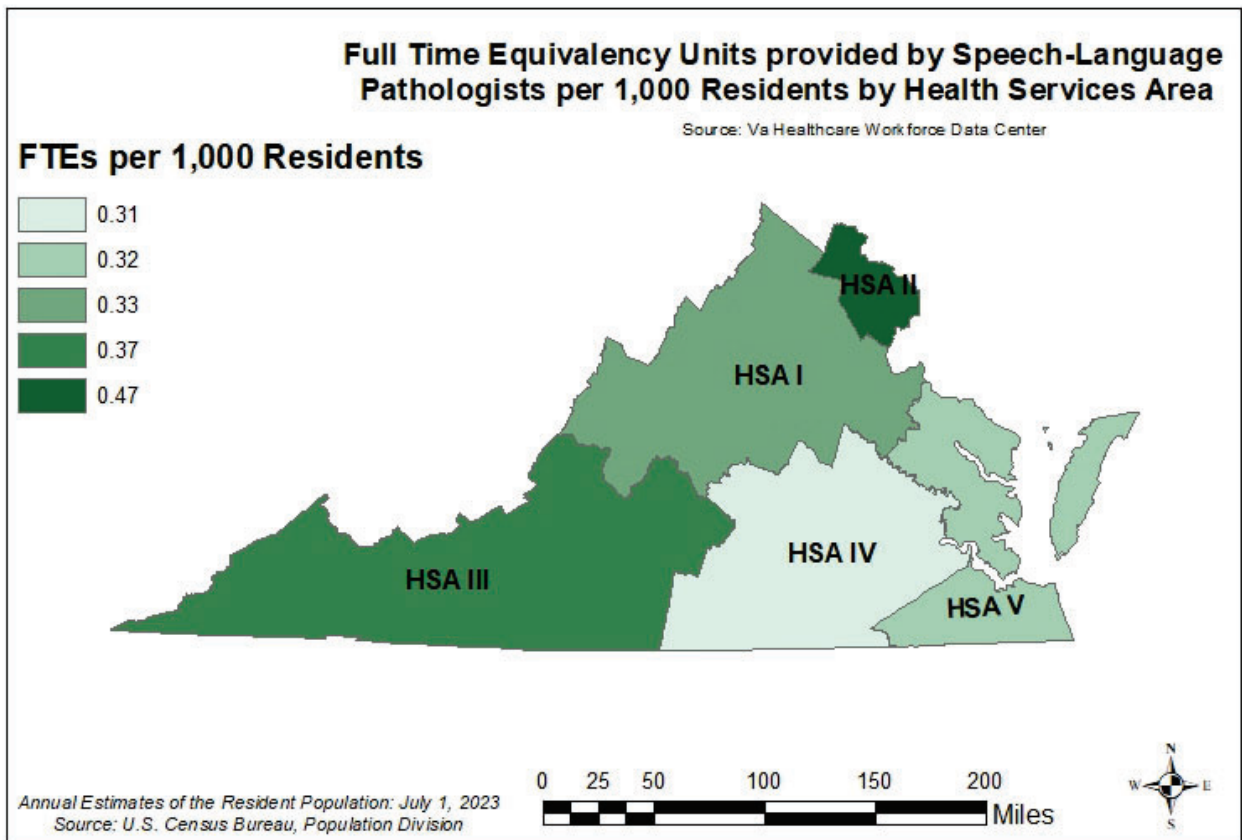
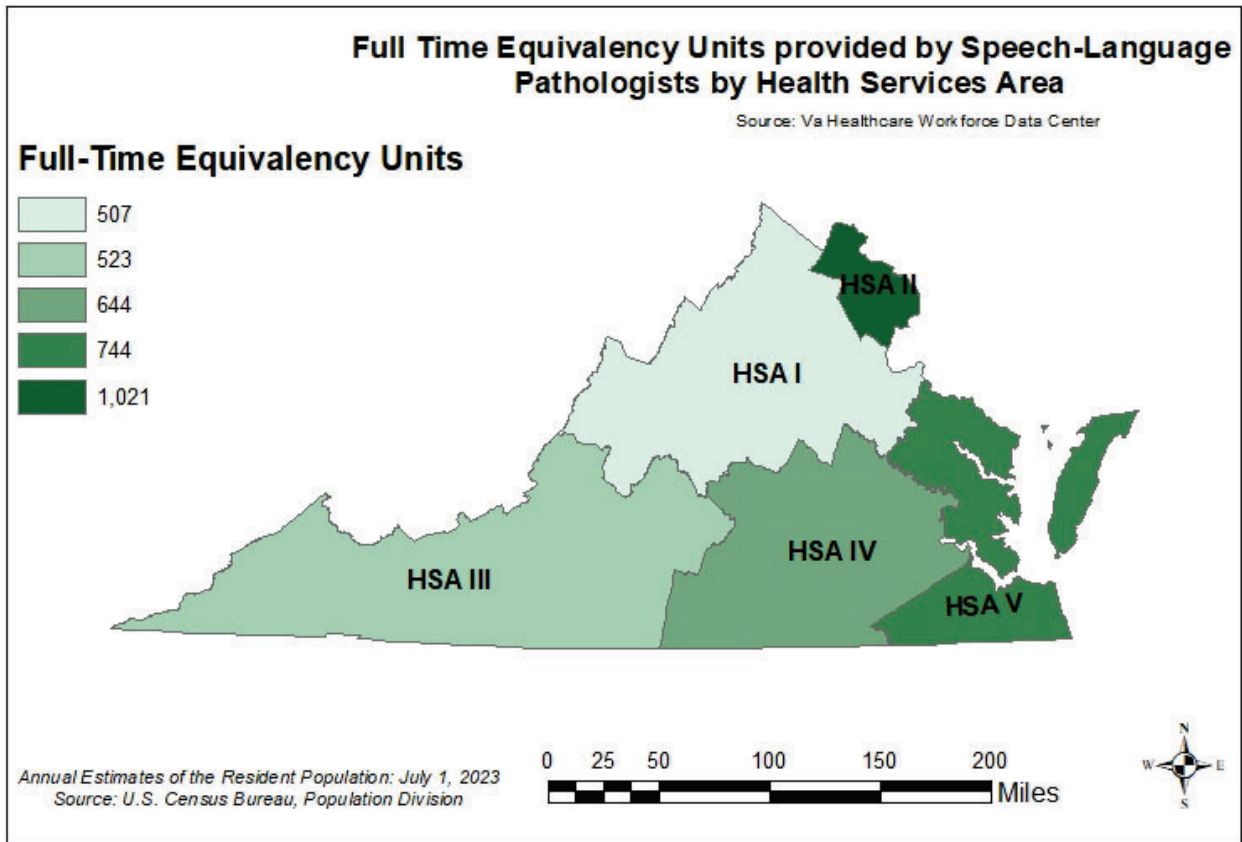
<sup>3</sup> Number of residents in 2023 was used as the denominator.

