SUPPLEMENTARY EVALUATION FOR EVERY THREE MONTHS OF THE PROFESSIONAL EMPLOYMENT EXPERIENCE

Form SPA-2B

Print clearly in black ink or type the following information.

APPLICANT NAME _____.

Check one: ☐ 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:

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:

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:

Signature of Provisional Licensee: Date:

DH-SPA-2B Effective 3/25/1991 Reference 64B20-2.004 (3)

TURN PAGE OVER AND COMPLETE OTHER SIDE.

Board of Speech-Language Pathology and Audiology
4052 Bald Cypress Way, Bin C06, Tallahassee, FL 32399-3256
Telephone: (850) 245-4161 FAX: (850) 921-6184

Applicant Name _____

IV. TYPE OF EVALUATION ACTIVITY

Activity	Number of 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	

V. EVALUATOR'S ON-SITE OBSERVATIONS AND MONITORING ACTIVITIES

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

Activity	On-site Observations	Monitoring Activities
1. Assessment/Diagnosis		
2. Habilitation/Rehabilitation		
3. Client/Patient Counseling		
4. Record Keeping		
5. Other		
TOTAL HOURS:		
TOTAL NUMBER OF ON-SITE VISITS:		
TOTAL NUMBER 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.

_____
_____
Signature of Evaluator Date

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.

_____ _____
Signature of Provisional Licensee Date

SUPERVISORY REPORT FOR PROVISIONAL LICENSEES

Form SPA-2C

Print clearly in black ink or type the following information:

APPLICANT NAME _____.

Check one: ☐ Speech-Language Pathologist ☐ Audiologist

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

I. GENERAL INFORMATION

Evaluator's Name: Business Phone:

Evaluator's License Number: ☐ Speech-Language Pathologist ☐ Audiologist

Evaluator's Business Address:

Office or Agency where experience took place:

Office or Agency Address:

Office or Agency Phone:

II. EVALUATION PERIOD

A. Dates of the applicant's professional employment experience:

Beginning: _____ Ending: _____ = _____
month/day/year month/day/year total number of weeks worked

B. Number of hours the applicant worked per week:

Signature of Provisional Licensee: Date:

Signature of Evaluator: Date:

DH-SPA-2C Effective 3/25/1991 Reference 64B20-2.004 (3)

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