Utah Department of Commerce
Office of Professional Licensure Review

2025 Periodic Review

Speech-Language Pathology

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Executive Summary

Background

Speech-language pathologists (SLPs) are healthcare providers who work to prevent, assess, diagnose, and treat disorders related to human communication, speech, voice, language, cognitive communication, and swallowing in patients of all ages. SLPs are independent practitioners that provide care predominantly in educational, healthcare, or private practice settings.

Utah currently requires SLPs to be licensed. Licensing and education requirements are nearly standard in states across the U.S. However, 43 states, including Utah, allow SLPs to perform invasive evaluations of swallowing disorders without any additional requirements, while some states require additional training, practice counts, or supervision to perform those procedures.

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 (related to fluency, literacy, education, employment, and in some cases medical complications) mean that 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
- The shift to mandatory certification would not change:
    - Current education, exam, and experience entry requirements for SLPs
    - 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: *Account for Potential Harm from Invasive Procedures through Unprofessional Conduct Provision*

- Establish a new unprofessional conduct provision to mitigate patient harm by preventing untrained SLPs from performing higher-risk procedures in non-healthcare settings.
    - SLPs may perform higher-risk swallowing procedures and assessments that, if performed by an untrained SLP in a setting without proper emergency protocols and oversight, could result in patient harm.

Context

Consistent with its legislative mandate,[1] the Office of Professional Licensure Review (OPLR) reviewed Utah's licensing laws for speech-language pathology 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[2]

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

Speech-language pathologists (SLPs) are healthcare providers who work to prevent, assess, diagnose, and treat disorders related to human communication, speech, voice, language, cognitive communication, and swallowing in patients of all ages.[3] SLPs work with individuals with speech disorders (e.g., stuttering, lisp, aphasia), which occur when an individual has issues producing speech sounds or has trouble with voice resonance. Cognitive-communication disorders, or issues related to organizing thoughts, paying attention, remembering, and/or problem solving, are also assessed and treated by SLPs. These disorders may happen as a result of a stroke, traumatic brain injury, or dementia. One other segment of practice for SLPs relates to dysphagia,[4] or swallowing disorders, which emerge when muscles or nerves of the throat are weakened or damaged due to surgery, injury, illness, or stroke. Related, SLPs help manage a variety of procedures, such as tracheoesophageal puncture,[5] total laryngectomy,[6] and patients on ventilators. The practice of SLPs vary and are dependent on the practice setting.

SLPs are autonomous practitioners that independently provide care predominantly in educational, healthcare (i.e., hospitals, residential, and nonresidential healthcare facilities), or private practice settings.[7] According to ASHA, "in many settings, SLPs often work as part of a

[1] UCA 13-1b-203(2)
[2] UCA 13-1b
[3] ASHA Speech-Language Pathologists
[4] Dysphagia is a term for difficulty swallowing, and SLPs manage dysphagia by identifying signs and symptoms, identifying normal and abnormal anatomy and physiology, providing treatment, and educating and counseling patients, caregivers, and other professionals. See Azer et al. (2023)
[5] A tracheoesophageal puncture is a surgical procedure that involves creating a small hole between the trachea (windpipe) and the esophagus (food pipe) to insert a voice prosthesis.
[6] Total laryngectomy is the surgical removal of the larynx, or the voice box.
[7] ASHA Employment Settings for SLPs; About 56% of SLPs are employed in educational settings and 39% are employed in healthcare settings (16% in nonresidential healthcare facilities, 13% in hospitals, and 10% in residential healthcare facilities). Additionally, 19% of all SLPs are employed either full- or part-time in private practice. Per ASHA

collaborative, interdisciplinary team, which may include teachers, physicians, audiologists, psychologists, social workers, physical and occupational therapists, and rehabilitation counselors.[8]

Profession in Utah

SLP is a licensed profession in Utah. There are 1,651 actively licensed SLPs and 16 dually licensed SLPs and audiologists (See Appendix 2.1).

The legal scope of practice for an SLP in Utah is defined broadly in statute and includes "examination, measurement, prevention, testing, identification, evaluation, diagnosis, treatment, instruction, modification, prescription, restoration, counseling, habilitation, prediction, management, and research" related to "human communication, speech, voice, language, cognitive communication, or oral, pharyngeal, or laryngeal sensorimotor competencies."[9,10]

To practice as an SLP 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 master's degree in speech-language pathology from an accredited college or university;
2. Compliance with the profession's regulations of conduct and codes of ethics;
3. At least nine months[11] of direct clinical experience in treatment and management of patients; and
4. Passing a nationally standardized examination in speech-language pathology.[12,13]

Furthermore, SLPs 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 50% of USBE SLPs also hold a DOPL license.

Approaches in Other Jurisdictions

Utah's current SLP license largely aligns with the standard model of regulation across the U.S. Forty-nine (49) states and the District of Columbia regulate SLPs through licensure.[14] Colorado

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About Speech-Language Pathologists, "SLPs work in many different research, education, and healthcare settings with varying roles, levels of responsibility, and client populations."

[8] ASHA About Speech-Language Pathologists

[9] Pharyngeal (throat) and laryngeal (voice box) sensorimotor competencies relate to the ability to integrate and engage sensory inputs (e.g., sight, touch) with voluntary motor actions (e.g., speaking, swallowing).