<sup>4</sup> Due to assumption violations in Mixed between-within ANOVA (Levene's Test was significant).











## Appendix

### Weights

Rural Status	Location Weight			Total Weight	
	#	Rate	Weight	Min.	Max.
<b>Metro, 1 Million+</b>	2,982	86.72%	1.153	1.075	1.413
<b>Metro, 250,000 to 1 Million</b>	338	86.69%	1.154	1.076	1.414
<b>Metro, 250,000 or Less</b>	463	88.77%	1.127	1.050	1.381
<b>Urban, Pop. 20,000+, Metro Adj.</b>	52	98.08%	1.020	0.951	1.250
<b>Urban, Pop. 20,000+, Non-Adj.</b>	0	NA	NA	NA	NA
<b>Urban, Pop. 2,500-19,999, Metro Adj.</b>	143	90.21%	1.109	1.034	1.359
<b>Urban, Pop. 2,500-19,999, Non-Adj.</b>	80	90.00%	1.111	1.036	1.362
<b>Rural, Metro Adj.</b>	86	79.07%	1.265	1.179	1.550
<b>Rural, Non-Adj.</b>	19	84.21%	1.188	1.107	1.456
<b>Virginia Border State/D.C.</b>	623	71.27%	1.403	1.308	1.720
<b>Other U.S. State</b>	845	68.76%	1.454	1.356	1.783

