Reset Form

VERIFICATION OF CLINICAL EXPERIENCE FOR SLP SUPPORT PERSONNEL – ASSISTANT

State Form 57796 (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 then forward this form to your previous or current speech-language pathology (SLP) supervisor(s) for completion of **SECTION B**.*
2. *Submit proof that you have acquired at least one hundred (100) hours of clinical experience.*
3. *This form may be duplicated if your one hundred (100) hours of experience have been completed under more than one (1) SLP supervisor.*
4. ***SECTION B** must be completed by the applicant's previous or current supervisor and sent directly 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 *
Name of SLP supervisor (first, middle, last, maiden or previous name)	License number of SLP supervisor
Location of clinical experience	Dates of clinical experience *(month, day, year)*

SECTION B / CLINICAL EXPERIENCE / SUPERVISOR'S INFORMATION	
Total number of hours the above-named applicant served in the clinical experience	Total number of hours obtained with direct face-to-face patient/client contact
Number of hours of direct face-to-face patient/client contact in speech disorders obtained by the above-named applicant	Number of hours of direct face-to-face patient/client contact in language disorders obtained by the above-named applicant
I swear that the above information is true and correct to the best of my knowledge and belief.	
Signature of SLP supervisor	Date signed *(month, day, year)*
Printed name of SLP supervisor	Daytime telephone number