[10] UCA 58-41-2

[11] This is equivalent to one academic year, as defined in UCA 58-41-5(4)(d).

[12] UCA 58-41-5

[13] Per UCA 58-41-5, the examination should be the same as or equivalent to the examination required for the Certificate of Clinical Competence and with pass-fail criteria equivalent to current American Speech-Language-Hearing Association (ASHA) standards. While there is no further specification in Utah rule regarding the examination, applicants in Utah must provide documentation of passing the PRAXIS exam for SLP or holding a current certification from the ASHA. Obtaining ASHA certification requires applicants to pass the PRAXIS.

[14] National Council of State Boards of Examiners

is unique and requires SLPs to obtain certification, rather than licensure, but it is functionally identical to the regulatory models in other states.[15] Furthermore, all states require at least a master's degree in the area of SLP to practice the profession.

The scope of practice varies between states with most having a broad scope (i.e., Utah, Washington, Maryland) and others having a specific (i.e., California, Virginia, Tennessee).[16] One specific difference relates to the assessment of swallowing disorders using instrumental procedures, an area identified as being higher-risk. Forty-three (43) states, including Utah, allow SLPs to assess swallowing and related disorders without any additional requirements. However, seven states specifically regulate these practices in statute and require additional training, practice counts, or supervision to perform these procedures. For example, Tennessee requires that an SLP who uses an endoscope to evaluate swallowing must successfully complete a university course or other educational program of at least 15 hours on endoscopy and successfully perform at least 25 endoscopic procedures under the supervision of an otolaryngologist or another speech language pathologist.[17] In Tennessee, endoscopic procedures must be performed in a setting that has protocols in place for emergency medical backup and a physician must provide general supervision. California has very similar regulations for instrumental procedures, specifically the use of rigid and flexible endoscopes and flexible fiber optic transnasal endoscopic procedures.[18]

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.[19] 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 of harm to the health,

[15] The entry and renewal requirements align with those of states that use licensure, see: Colorado Revised Statutes 12-305-104(3).
[16] In states with a specific scope of practice, the practice act describes permissible practices, such as the use of instrumental procedures and suctioning and the training required to perform a flexible fiber optic transnasal endoscopic (FEES) procedure or other endoscopic evaluations of swallowing.
[17] Tenn. Code Ann. § 63-17-103
[18] CA Bus & Prof Code § 2530.2 (2024)
[19] 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

safety and financial welfare of the public.[20] OPLR's analysis considered the entire scope of SLP, including procedures performed in different practice settings (e.g., educational and medical settings). This includes procedures that are considered to be more risky, such as instrumental swallowing assessments (e.g., fiberoptic endoscopic evaluation of swallowing or FEES[21]), dysphagia management, neuromuscular electrical stimulation[22], pharyngeal electrical stimulation[23], vestibular testing, and tracheoesophageal puncture management.

Overall, OPLR's analysis concluded that the potential for harm in SLP is low, although there are areas that pose a moderate potential for harm. Most tasks performed by SLPs, such as treating speech and language, social communication, and cognitive-communication disorders, pose little risk to patients. Despite this, there are certain procedures that present a higher risk of physical harm, particularly in a medical setting.[24] For invasive procedures, there are risks of discomfort, nosebleed, vomiting, infection, irritation, laryngospasm (airway spasm), or aspiration. The potential for harm also exists if feeding and swallowing disorders are mismanaged. These harms include malnutrition, airway obstruction, or aspiration pneumonia. While these harms can be moderate to more severe, they are largely mitigated by the highly regulated medical settings in which they occur. Additionally, these harms are most often temporary and reversible.

However, many SLPs work in an educational setting.[25] Nationally, the majority of SLPs work in educational settings,[26] where the extent of performing higher-risk feeding and swallowing services is less prevalent. For example, in educational settings, SLPs perform routine screenings and diagnostic evaluations and work with children of varying abilities on listening, speaking, reading, and writing strategies.[27]

OPLR determined that the potential harm associated with boundary issues or similar conduct (e.g., inappropriate physical touch) is low to moderate. While SLPs do frequently touch patients to perform evaluations, assessments, and treatments, the work of an SLP is focused on a

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[20] UCA 13-1b-302(2)

[21] Per Johns Hopkins Medicine, a fiberoptic endoscopic evaluation of swallowing (FEES) test is a procedure used to assess swallowing. During the procedure, an SLP passes a thin, flexible instrument through the nose to view parts of the throat during swallowing.

[22] An instrumental approach relying on electrical impulses to strengthen muscles, prevent muscle atrophy, and re-educate patients following poststroke dysphagia and central facial palsy. (Berenati et al., 2021)

[23] This technique inserts a catheter through the nose and enables clinicians to electrically stimulate the pharynx directly to improve swallowing performance with conditions associated with stroke and multiple sclerosis. (Restivo & Hamdy, 2018)

[24] Swallowing disorders, which pose a greater potential for harm, comprise a large caseload among adult patients in healthcare settings. Additionally, SLPs in healthcare settings do treat and assess pediatric feeding and swallowing disorders, although the caseload is lower than among adults.

