

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/speechlic.htm or contact the Audiology Board office at 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.