Complete forms may be sent to the board office at info@floridasspeechaudiology.gov, or mailed to:

Board *of* Speech-Language Pathology & Audiology
4052 Bald Cypress Way Bin C-06
Tallahassee, FL 32399-3256

Board *of* Speech-Language Pathology & Audiology
Supervisory Report for Provisional Licensees

Applicant Name: _____

Select the appropriate license type:			
☐	Speech-Language Pathologist	☐	Audiologist

Each evaluator must complete a separate form verifying the professional employment experience they supervised.

I. General Information		
Evaluator Name:		
Business Phone:		
Evaluator License Number:	☐ Speech-Language Pathologist	☐ Audiologist
Evaluator Business Address:		
Office or Agency Where Experience Took Place:		
Office or Agency Address:		
Office or Agency Phone:		
II. Evaluation Period		
List the applicant's dates of professional employment experience below.		
Beginning (MM/DD/YYYY):	Ending (MM/DD/YYYY):	Total # Weeks Worked:
Number of hours the applicant worked per week:		
Signature of Provisional Licensee:		Date (MM/DD/YYYY):
Signature of Evaluator:		Date (MM/DD/YYYY):

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Tallahassee, FL 32399-3256

Board *of* Speech-Language Pathology & Audiology Supplementary Evaluation for Each One Third of the Professional Employment Experience

Provisional Licensee Name: _____

Select the appropriate license type:			
☐	Speech-Language Pathologist	☐	Audiologist

I. Evaluation: First One-Third			
Area	**Below**	**Achieves**	**Exceeds**
1. Assessment/Diagnosis	☐	☐	☐
2. Habilitation/Rehabilitation	☐	☐	☐
3. Client/Patient Counseling	☐	☐	☐
4. Record Keeping	☐	☐	☐
5. Other	☐	☐	☐
Signature of Evaluator:			Date (MM/DD/YYYY):

II. Evaluation: Second One-Third			
Area	**Below**	**Achieves**	**Exceeds**
1. Assessment/Diagnosis	☐	☐	☐
2. Habilitation/Rehabilitation	☐	☐	☐
3. Client/Patient Counseling	☐	☐	☐
4. Record Keeping	☐	☐	☐
5. Other	☐	☐	☐
Signature of Evaluator:			Date (MM/DD/YYYY):

III. Evaluation: Third One-Third			
Area	**Below**	**Achieves**	**Exceeds**
1. Assessment/Diagnosis	☐	☐	☐
2. Habilitation/Rehabilitation	☐	☐	☐
3. Client/Patient Counseling	☐	☐	☐
4. Record Keeping	☐	☐	☐
5. Other	☐	☐	☐
Signature of Evaluator:			Date (MM/DD/YYYY):
Signature of Provisional Licensee:			Date (MM/DD/YYYY):

Board *of* Speech-Language Pathology & Audiology
Supplementary Evaluation for Each One Third of the Professional Employment Experience

Provisional Licensee Name: _____

IV. Type of Evaluation Activity	
Activity	**Hours Per Week Spent by Provisional Licensee Performing Activity**
1. Assessment/Diagnosis	
2. Habilitation/Rehabilitation	
3. Client/Patient Counseling	
4. Record Keeping	
5. Other	
Total Hours:	

Indicate below the number of hours per week you spent providing on-site observation or other monitoring activities to the provisional licensee.

V. Evaluator's On-Site Observations and Monitoring Activities		
Activity	**On-Site Observations**	**Monitoring Activities**
1. Assessment/Diagnosis		
2. Habilitation/Rehabilitation		
3. Client/Patient Counseling		
4. Record Keeping		
5. Other		
Total Hours:	**Total # of On-Site Visits:**	**Total # of Monitoring Visits:**

VI. Certification	
I have discussed this report with the provisional licensee, and I recommend the provisional licensee for active licensure. I certify that the above information is true and correct to the best of my knowledge.	
Evaluator Signature:	Date (MM/DD/YYYY):
I have read and discussed this report with my evaluator. I certify that the above information is true and correct to the best of my knowledge.	
Provisional Licensee Signature:	Date (MM/DD/YYYY):