[25] Data provided by a stakeholder shows that SLPs in a pediatric healthcare setting predominantly treat speech sound disorders, language and literacy, feeding and swallowing disorders, autism, and cognitive communication (ordered from greatest to least caseload, as best interpreted). This caseload is similar to what an SLP employed in an educational setting may encounter.

[26] According to AHSA data, over half of SLPs (56%) are employed in educational settings. However, according to the Utah Audiology and Speech Language Pathology Workforce Survey and after factoring in the share of SLPs licensed through USBE, about 49% of SLPs work in an educational setting. The state survey received 574 responses, or a response rate of roughly 30%. Furthermore, roughly 50%, or 660 individuals, of SLPs are USBE licensed, so, after applying the survey response rate, roughly 210 additional SLPs were determined to be practicing in an educational setting. See: ASHA Employment Settings for SLPs and Appendix 3.2

[27] ASHA Employment Settings for SLPs

patient's head and neck region. However, this is complicated by the patient populations served by SLPs, which includes vulnerable populations. In medical settings, SLPs work on interdisciplinary teams where violations of a patient's boundaries would be clear to other healthcare professionals. Additionally, healthcare facilities have their own policies and procedures in place to prevent these types of harms for vulnerable patients. In school settings, SLPs work with children, who are a particularly vulnerable population. Despite this, the potential harm to children is largely addressed through oversight by USBE, as discussed in the next section.

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 were made.[28] 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. SLPs have a score of 55 out of 100, which is categorized by O*NET as "serious".[29] Physical therapists (O*NET score of 69) have a higher risk score than SLPs but are in the same severity category, while nurse practitioners (O*NET score of 85) have both a higher score and are in a higher severity category. However, occupational therapists (O*NET score of 47) have a lower score and are in a lower severity category than SLPs.[30]

Finally, ineffective care by an SLP 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. For example, in an educational setting, the improper or ineffective treatment of speech disorders, like a stutter, may result in a life-long speech impediment. Similarly, in a medical setting, the ineffective treatment of cognitive-communication disorders, which can occur after a stroke or traumatic brain injury, could result in a patient's long-term inability to organize and process thoughts. There is a compelling need for competent SLP practitioners due to the benefits they can provide, even if the practice itself carries a lower direct public safety risk generally.

Related Factors

SLPs operate with a high level of clinical independence and varying levels of oversight depending on the practice setting. Many SLPs in Utah work in an educational setting, where they may be the only SLP in a school.[31] Despite this, SLPs in this setting work under a relatively high degree of oversight, as they are required to obtain a Utah educator license, comply with

[28] O*NET Consequence of Error
[29] 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 50-60 range are chief executives, electrical engineers, financial managers, court reporters, medical secretaries, machinists, and airfield operations specialists.
[30] Comparator professions were selected based on similar education, training, and clinical independence.
[31] Approximately 1,330 SLPs are licensed by USBE. OPLR's analysis estimates that about 50% of USBE licensed SLPs also hold a DOPL license.

USBE standards and regulations, and work only in a school setting. In addition to being licensed through USBE, roughly half of USBE SLPs also choose to hold a DOPL license. Therefore, SLPs in this setting are overseen by a minimum of three entities: USBE, the local education agency (or district), and the school.

Furthermore, SLPs practicing in healthcare settings function as part of a comprehensive medical team, made up of physicians, nurses, and other allied healthcare professionals, such as physical and occupational therapists. Interviews with SLPs practicing in hospital settings that treat vulnerable patients told OPLR that hospitals provide training for more complex or specialized procedures, such as those used to treat and assess feeding and swallowing disorders.[32] Additionally, hospitals and other medical facilities are highly regulated by state and federal oversight (e.g., Utah DHHS facility licensing), tort liability, employer privileging processes, and payor credentialing, in addition to individual DOPL licensing.[33] 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.[34] Therefore, SLPs practicing in healthcare settings have substantial facility and health system oversight.

There is relatively low patient choice and information availability in both educational and healthcare settings. In a school setting, a child is assigned to a SLP by the school. Similarly, in a healthcare setting, a patient has limited ability to select their SLP. While patient choice and information availability in schools and healthcare facilities is low, these settings confer a high level of oversight and help mitigate risk. Conversely, SLPs working in private practice (about 19% of the national SLP workforce or 15% of Utah SLPs[35]) lack high levels of employer oversight, but patient choice and information availability are more robust. Patients scheduling an appointment with an SLP in private practice can access information, available through online reviews, to make a more informed decision about their provider.

For more details on OPLR's analysis of SLP according to the framework, see Appendix 3.4.

Recommendation: Shift the Regulatory Model from Licensure to Mandatory Certification

In evaluating the regulatory model for SLPs, OPLR determined that certification would be a more appropriate choice than licensure. The potential for harm and the harm associated with conduct (e.g., physical touch, private setting, patient vulnerability) is generally low and otherwise mitigated through existing forms of oversight. However, given the potential downstream effect of poor SLP care (e.g., inadequately treated speech disorders) and the importance of ensuring provider competence, OPLR concluded that the certification should be mandatory, not voluntary, to ensure robust minimum education and training.