Source: Va. Healthcare Workforce Data Center

Age	Age Weight			Total Weight	
	#	Rate	Weight	Min.	Max.
<b>Under 30</b>	788	67.39%	1.484	1.250	1.783
<b>30 to 34</b>	978	80.88%	1.236	1.041	1.485
<b>35 to 39</b>	866	84.87%	1.178	0.992	1.415
<b>40 to 44</b>	714	86.55%	1.155	0.973	1.388
<b>45 to 49</b>	622	87.62%	1.141	0.961	1.371
<b>50 to 54</b>	590	87.46%	1.143	0.963	1.374
<b>55 to 59</b>	438	88.58%	1.129	0.951	1.356
<b>60 and Over</b>	635	82.99%	1.205	1.015	1.447

Source: Va. Healthcare Workforce Data Center

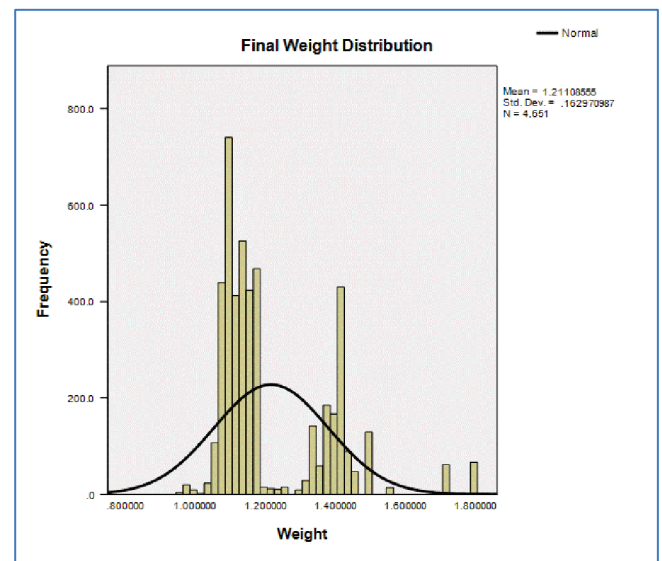
See the Methods section on the HWDC website for details on HWDC methods:

<https://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/>

Final weights are calculated by multiplying the two weights and the overall response rate:

$$\text{Age Weight} \times \text{Rural Weight} \times \text{Response Rate} = \text{Final Weight.}$$

**Overall Response Rate: 0.825963**



Source: Va. Healthcare Workforce Data Center

# Sanctioning Reference Points Instruction Manual

## Board of Audiology & Speech-Language Pathology

Adopted June 2010  
Revised November 2011  
Revised July 2025

Prepared for  
Virginia Department of Health Professions  
Perimeter Center  
9960 Mayland Drive, Suite 300  
Henrico Virginia 23233-1463  
804-367-4400 tel  
dhp.virginia.gov

Prepared by  
VisualResearch, Inc.  
Post Office Box 1025  
Midlothian, Virginia 23113  
vis-res.com

# Table Of Contents

## **General Information**

Overview	3
Background	3
Goals	3
Methodology	4
Qualitative Analysis	4
Quantitative Analysis	4

## **Characteristics of Sanctioning Reference Points System**

Wide Sanctioning Ranges	4
Sanctioning Thresholds	4
Voluntary Nature	5

## **Case Types Covered by the Sanctioning Reference Points System**

SRP Case Types Table	5
Worksheets Not Used in Certain Cases	5
Completing the SRP Worksheet and Coversheet	6
Worksheets	6
Coversheets	6
Determining a Specific Sanction	6

## **Board of ASLP Sanctioning Reference Points Coversheet, Worksheet, and Instructions**

Sanctioning Reference Points Coversheet	8
Sanctioning Reference Points Worksheet	9
Sanctioning Reference Points Worksheet Instructions	10

# General Information

## Overview

The Virginia Department of Health Professions (DHP) has spent the last 20 years studying sanctioning in disciplinary cases. The study has examined all of DHP's health regulatory Boards. Focusing on the Board of Audiology & Speech-Language Pathology (ASLP), this manual contains background on the project, the goals and purposes of the Sanctioning Reference Points (SRP) system, and a revised offense-based worksheet with sanctioning recommendation thresholds used to help Board members determine how similarly situated respondents have been treated in the past.

