

THE UNIVERSITY OF SOUTHERN MISSISSIPPI  
SPEECH AND HEARING CLINIC  
SEMESTER TREATMENT PLAN

CLINIC NUMBER \_\_\_\_\_

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ C.A. \_\_\_\_\_

TYPE OF DISORDER \_\_\_\_\_ SEMESTER \_\_\_\_\_

CLINICIAN \_\_\_\_\_ NO. SESSIONS PER WK. \_\_\_\_\_

LENGTH OF SESSION \_\_\_\_\_

PRESENT STATUS

SEMESTER GOALS

THERAPY PROCEDURES

Give specific descriptions of techniques used to achieve semester goals.

CRITERION

EVALUATION

APPROVED BY \_\_\_\_\_

Jane Doe, M.S., CCC-SLP, Supervisor

Date