OPLR recommends shifting the regulatory model for SLP from the current licensure model to a

[32] OPLR interview series
[33] As stated in the background section, SLPs work independently, not under the supervision of any other provider.
[34] See Appendix 3.3 for OPLR's analysis of the FDA MAUDE database.
[35] Per ASHA Employment Settings for SLPs, about 19% of SLPs are employed full- or part-time in private practice. See also Appendix 3.2.

mandatory certification model. Mandatory certification of SLP 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 (e.g., accredited Master's degree;
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 SLP applicants to submit documentation certifying their credentials to DOPL. This process would still require applicants to verify with DOPL that they obtained the appropriate education, examination, and experience. However, after this initial certification by DOPL, OPLR recommends eliminating the requirement for SLPs to undergo a biennial renewal process to lower the administrative burden for the individual and DOPL.

Instead of renewing with DOPL, SLPs 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 SLPs stay current and accountable to the profession and their patients without requiring that they formally interact with and pay a renewal fee to DOPL.

The SLPs 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 competence. For example, maintaining national certification with ASHA requires SLPs to acquire 30 hours of professional development hours every three years, while Utah Rule requires 20 continuing education hours every two years.[36,37] Similar to the nursing profession, OPLR proposes allowing an SLP to provide evidence of continued practice without lapse.[38] 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

[36] ASHA Maintaining Your Certification
[37] R156-41-304
[38] 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.

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 shows that administrative items and industry-relevant updates took up the majority of board meeting time over the past five years (rather than technical advice for DOPL investigations).[39,40] 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 did not find evidence that licensed SLPs in Utah are causing harm to patients. Using DOPL complaint data for SLPs, OPLR's analysis found that there were only two substantiated complaints between 2017 and 2022, for a rate of 0.02 substantiated complaints per 100 SLPs annually.[41] The SLP substantiated complaint rate represents the lowest among all the professions reviewed in 2025.[42] Upon reviewing both substantiated complaints, one was related to unauthorized practice of an unlicensed professional, while the other was related to criminal conduct unrelated to their practice as an SLP. Neither of these substantiated complaints were related to patient harm or endangerment.

In an analysis of American Speech-Language-Hearing Association (ASHA) Board of Ethics decisions from the past 15 years, the professional organization issued one public sanction against a Utah SLP. It was related to falsifying client records and fraudulently billing for services not rendered.[43]

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[39] See Appendix 3.5 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

[40] 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.

[41] See Appendix 4.2 for a description of the DOPL complaint analysis

[42] Professions included in OPLR's 2025 review include, physician assistants, nurses (e.g., advanced practice registered nurses, registered nurses, licensed practical nurse), physical therapists, occupational therapists, athletic trainers, and acupuncturists. OPLR is cautious when comparing complaint rates across professions, however, because professions engage in different services that contain different levels of risk for patients.

[43] ASHA is a professional association for audiologists and SLPs, and they receive and review ethics complaints filed against ASHA members and/or certificate holders.

SLPs perform a variety of higher risk procedures that have a moderate potential for harm. However, even among these higher risk procedures, complications remain low.[44] For example, the FEES procedure results in complications such as anterior epistaxis (nosebleed), posterior epistaxis,[45] vasovagal crises,[46] and laryngospasm[47] at rates of 0.1%, 0.02%, 0.08%, and 0.04%, respectively.[48] Additionally, pneumonia after videofluoroscopic swallow study (VFSS) is considered to be a serious complication caused by aspiration; however, the incidence of VFSS-related pneumonia was shown to be 1%.[49]Additionally, SLPs use a variety of medical devices to perform the more invasive assessments. Among these devices, those commonly used by SLPs in higher-risk procedures and assessments are highly regulated and monitored and were shown to result in minimal adverse events that caused patient harm.[50]

In addition to DOPL complaints, SLPs 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 SLPs begin at around $150 to $220 annually,[51] while premiums for physical therapists, nurse practitioners, and occupational therapists range between 1 to 13 times as much annually.[52,53,54] Low malpractice premiums indicate that SLPs 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

Nationally, access to SLP services generally does not pose a significant barrier.[55] However, Utah's somewhat limited data indicates challenges related to the supply of SLPs. While the long-term national trend shows supply adequacy, the HRSA data is not granular enough to show Utah-specific supply and demand.

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[44] Nacci A., Simoni, F. et al. (2022) Complications during Fiberoptic Endoscopic Evaluation of Swallowing in 5,680 Examinations
[45] Epistaxis is the medical term for a nose bleed.
[46] Vasovagal crisis is an episode describing a failure in the body's regulation, or autoregulation, of blood pressure. This can cause someone to faint or pass out temporarily.
[47] Laryngospasm is a condition that causes one's vocal cords to suddenly seize up, making breathing more difficult. These spasms are rare and typically last for fewer than a minute.
[48] See Nacci A. et al.
[49] See Jo, H., et al.
[50] 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.
[51] Career Shield Insurance
[52] Physical Therapy Malpractice Insurance
[53] Nurse Practitioner Malpractice Insurance
[54] Occupational Therapist Malpractice Insurance
[55] According to the 2025 U.S. Health Resources and Services Administration (HRSA) workforce projections, the national supply and demand of SLPs appears balanced (100% adequacy). By 2037, HRSA estimates that the percent adequacy will increase to 105% due to supply slightly outpacing demand.

