



UTAH DEPARTMENT  
OF COMMERCE

Office of Professional Licensure Review

# 2025 Periodic Review

# Audiology

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# Executive Summary

## **Background**

Audiologists are the primary healthcare professionals responsible for the prevention, identification, diagnosis, and treatment of all forms of hearing loss, and symptoms related to vestibular disorders, for individuals of all ages. Audiologists often treat the elderly and infant patients in private or group settings, as well as hospitals, or outpatient clinics.

Utah currently requires audiologists to be licensed. Licensing and education requirements, such as a clinical doctoral degree in audiology and passing a nationally standardized examination in audiology, are nearly ubiquitous in states across the U.S.

## **Regulatory Model Recommendation:** *Shift the regulatory model from licensure to mandatory certification*

- The potential for harm is generally low and mitigated by existing forms of oversight.
- However, the potential lifetime effects of poor care mean provider competence is important, prompting the recommendation of mandatory certification.
- Mandatory certification entails reducing the administrative burden of regulation through:
  - Allowing ‘once and done’ certification; no renewal with DOPL
  - Moving from a single CE requirement to three options: 1) CEs or 2) national certification or 3) minimum number of working hours without a lapse (e.g., 500 hours every 2 years)
  - Eliminating the ‘Speech-Language Pathology and Audiology’ DOPL advisory board
- Shifting to mandatory certification would not change:
  - Current education, exam, and experience entry requirements for audiologists
  - Background checks (moving to continuous FBI RapBack system over time)
  - DOPL oversight via investigation, discipline, and enforcement (e.g., DOPL’s ability to remove an individual from the profession)

## **Recommended Regulatory Adjustments:** *Align unprofessional conduct standards between audiologists and hearing instrument specialists for dispensing hearing instruments*

- The only instance of substantiated consumer harm by audiologists in Utah was related to the sale of hearing aids.
- Since the act of dispensing hearing aids is the same between audiologists and hearing instrument specialists, the professions should be held to the same unprofessional conduct standards.

## Context

Consistent with its legislative mandate,<sup>1</sup> the Office of Professional Licensure Review (OPLR) reviewed Utah's licensing laws for audiology practitioners. The review evaluated how well current regulations:

1. Protect the public from present and consequential physical and financial harm
2. Balance public and practitioner access to the occupation
3. Limit the economic impact of regulation on consumers, practitioners and the state<sup>2</sup>

OPLR's research for this review included analysis of Utah's current laws and rules, licensing and complaint data from the Division of Professional Licensing (DOPL), academic literature, regulations in other states, and other secondary analyses. OPLR also conducted interviews with prominent stakeholders. See [Appendix 1](#) for more information.

## Background

### *Profession Overview*

Audiologists are the primary healthcare professionals responsible for providing care in the prevention, identification, diagnosis, and treatment of all forms of hearing loss and symptoms related to vestibular disorders<sup>3</sup> for individuals of all ages. Common conditions managed by audiologists include: hearing loss, tinnitus, auditory processing disorders, and vestibular disorders. Audiologists provide care by performing hearing tests, fitting hearing aids, cochlear implants, and hearing assistive devices, and performing vestibular testing.

Audiologists are independent and autonomous practitioners, often treating the elderly and infant patients in private or group practice settings, hospitals, or outpatient clinics affiliated with a hospital or hospital system.<sup>4</sup> However, when patients require further medical or surgical evaluation outside of their scope of practice or expertise, audiologists refer patients to an otolaryngologist (ENT), otologist, or other physician.

### *Evolution of Audiology*

The field of audiology has undergone two important shifts over the last several decades. First, the education requirement to become an audiologist transitioned from a Master's to a doctoral degree. Nationwide, the AuD degree became the entry-level degree for the clinical practice of audiology in 2007,<sup>5</sup> while an applicant for an audiology license in Utah could provide verification

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<sup>1</sup> [UCA 13-1b-203\(2\)](#)

<sup>2</sup> [UCA 13-1b](#)

<sup>3</sup> Vestibular disorders include conditions that affect an individual's sense of balance. The vestibular system includes inner ear and brain structures that help maintain balance.

<sup>4</sup> OPLR's analysis of the 2024 Utah Audiology and Speech Language Pathology Workforce Survey

<sup>5</sup> [Audiology Doctoral Programs By State](#)

of having received at least a Master's degree in the area of audiology until 2010.<sup>6</sup>

The second shift relates to dispensing hearing aids. Until the 1970s, audiologists were primarily engaged in the evaluation of hearing, and the American Speech-Language-Hearing Association (ASHA) Code of Ethics prohibited the sale of hearing aids by clinical audiologists due to the fear that dispensing hearing instruments for-profit would jeopardize the profession's commitment to public trust.<sup>7</sup> In 1978, the direct dispensing of hearing aids by audiologists became recognized by ASHA, spurring from the growing concern that, in their view, commercially driven and minimally trained hearing aid dealers controlled a significant portion of the market.<sup>8</sup> As a result of ASHA's decision, hearing aid dispensing has become a major professional activity of audiologists in addition to the other aspects of the profession.

### *Profession in Utah*

Audiology is a licensed profession in Utah. There are 420 actively licensed audiologists and 16 dually licensed speech-language pathologists and audiologists (See [Appendix 2.1](#)).

The legal scope of practice for an audiologist in Utah is defined broadly in statute and includes “measuring, testing, examining, interpreting, diagnosing, predicting, evaluating, prescribing, consulting, treating, instructing, and researching” related to “hearing, vestibular function, and the disorders of hearing”.<sup>9</sup> Audiology also includes performing “hearing aid evaluation, assistive listening device evaluation, prescription, preparation, and dispensing”.<sup>10</sup>

To practice as an audiologist in Utah, an individual must obtain and maintain a license through the Division of Professional Licensing (DOPL) within the Utah Department of Commerce. The requirements for licensure include:

1. A clinical doctoral degree in audiology (AuD);
2. Compliance with the regulations of conduct and codes of ethics;
3. At least one academic year of professional experience of direct clinical experience in treatment and management of patients; and
4. Passing a nationally standardized examination in audiology.<sup>11</sup>

Furthermore, audiologists working in an educational setting may be licensed by the Utah State Board of Education (USBE), either alone or in addition to their DOPL license. Roughly 55% of USBE audiologists also hold a DOPL license.

### *Approaches in Other Jurisdictions*

Utah's current audiology license largely aligns with the standard model of regulation across the

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<sup>6</sup> [UCA 58-41-5\(2\)](#)

<sup>7</sup> [Wayne Staab \(2013\). History of Hearing Aid Dispensing](#)

<sup>8</sup> [Punch, J.L. and Jarrett, A.M. \(1994\). Hearing Aid Licensing Statutes and the Audiologist](#)

<sup>9</sup> [UCA 58-41-2](#)

<sup>10</sup> Ibid.

<sup>11</sup> [UCA 58-41](#)

U.S. All 50 states and the District of Columbia regulate audiology through licensure.<sup>12</sup> Utah's scope of practice largely aligns with that of ASHA and other states; although, ASHA and a few states have scopes that are more prescriptive and specific.<sup>13</sup> Furthermore, 36 states (including Utah) require a doctoral degree to practice as an entry-level audiologist. While the statutes in some states do not explicitly require an audiologist to have a doctoral degree, this degree level is often implied through additional requirements. This includes requiring applicants to obtain the Certificate of Clinical Competence in Audiology (CCC-A), which specifies individuals need to hold a doctoral degree in audiology. Furthermore, the Council on Academic Accreditation no longer accredits Master's-level audiology programs, essentially making those programs moot.

