

**SUPERVISION FORM 200 FOR THE SPEECH-LANGUAGE PATHOLOGY ASSISTANT AND  
PROVISIONAL SPEECH-LANGUAGE PATHOLOGY ASSISTANT LICENSE**

**JULY 2020**

**Licensee's Name:** \_\_\_\_\_ **License No.** \_\_\_\_\_  
**Place of Employment:** \_\_\_\_\_ **Work Setting:** \_\_\_\_\_  
**Check applicable boxes:**     Full time (21-40 hours)     Part time (20 hours or less)     9 month employee     12 month employee

**Direct Supervision**

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL	
Articulation Therapy																																	
Language Therapy																																	
Other Therapy																																	
Speech/Language Screening																																	
Hearing Screening																																	
Parent/Family/Teacher Conf																																	

**Indirect Supervision**

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL	
Review of client folders																																	
Telephone Conference																																	
Record-Keeping																																	
In-service/Staffing																																	
Ck Maintenance of Equipment																																	
Scheduling/Planning																																	
Consultation																																	

**I hereby attest that the supervision documented for this month is true and correct, and that the supervision represented actually occurred. I understand that supervision records must be kept for a period of 3 years by the supervisor and supervisee and that the Board may request such documentation.**

Supervisor Signature	License #	Supervisee Signature	License #
Supervisor's Printed Name		Supervisee's Printed Name	
Supervisor's Address		Supervisee's Address	

**SUPERVISION FORM 200 FOR THE SPEECH-LANGUAGE PATHOLOGY ASSISTANT AND  
PROVISIONAL SPEECH-LANGUAGE PATHOLOGY ASSISTANT LICENSE**

**AUGUST 2020**

**Licensee's Name:** \_\_\_\_\_ **License No.** \_\_\_\_\_  
**Place of Employment:** \_\_\_\_\_ **Work Setting:** \_\_\_\_\_  
**Check applicable boxes:**     Full time (21-40 hours)     Part time (20 hours or less)     9 month employee     12 month employee

**Direct Supervision**

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Supervisor's Printed Name		Supervisee's Printed Name	
Supervisor's Address		Supervisee's Address	

**SUPERVISION FORM 200 FOR THE SPEECH-LANGUAGE PATHOLOGY ASSISTANT AND  
PROVISIONAL SPEECH-LANGUAGE PATHOLOGY ASSISTANT LICENSE**

**SEPT 2020**

**Licensee's Name:** \_\_\_\_\_ **License No.** \_\_\_\_\_  
**Place of Employment:** \_\_\_\_\_ **Work Setting:** \_\_\_\_\_  
**Check applicable boxes:**     Full time (21-40 hours)     Part time (20 hours or less)     9 month employee     12 month employee

**Direct Supervision**

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Articulation Therapy					■	■						■	■						■	■						■	■							■		
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Other Therapy					■	■						■	■						■	■							■	■							■	
Speech/Language Screening					■	■						■	■						■	■							■	■							■	
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**Indirect Supervision**

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL				
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Scheduling/Planning					■	■						■	■						■	■							■	■							■	
Consultation					■	■						■	■						■	■							■	■							■	

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Supervisor's Printed Name		Supervisee's Printed Name	
Supervisor's Address		Supervisee's Address	

**SUPERVISION FORM 200 FOR THE SPEECH-LANGUAGE PATHOLOGY ASSISTANT AND  
PROVISIONAL SPEECH-LANGUAGE PATHOLOGY ASSISTANT LICENSE**

**OCTOBER 2020**

**Licensee's Name:** \_\_\_\_\_ **License No.** \_\_\_\_\_  
**Place of Employment:** \_\_\_\_\_ **Work Setting:** \_\_\_\_\_  
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**Direct Supervision**

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Supervisor's Printed Name		Supervisee's Printed Name	
Supervisor's Address		Supervisee's Address	

**SUPERVISION FORM 200 FOR THE SPEECH-LANGUAGE PATHOLOGY ASSISTANT AND  
PROVISIONAL SPEECH-LANGUAGE PATHOLOGY ASSISTANT LICENSE**

**NOVEMBER 2020**

**Licensee's Name:** \_\_\_\_\_ **License No.** \_\_\_\_\_  
**Place of Employment:** \_\_\_\_\_ **Work Setting:** \_\_\_\_\_  
**Check applicable boxes:**     Full time (21-40 hours)     Part time (20 hours or less)     9 month employee     12 month employee

**Direct Supervision**

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Supervisor's Printed Name		Supervisee's Printed Name	
Supervisor's Address		Supervisee's Address	

**SUPERVISION FORM 200 FOR THE SPEECH-LANGUAGE PATHOLOGY ASSISTANT AND  
PROVISIONAL SPEECH-LANGUAGE PATHOLOGY ASSISTANT LICENSE**