Utah's location quotient, or the share of SLP employment in Utah relative to the rest of the U.S., is 73% which indicates that Utah has fewer SLPs than the U.S. generally.[56] The average location quotient for Utah healthcare practitioners and technical occupations is 80%, indicating that Utah's share of SLPs is lower than for the medical field in general. Conversations with stakeholders mirrored these findings; OPLR heard that some sectors, particularly long-term care facilities, were having trouble hiring SLPs.

While Utah's supply and demand outlook differs from the national outlook, the 2024 Utah Audiology and Speech Language Pathology Workforce Survey indicates that about 85% of SLPs plan to continue working at their current rate or increasing their hours over the next two years.[57] Of this group, approximately 55% currently work 25 or more hours a week, while approximately 40% 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 significant number of hours.

OPLR identified barriers to increasing the supply of SLPs. These include: relatively small graduate program capacity[58], high program costs[59], and low reimbursement rates. While important, these factors fall outside the purview of licensing policy.

Recommendation: Account for Potential Harm from Invasive Procedures through Unprofessional Conduct Provision

OPLR recommends defining instrumental swallowing assessments and other invasive procedures as unprofessional conduct if these procedures are performed in a setting other than a licensed healthcare facility and without proper training, education, and experience. SLPs perform some higher-risk swallowing procedures and assessments that, if performed by an untrained SLP in a setting without proper emergency protocol and oversight, could result in patient harm, like aspiration pneumonia, malnutrition, or airway obstruction. Complaint data did not show that these procedures and assessments are resulting in significant patient harm. However, SLPs OPLR spoke with emphasized the associated risks. Additionally, these procedures are regulated in a few other states.

While these procedures predominantly take place in a licensed medical or healthcare facility by competent SLPs, the state is reliant on employers to ensure this. Therefore, OPLR recommends creating a new unprofessional conduct provision to ensure that only SLP practitioners with the appropriate training, education, and experience can perform these more risky procedures in an appropriate setting.

Most U.S. states do not have any special provisions regulating swallowing assessments. However, California and a few other states have very specific provisions regarding these

[56] OPLR's analysis of U.S. Bureau of Labor Statistics data
[57] OPLR's analysis of the 2024 Utah Audiology and Speech Language Pathology Workforce Survey
[58] Four universities in Utah offer an SLP degree. These programs graduated a total of 107 SLPs in 2023-24.
[59] In Utah, to get an SLP degree, it will cost a student between $22,000 and $81,000 depending on whether s/he qualifies for in-state tuition.

procedures, as described earlier.[60] While OPLR's recommendation is not as restrictive as these states, creating a new unprofessional conduct provision should mitigate the potential for patient harm by preventing untrained SLPs from performing these higher risk procedures in non-healthcare settings.

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).[61,62] There is concern from SLPs 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 development options, and eliminating the Board) would prevent Utah from participating in the ASLP-IC.

The ASLP-IC's legislation states that SLPs must be licensed by their home state to participate in the compact. An ASHA representative confirmed that despite the use of the term 'license', the compact does not (and cannot) dictate the name of a profession's regulatory model. Therefore, so long as Utah requires the same level of oversight and practitioner requirements, the name of the regulation would not, by itself, disqualify the state from participating in the compact.[63] Since OPLR's recommendation for mandatory certification includes the same entry requirements and level of DOPL oversight, the name 'mandatory certification' would not bar Utah from the compact. This is corroborated by the fact that Colorado, a member of the ASLP-IC, certifies (rather than licenses) SLPs.[64]

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".[65] Therefore, if Utah does not require SLPs to renew their license, the ASLP-IC's requirements would be met.

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[60] For more details, please refer to the 'Approaches in Other Jurisdictions' section.
[61] UCA 58-41a
[62] 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.
[63] Per an email from September 24, 2025 with an ASHA representative
[64] CO Rev Stat § 12-305 (2025)
[65] UCA 58-41a-102

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 for purposes of this and many other compacts. 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 SLP 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[66], establishing a minimum number of hours of certified practice without lapse to maintain certification, and adding a new provision regarding unprofessional conduct.

[66] Renewal cycle is defined in R156-303

Appendix

Contents

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 Speech-Language Pathology Renewal Survey

Survey overview

OPLR utilized a DOPL survey available to SLPs during their 2025 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 SLPs licensees during the license renewal process so results were not affected by sampling bias. The response rate was around 32% for SLPs. 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). SLPs 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 Speech-Language Pathology Policy Scan

To better understand the regulatory environment for SLP, 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.[67] This resource contains information on each state's licensing legislation history, current regulatory approach, and status in the ASLP-IC, CE requirement.