Utah and 41 other states allow audiologists to dispense hearing aids with an audiology license, but eight states require audiologists to obtain a separate license or certification for dispensing hearing aids. Thirty-seven states (including Utah) are part of the Audiology & Speech-Language Pathology Interstate Compact (ASLP-IC). Currently, the ASLP-IC has met the threshold number of states to become operational, but due to the development of a data system, the process to apply for and receive compact privileges is still in the works but close to being launched.

## Regulatory Model Assessment & Recommendation

### *The Framework*

In an effort to standardize how appropriate regulatory models are determined for each profession (e.g. license, registry, no regulation, etc.), OPLR developed a framework which incorporates its statutory review criteria.<sup>14</sup> Appropriate models are determined principally by an evaluation of the potential for harm and related factors that may aggravate or mitigate the potential for harm. These factors include the availability of consumer choice, vulnerability of patients, and independence of practice. See [Appendix 3.1](#) for potential regulatory models and the factors in OPLR's framework.

### *Potential for Harm*

Potential for harm considers the severity, probability, and permanence for harm to the health, safety and financial welfare of the public.<sup>15</sup> OPLR's evaluation considered the entire scope of audiology, including assessing and identifying disorders of hearing, balance, and tinnitus (e.g., pure-tone testing, auditory brainstem response), managing and treating patients (e.g., conducting otoscopic exams, making ear impressions, dispensing hearing instruments), and providing patient education.

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<sup>12</sup> [National Council of State Boards of Examiners](#)

<sup>13</sup> Examples of states that have a more prescriptive scope of practice include Arizona, Arkansas, Colorado, and Maryland. Furthermore, Arkansas and Maryland specifically list cerumen removal and ordering bloodwork and imaging as being in an audiologist's scope of practice.

<sup>14</sup> Among other criteria, OPLR is required to evaluate "whether the regulation of the occupation is necessary to address a present, recognizable, and significant harm to the health, safety, or financial welfare of the public" and consider "potentially less burdensome alternatives to the... existing regulation". [UCA 13-1b-302](#)

<sup>15</sup> [UCA 13-1b-302\(2\)](#)

OPLR found the risk of severe and permanent harm to be quite low overall. While there are certain procedures that pose an elevated risk of temporary or less severe physical harm, such as ear mold impressions, many of the tests and procedures performed by audiologists are inherently relatively safe. Additionally, medical devices commonly used by audiologists in higher-risk procedures and assessments are highly regulated and monitored and were shown to result in minimal adverse events that caused patient problems.<sup>16</sup> Cerumen management is cited as one of the more invasive procedures that could cause complications such as tympanic membrane perforation, ear canal laceration, infection of the ear, bleeding, or hearing loss.<sup>17</sup> However, these complications occur at a rate of about 1 in 1,000 ear irrigations, or 0.1%, indicating that highly trained and educated audiologists are relatively safe in performing these complex procedures.<sup>18</sup> Furthermore, earmold impressions, another procedure cited as being highly invasive, have a relatively low complication rate.<sup>19,20</sup>

The Occupational Information Network (O\*NET), developed under the sponsorship of the U.S. Department of Labor, estimates an occupation's consequence of error based on how serious the result would be if a mistake was made.<sup>21</sup> Based on the methodology, the O\*NET does not allow for fine comparisons across occupations, but may be directionally helpful in assessing higher versus lower risk. Audiologists have a consequence of error score of 40 out of 100, which is categorized by O\*NET as "fairly serious".<sup>22</sup> Nurse anesthetists (O\*NET score of 94), nurse practitioners (O\*NET score of 85), and dentists (O\*NET score of 80) have both a higher score and are in a higher severity category.<sup>23</sup>

Despite the relatively low potential for harm, there are some, although rare, potential negative downstream effects if poor care or inaccurate and delayed testing and treatment is provided. For example, failure to properly fit a hearing aid could result in over-amplification, which could cause further hearing damage. Additionally, failing to identify more serious audiological conditions, like

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<sup>16</sup> See [Appendix 3.3](#) for OPLR's analysis of the U.S. Food and Drug Administration (FDA) Manufacturer and User Facility Device Experience (MAUDE) database. OPLR's analysis highlighted that medical devices commonly used in higher-risk procedures were, in general, not causing patient problems related to clinical signs, symptoms, and conditions.

<sup>17</sup> [American Academy of Audiology Policy Position Statement on Cerumen Management/Removal](#)

<sup>18</sup> Sharp et al. (1990) [Earwax removal: a survey of current practice](#)

<sup>19</sup> Among 2,050 institutions, 15% indicated experience with secondary injuries caused during the taking of an ear impression for hearing aids. The most common type of secondary injury was caused by the presence of foreign bodies in the ear, which was a result of complications occurring during the removal of residual ear impression material. See [Sugiuchi, T. et al. Complications Resulting from Taking Ear Impressions](#)

<sup>20</sup> While the Sugiuchi et al. study reports complications in the Japanese setting, other studies corroborate the rarity of complications with ear mold impressions but note the challenges quantifying the actual incidence. See [Meyers, J. et al. \(2013\) Complication from hearing aid mold material: A case report and review of legal matters](#): "Ear mold impression middle ear foreign bodies are a rare complication of hearing aid fitting. Only a small number of cases have been reported; however, the actual incidence is unknown and likely much higher than expected." and [Kim, H. et al. \(2021\) Surgical Removal of Hearing Aid Earmold Impression Material in the Middle Ear](#): "It [Earmold impression] usually causes no problems, although in rare cases, the earmold passes through the middle ear through tympanic membrane perforations."

<sup>21</sup> [O\\*NET Consequence of Error](#)

<sup>22</sup> O\*NET scores are categorized as "extremely serious" (at 100), "very serious", "serious", "fairly serious", and "not serious at all" (at 0) based on an analysis of survey results examining how serious the result would be if a worker made a mistake that was not easily correctable. Other occupations within the 35-45 range are building inspectors, data entry keyers, dental hygienists, medical equipment preparers, telecom installers, and real estate appraisers.

<sup>23</sup> Comparator professions were selected based on similar education, training, and clinical independence.

acoustic neuromas<sup>24</sup>, sudden sensorineural hearing loss<sup>25</sup>, vestibular disorders linked to stroke or neurological disease, and auditory neuropathy spectrum disorders in infants<sup>26</sup>, could lead to further deterioration of hearing or other complications. These potential downstream implications highlight the need for competent practitioners.

Ineffective care by an audiologist can prevent a patient from gaining significant, long-term benefits. However, OPLR distinguishes between the potential for actively doing harm, and failing to benefit a patient due to ineffective or inappropriate care. Occupational regulation exists to prevent active, direct harm of consumers by professionals—regulation is not intended to ensure that professionals' services are effective and benefit the consumer. There is a compelling need for competent audiology practitioners due to the benefits they can provide, even if the practice itself carries a lower direct public safety risk generally.

### *Related Factors*

In addition to the potential for harm, OPLR's regulatory model analysis considered the practice setting and non-government oversight of audiologists. According to national ASHA data, nearly 75% of audiologists work in healthcare facilities, which includes hospitals and nonresidential and residential healthcare facilities.<sup>27</sup> More specifically, in Utah, about a third of audiologists work in a hospital or outpatient clinic associated with a hospital or health system.<sup>28</sup> These practice settings confer a high degree of oversight via internal employer or healthcare facility policy (e.g., hospital credentialing and privileging), state and federal oversight by different agencies,<sup>29</sup> and by insurers.<sup>30</sup> The FDA's monitoring of medical device performance, device-rated safety issues, and trends via the MAUDE database highlights the robust and layered nature of oversight.<sup>31</sup> Furthermore, about a quarter work in a private or group practice.

