

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

JULY 2019

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 2019

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 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**

SEPT 2019

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 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**

OCTOBER 2019

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 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**

NOVEMBER 2019

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 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**

DECEMBER 2019

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 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**

JANUARY 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 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**

FEBRUARY 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 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 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	
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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 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

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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**

MAY 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 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**

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