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 SLP licenses in Utah grew with a Compound Annual Growth Rate (CAGR) of 7.6%, which far outpaced the growth in the population of Utah during that period (1.8%).[68]

[67] NCSB, States that Regulate Audiology and Speech-Language Pathology
[68] 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/

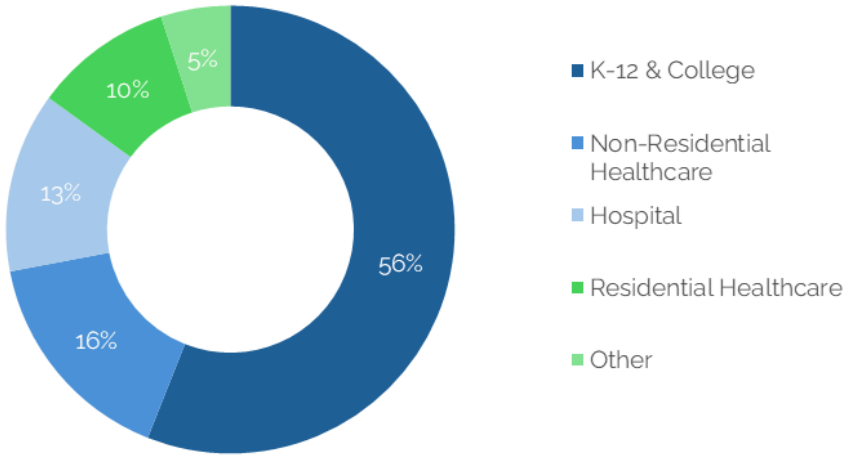
3. Regulatory Model Assessment & Recommendation

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.[69]

3.2 Speech-Language Pathology Practice Setting

American Speech-Language-Hearing Association Speech-Language Pathology Practice Setting[70]

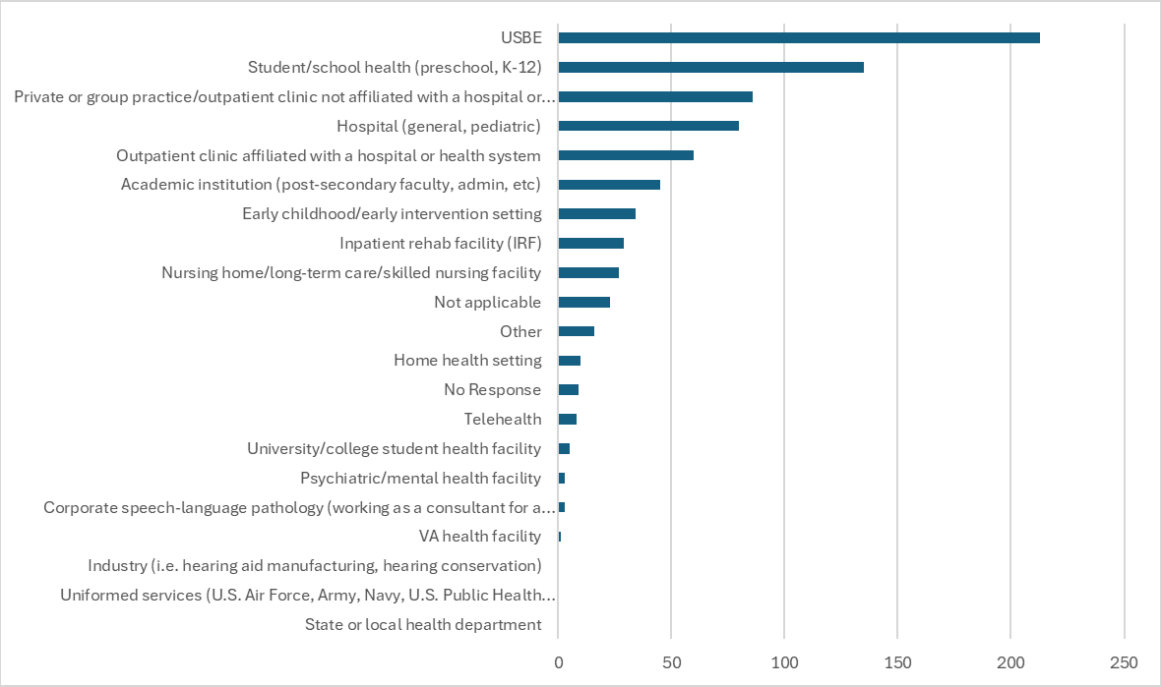


As some SLPs may have multiple forms of employment, an additional 19% of SLPs nationally are employed either full- or part-time in private practice.

[69] The document is also available on OPLR's website in the "About OPLR" section, accessible here: https://oplr.utah.gov/about-oplr/

[70] ASHA Employment Settings for SLPs

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



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

SLPs 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.[71] 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

[71] About Manufacturer and User Facility Device Experience (MAUDE) Database

an event occurring because of the potential for under-reporting and the lack of information about the frequency of device use.[72]

OPLR used the FDA MAUDE database to analyze the occurrences and characteristics of reported adverse events associated with flexible endoscopes[73], tracheostomy kits[74], and ventilator care. OPLR queried the MAUDE database and used the categories of "Endoscope, Flexible", "Tracheostomy Kit", "Tracheotomy Care Kit", "Ventilator, Continuous, Facility Use", and "Ventilator Tubing and Accessories" to filter product class, looking for all medical device reports from January 1, 2020 through November 30, 2025.[75]

Over the five-year timeframe, the query for flexible endoscopes produced 28 records total, although, after careful review of the device type, only 15 devices were endoscopes or flexible endoscopes (6 were video colono scopes, 3 were forceps, 2 were unknown, 1 was a choled-nephro scope, and 1 was a scope mount adapter). Out of the 15 medical device reports over the past five years, 12 resulted in no clinical signs, symptoms, or conditions for the patient, while two reports resulted in unspecified infections and one report resulted in a patient having an allergic reaction to the reprocessing agent.