There is a moderate level of patient choice when selecting an audiologist. However, patient choice may depend on other factors related to getting a referral from a physician or selecting a practitioner covered by an insurance plan. Information availability about individual practitioners is often unavailable or limited. In general, a moderate level of patient choice helps mitigate the

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<sup>24</sup> An acoustic neuroma is a non-cancerous tumor that develops on the main nerve (vestibular nerve) leading from the inner ear to the brain. Branches of the nerve directly affect balance and hearing. Pressure from this tumor can cause hearing loss, ringing in the ear, and trouble balancing.

<sup>25</sup> Sudden sensorineural hearing loss (SSNHL) is an emergency defined as a loss of hearing of 30 dB HL or more, over at least three contiguous frequencies, that develops within three days. Idiopathic SSNHL affects approximately 5-20 per 100,000 people per year. The hearing loss can range from mild to profound and can be temporary or permanent. ([National Guideline Centre, 2018](#))

<sup>26</sup> Auditory Neuropathy Spectrum Disorder (ANSD) is a hearing problem in which the ear detects sound normally, but has a problem sending it to the brain. Audiologists use a combination of tests to diagnose this disorder, and making a diagnosis may be challenging as a child may appear to hear one day and not hear the next. ([Wingo, 2023](#))

<sup>27</sup> [Employment Settings for Audiologists](#)

<sup>28</sup> See [Appendix 3.4](#) Audiology Practice Setting; OPLR's analysis of the 2024 Utah Audiology and Speech Language Pathology Workforce Survey.

<sup>29</sup> Other state and federal oversight includes licensing required by the Utah State Board of Education for audiologists practicing in schools and regulations from the Centers for Medicare & Medicaid Services and the Utah Department of Health & Human Services

<sup>30</sup> As stated in the background section, audiologists work independently, not under the supervision of any other provider.

<sup>31</sup> See [Appendix 3.3](#) for OPLR's analysis of the FDA MAUDE database.



potential harm, but this can be limited without a high degree of information availability.

For more details on OPLR's analysis of audiology according to the framework, see [Appendix 3.5](#).

*Recommendation: Shift the Regulatory Model from Licensure to Mandatory Certification*

In evaluating the regulatory model for audiologists, OPLR determined that certification would be a more appropriate model choice than licensure. The potential for harm and the harm associated with conduct is generally low and mitigated by existing forms of oversight. However, given the potential downstream effects of poor care (e.g., failure to identify more serious health conditions) and the importance of ensuring practitioner competence, OPLR concluded that the certification should be mandatory, rather than voluntary.

OPLR proposes shifting the regulatory model for audiology from the current licensure model to a mandatory certification model. Mandatory certification of audiology should:

1. require applicants to certify with the Utah Division of Professional Licensing (DOPL) only once, without the need for renewal, using existing entry requirements;
2. maintain either national certification or continuing education or a minimum number of hours of practice without lapse; and
3. eliminate the Speech-Language Pathology and Audiology Board.

While OPLR recommends the aforementioned changes, there are several key elements that would not change. These include:

1. keeping current education, examination, and experience entry requirements;
2. continuing background checks (moving to continuous FBI RapBack system over time); and
3. maintaining DOPL oversight via investigation, discipline, and enforcement (e.g., DOPL's ability to remove an individual from the profession)

Mandatory certification would require audiologist applicants to submit documentation certifying their credentials to DOPL. This process would still require applicants to verify with DOPL that they obtained the appropriate doctoral level education, examination, and experience. However, after this initial certification by DOPL, OPLR recommends eliminating the requirement for audiologists to undergo a biennial renewal process to lower the burden on them and DOPL.

Instead of renewing with DOPL, audiologists would be required to either maintain national certification, or complete continuing education, or a minimum number of hours of practice without lapse to ensure ongoing competence. This would ensure audiologists stay current and accountable to the profession and their patients without requiring that they formally interact with and pay a renewal fee to DOPL.

Many practitioners that OPLR spoke to highlighted the importance of continuing education, especially as new technologies emerge. For this reason, OPLR's recommendation simply



expands the available maintenance options, while lowering the burden of interacting with DOPL. OPLR's proposal does not eliminate the requirement for continuing education or continued experience. For example, maintaining national certification with ASHA requires audiologists to acquire 30 hours of professional development hours every three years, while Utah Rule requires 20 continuing education hours every two years.<sup>32,33</sup> Similar to the nursing profession, OPLR proposes allowing an audiologist to provide evidence of continued practice without lapse.<sup>34</sup> As is the case in other professions, the law would still require that individuals maintain records of meeting these requirements and provide them to DOPL if requested.

OPLR recommends eliminating the Speech-Language Pathology and Audiology Board (the Board). One primary function of the Board includes advising and providing technical assistance to DOPL for purposes of discipline. In reviewing substantiated DOPL complaints from 2017-2022, OPLR concluded that the Board's technical expertise was rarely, if ever, accessed by DOPL because the complaint patterns did not warrant it. OPLR's analysis of the Board meeting minutes, concluded that it allocated nearly two-thirds of its time to administrative items or industry-relevant updates over the past five years.<sup>35,36</sup> OPLR suggests that in the absence of the Board, DOPL and the relevant industry association would continue to fulfill the Board's current functions. Under its authority in UCA 58-1-106, DOPL has the ability to consult with experts for decision making when necessary.

## Regulatory Model Adjustments & Recommendations

After determining an appropriate regulatory model, OPLR's framework also evaluates whether adjustments should be made within a recommended model to address any material and existing safety and access issues affecting the Utah public and practitioners. Regulatory model adjustments may include changing entry qualifications, the scope of practice, unprofessional or unlawful conduct, and/or supervision and independence provisions (see [Appendix 4.1](#)).

### *Safety Issues*

OPLR observed low levels of reported harm by audiologists from available data. There are very few substantiated DOPL complaints about audiologists. Between 2017 and 2022, there were a total of seven substantiated complaints, for a rate of 0.3 substantiated complaints per 100 audiologists annually. Of the seven substantiated complaints, only one was related to client harm or endangerment (selling used hearing aids as new), which highlights the presence of financial harm, rather than physical harm. The other substantiated complaints were related to

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<sup>32</sup> [ASHA Maintaining Your Certification](#)

<sup>33</sup> [R156-41-304](#)

<sup>34</sup> Prior to renewing an RN or LPN license, a licensee must have completed licensed practice of at least 400 hours, or at least 200 hours with 15 hours of approved continuing education, or completed 30 hours of approved continuing education.

<sup>35</sup> See [Appendix 3.6](#) for OPLR's analysis of Speech-Language Pathology and Audiology Board counts of agendas items. The analysis excludes standing agenda items such as calling meeting to order and approving previous meeting minutes; n=57 agenda items

<sup>36</sup> In OPLR's analysis of the Board's meeting minutes, other categories undertaken by the board include fulfilling the statutory duties (as defined by 58-1-202 & 58-1-203) and reviewing complaints.

misrepresentation of credentials and fraudulent claims of effectiveness.<sup>37</sup> Additionally, in an analysis of ASHA Board of Ethics decisions from the past 15 years, the professional organization did not issue any public sanctions against a Utah audiologist.<sup>38</sup>

In addition to DOPL complaints, audiologists have markedly lower individual insurance premiums compared to other healthcare professions with similar education and training requirements and clinical independence. Estimating individual premiums can be complex, since the cost of malpractice insurance is influenced by geographic location, years of experience, coverage limits, and employment setting. According to public information, premiums for audiologists begin at around \$60 to \$150 annually,<sup>39,40</sup> while premiums for nurse anesthetists, nurse practitioners, and dentists cost roughly 5 to 35 times as much annually.<sup>41,42,43</sup> Low malpractice premiums indicate that audiologists safely practice the profession and are at relatively low risk of having frequent and severe claims filed against them for patient harm through errors, omissions, or misdiagnoses.

