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

Month_____Year_____

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