The tracheostomy kit and tracheotomy care kit query revealed seven medical device reports over the five-year timeframe. None of these reports appeared to result in harm or adverse events for patients; rather, the reports related to missing components, difficulties with fitting, and one incident of device contamination and corrosion.

For the ventilator related queries, 435 medical device reports were returned over the half-month timeframe (November 1, 2025-November 15, 2025). Of the 435 medical device reports during the timeframe, 418 resulted in no clinical signs, symptoms, or conditions for patients, as device problems commonly included insufficient flow or under infusion and output problems. When patient problems were reported, events were related to insufficient information (7), low oxygen saturation (6), asthma (1), hypoventilation (1), hypoxia (1), and respiratory failure (1).

3.4 Assessment of Speech-Language Pathology

The following table summarizes OPLR's analysis of SLP 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 SLP are highlighted in bold.

[72] Manufacturer and User Facility Device Experience
[73] A flexible endoscope is a medical device commonly utilized by SLPs to perform flexible endoscopic evaluation of swallowing (FEES) or other assessments.
[74] Kits that contain supplies for managing, caring for, and cleaning a tracheostomy.
[75] The FDA MAUDE database can only return a maximum of 500 records at a time. When filtering the device category by "Ventilator, Continuous, Facility Use" over the five-year period, the query reported that more than 500 records were identified. To see all of the medical device reports during a time-period, the date was adjusted to show results for November 1, 2025 through November 15, 2025

Model Assessment of Speech-Language Pathologists	
Harm Factors	
Mechanism of Harm	**SLPs perform many routine assessments and diagnoses to treat patients with a wide variety of speech and communication disorders. These generally present a low risk to patient safety. However, SLPs in medical settings also perform instrumental assessments, which confers an increased risk and mechanism of harm.**
Severity, Permanence, and Likelihood of Harm	SLPs generally perform low-risk procedures. In some medical settings (e.g., procedures involving swallowing), incompetent care could result in severe patient harm and potentially death.
Consequence of Error	**55 out of 100***
Downstream Impact	**If an SLP provides poor levels of care, patients could have a worsened or lifelong disability, even if a practice itself presents low safety risks.**
Consumer & Setting Factors	
Patient Vulnerability	SLPs work with patients of all ages, including infants, children, and the elderly. These patients can be in the intensive care unit, pediatric intensive care unit, neonatal intensive care unit, private practice, or acute care setting. However, given the diversity of settings that many SLPs work, including in educational settings with children, there is a moderate degree of patient vulnerability.
Frequency of Physical Touch	**SLPs do physically touch patients during assessments and procedures. However, this is limited to contact around the head and neck region.**
Frequency of Private Setting	SLPs frequently work on interdisciplinary care teams, limiting the frequency of treating patients in a private setting.
Information Asymmetry	SLPs perform specialized assessments, tests, and treatments. A typical patient would likely not have knowledge to evaluate this. However, a patient would know if their symptoms and disorders are improving.
Related factors	
Independence	SLPs have a high degree of clinical independence.
Patient Choice	Patients have limited choice about their SLP in a medical and educational setting. There is patient choice about SLPs in private practice.
Information Availability	Because of the limited patient choice in a healthcare and

	educational setting, there may be little information available to patients regarding the quality of care provided by an SLP. However, among private practice, patients can rely on online reviews to select a provider.
Level of Oversight	***Employers:*** **In a medical and educational setting, the level of oversight is high. Low oversight in private practice is mitigated by patient choice and information availability.** ***Private Bodies:*** **SLPs have an optional private certifying body (ASHA).****

*O*Net Consequence of Error Ranking based on practitioner

**ASHA Certification in Speech-Language Pathology

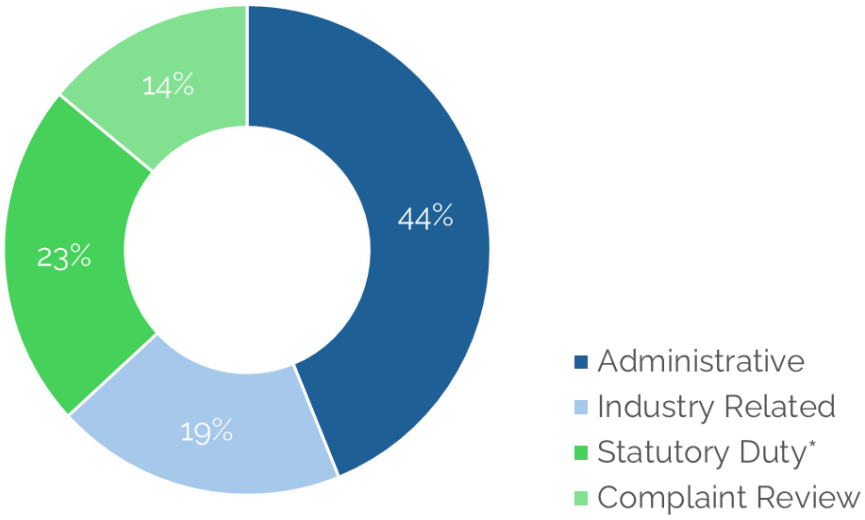
3.5 Analysis of Speech-Language Pathology and Audiology Board Agenda

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 categorized as:

- administrative (included electing a chairperson and appointing a replacement delegate for the ASLP-Interstate Compact Board);
- industry-related (included discussing legislation and providing updates on the compact);
- statutory duty[76] (included discussions about scope of practice, telehealth, and continuing education requirements); and
- complaint review (discussing compliance and conducting probation reviews).

