



**APPLICATION FOR TRANSFER OF SUPERVISION
SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY
CLINICAL FELLOWSHIP YEAR**

State Form 50321 (R2 / 3-11)

**SPEECH LANGUAGE PATHOLOGY AUDIOLOGY BOARD
PROFESSIONAL LICENSING AGENCY**
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2064
E-mail: pla5@pla.IN.gov

*** Your Social Security number is being requested by this state agency in accordance with I.C. 25-1-5-11. Disclosure is mandatory, and this record cannot be processed without it.**

FOR OFFICE USE ONLY

| | | | |
|--|--|---|--|
| DATE RECEIVED (<i>month, day, year</i>) | | DATE COMPLETED (<i>month, day, year</i>) | |
|--|--|---|--|

DO NOT WRITE ABOVE THIS LINE - FOR OFFICE USE ONLY

PLEASE TYPE OR PRINT AND ANSWER ALL QUESTIONS.

APPLICANT INFORMATION

| | | | |
|--|---|---|----------|
| Name of applicant (<i>last, first, middle, maiden</i>) | | Social Security number* | |
| Registration number | | Expiration date (<i>month, day, year</i>) | |
| Address (<i>number and street or rural route</i>) | | | |
| City | | State | ZIP code |
| Date of birth (<i>month, day, year</i>) | Place of birth (<i>city and state or country</i>) | | |
| Telephone number (<i>daytime</i>) () | | E-mail address | |

NAME OF CURRENT SUPERVISOR

| | |
|----------------------------|----------------|
| Name of current supervisor | License number |
|----------------------------|----------------|

NAME OF NEW SUPERVISOR

| | |
|------------------------|----------------|
| Name of new supervisor | License number |
|------------------------|----------------|

DATES OF NEW CLINICAL FELLOWSHIP

| | |
|--|--|
| STARTING DATE (<i>month, day, year</i>) | COMPLETION DATE (<i>month, day, year</i>) |
| | |

LOCATION OF NEW CLINICAL FELLOWSHIP

| | | |
|--|----------------|----------|
| Name of hospital or facility | | |
| Address (<i>number and street, or rural route</i>) | | |
| City | State | ZIP code |
| Telephone number () | E-mail address | |

LIST ANY ADDITIONAL WORK SITE ADDRESSES ON A SEPARATE SHEET OF PAPER

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct. I am aware of the requirements set forth in 880 IAC 1-1-3.1 and understand that I may practice under the direct supervision of the person whose name appears on this application until the expiration of my registration.

| | |
|------------------------|---|
| Signature of applicant | Date signed (<i>month, day, year</i>) |
|------------------------|---|

CLINICAL FELLOW SUPERVISOR'S INFORMATION

PLEASE TYPE OR PRINT AND ANSWER ALL QUESTIONS.

SUPERVISOR'S INFORMATION

| | | | |
|--|---|---------------------------|---|
| Name (<i>last, first, middle, maiden</i>) | | | |
| Indiana license number | Expiration date (<i>month, day, year</i>) | ASHA certification number | Expiration date (<i>month, day, year</i>) |
| Address (<i>number and street, or rural route</i>) | | | |
| City | | State | ZIP code |
| Telephone number () | | E-mail address | |

CLINICAL FELLOW INFORMATION

| | | | |
|---|--|---|----------|
| I will be supervising the following clinical fellow, at the dates indicated and at the following location(s): | | | |
| Name of clinical fellow | | Social Security number * | |
| Starting date (<i>month, day, year</i>) | | Completion date (<i>month, day, year</i>) | |
| Name of hospital or facility | | | |
| Address (<i>number and street, or rural route</i>) | | | |
| City | | State | ZIP code |
| Telephone number () | | E-mail address | |

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APPLICATION AFFIRMATION

| | |
|---|---|
| I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct. I am aware of the requirements set forth in 880 IAC 1-1-3.1 and understand and agree that I shall supervise the person for whom this application is submitted. | |
| Signature of supervisor | Date signed (<i>month, day, year</i>) |