**DECEMBER 2020**

**Licensee's Name:** \_\_\_\_\_ **License No.** \_\_\_\_\_  
**Place of Employment:** \_\_\_\_\_ **Work Setting:** \_\_\_\_\_  
**Check applicable boxes:**     Full time (21-40 hours)     Part time (20 hours or less)     9 month employee     12 month employee

**Direct Supervision**

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Supervisor's Printed Name		Supervisee's Printed Name	
Supervisor's Address		Supervisee's Address	

**SUPERVISION FORM 200 FOR THE SPEECH-LANGUAGE PATHOLOGY ASSISTANT AND  
PROVISIONAL SPEECH-LANGUAGE PATHOLOGY ASSISTANT LICENSE**

**JANUARY 2021**

**Licensee's Name:** \_\_\_\_\_ **License No.** \_\_\_\_\_  
**Place of Employment:** \_\_\_\_\_ **Work Setting:** \_\_\_\_\_  
**Check applicable boxes:**     Full time (21-40 hours)     Part time (20 hours or less)     9 month employee     12 month employee

**Direct Supervision**

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Supervisor's Printed Name		Supervisee's Printed Name	
Supervisor's Address		Supervisee's Address	

**SUPERVISION FORM 200 FOR THE SPEECH-LANGUAGE PATHOLOGY ASSISTANT AND  
PROVISIONAL SPEECH-LANGUAGE PATHOLOGY ASSISTANT LICENSE**

**FEBRUARY 2021**

**Licensee's Name:** \_\_\_\_\_ **License No.** \_\_\_\_\_  
**Place of Employment:** \_\_\_\_\_ **Work Setting:** \_\_\_\_\_  
**Check applicable boxes:**     Full time (21-40 hours)     Part time (20 hours or less)     9 month employee     12 month employee

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Articulation Therapy						■	■						■	■							■	■							■	■	■	
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Ck Maintenance of Equipment						■	■						■	■							■	■							■	■	■	
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Consultation						■	■						■	■							■	■							■	■	■	

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Supervisor Signature	License #	Supervisee Signature	License #
Supervisor's Printed Name		Supervisee's Printed Name	
Supervisor's Address		Supervisee's Address	



**SUPERVISION FORM 200 FOR THE SPEECH-LANGUAGE PATHOLOGY ASSISTANT AND  
PROVISIONAL SPEECH-LANGUAGE PATHOLOGY ASSISTANT LICENSE**

**MARCH 2021**

**Licensee's Name:** \_\_\_\_\_ **License No.** \_\_\_\_\_  
**Place of Employment:** \_\_\_\_\_ **Work Setting:** \_\_\_\_\_  
**Check applicable boxes:**     Full time (21-40 hours)     Part time (20 hours or less)     9 month employee     12 month employee

**Direct Supervision**

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Articulation Therapy						■	■						■	■							■	■					■	■					
Language Therapy						■	■						■	■							■	■					■	■					
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Speech/Language Screening						■	■						■	■							■	■					■	■					
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Supervisor Signature	License #	Supervisee Signature	License #
Supervisor's Printed Name		Supervisee's Printed Name	
Supervisor's Address		Supervisee's Address	

**SUPERVISION FORM 200 FOR THE SPEECH-LANGUAGE PATHOLOGY ASSISTANT AND  
PROVISIONAL SPEECH-LANGUAGE PATHOLOGY ASSISTANT LICENSE**

**APRIL 2021**

**Licensee's Name:** \_\_\_\_\_ **License No.** \_\_\_\_\_  
**Place of Employment:** \_\_\_\_\_ **Work Setting:** \_\_\_\_\_  
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Supervisor Signature	License #	Supervisee Signature	License #
Supervisor's Printed Name		Supervisee's Printed Name	
Supervisor's Address		Supervisee's Address	

**SUPERVISION FORM 200 FOR THE SPEECH-LANGUAGE PATHOLOGY ASSISTANT AND  
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**MAY 2021**

**Licensee's Name:** \_\_\_\_\_ **License No.** \_\_\_\_\_  
**Place of Employment:** \_\_\_\_\_ **Work Setting:** \_\_\_\_\_  
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Supervisor Signature _____ License # _____		Supervisee Signature _____ License # _____	
Supervisor's Printed Name _____		Supervisee's Printed Name _____	
Supervisor's Address _____		Supervisee's Address _____	

**SUPERVISION FORM 200 FOR THE SPEECH-LANGUAGE PATHOLOGY ASSISTANT AND  
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**JUNE 2021**

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**Indirect Supervision**

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Supervisor's Printed Name		Supervisee's Printed Name	
Supervisor's Address		Supervisee's Address	