This SRP system is based on a specific sample of cases, and thus only applies to people sanctioned by the Virginia Board of Audiology & Speech-Language Pathology. Moreover, the worksheet has not been tested or validated on any other groups of people. Therefore, it should not be used to sanction respondents coming before other health regulatory boards, other states, or other disciplinary bodies.

The current SRP system is comprised of a single worksheet which scores case types and factors identified using statistical analysis and is built upon the Department's effort to maintain consistent sanctioning practices over time. The original ASLP SRP Manual was adopted in June 2010 and has been applied to cases closed in violation for the last 15 years. This lengthy board history allows for a comprehensive look at past sanctioning practices while also serving as a baseline for changing future sanctioning policy.

These instructions and the use of the SRP system fall within current DHP and ASLP policies and procedures. Furthermore, all sanctioning recommendations are those currently available to and used by the Board and are specified within existing Virginia statutes. If a SRP worksheet recommendation is more or less severe than a Virginia statute or DHP regulation, the existing law or policy supersedes the worksheet recommendation.

## Background

When the Board adopted their first SRP manual, it was understood that a sanctioning system of this type was not intended to be a static document. The culture of the profession changes over time as do the types of cases, the factors related to sanctioning, and the sanctioning decisions themselves. The Board recognizes that ongoing monitoring and updating of the SRP worksheet and manual will be an inherent part of the process of consistency and fairness in sanctioning licensees with the goal of protecting the public.

This study of ASLP's sanctioning practices relied on a quantitative analysis of recent cases ending in violation coupled with a qualitative analysis of Board member and staff input. The analysis resulted in changes to the worksheet and manual for the Board of ASLP.

## Goals

Since inception, the Department of Health Professions and the Board of ASLP have continually cited the following purposes and goals for establishing SRPs:

- Making sanctioning decisions more predictable
- Providing an education tool for new Board members
- Adding an empirical element to a process that is inherently subjective
- Providing a resource for those involved in proceedings
- Neutralizing sanctioning inconsistencies
- Validating Board member or staff recall of past cases
- Reducing the influence of undesirable factors
- Helping to predict future caseloads or need for services

## Methodology

The fundamental dilemma when developing a sanctioning reference system is deciding whether the supporting analysis should be grounded in historical data (a descriptive approach) or whether it should be developed normatively (a prescriptive approach). A normative approach reflects what policymakers feel sanction recommendations should be, as opposed to what they have been. SRPs can also be developed using historical data analysis with normative adjustments. This approach combines information from past practice with policy adjustments to achieve a more balanced outcome. The SRP manual adopted in 2010 was based on a descriptive approach with normative adjustments. This newly revised manual continues to make use of the same approach, drawing from historical data to inform worksheet modifications. The normative adjustments were largely based on data gathered through the ongoing monitoring of previously implemented Boards. It was necessary, in part, to consider the experience of previous boards due to the relatively small ASLP disciplinary caseload.

### Qualitative Analysis

Researchers conducted in-depth personal interviews with Board members and staff, as well as holding informal conversations with representatives from the Attorney General's office. The interview results were used to build consensus regarding the purpose and utility of SRPs and to further frame the study's analysis. Additionally, interviews helped ensure the factors that Board members consider when sanctioning continued to be included during the quantitative phase of the study. Previous scoring factors were examined for their continued relevance and sanctioning influence.

### Quantitative Analysis

In order to update the previous SRP manual, researchers reviewed cases that had closed in violation between 2018 and 2025. Over 75 different factors were collected on these cases to describe the attributes interviewees identified as potentially impacting sanctioning decisions. Researchers used data available through the DHP case management system combined with primary data collected from stored files. The files contained investigative reports, Board notices, Board orders, and all other documentation made available to Board members when deciding a case sanction.