### *Access Issues*

Access to audiology services poses a moderate, but not significant, barrier for patients. According to the 2025 U.S. Health Resources and Services Administration (HRSA) workforce projections, the national supply and demand of audiologists is nearly in balance (96% adequacy).<sup>44</sup> However, by 2037, HRSA estimates that the percent adequacy will decline to 91% due to demand outpacing supply. While this represents a long-term national trend, the data in Utah indicates a more complex landscape.

In Utah specifically, the supply of audiologists appears adequate, although there is some anecdotal evidence of areas of need, such as in pediatric audiology. Utah's location quotient, or the share of audiology employment in Utah relative to the rest of the U.S., is 93% which indicates that Utah has slightly fewer audiologists than the U.S. generally.<sup>45</sup> Despite Utah's location quotient for audiologists being slightly lower compared to the U.S., the average location quotient for Utah healthcare practitioners and technical occupations is 80%. Additionally, the 2024 Utah Audiology and Speech Language Pathology Workforce Survey indicates that about 95% of audiologists plan to continue working at their current rate or increasing their hours over the next two years.<sup>46</sup> Of this group, approximately 75% currently work 25 or more hours a week, while approximately 60% work 37 or more hours per week. This suggests that the profession is at low risk of large-scale retirement or switching to other fields, and many will continue to work a

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<sup>37</sup> See [Appendix 4.2](#) for OPLR's analysis of DOPL complaints

<sup>38</sup> [ASHA Board of Ethics Decisions](#); ASHA does issue non-public sanctions, but those are not public information or provided to state boards.

<sup>39</sup> [Speech-Language Pathologists Liability Insurance](#)

<sup>40</sup> [Career Shield Insurance](#)

<sup>41</sup> [CRNA Malpractice Insurance](#)

<sup>42</sup> [Nurse Practitioner Malpractice Insurance](#)

<sup>43</sup> [Dental Malpractice Insurance](#)

<sup>44</sup> [Health Resources and Services Administration \(HRSA\) Workforce Projections](#)

<sup>45</sup> OPLR's analysis of U.S. Bureau of Labor Statistics data

<sup>46</sup> OPLR's analysis of the 2024 Utah Audiology and Speech Language Pathology Workforce Survey

significant number of hours.

There are several financial and time barriers that limit the number of available practitioners. These include small graduate program capacity<sup>47</sup>, high program costs<sup>48</sup>, and low reimbursement rates. While important, these factors fall outside the purview of licensing policy.

*Recommendation: Align Unprofessional Conduct Standards between Audiologists and Hearing Instrument Specialists for Dispensing Hearing Instruments*

As noted above, the only instance of substantiated consumer harm by an audiologist in the state was related not to physical harm but financial harm from the sale of hearing aids—this is the most probable avenue for consumer harm in audiology. OPLR proposes aligning unprofessional conduct standards around the selling and dispensing of hearing instruments between audiologists and hearing instrument specialists (HIS).

While the scope of practice for audiologists is broader compared to HISs, both dispense and sell hearing instruments. Currently, the unprofessional conduct for audiologists includes general provisions<sup>49</sup> that apply to all licensed professions and profession specific provisions<sup>50</sup> regarding the requirements to sell hearing aids. These specific requirements are relatively limited compared to the unprofessional conduct standards for HIS. Therefore, since the act of dispensing hearing aids is the same between audiologists and hearing instrument specialists, it's recommended to align and streamline the audiology unprofessional conduct language with that of HIS.

## Other Considerations

Along with the recommendation above, OPLR considered the following:

*The Audiology & Speech-Language Pathology Interstate Compact, Reciprocity, and Mobility of Practitioners*

During the 2020 general session, the Utah Legislature adopted legislation to join the Audiology and Speech-Language Pathology Interstate Compact (ASLP-IC).<sup>51,52</sup> There is concern from audiologists in Utah that moving from licensure to mandatory certification (i.e., changing the name of the regulatory model, replacing the renewal requirement with a range of professional

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<sup>47</sup> Two universities in Utah offer an AuD degree. These programs graduated a total of 13 audiologists in 2023-24.

<sup>48</sup> To get an AuD degree, it will cost a student between \$41,000 and \$182,000 depending on whether s/he qualifies for in-state tuition.

<sup>49</sup> [UCA 58-1-501](#)

<sup>50</sup> [UCA 58-41-17](#)

<sup>51</sup> [UCA 58-41a](#)

<sup>52</sup> [Audiology & Speech-Language Pathology Interstate Compact](#); Thirty-seven jurisdictions (36 states and 1 territory) have enacted ASLP-IC legislation to be part of the compact. However, it is not fully operational yet, as the collaborative licensure compact data system was just launched and states are being onboarded. As a result, applications for compact privileges have not opened.

development options, and eliminating the Board) would prevent Utah from participating in the ASLP-IC.

The ASLP-IC's legislation states that audiologists must be licensed by their home state to participate in the compact. Despite the use of the term 'license', the compact cannot dictate to Utah the name of a profession's regulatory model. Since OPLR's mandatory certification requires the same entry requirements and level of DOPL oversight and meets the practitioner requirements, the name of the regulatory model does not, by itself, disqualify a state from participating in the compact.<sup>53</sup>

Furthermore, the ASLP-IC states that state participation in the compact relies on the requirement of an applicant to "obtain or retain a license in the home state and meet the home state's qualification for licensure *or* renewal of a licensure".<sup>54</sup> Therefore, if Utah does not require audiologists to renew their license, this still meets ASLP-IC's requirements.

OPLR is recommending, as part of mandatory certification, the elimination of the Board. The ASLP-IC defines a licensing board as the agency responsible for licensing and regulating audiologists and SLPs. In Utah, DOPL is this agency and functions as the licensing board. Therefore, eliminating the Board should not disqualify Utah from participating in the ASLP-IC.

## Rule Review

In accordance with Utah Code 13-1b-203(5), OPLR conducted an in-depth review of DOPL's audiology rules, found in R156-41.

The rule review covered potential rule changes needed to:

1. address specific rules that may be either overly burdensome (e.g., for individuals seeking to practice a profession or given the potential risk to public safety from a profession, etc) or insufficient (e.g., to ensure safe practice);
2. address rules misaligned with statutory language;
3. clarify language and correct references to statute or other rules; or
4. support OPLR's recommendations.

OPLR's review of R156-41 found:

1. no overly burdensome rules.
2. no rules misaligned with statutory language.
3. four incorrect references to statute. These are outlined in [Appendix 5.1](#).
4. new rules will need to be written to support the shift to mandatory certification. These rules include removing the license renewal requirements<sup>55</sup>, establishing a minimum number of hours of certified practice without lapse to maintain certification, and streamlining consumer protection provisions.

