FORM 4B

☐ **Speech Language Pathologist**

☐ **Audiologist**

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

RECORD OF SUPERVISED EXPERIENCE

APPLICANT INSTRUCTIONS

1. Complete Section I, Applicant Information. Enter your name as it appears on your licensure application (Form 1). Be sure to sign and date item 6.

2. Have your supervisor complete Section II, Verification of Supervised Experience and forward the form directly to the Office of the Professions at the address at the end of this form at the **end** of the supervised experience. This form will not be accepted by the Office of the Professions if not submitted by the supervisor.

SECTION I
APPLICANT INFORMATION

1 SOCIAL SECURITY NUMBER ☐☐☐-☐☐-☐☐☐☐

(Leave this blank if you do not have a U.S. Social Security Number)

2 BIRTH DATE ☐☐ ☐☐ ☐☐

Month Day Year

3 PRINT NAME EXACTLY AS IT APPEARS ON YOUR LICENSURE APPLICATION (FORM 1)

Last

First

Middle

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

5 Name of supervisor: ______________________________

Address of supervisor: ______________________________

____

Duration of supervised experience:

Date beginning: _______ / _______ / _______
mo. day yr.

Date ending: _______ / _______ / _______
mo. day yr.

6 I request and give my permission to the individual named in item 5 above to complete Section II of this form and mail it to the New York State Education Department and to release any other information required by the State Education Department in connection with my application for licensure.

Applicant's signature: ______________________________ Date: _______ / _______ / _______
mo. day yr.

SECTION II: VERIFICATION OF SUPERVISED EXPERIENCE (This form will not be accepted if not sent directly by the supervisor.)

Instructions to the supervisor: Complete Section II, items A-D, sign and date the attestation and send this form directly to the Office of the Professions at the address at the end of this form.

A. Name of Supervisor: ______________________________

Duration of Supervised Experience:

Date beginning: ______ / ______ / ______ (mo. / day / yr.) Date ending: ______ / ______ / ______ (mo. / day / yr.) Total Months: ____________

B. Complete the chart below only if significant changes have taken place in the applicant's supervisory plan originally described on the Form 4A, "Identification of Supervisor and Setting".

	APPLICANT ACTIVITY Hrs. per week	SUPERVISORY ACTIVITY Direct Observation Hrs. per week
1. Diagnosis, Evaluation and Testing	____________	____________
2. Screening	____________	____________
3. Habilitation and Rehabilitation	____________	____________
4. Consultation and Conference	____________	____________
5. Staff Meeting	____________	____________
6. Instruction	____________	____________
7. Preparation and Record keeping	____________	____________
8. Other (Specify) ______________________________ ______________________________	____________	____________
TOTAL	____________	____________

C. Verification of professional experience:

As supervisor of the applicant, I verify that I am familiar with the guidelines for professional competence listed below and that I have used them, as appropriate, in supervising.

Guidelines for Professional Competence

General – The applicant

1. Demonstrates ability to communicate effectively.
2. Demonstrates understanding of human growth and development.
3. Demonstrates professional responsibility and conduct.
4. Displays understanding of the roles and responsibilities of other professionals and the importance of interdisciplinary cooperation.

Specific – The applicant

1. Applies a functional understanding of communication development in the delivery of clinical services.
2. Uses appropriate, representative methods and materials in diagnosis/assessment.
3. Effectively uses appropriate equipment in diagnosis/assessment and treatment/remediation.
4. Plans, organizes, and implements an effective and efficient treatment/remediation program.
5. Displays a fundamental knowledge of the principles underlying the treatment/remediation of communication disorders, uses appropriate methods and techniques in the provision of services, and maintains appropriate records.

D. Attestation:

1. ______________________________ (Name of applicant) has ☐ has not ☐ successfully completed a supervised experience for the duration of time indicated herein and I declare that I have completed the above form and that the statements made are true, complete and correct.

______________________________ Date: ______ / ______ / ______
Signature of supervisor (mo. / day / yr.)

2. Comments: (Please attach a separate sheet, if additional space is needed) ______________________________

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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.**