A comprehensive database was created to analyze the offense and respondent factors which were identified as potentially influencing sanctioning decisions. Weights were assigned to the selected factors based on their relative influence in the sanctioning process. Those factors and weights were formulated into worksheet factors and sanctioning thresholds. Although a myriad of factors can help explain sanction variation, only those "legal" factors the Board felt should consistently play a role in sanctioning decisions continued to be included on the worksheets. By using this method, the goal was to achieve more neutrality in sanctioning by ensuring the Board considers the same set of "legal" factors for each case that comes before the Board for sanctioning.

## Wide Sanctioning Ranges

The SRPs consider and weigh the circumstances of an offense and the relevant characteristics of the respondent, providing the Board with a sanctioning model that encompasses roughly 75% of historical practice. This means that approximately 25% of past cases receive sanctions either higher or lower than what the reference points indicate, recognizing that aggravating and mitigating factors play a role in sanctioning. The wide sanctioning ranges allow the Board to customize a particular sanction within the broader SRP recommended range.

## Sanctioning Thresholds

The Board indicated early in the SRP study that sanctioning can be influenced by several factors like: case type, patient vulnerability, and monetary gain, all of which are unique in any particular case. The analysis supported this notion and subsequently, the SRPs make use of case type, patient injury, and other specific offense factors to arrive at a "Total Worksheet Score" which is then used to determine the statistically driven sanctioning recommendation.

## Voluntary Nature

The SRP system should be viewed as a decision-aid to be used by the Board of Audiology & Speech-Language Pathology. Sanctioning within the SRP ranges is "totally voluntary," meaning that the system is viewed strictly as a tool and the Board may choose any sanction outside the recommendation. The Board maintains complete discretion in determining the sanction handed down. However, a structured sanctioning system is of little value if the Board is not provided with the appropriate coversheet and worksheet in every case eligible for scoring. A coversheet and worksheet should be completed in cases resolved by Informal Conferences or Pre-Hearing Consent Orders. The coversheet and worksheets will be referenced by Board members during executive session only after a violation has been determined.

## Case Types Covered by the SRP System

A single sanctioning reference points worksheet is used to score all types of disciplinary cases. When multiple cases have been combined for disposition by the Board into one order, enter the point value for the case type group which appears highest on the following table and receives the most points. This table assigns the various case types brought before the Board to one of three broader case type categories on the worksheet. If a case type is not listed, find the most analogous offense type and use the appropriate score.

One coversheet and worksheet are completed that encompasses the entire event. For instance, if a respondent is before the Board for both a Standard of Care and an Impairment violation, the Case Type selected would be Impairment because it is higher on the table and receives a greater number of points.

### SRP Case Types Table

<b>Abuse/Inappropriate Relationship</b>	<ul style="list-style-type: none"> <li>Any sexual assault, mistreatment of a patient</li> <li>Dual, sexual, or other boundary issue. This can include inappropriate touching and written or oral communications.</li> </ul>	<b>25</b>
<b>Inability to Safely Practice</b>	<ul style="list-style-type: none"> <li>Impairment due to use of alcohol, illegal substances, or prescription drugs or incapacitation due to mental, physical, or medical conditions.</li> </ul>	<b>15</b>
<b>Fraud/Standard of Care/Unlicensed Activity</b>	<ul style="list-style-type: none"> <li>Falsification/alteration of patient records</li> <li>Fraudulent patient billing</li> <li>Falsification of licensing/renewal documents</li> <li>Diagnosis/treatment was improper, delayed, or unsatisfactory. Also includes failure to diagnose/treat, &amp; other diagnosis/treatment issues</li> <li>Practicing a profession or occupation without holding a valid license as required by statute or regulation as well as aiding and abetting the practice of unlicensed activity</li> <li>Performing unwarranted/unjust services</li> <li>Disclosing unauthorized client information without permission or necessity</li> </ul>	<b>10</b>

### Worksheets Not Used in Certain Cases

The SRPs are not applied in any of the following circumstances:

- Action by Another Board - When a case which has already been adjudicated by a Board from another state appears before the Virginia Board of Audiology & Speech-Language Pathology, Virginia often attempts to mirror the sanction handed down by the other Board typically requiring that all conditions set by the other Board are completed or complied with in Virginia. The SRPs do not apply to cases previously heard and adjudicated by another Board.
- Compliance/Reinstatement - The SRPs should be applied to new cases only.