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<sup>53</sup> Per communication with the ASHA Director of State and Regulatory Affairs

<sup>54</sup> [UCA 58-41a-102](#)

<sup>55</sup> Renewal cycle is defined in R156-303

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# 1. Context

## 1.1 General Research Methodology

OPLR's methodology combines qualitative and quantitative methods with robust stakeholder engagement. Methods include:

- Analyzing data from workforce surveys administered by the Department of Professional Licensing (DOPL) as part of licensure renewal
- Conducting quantitative analysis of DOPL licensee and complaint data and publicly available data from other state and federal government entities (e.g., DWS, HRSA)
- Reviewing academic literature and reports on a profession's practice, efficacy and safety
- Scanning education and credentialing requirements, programs and content
- Reviewing state occupational regulation policies across the U.S.
- Engaging with a wide range of stakeholders, including: Utah governments and agencies, industry organizations, researchers, practitioners, and business owners and employers within a variety of settings

## 1.2 DOPL Audiology Renewal Survey

### *Survey overview*

OPLR utilized a DOPL survey available to audiologists during their 2024/25 renewal period for information on the workforce in Utah. This survey is administered by DOPL for use by the Health Workforce Information Center (HWIC) to inform legislators and the public about workforce trends and projections. For more information regarding the information collected, the survey instrument can be found [here](#).

### *Survey Limitations*

The survey was available to all audiology licensees during the license renewal process so results were not affected by sampling bias. The response rate was around 35% for audiologists. Results may be affected by non-response bias (e.g., if those who chose to respond to the survey shared characteristics not representative of the true population). Audiologists were, on average, more experienced and further along in their career than non-respondents.

Other possible limitations include measurement error (which occurs when questions do not accurately measure the variable interest due to errors in question design) and recall bias (where respondents misremember and inaccurately answer questions). For example, recall bias may impact the estimates of hours worked per week or debt at graduation. All of these potential errors may cause some variability or systematic bias.

OPLR uses this to provide background understanding of a profession, outline patterns, and identify general trends rather than to provide exact estimates. Therefore, the limitations articulated above should not unduly impact OPLR's findings or recommendations.

## 1.3 Audiology Policy Scan

To better understand the regulatory environment for audiology, OPLR conducted a review of state occupational regulation in the U.S., which was heavily informed by the National Council of State Boards of Examiners (NCSB) and state laws and rules. The sources were used to map the national policy landscape, find patterns in regulation, make cross-state comparisons, and discover outliers. OPLR also used the data to help inform recommendations.

OPLR used the NCSB's licensing overview information to understand jurisdictions' general approach to licensing.<sup>56</sup> This resource contains information on each state's licensing legislation history, current regulatory approach, status in the ASLP-IC, education requirement, CE requirement, and approach to dispensing hearing aids with an audiology license.

This review does contain limitations related to normal human error. It is possible that there is slight misreporting of some data due to limited accessible state information, or errors in data entry.

## 2. Background

### 2.1 DOPL Licensee Data

OPLR used DOPL licensee data queried in January of 2025 to conduct analyses on the number of licensees per year, inflow and outflow of licensees, overlap of licenses, and time with license. The dataset included individuals first licensed after 1970 to those actively licensed as of January 2025. Each row in this dataset was a unique combination of individual and license type and contained information regarding when the license was issued, the status of the license, the date the status was last updated, and the sex and year of birth of the individual. OPLR estimated the number of licensees in each year by summing the number of unique individuals whose licenses were active during any point in each year. Additionally, OPLR excluded any individual with a null or incorrect value for their license issue date and license expiration date, as OPLR could not determine how long or for what years they were actively licensed. License counts may slightly underestimate the true number of licensees due to this, but the effect is fairly negligible given OPLR's use of the data to determine trends over time rather than estimate with precision for specific dates.

Between 2014-2024, the number of audiology licenses in Utah grew with a Compound Annual Growth Rate (CAGR) of 5.5%, which far outpaced the growth in the population of Utah during that period (1.8%).<sup>57</sup>

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<sup>56</sup> NCSB, [States that Regulate Audiology and Speech-Language Pathology](#)

<sup>57</sup> Retrieved Mon, 03 November 2025 from the Utah Department of Health and Human Services, Indicator-Based Information System for Public Health website: <https://ibis.utah.gov/ibisph-view/>



### 3. Regulatory Model Assessment & Recommendation

#### 3.1 Menu of Regulatory Models and Factors Considered in Framework

Please see [this working document](#), OPLR's Occupational Regulation Framework, for a more detailed explanation of OPLR's approach to assessing occupational regulation and evaluating different regulatory models.<sup>58</sup>

#### 3.2 Audiologist's Role in the Healthcare Landscape

Audiologists serve a critical function in the healthcare landscape by improving hearing loss. Research indicates that untreated hearing loss is associated with numerous adverse outcomes, including declines in cognitive and physical function and social isolation, especially for older adults. For example, age-related peripheral hearing impairment, which is modifiable, has been associated with increased risk of developing dementia in older adults.<sup>59</sup> Additionally, hearing loss was not only found to be independently associated with incident dementia,<sup>60</sup> but rates of cognitive decline and the risk of incident cognitive impairment were linearly associated with the severity of an individual's baseline hearing loss.<sup>61</sup> Finally, hearing loss has also been associated with lower overall physical well-being among older adults.<sup>62</sup> By treating and managing underlying hearing loss, audiologists not only improve hearing but play an important role in reducing the potential negative downstream impacts on cognitive and physical function, especially among older adults.

In addition to cognitive and physical function, accessing hearing care can have positive economic impacts, although the evidence is mixed. In an analysis of Medicare beneficiaries using hearing aids, those who self-reported using hearing care services spent, on average, \$2,500 less than those who did not use hearing care services.<sup>63</sup> Furthermore, in an analysis of privately insured and Medicare Advantage enrollees in a large, private, U.S. health plan, untreated hearing loss was associated with \$22,434 higher total healthcare costs over a 10-year period (\$3,852 over a 2-year period) compared to those without hearing loss.<sup>64</sup> While these analyses show promising economic impacts, other research of Medicare beneficiaries with and without hearing aids showed a less conclusive result. Adults with hearing aids had higher total annual healthcare spending (\$1,125) and higher out-of-pocket spending (\$325) but lower Medicare spending (\$71).<sup>65</sup> As indicated by the research, properly treating disorders related to hearing loss has far reaching implications and has a potentially important economic role in

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<sup>58</sup> The document is also available on OPLR's website in the "About OPLR" section, accessible here: <https://oplr.utah.gov/about-oplr/>

<sup>59</sup> Deal, J. A., et al. (2017). [Hearing Impairment and Incident Dementia and Cognitive Decline in Older Adults: The Health ABC Study](#)

<sup>60</sup> Lin, F. R., et al. (2011). [Hearing loss and incident dementia](#)

<sup>61</sup> Lin, F. R., et al. (2013). [Hearing loss and cognitive decline in older adults](#)

<sup>62</sup> Martinez-Amezcu, P., et al. (2020). [The Association Between Hearing and Physical Functioning in the Atherosclerosis Risk in Communities Study](#)

<sup>63</sup> Willink, A., et al. (2019). [Cost-Benefit Analysis of Hearing Care Services: What Is It Worth to Medicare?](#)

<sup>64</sup> Reed NS, et al. (2019). [Trends in Health Care Costs and Utilization Associated With Untreated Hearing Loss Over 10 Years](#)

<sup>65</sup> Mahmoudi, E., et. al (2018). [Association Between Hearing Aid Use and Health Care Use and Cost Among Older Adults With Hearing Loss](#)

containing healthcare costs.

### **3.3 Assessment of the U.S. Food and Drug Administration (FDA) Manufacturer and User Facility Device Experience (MAUDE) database**

Audiologists utilize a wide range of devices to conduct procedures and assessments. The U.S. Food and Drug Administration (FDA) maintains the Manufacturer and User Facility Device Experience (MAUDE) database, which contains medical device reports of adverse events.<sup>66</sup> This dashboard promotes transparency by publishing device and patient problems. Additionally, the FDA uses the database to monitor device performance, detect potential device-related safety issues, and contribute to benefit-risk assessments of these products. Submissions to the database are made by mandatory reporters (i.e., manufacturers, importers, and device user facilities) and volunteer reporters (i.e., patients, consumers, practitioners).

