

Maryland Department of Health
**Board of Examiners for Audiologists, Hearing Aid Dispensers,
Speech-Language Pathologists and Music Therapist**
4201 Patterson Avenue, Baltimore, Maryland 21215-2299
Phone 410-764-4725 Fax 410-358-0273
TTY/Maryland Relay Service 1-800-735-2258

**Verification of Supervision for
Speech-Language Pathology Clinical Fellowship Year**

****Applicant, please check if any of the following apply regarding the submission of this form:*

<input type="checkbox"/>	Change in Employment Site	<input type="checkbox"/>	Additional Site	<input type="checkbox"/>	Change of Supervisor
<input checked="" type="checkbox"/>	Additional Supervisor	<input type="checkbox"/>	Change in Hours		

1. Applicant (Please type or print)

A. Name: _____
Last _____ First _____ Middle/Maiden _____

B. Address: _____
Street _____ Apt. _____

City _____ State _____ Zip Code _____

Phone: _____ Alternate #: _____ Email: _____

C. Academic Status: _____
College _____ Degree Date Awarded _____

D. Employment Setting:

1. Facility Name: _____

2. Street Address: _____

_____ City _____ State _____ Zip Code _____

Phone: _____ Fax: _____

3. Beginning date of employment: _____
Month _____ Day _____ Year _____

4. Hours per week spent in Speech-language Pathology? _____

5. Is applicant completing a CFY? Yes No
Form AS2

II. Supervisor of Limited Licensure year (please print or type)

A. Name: _____
 Last _____ First _____ Middle/Maiden _____

B. Street Address: _____

City _____ State _____ Zip Code _____

C. Place of Employment: _____
 Facility Name _____
 Street _____
 City _____ State _____ Zip Code _____
 Phone: _____ Alternate # _____

III. Clinical and Supervisory Responsibility

Applicant Activity	Hours/Week Spent by Applicant	Hours/Month Spent by Supervisor	
		On-Site Observation	Other Monitoring Activities (minimum of 2 hours required)
1. Assessment, diagnosis and/or evaluations			
2. Screening			
3. Habilitation/rehabilitation			
4. Staff Meetings			
5. Supervisory Conferences			
6. In-Service Training			
7. Record Keeping			
8. Other (Must Specify)			
Total			

Signature of Applicant _____ Date _____

Signature of Supervisor _____ Date _____

Supervisor:

Holds ASHA CCC-SLP, ASHA Certificate # _____

Holds MD License in Speech-Language Pathology, License # _____

Holds License in Speech-Language Pathology in State of _____

Form AS2