- Confidential Consent Agreement (CCA) - SRPs will not be used in cases settled by CCA.
- Formal Hearings - SRPs will not be used in cases that reach a Formal Hearing level.
- Mandatory Suspensions - Virginia law requires that under certain circumstances (conviction of a felony, declaration of legal incompetence or incapacitation, license revocation in another jurisdiction, etc.) a license must be suspended. The sanction is defined by law and is therefore excluded from the SRP system.
- Pre-Defined Sanctions – The SRP system does not apply to certain cases that have already been assigned pre-determined actions as set by the Board of Audiology & Speech-Language Pathology.

## Completing the SRP Worksheet & Coversheet

Ultimately, it is the responsibility of the Board to complete the SRP coversheet and worksheet in all applicable cases. The information relied upon to complete a coversheet and worksheet is derived from the case packet provided to the Board and the respondent. It is possible that information discovered at the time of the informal conference may impact worksheet scoring. The SRP coversheet and worksheet, once completed, are confidential under the Code of Virginia. Additionally, the manual, including blank coversheets and worksheets, can be found at: [www.dhp.state.va.us](http://www.dhp.state.va.us) (paper copy also available on request).

### Worksheets

Scoring instructions are contained adjacent to the worksheet in a subsequent section of this manual. Detailed instructions are provided for each factor and should be referenced to ensure accurate scoring. When scoring, the scoring weights assigned to a factor on the worksheet cannot be adjusted. The scoring weights can only be applied as ‘yes or no’ with all or none of the points applied. In instances where a scoring factor is difficult to interpret, the Board has final authority over how a case is scored.

### Coversheets

The coversheet (shown on page 8) is completed to ensure a uniform record of each case and to facilitate recollection of other pertinent information critical for continued system monitoring, evaluation, and improvement. If the Board feels the sanctioning threshold does not recommend an appropriate sanction, the Board should depart either high or low when handing down a sanction. If the Board disagrees with the sanctioning recommendation and imposes a sanction greater or lesser than the recommended sanction, a short explanation should be recorded on the coversheet. The explanation could identify the factors and reasons for departure (see examples below). This process ensures worksheets are revised to reflect current Board practice and to maintain the dynamic nature of the system. For example, if a particular reason is continually cited, the Board can examine the issue more closely to determine if the worksheets should be modified to better reflect Board practice.

Aggravating and mitigating circumstances that may influence Board decisions can include, but should not be limited to, factors such as:

- Age of prior record
- Dishonesty/Obstruction
- Motivation/Intent
- Remorse
- Extreme patient vulnerability
- Restitution/Self-corrective action
- Multiple offenses/Isolated incident

### Determining a Specific Sanction

The worksheet has a set of scoring thresholds which directly correspond to sanctioning recommendations. The recommendations can include, on the low end, a Reprimand or Continuing Education and on the high end, a Loss of License or the case being Referred to a Formal Hearing. After considering the sanction recommendation, the Board should fashion a more detailed sanction(s) based on the individual case circumstances.

# **Sanctioning Reference Points**

## **Coversheet, Worksheet, and Instructions**

**Board of Audiology &  
Speech-Language Pathology**

# Sanctioning Reference Points Coversheet

Board of ASLP  
Adopted July 2025

1. Complete the Case Type and Offense and Respondent Factors scoring sections.
2. Determine the Sanctioning Recommendation based on the Total Worksheet Score and Scoring Ranges.
3. Complete this coversheet, noting the sanctioning outcome and reason for departure, if applicable.

