FORM A-1
VERIFICATION OF SLP SUPPORT PERSONNEL FIELD EXPERIENCE – ASSOCIATE

Part of State Form 53764 (R10 / 10-22)
Approved by State Board of Accounts, 2017

INSTRUCTIONS:

*1. Complete **SECTION A** and forward this form to your field supervisor.*
*2. **SECTION B** must be completed by an official of the institution that has granted you the academic credit for this supervised field experience.*
3. Return this form to:

Indiana Professional Licensing Agency
402 West Washington Street, Room W072
Indianapolis, IN 46024

SECTION A / APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden or previous name*)	Social Security Number *

My minimum one hundred (100) hour supervised field experience was completed under the auspices of the following educational institution:

_____ located at _____
Name of Institution *City and State*

I completed the supervised field experience between the following dates:

_____ _____
Date began (month / year) *Date completed (month / year)*

I completed the supervised field experience at the following location:

_____
Specific location of field experience

SECTION B / VERIFICATION OF COMPLETION OF THE ONE HUNDRED (100) HOUR FIELD EXPERIENCE

As an official of the school named above, I certify that the above-named applicant has completed at least the following experience during the completion of the supervised field experience:

(1) Applicant has completed at least a one hundred (100) hour field experience that enabled the applicant to develop the core technical skills needed to assist in the treatment of communication disorders.

As an official of the school named above, I certify that the above-named applicant was valuated throughout the field experience and the applicant's performance was satisfactory.

I further certify that the supervision for this field experience was conducted by either a program faculty member or a supervisor working under the supervision of a program faculty member. The applicant's supervisor(s) held the following position(s), degree(s), license(s), and / or certification(s) – *(Provide name(s) and qualification(s) below):*

Program faculty member	
Alternate supervisor	
Site supervisor	
Position held at the institution	Name of institution
Name (*last, first, middle, maiden or previous name*)	

SUPERVISION OF SPEECH-LANGUAGE PATHOLOGY SUPPORT PERSONNEL

1. Support personnel's level of academic training.

2. Specify method of supervision.

3. Specify training program

4. Specify all procedures to be performed by the support personnel.

5. Describe in detail the pertinent educational and work experience for the support personnel for which authorization is sought.

APPLICATION AFFIRMATION

I hereby swear or affirm under penalties of perjury, that the statements made in this application are true, complete, and correct. I shall be responsible for the direct supervision of the support personnel for whom the application is submitted in compliance with requirements set forth in IC 25-35.6-1-2 (g) and 880 IAC 1-2.1.

Signature of supervisor	Date *(month, day, year)*