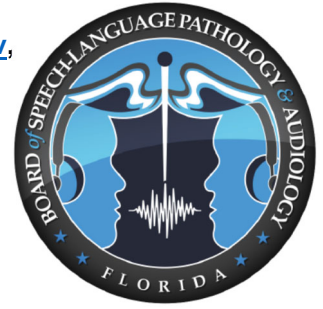


Complete forms may be sent to the board office at info@floridasspeechaudiology.gov, or mailed to:

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



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

Page 1 of 2

Provisional Licensee Name: _____

| Select the appropriate license type: | |
|--|--------------------------------------|
| <input type="checkbox"/> Speech-Language Pathologist | <input type="checkbox"/> 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

Page 2 of 2



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): |

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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: | |
|--|--------------------------------------|
| <input type="checkbox"/> Speech-Language Pathologist | <input type="checkbox"/> 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: | <input type="checkbox"/> Speech-Language Pathologist | <input type="checkbox"/> 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): |