Case Number(s): \_\_\_\_\_

Respondent Name: \_\_\_\_\_

License Number(s): \_\_\_\_\_

Resolution Method:  Informal Conference  
 Pre-Hearing Consent Order

Case Type:  Abuse/Inappropriate Relationship  
 Inability to Safely Practice  
 Fraud/Standard of Care/Unlicensed Activity

Sanctioning Result:  No Sanction/ Reprimand/ Monetary/CE  
 Treatment/Monitoring  
 Loss of License/ Refer to Formal

Imposed Sanction(s):  No Sanction  
 Reprimand  
 Monetary Penalty \$ \_\_\_\_\_  
 Stayed Monetary Penalty \$ \_\_\_\_\_  
 Probation  
 Stayed Suspension  
 Suspension  
 Revocation  
 Surrender  
 Recommend Formal  
 Other Sanction: \_\_\_\_\_

Terms:  Continuing education  
 Submit CE documentation upon renewal \_\_\_\_\_ years  
 HPMP (enter/continue)  
 Other Terms: \_\_\_\_\_

Was imposed sanction a departure from the recommendation?  No  Yes, give reason below

Reasons for Departure from Sanctioning Recommendation: \_\_\_\_\_

Worksheet Preparer's Name: \_\_\_\_\_

Date Worksheet Completed: \_\_\_\_\_

Confidential pursuant to § 54.1-2400.2 of the Code of Virginia

# Sanctioning Reference Points Worksheet

Board of ASLP  
Adopted July 2025

<b>Case Type</b> (score only one)	<u>Points</u>	<u>Score</u>
a. Abuse/Inappropriate Relationship	25	_____
b. Inability to Safely Practice	15	_____
c. Fraud/Standard of Care/Unlicensed Activity	10	_____
<b>Offense and Respondent Factors</b> (score all that apply)		
a. Patient mistreatment	25	_____
b. Any patient injury	20	_____
c. Impaired or incapacitated on duty	15	_____
d. Past difficulties with drugs or alcohol	15	_____
e. License ever taken away	15	_____
f. Any patient involvement	10	_____
g. Concurrent action	10	_____
h. Any prior Board violations	10	_____
i. Previous violation similar to current offense	5	_____
j. Patient especially vulnerable	5	_____
k. Past difficulties with mental or physical	5	_____
l. Financial or material motivation	5	_____
m. Respondent failed to initiate corrective action	5	_____
<b>Total Worksheet Score</b>		_____

Scoring Ranges	Sanctioning Recommendations	Monetary Penalty
0 - 40	No Sanction Reprimand Monetary Penalty Stayed Monetary Penalty Terms: Continuing Education	Up to \$1,000
41 - 80	Probation Stayed Suspension Terms: HPMP (enter/continue) Submit CE documentation upon renewal	\$500 to \$2,500
81 and up	Revocation Suspension Surrender Refer to Formal Hearing	\$2,500 and up

Confidential pursuant to § 54.1-2400.2 of the Code of Virginia

# Sanctioning Reference Points Worksheet Instructions

Board of ASLP  
Adopted July 2025

## Step 1: Case Type (score only one)

Enter the point value that corresponds to the case type. If a case has multiple aspects, enter the point value for the one most serious case type that is highest on the list. (See page 5 or an expanded list)

- |   |           |
|---|-----------|
| a. Abuse/Inappropriate Relationship           | 25 Points |
| b. Inability to Safely Practice               | 15 Points |
| c. Fraud/Standard of Care/Unlicensed Activity | 10 Points |