Despite being used to monitor and detect safety issues and to promote transparency, the medical device reports are not intended to evaluate rates of adverse events, evaluate a change in the rates over time, or to compare adverse event occurrence rates across devices. Furthermore, the submission of a medical device report itself does not necessarily demonstrate that the device caused or contributed to the adverse outcome or event. Other limitations include the potential submissions of incomplete, inaccurate, untimely, unverified, or biased data. Additionally, this database alone should not be used to determine the incidence or prevalence of an event occurring because of the potential for under-reporting and the lack of information about the frequency of device use.<sup>67</sup>

OPLR used the FDA MAUDE database to analyze the occurrences and characteristics of reported adverse events associated with audiometers<sup>68</sup> and curettes used in cerumen management.<sup>69</sup> OPLR queried the MAUDE database and used the categories of “Audiometer” and “Curette, Ear” to filter product class, looking for all medical device reports from January 1, 2020 through November 30, 2025.

The audiometer query revealed 31 medical device reports over the five-year timeframe. Of the 31 medical device reports during the timeframe, 18 resulted in no clinical signs, symptoms, or conditions for patients, as device problems commonly included excessive heating or electrical problems/electro-static discharge. When patient problems were reported, events were related to abrasion, laceration, tinnitus, sleep dysfunction, or there was not enough information.

For the curette query, only four medical device reports were identified over the five-year period. Each report was related to a curette that broke during a procedure; however, none of the reports cited patient problems or harm, except one where there was insufficient information.

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<sup>66</sup> [About Manufacturer and User Facility Device Experience \(MAUDE\) Database](#)

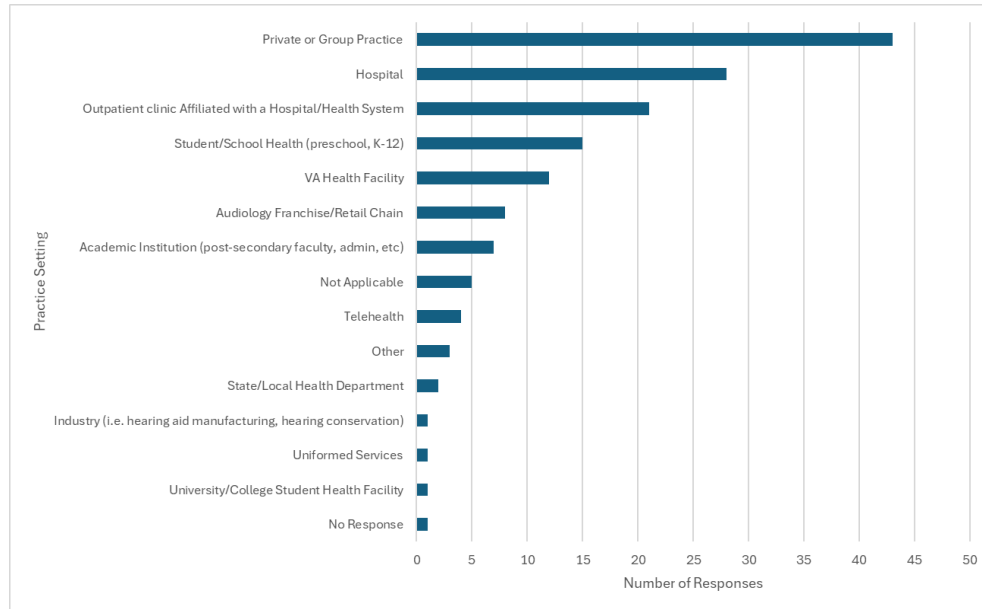
<sup>67</sup> [Manufacturer and User Facility Device Experience](#)

<sup>68</sup> Audiometers are medical devices used to measure hearing acuity by producing controlled levels of tones and signals.

<sup>69</sup> A curette is a device used in many medical settings for a variety of reasons. This analysis focused on curettes used in relation to the ear to assist in removing excess earwax and manage cerumen.

### 3.4 Audiology Practice Setting

#### Utah Audiology and Speech Language Pathology Workforce Survey Practice Setting (2024)



### 3.5 Assessment of Audiology

The following table summarizes OPLR’s analysis of audiology according to factors that OPLR determined should influence the appropriate regulatory model for an occupation. Factors that OPLR considered as particularly determinative in its assessment of audiology are highlighted in bold.

Model Assessment of Audiology	
Harm Factors	
Mechanism of Harm	<b>Audiologists perform many routine tests to assess and identify disorders of hearing, balance, and tinnitus, manage and treat patients, and provide patient education. The improper diagnosis or treatment has relatively low consequences. In relation to dispensing hearing instruments, there is a moderate degree of financial harm, although somewhat rare.</b>
Severity, Permanence, and Likelihood of Harm	An untrained audiologist would likely misdiagnose or improperly manage or treat a patient. This could result in a worsening of a patient’s condition. Additionally, incompetent care could cause direct patient harm (e.g., causing harm during an ear mold impression). However, given an audiologist's training and

	education, the risk is low.
<b>Consequence of Error</b>	<b>40 out of 100*</b>
Downstream Impact	If an audiologist provides poor care, or inaccurate or delayed testing and treatment, a patient could have lifelong disability (especially for children) or worsened disability.
<b>Consumer &amp; Setting Factors</b>	
<b>Patient Vulnerability</b>	<b>Audiologists work with patients of all ages, including infants, children, and the elderly. Given the populations generally impacted by hearing loss, there is a moderate degree of patient vulnerability.</b>
Frequency of Physical Touch	Audiologists do physically touch patients during examinations. However, this is limited to contact around the ears and head.
Frequency of Private Setting	Many audiologists work in a healthcare setting, with some frequency of private contact with patients. Others work in private practice or schools, where there is potential for more private contact.
Information Asymmetry	Audiologists perform specialized testing and treatment. A typical patient may not have the knowledge to evaluate the specific task performed by an audiologist, but a patient would have the knowledge to know if their symptoms or hearing and vestibular problems are improving.
<b>Related factors</b>	
Independence	Audiologists have a high degree of clinical independence.
Patient Choice	Patients have some choice in their audiologist, but their options could be limited by insurance coverage and proximity to practitioners.
Information Availability	Information availability is somewhat limited, especially for individual practitioners. This can make it difficult to make an informed choice when selecting a practitioner.
Level of Oversight	<p><i>Employers:</i> Depending on the practice setting, there are varying degrees of employer oversight. In hospitals or clinics associated with a healthcare system, the oversight is high, but in private practice the employer oversight is low.</p> <p><i>Private Bodies:</i> Audiologists have an optional private certifying body (ASHA).**</p>

\*[O\\*Net Consequence of Error Ranking](#) based on practitioner

\*\*[ASHA Certification in Audiology](#)

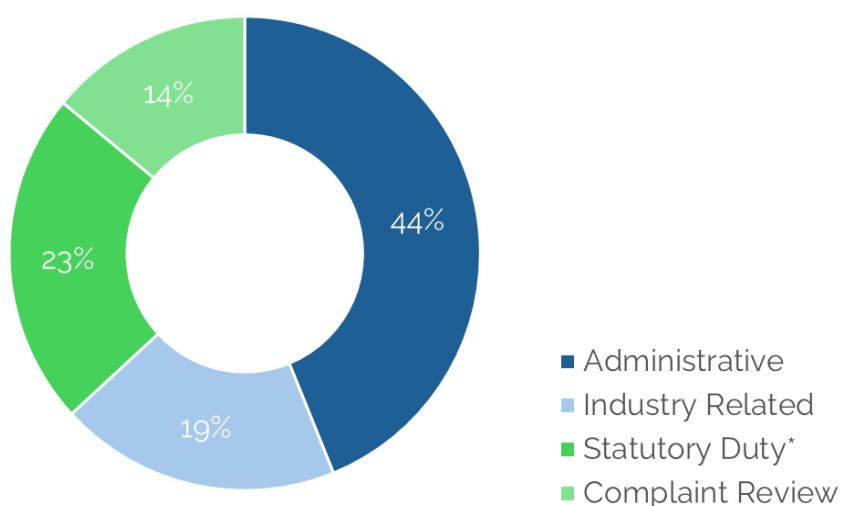
### 3.6 Analysis of Speech-Language Pathology and Audiology Board Agenda

