

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

June 2022

Supervisee'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				■	■						■	■						■	■						■	■												■	
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. Submission of inaccurate or falsified supervision documentation may result in disciplinary action.

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

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

July 2022

Supervisee'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		■	■						■	■						■	■						■	■							■	■	
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. Submission of inaccurate or falsified supervision documentation may result in disciplinary action.

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

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

August 2022

Supervisee'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						■	■						■	■							■	■					■	■					
Scheduling/Planning						■	■						■	■							■	■					■	■					
Consultation						■	■						■	■							■	■					■	■					

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

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

September 2022

Supervisee'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			■	■						■	■						■	■						■	■									■
Scheduling/Planning			■	■						■	■						■	■						■	■									■
Consultation			■	■						■	■						■	■						■	■									■

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

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

October 2022

Supervisee'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	■	■						■	■						■	■						■	■						■	■			
Scheduling/Planning	■	■						■	■						■	■						■	■						■	■			
Consultation	■	■						■	■						■	■						■	■						■	■			

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

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

November 2022

Supervisee'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					■	■						■	■						■	■					■	■														■	
Scheduling/Planning					■	■						■	■						■	■					■	■														■	
Consultation					■	■						■	■						■	■					■	■														■	

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

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

December 2022

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

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

January 2023

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

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

February 2023

Supervisee'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				■	■						■	■						■	■						■	■			■	■	■	
Scheduling/Planning				■	■						■	■						■	■						■	■			■	■	■	
Consultation				■	■						■	■						■	■						■	■			■	■	■	

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

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

March 2023

Supervisee's Name: _____	License No. _____
Place of Employment: _____	Work Setting: _____
Check applicable boxes: <input type="checkbox"/> Full time (21-40 hours) <input type="checkbox"/> Part time (20 hours or less) <input type="checkbox"/> 9 month employee <input type="checkbox"/> 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																																	
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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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Supervisee Signature _____	Supervisor Signature _____
License # _____	License # _____
Supervisee's Printed Name _____	Supervisor's Printed Name _____
Supervisee's Address _____	Supervisor's Address _____

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

April 2023

Supervisee'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	■	■						■	■						■	■						■	■						■	■	■	
Scheduling/Planning	■	■						■	■						■	■						■	■						■	■	■	
Consultation	■	■						■	■						■	■						■	■						■	■	■	

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

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

May 2023

Supervisee's Name: _____	License No. _____
Place of Employment: _____	Work Setting: _____
Check applicable boxes: <input type="checkbox"/> Full time (21-40 hours) <input type="checkbox"/> Part time (20 hours or less) <input type="checkbox"/> 9 month employee <input type="checkbox"/> 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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Language Therapy																																	
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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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Supervisee Signature _____	Supervisor Signature _____
License # _____	License # _____
Supervisee's Printed Name _____	Supervisor's Printed Name _____
Supervisee's Address _____	Supervisor's Address _____