## Step 2: Offense and Respondent Factors (score all that apply)

- Enter "25" if the case had an element of patient mistreatment. Examples include verbal abuse or physical assault.
- Enter "20" if a patient was injured and/or required subsequent treatment from a licensed healthcare practitioner. Patient injury is also indicated when first aid is administered or there is visually identifiable harm such as that resulting from assault. This factor is scored without regard to a respondent's intent to harm (i.e., neglect or accidental injury).
- Enter "15" if the respondent was impaired or incapacitated while practicing. Score this factor only if the respondent was at work during the time of impairment or incapacitation. Impairment includes substance abuse (alcohol or drugs) while incapacitation includes mental or physical concerns.
- Enter "15" if the respondent has had any past difficulties with drugs or alcohol. Examples may include prior convictions for DUI/DWI or inpatient/outpatient treatment.
- Enter "15" if the respondent's license has been previously revoked, suspended, or summarily suspended by any state including Virginia.
- Enter "10" if the offense involves a patient. Patient involvement does not require direct contact with a patient (i.e., fraudulently billing multiple patients).
- Enter "10" if there was a concurrent criminal action, action by the employer, by another state or by another entity due to the incident. Examples of other entities include ASHA, DSS/CPS/APS, HPMP, or Temporary Detention Orders (TDOs).
- Enter "10" if the respondent has any prior violations decided by the Virginia Board of Audiology & Speech-Language Pathology or the Virginia Department of Professional and Occupational Regulation as a Hearing Aid Specialist.
- Enter "5" if the respondent has any prior similar Virginia Board of Audiology & Speech-Language Pathology or Virginia Department of Professional and Occupational Regulation Hearing Aid Specialist violations. Similar violations would be those listed under the same case type heading in Step 1.
- Enter "5" if the patient is especially vulnerable. Patients in this category fulfill at least one of the following descriptions: under age 18, over age 65, or mentally/physically handicapped.
- Enter "5" if the respondent has had any past difficulties with mental or physical capabilities. Examples include inpatient/outpatient treatment, or bona fide mental health care for a condition affecting his/her abilities to function safely or properly.
- Enter "5" if there was financial or material motivation by the respondent.
- Enter "5" if the respondent failed to take corrective action prior to the time at which the SRP worksheet is being considered.

## Step 3: Total Worksheet Score

Add all Case Type and Offense and Respondent Factor Scores for a Total Worksheet Score.

## Step 4: Recommendations for Sanctioning

The Total Worksheet Score corresponds to the Sanctioning Reference Points recommendations at the bottom of the worksheet. To determine the appropriate recommended sanction, find the score range on the left that corresponds to the Total Worksheet Score that was calculated. That range then corresponds to a "Sanction Recommendation." For instance, a Total Worksheet Score of 60 is recommended for "Probation, Stayed Suspension, or Terms."

“Monetary Penalty Ranges” in the last column correspond to the point ranges in the first column. However, for a sanction to be considered in agreement with the worksheet recommendation, it must only correspond with the Sanction Recommendation column (agreement or disagreement with the Monetary Penalty Ranges column is not used when tracking compliance with the SRP worksheets).

**Step 5: Coversheet**

Complete the coversheet, including the SRP sanction result, the imposed sanction, and the reason for departure if applicable.

Policy Name	Conflict of interest policy acknowledgment for board members		Policy Number	76-10.24
Section Title	Case Decision and Discipline	Section Number	76-10	Former Policy No.
Approval Authority	Agency Director		Effective Date	6/30/2025
Responsible Executive	Chief Operating Officer		Revised Date	6/23/2025
Responsible Office	Director's Office		Last Reviewed	6/23/2025
Responsible Reviewer	Barrett, Erin			

---

**Purpose:**

The purpose of this policy is to ensure acknowledgment by Board members of the need to notify Board administration of any conflicts of interest regarding investigations or disciplinary matters.

---

**Policy:**

All Board members will sign and date the conflict of interest acknowledgment as noted below.

---

**Procedures:**

Upon orientation to the Board, Board members and advisory board members will sign and date a document that states the following:

"As a Board member or Advisory Board member, it is your duty to notify the Executive Director (or designee) of any conflicts of interest between you and the subject of any investigation or disciplinary action. Such notification must occur as soon as you are aware of the conflict."

The applicable board will maintain an electronic copy of the signed acknowledgment in a manner determined by the custodian of the record for the Board.

# AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY

## 2026 CALENDAR

March 20, 2026 (Friday)	TR 1 9:00 AM	INFORMAL CONFERENCE(S)
<b>April 21, 2026 (Tuesday)</b>	<b>BR 3 9 a.m.</b>	<b>BOARD MEETING FORMAL HEARING IF NEEDED</b>
<b>July 7, 2026 (Tuesday)</b>	<b>BR 4 9 a.m.</b>	<b>BOARD MEETING FORMAL HEARING IF NEEDED</b>
September 25, 2026 (Friday)	TR 1 9:00 AM	INFORMAL CONFERENCE(S)
<b>December 8, 2026 (Tuesday)</b>	<b>BR 3 9:00 AM</b>	<b>BOARD MEETING FORMAL HEARING IF NEEDED</b>

CALENDAR\_ASLP\_2026