

# Form 4A

The University of the State of New York  
 THE STATE EDUCATION DEPARTMENT  
 Office of the Professions  
 Division of Professional Licensing Services  
 www.op.nysed.gov

**Speech-Language Pathologist**

**Audiologist**

## Identification of Supervisor and Setting

### Applicant Instructions

An Application for Licensure (Form 1) and Certification of Professional Education (Form 2) must be received and approved before this form can be reviewed.

1. Complete Section I. In item 3, enter your name exactly as it appears on your Application for Licensure (Form 1).
2. Have your supervisor complete Section II, Part A.
3. Complete the rest of Section II with your employer and/or supervisor and send the entire form directly to the Office of the Professions at the address at the end of this form.

### Section I: Applicant Information

**1 Social Security Number**             **2 Birth Date** Month   Day   Year    
*(Leave this blank if you do not have a U.S. Social Security Number)*

**3 Print Name As It Appears On Your Application for Licensure (Form 1)**

Last                       
 First                      
 Middle

**5 Telephone/E-Mail Address**

Daytime phone

Area Code Phone

**E-mail Address** (please print clearly)

**4 Mailing Address** (You must notify the Department promptly of any address or name changes.)

Line 1                       
 Line 2                       
 Line 3                       
 City                       
 State   Zip Code                     
 Country/Province

### Section II: Identification of Supervisor and Setting

#### Part A - Identification of the Supervisor

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Business Address: \_\_\_\_\_  
 \_\_\_\_\_

Telephone: \_\_\_\_\_ ext. \_\_\_\_\_ Fax number: \_\_\_\_\_ E-mail: \_\_\_\_\_

Are you employed at the same place of employment as the applicant?  Yes  No

If yes, how many hours per week are you employed there? \_\_\_\_\_

#### Credentials

Supervision must be provided by a New York State licensed Speech-Language Pathologist or Audiologist except experience gained outside New York State or in an exempt setting may be provided by a person with the ASHA Certificate of Clinical Competence.

New York State license number: \_\_\_\_\_

ASHA number (if applicable): \_\_\_\_\_

**Section II: Identification of Supervisor and Setting (continued)**

**Part B - Applicant Experience Information**

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Site: \_\_\_\_\_

Address: \_\_\_\_\_

Site: \_\_\_\_\_

Address: \_\_\_\_\_

If more than 2 sites, please attach an additional sheet of paper listing the name and address of each site.

Beginning date of supervised period: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Ending date of supervised period: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr. mo. day yr.

Total number of hours per week worked by the applicant: \_\_\_\_\_.

(Note: If working part-time, the applicant must meet the full-time requirement of at least 36 weeks.)

**Part C - Supervised Experience Requirements**

To successfully complete the supervised experience in Speech Language Pathology the applicant must meet all the following requirements:

- Complete at least 36 weeks of supervised experience within any four-year period following completion of the educational program. (A week of acceptable experience is defined as not less than 35 clock hours.)
- If the experience is part-time, it must be accumulated at the rate of not less than 12 hours per week for continuous periods of not less than six months.
- Supervision of the experience shall include meeting with and observing the applicant on a regular basis to review and evaluate the supervised experience and to foster professional development; regular observation of the applicant while the applicant is providing assessment and intervention services; and take place at the beginning of the treatment and periodically throughout the treatment. The supervisor shall be familiar with the applicant's treatment plans, have ongoing involvement in the care provided, and review the need for ongoing services. Please note that the New York State Board for Speech-Language Pathology & Audiology recommends a minimum of 3 hours per week of direct supervision.

Audiology applicants should review the Web site at [www.op.nysed.gov/prof/slpa](http://www.op.nysed.gov/prof/slpa) or contact the Audiology Board office by e-mailing [speechbd@mail.nysed.gov](mailto:speechbd@mail.nysed.gov) for a description of experience requirements.

**Part D - Applicant/Supervisor/Employer Certification of Agreement to the Plan for Supervision**

\_\_\_\_\_  
Signature of applicant Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr.

\_\_\_\_\_  
Signature of supervisor Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr.

**Employer Certification**

Employment must be verified by an official administrator other than the supervisor.

As the employer of the applicant, I agree to the proposed plan of supervision:

Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr.

Print or type name \_\_\_\_\_

Title \_\_\_\_\_

**Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Speech-Language Pathology and Audiology Unit, 89 Washington Avenue, Albany, NY 12234-1000.**