To better understand the role of the Speech-Language Pathology and Audiology Board in Utah, OPLR reviewed the board meeting agendas from January 2020 to the most recently held meeting in July 2025. Agenda items from these board meeting were extracted and categorized as:

1. administrative (included electing a chairperson and appointing a replacement delegate for the ASLP-Interstate Compact Board);
2. industry related (included discussing legislation and providing updates on the compact);
3. statutory duty<sup>70</sup> (included discussions around the scope of practice, telehealth, and continuing education requirements); and
4. complaint review (discussing compliance and conducting probation reviews).

The analysis excluded recurring agenda items with no substance, like calling the meeting to order and approving previous meeting minutes.

The analysis shows that a significant amount of the Board's time was allocated to its time to administrative items or industry-relevant updates over the past five years.



## 4. Regulatory Model Adjustments & Recommendation

### 4.1 Possible Adjustments

Please see [this working document](#), OPLR's Occupational Regulation Framework, for a more detailed explanation of how OPLR approaches whether adjustments should be made within a recommended regulatory model.<sup>71</sup>

<sup>70</sup> As defined by 58-1-202 and 58-1-203

<sup>71</sup> The document is also available on OPLR's website in the "About OPLR" section, accessible here: <https://oplr.utah.gov/about-oplr/>

## 4.2 DOPL Complaint Data

The Division of Professional Licensing (DOPL) receives complaints from individuals, other state agencies, co-workers, professional associations, and licensing boards. DOPL is required to “investigate unlicensed practice in regulated professions, acts or practices inconsistent with recognized standards of conduct, allegations of gross negligence or incompetence, and patterns of gross negligence or incompetence”.<sup>72</sup> Violations that meet the criteria for investigation are then prioritized and assigned to an investigator. DOPL may resolve investigations in a variety of ways, including: closing an investigation due to a lack of evidence; referring the case to another agency or to law enforcement if appropriate; carrying out informal or formal administrative sanctions or stipulated agreements; issuing a citation; or denying, suspending, or revoking an individual’s license.

To analyze complaints sent to DOPL, OPLR used My License Office (MLO) to access closed complaints investigated by DOPL between 2017-2022 for all licenses/professions. This data contains information on the license name, the complaint type, and the disposition of the complaint, among many other data fields not relevant to OPLR’s analysis. DOPL personnel helped code the complaint dispositions as either substantiated, unsubstantiated, or no jurisdiction. Substantiated complaints are those where a disposition includes some type of disciplinary action, whether formal or informal (e.g., letter of concern, verbal warning, surrender of license). Unsubstantiated complaints have dispositions without a disciplinary action (e.g., dismissed, lack of evidence, unfounded). ‘No jurisdiction’ complaints are complaints that may or may not have basis, but DOPL was not able to take action on the case.

OPLR filtered complaints to exclude any likely duplicates and then used substantiated complaints to calculate the number of complaints per license type or profession. OPLR estimated the complaint rate for each license type by dividing the number of substantiated complaints by the number of unique individuals who held that license type over the same period.

### *Complaint Case Notes Analysis*

A more detailed analysis of historical case notes was conducted on audiology complaints closed between 2017-2022. OPLR analysts read through case notes from all seven complaints and for each complaint summarized the issue, noted whether or not client harm occurred or potentially occurred, and if harm was present, the type and severity.

### *Limitations*

There are significant limitations to this analysis, and the information collected should not be interpreted as a precise estimate of harm caused by audiologists. DOPL data likely underestimates true harm, as many instances of harm may be handled in other ways (e.g., directly by employers), reported to other entities, or may never be reported. Additionally, some

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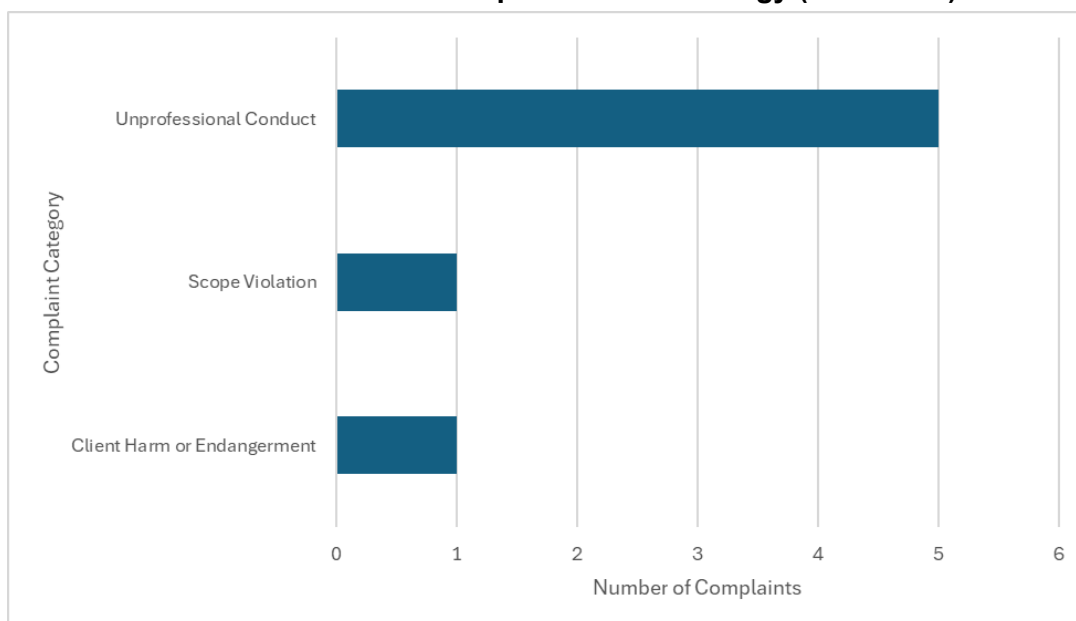
<sup>72</sup> DOPL, [An Explanation of the Complaint Handling Process for the Division of Occupational and Professional Licensing](#)

unsubstantiated complaints may have resulted in harm but the necessary evidence was not produced.

There could also be latent factors correlated with both the likelihood of complaint and the profession, systematically biasing the comparisons across professions. This is especially true in healthcare, as certain professions, by their nature, include a greater potential for harm and may generate more complaints. For example, surgeons have a higher likelihood of causing severe harm to a patient than audiologists because surgery is inherently far riskier, not because surgeons are “less safe” or less competent than audiologists.

For these reasons, OPLR uses DOPL complaint data as directionally informative, but avoids direct comparisons across professions wherever possible. Fine comparisons across professions are unwarranted and unsupported by these data.

**DOPL Substantiated Complaints for Audiology (2017-2022)**





## 5. Rule Review

### 5.1 Incorrect References

OPLR identified the following incorrect references in the Speech-Language Pathology and Audiology Licensing Act Rule.