The analysis excluded recurring agenda items with no substance, such as 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.[77]

[76] As defined by 58-1-202 and 58-1-203
[77] 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 Analysis

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".[78] 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 SLP complaints closed between 2017-2022. OPLR analysts read through case notes from both 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 SLPs. 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

[78] 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 SLPs because surgery is inherently far riskier, not because surgeons are "less safe" or less competent than SLPs.

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.

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 SLPs, SLP 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 SLP 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 SLP (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, SLPs, 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	
Utah Department of Commerce	**Margaret Busse**, Executive Director **Carolyn Dennis**, Deputy Director **Jacob Hart**, Deputy Director **Mark Steinagel**, Director, Division of Professional Licensing **Lisa Martin**, Bureau Manager, Division of Professional Licensing **Tracy Taylor**, Bureau Manager, Division of Professional Licensing **Lindsay Aagaard**, Licensing Specialist, Division of Professional Licensing **Brylee Vanderwarf**, Board Secretary, Division of Professional Licensing
Division of Professional Licensing (DOPL) Board	**Brooke Hammond**, Audiology Board Member, Speech-Language Pathology and Audiology Board **Lindsey Hardcastle**, Speech-Language Pathology Board Member, Speech-Language Pathology and Audiology Board **Robert Kraemer**, Speech-Language Pathology Board Member, Speech-Language Pathology and Audiology Board **Lauren Snyder**, Audiology Board Member, Speech-Language Pathology and Audiology Board
Utah Department of Health and Human Services	**Shandi Adamson**, Office Director, Division of Integrated Healthcare **Stephanie McVicar**, Program Manager, Early Hearing Detection and Intervention, Office of Children with Special Health Care

	Needs **Jenny Pedersen**, Coordinator, Children's Hearing Aid Program (CHAP), Office of Children With Special Health Care Needs **Jessie Rodriguez**, Health Program Manager, Division of Integrated Healthcare **Jim Stamos,** Director, Office of Healthcare Policy and Authorization at Utah Medicaid **Gregory Trollan**, Office Director, Division of Integrated Healthcare **Debi Walker,** Health Program Manager, Division of Integrated Healthcare **Shannon Wnek**, Audiologist, Early Hearing Detection and Intervention (EDHI), Office of Children with Special Health Care Needs
Utah State Board of Education	**Kristin Campbell**, Research Consultant **Megan Carlisle**, Educator License Equivalency Specialist **Jonathan Collins**, Research Consultant **Jordan DeHaan-Magalei**, Supporting Personnel and Preparation Coordinator **Kim Fratto**, Director of Special Education Programs **Maria Hawley**, Related Services Personnel Preparation Specialist **Malia Hite**, Executive Coordinator of Education Licensing **Lisa McLachlan**, Educator Preparation Coordinator
Industry Stakeholders	
Industry Associations	**Susan Adams**, Director of State Legislative & Regulatory Affairs, ASHA **Matt Hansen**, Executive Director, Homecare & Hospice Association of Utah **Kenyatta Jones Hunt**, Certification Program Director, National Board for Certification in Hearing Instrument Sciences **Katie Meyer**, Senior Director of Ethics, ASHA **Peter Mihalick**, Health Policy and Advocacy Director, International Hearing Society **McKenna Nobis**, President-Elect & SLP Clinician, Utah Speech-Language Hearing Association **Lee Robinson**, President, Utah Speech-Language Hearing Association; Professor, Brigham Young University Department of Communication Disorders **Christine Seitz**, Manager of Government Affairs, International Hearing Society **Allison Spangler**, President & CEO, Utah Health Care Association **Mary Stone**, Senior Certification Administrator, National Board for Certification in Hearing Instrument Sciences
Employers	**Jeffrey Elliott**, Optical/Hearing Regional Manager, Costco Wholesale **Joseph Kamerath**, Physical Medicine and Rehabilitation, Intermountain Health **Tammy Miller**, Director of Training for Hearing Aids, Costco Wholesale
Higher Education	**Sarah Hargus Ferguson**, Professor, University of Utah Department of Communication Sciences & Disorders

	Mark Rasmussen, Clinical Professor, University of Utah Department of Communication Sciences and Disorders **Teresa Ukrainetz**, Assistant Department Head & SLP Division Chair, Speech and Hearing Sciences, Utah State University
Subject-Matter Experts	
Academics, Researchers, & Clinicians	**Julie Barkmeier-Kraemer**, SLP Clinician & Professor, University of Utah Health **Jordan Bigler**, HIS, Pure Hearing **Joe Dansie**, AUD Clinician & Founder, Conditioned Play Innovations **Noah Hadley**, Clinical SLP, Copper Ridge Health Care - Skilled Nursing **Kate Johnson**, Clinical Audiologist, University of Utah Health **Harry Leibovich Sr.**, 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 Puntil**, 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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