Reset Form

CHANGE OR ADDITION OF SPEECH-LANGUAGE SUPPORT PERSONNEL SUPERVISOR'S INFORMATION

State Form 56278 (R / 6-22)

SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY BOARD
PROFESSIONAL LICENSING AGENCY
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INSTRUCTIONS:

1. *Please complete this form only if you are changing supervisors, but are still with the same employer. If you have changed employers you must complete a new Registration application and obtain a new license number.*
2. *No fee due for this application.*
3. *Complete **SECTION A** and forward this form to your field supervisor.*
4. ***SECTION C** must be completed by a speech-language pathologist licensed by the board.*
5. *List any additional work site addresses on a separate sheet of paper.*

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is mandatory and this record cannot be processed without it.

Are you submitting this form because you have changed employers? ☐ Yes ☐ No	*If Yes, you do not need to submit this form. Instead, you need to submit a new application and obtain a new license number.*

SECTION A - APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden or previous name*)		Social Security Number *
Level of supervision (*Please check one only.*) ☐ Aide ☐ Associate ☐ Assistant	Current license number	Type of change (*Please check one only.*) ☐ Changing Supervisor ☐ Adding Supervisor

Please delete the following supervisor(s). Use a separate page, if necessary.

NAME	LICENSE NUMBER

The following supervisor(s) should remain as my supervisor(s).

NAME	LICENSE NUMBER

SECTION B - EMPLOYER INFORMATION

Name of employer (*school, hospital, facility, company*)	
Address (*number and street or rural route, city, state, and ZIP code*)	
Telephone number ( )	E-mail address

SECTION C - SUPERVISOR'S INFORMATION

Name of new supervisor (*last, first, middle, maiden or previous name*)			Number of years of clinical experience
Indiana license number	Date of expiration (*month, day, year*)	ASHA certification number	Date of expiration (*month, day, year*)
Address (*number and street or rural route, city, state, and ZIP code*)			
Daytime telephone number ( )	E-mail address		

Please list the name(s) and registration number(s) of the support personnel currently registered under your license.

NAME	REGISTRATION NUMBER

Signature of supervisor	Date (*month, day, year*)
Signature of Aid / Associate / Asssitant	Date (*month, day, year*)