Reset Form

APPLICATION FOR TRANSFER OR ADDITION OF SUPERVISION SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY CLINICAL FELLOWSHIP YEAR

State Form 50321 (R4 / 2-14)

SPEECH LANGUAGE PATHOLOGY AUDIOLOGY BOARD
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2067
E-mail: pla4@pla.IN.gov

INSTRUCTIONS: Please type or print and answer all questions.

*** Your Social Security number is being requested by this state agency in accordance with I.C. 25-1-5-11. Disclosure is mandatory, and this record cannot be processed without it.**

FOR OFFICE USE ONLY			
DATE RECEIVED (*month, day, year*)		**DATE COMPLETED (*month, day, year*)**	

DO NOT WRITE ABOVE THIS LINE - FOR OFFICE USE ONLY

Check one only: ☐ Transfer of Supervision ☐ Addition of Supervision

APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden*)		Social Security number*
Registration number	Expiration date (*month, day, year*)	
Address (*number and street or rural route*)		
City	State	ZIP code
Date of birth *(month, day, year)*	Place of birth (*city and state or country*)	
Telephone number (*daytime*) ( )	E-mail address	

NAME OF CURRENT SUPERVISOR

Name of current supervisor	License number

NAME OF NEW SUPERVISOR

Name of new supervisor	License number

DATES OF NEW CLINICAL FELLOWSHIP

STARTING DATE (*month, day, year*)	COMPLETION DATE (*month, day, year*)

LOCATION OF NEW CLINICAL FELLOWSHIP

Name of hospital or facility		
Address (*number and street, or rural route*)		
City	State	ZIP code
Telephone number ( )	E-mail address	

LIST ANY ADDITIONAL WORK SITE ADDRESSES ON A SEPARATE SHEET OF PAPER

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct. I am aware of the requirements set forth in 880 IAC 1-1-3.1 and understand that I may practice under the direct supervision of the person whose name appears on this application until the expiration of my registration.

Signature of applicant	Date signed (*month, day, year*)

CLINICAL FELLOW SUPERVISOR'S INFORMATION

PLEASE TYPE OR PRINT AND ANSWER ALL QUESTIONS.

NEW SUPERVISOR'S INFORMATION

Name (*last, first, middle, maiden*)			
Indiana license number	Expiration date (*month, day, year*)	ASHA certification number	Expiration date (*month, day, year*)
Address (*number and street, or rural route*)			
City		State	ZIP code
Telephone number ( )		E-mail address	

CLINICAL FELLOW INFORMATION

I will be supervising the following clinical fellow, at the dates indicated and at the following location(s):

Name of clinical fellow	Social Security number *
Starting date (*month, day, year*)	Completion date (*month, day, year*)
Name of hospital or facility	
Address (*number and street, or rural route*)	

City	State	ZIP code
Telephone number ( )	E-mail address	

LIST ANY ADDITIONAL WORK SITE ADDRESSES ON A SEPARATE SHEET OF PAPER

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct. I am aware of the requirements set forth in 880 IAC 1-1-3.1 and understand and agree that I shall supervise the person for whom this application is submitted.

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