Rule	Incorrect Reference	Correct Reference
R156-41-104	R156-1-107	Reference does not exist
R156-41-302a	58-41-5(1)(f)	58-41-5(1)(e)
R156-41-302b(1)	R156-1-102a(4)(c)	R156-1-102a(1)(c)
R156-41-302c(1)	R156-1-102a(4)(c)	R156-1-102a(1)(c)

## 6. Stakeholder Engagement

### 6.1 OPLR Interview Series

OPLR relied heavily on stakeholder engagement and qualitative interview data, combined with OPLR's other analysis, to conduct this review and develop recommendations. OPLR engaged with audiologists, audiologist business owners and employers, audiologist educators, industry associations, Utah legislators, and Utah and other state regulators. OPLR prioritized diversity of perspective and relevance to the industry in selecting stakeholders. Variety in practice setting was also prioritized.

Interviews were conducted via video conferencing using semi-structured interview methods; they were conducted one-on-one and with multiple members. Extensive notes were taken for all interviews.

OPLR conducted initial interviews to understand the audiology industry, determine the largest issues related to safety and access, and identify potential areas for change. OPLR engaged with stakeholders later in its review to test initial findings from analysis and preliminary recommendations. OPLR reflected on and synthesized feedback across multiple discussion sessions to develop clear and achievable evidence-based recommendations.

#### *Limitations*

This interview sample was not randomly selected and, therefore, is not completely representative. OPLR spoke to individuals most likely to represent the broad aims and concerns of their groups. Additionally, OPLR did not contact "consumers" of audiology (i.e. patients), so their perspectives were not incorporated into this review. Thus, the stakeholder engagement and findings from these interviews should not be understood to be fully representative of the

views of all Utahns, audiologists, audiologist employers or clinic owners, or any other person, group, or population.

Note that stakeholders' views are not always reflected in OPLR's recommendations. OPLR is directed by Utah Code 13-1b-302 to apply specific review criteria. These can and do lead to recommendations that diverge from stakeholder preferences. A stakeholder's appearance here is not an endorsement of OPLR's recommendations as such.

Stakeholder Engagement Summary - Speech & Hearing Professions	
Government Stakeholders	
<b>Utah Department of Commerce</b>	<b>Margaret Busse</b> , Executive Director <b>Carolyn Dennis</b> , Deputy Director <b>Jacob Hart</b> , Deputy Director <b>Mark Steinagel</b> , Director, Division of Professional Licensing <b>Lisa Martin</b> , Bureau Manager, Division of Professional Licensing <b>Tracy Taylor</b> , Bureau Manager, Division of Professional Licensing <b>Lindsay Aagaard</b> , Licensing Specialist, Division of Professional Licensing <b>Brylee Vanderwarf</b> , Board Secretary, Division of Professional Licensing
<b>Division of Professional Licensing (DOPL) Board</b>	<b>Brooke Hammond</b> , Audiology Board Member, Speech-Language Pathology and Audiology Board <b>Lindsey Hardcastle</b> , Speech-Language Pathology Board Member, Speech-Language Pathology and Audiology Board <b>Robert Kraemer</b> , Speech-Language Pathology Board Member, Speech-Language Pathology and Audiology Board <b>Lauren Snyder</b> , Audiology Board Member, Speech-Language Pathology and Audiology Board
<b>Utah Department of Health and Human Services</b>	<b>Shandi Adamson</b> , Office Director, Division of Integrated Healthcare <b>Stephanie McVicar</b> , Program Manager, Early Hearing Detection and Intervention, Office of Children with Special Health Care Needs <b>Jenny Pedersen</b> , Coordinator, Children's Hearing Aid Program (CHAP), Office of Children With Special Health Care Needs <b>Jessie Rodriguez</b> , Health Program Manager, Division of Integrated Healthcare <b>Jim Stamos</b> , Director, Office of Healthcare Policy and Authorization at Utah Medicaid <b>Gregory Trollan</b> , Office Director, Division of Integrated Healthcare <b>Debi Walker</b> , Health Program Manager, Division of Integrated Healthcare <b>Shannon Wnek</b> , Audiologist, Early Hearing Detection and Intervention (EDHI), Office of Children with Special Health Care Needs
<b>Utah State Board of Education</b>	<b>Kristin Campbell</b> , Research Consultant <b>Megan Carlisle</b> , Educator License Equivalency Specialist

	<b>Jonathan Collins</b> , Research Consultant <b>Jordan DeHaan-Magalei</b> , Supporting Personnel and Preparation Coordinator <b>Kim Fratto</b> , Director of Special Education Programs <b>Maria Hawley</b> , Related Services Personnel Preparation Specialist <b>Malia Hite</b> , Executive Coordinator of Education Licensing <b>Lisa McLachlan</b> , Educator Preparation Coordinator
Industry Stakeholders	
<b>Industry Associations</b>	<b>Susan Adams</b> , Director of State Legislative & Regulatory Affairs, ASHA <b>Matt Hansen</b> , Executive Director, Homecare & Hospice Association of Utah <b>Kenyatta Jones Hunt</b> , Certification Program Director, National Board for Certification in Hearing Instrument Sciences <b>Katie Meyer</b> , Senior Director of Ethics, ASHA <b>Peter Mihalick</b> , Health Policy and Advocacy Director, International Hearing Society <b>McKenna Nobis</b> , President-Elect & SLP Clinician, Utah Speech-Language Hearing Association <b>Lee Robinson</b> , President, Utah Speech-Language Hearing Association; Professor, Brigham Young University Department of Communication Disorders <b>Christine Seitz</b> , Manager of Government Affairs, International Hearing Society <b>Allison Spangler</b> , President & CEO, Utah Health Care Association <b>Mary Stone</b> , Senior Certification Administrator, National Board for Certification in Hearing Instrument Sciences
<b>Employers</b>	<b>Jeffrey Elliott</b> , Optical/Hearing Regional Manager, Costco Wholesale <b>Joseph Kamerath</b> , Physical Medicine and Rehabilitation, Intermountain Health <b>Tammy Miller</b> , Director of Training for Hearing Aids, Costco Wholesale
<b>Higher Education</b>	<b>Sarah Hargus Ferguson</b> , Professor, University of Utah Department of Communication Sciences & Disorders <b>Mark Rasmussen</b> , Clinical Professor, University of Utah Department of Communication Sciences and Disorders <b>Teresa Ukrainetz</b> , Assistant Department Head & SLP Division Chair, Speech and Hearing Sciences, Utah State University
Subject-Matter Experts	
<b>Academics, Researchers, &amp; Clinicians</b>	<b>Julie Barkmeier-Kraemer</b> , SLP Clinician & Professor, University of Utah Health <b>Jordan Bigler</b> , HIS, Pure Hearing <b>Joe Dansie</b> , AUD Clinician & Founder, Conditioned Play Innovations <b>Noah Hadley</b> , Clinical SLP, Copper Ridge Health Care - Skilled Nursing <b>Kate Johnson</b> , Clinical Audiologist, University of Utah Health <b>Harry Leibovich Sr.</b> , Audioprosthologist, Miracle-Ear Hearing Aid

Center

**Angela Menlove**, Clinical SLP, Intermountain Health

**Kacee Muller**, Clinical SLP

**Jessica Nelson**, Director of Treatment, Timpanogos Hearing & Tinnitus

**Michael Page**, Audiologist

**Neil Patel**, Professor and Otolaryngologist, University of Utah Health and Intermountain Health

**Jo Punttil**, SLP Clinician & ASHA Fellow, St. George Regional Hospital/Intermountain Health

**Katie Stone**, Professor, Brigham Young University Department of Communication Disorders

**Katie Tonkovich**, Audiologist, Primary Children's Hospital

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