Reset Form

VERIFICATION OF SPEECH-LANGUAGE SUPPORT PERSONNEL SUPERVISOR'S INFORMATION

State Form 57794 (4-25)
INDIANA PROFESSIONAL LICENSING AGENCY
Approved by State Board of Accounts, 2017

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

1. *Complete **SECTION A** and forward this form to your field supervisor.*
2. ***SECTION B** must be completed by a speech-language pathologist licensed by the board.*
3. *List any additional work site addresses on a separate sheet of paper.*
4. *Return this form to the address listed above.*

* 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.

SECTION A / APPLICANT INFORMATION

Name of applicant (first, middle, last, maiden or previous name)	Social Security Number *

Level of supervisor *(please check one only)*

☐ Aide ☐ Associate ☐ Assistant

SECTION B / SUPERVISOR'S INFORMATION

Name of supervisor *(first, middle, last, 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)***

NAME OF SCHOOL / HOSPITAL / FACILITY / COMPANY WHERE THE SUPPORT PERSONNEL WILL BE EMPLOYED

Name of school / hospital / facility / company		
Address *(number and street or rural route)*		
City	State	ZIP Code
Telephone number	E-mail address	

ADDRESS OF LOCATION WHERE SERVICES WILL BE PROVIDED

Address of location *(number and street or rural route)*		
City	State	ZIP Code

SUPPORT PERSONNEL REGISTERED UNDER YOUR LICENSE

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

NAME	REGISTRATION NUMBER

AFFIRMATION

I hereby swear or affirm under the penalties of perjury that the statements made in this application are true, complete, and correct. I shall be responsible for supervision of the support personnel for whom this application is submitted in compliance with requirements set forth in IC 25-35.6-1-2 (g) and IAC 1-2.1.

Signature of supervisor	Date *(month, day, year)*