STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
SUPERVISED PROFESSIONAL EXPERIENCE REPORT:

AUDIOLOGY

NAME:____
LAST FIRST MIDDLE MAIDEN

ADDRESS:____
NO. & STREET CITY STATE ZIP CODE

TELEPHONE NO.:____
WHERE YOU CAN BE REACHED MON. - FRI., 8:30 a.m. - 4:30 p.m.

EMPLOYMENT
ADDRESS:____
NO. & STREET CITY STATE ZIP CODE

****

CAREER OBJECTIVES:____

____

____

SPE SETTING:____
NAME

ADDRESS:____
NO. & STREET CITY STATE ZIP CODE

BEGINNING DATE:_________________________ **ENDING DATE**:_____________
mo./day/year mo./day/year

DID APPLICANT WORK: CALENDAR YEAR __________________ ACADEMIC YEAR____________

IF ACADEMIC YEAR, INCLUSIVE DATES OF EMPLOYMENT:
FROM____________TO____________; FROM____________TO:______________

HOW MANY HOURS DID THE CANDIDATE WORK PER WEEK?_____SPEECH PATHOLOGY______AUDIOLOGY

WAS THE SPE PLAN IMPLEMENTED EXACTLY AS SUBMITTED? ________ YES _________ NO. **IF NO**, PLEASE EXPLAIN (USE ADDITIONAL SHEETS AS NECESSARY):

____

____

****

<u>SPE SUPERVISOR:</u>
NAME:____

PROFESSIONAL ADDRESS:____

CT LICENSE NO:_____________________________________ **DATE ISSUED:**_______________________________

TELEPHONE NO.:____
(WHERE YOU CAN BE REACHED MON. - FRI. 8:30 a.m. - 4:30 p.m.

SUPERVISOR: AT THE CONCLUSION OF THREE, SIX AND NINE MONTHS OF THE SPE, PLEASE EVALUATE THE APPLICANT'S COMPETENCY IN EACH OF THE PROFESSIONAL SKILL AREAS SPECIFIED; USE THE FOLLOWING RATING SCALE AND ENTER THE APPROPRIATE RATINGS IN THE EVALUATION RECORD BELOW.

1. ABLE TO FUNCTION COMPETENTLY WITHOUT SUPERVISION
2. ABLE TO FUNCTION COMPETENTLY ONLY WITH SUPERVISION
3. UNABLE TO FUNCTION COMPETENTLY, EVEN WITH SUPERVISION

SKILL AREA:	**3 MONTH. EVAL.**	**6 MONTH. EVAL.**	**9 MONTH EVAL.**
ASSESSMENT, DIAGNOSIS/OR EVALUATION			
HABILITATION, REHABILITATION			
DEFINING GOALS AND OBJECTIVES			
CLIENT/PARENT COUNSELING			
PROFESSIONAL RELATIONSHIPS			
RECORD KEEPING			

BRIEFLY DESCRIBE THE APPLICANTS STRENGTHS AND
WEAKNESSES:____

____

____

HAS THE APPLICANT DEMONSTRATED DURING THE PROFESSIONAL EXPERIENCE PERIOD THAT HE/SHE IS FULLY COMPETENT TO FUNCTION INDEPENDENTLY AND WITHOUT SUPERVISION?
__________YES, __________NO, PLEASE EXPLAIN:____

____

____

HAS THE APPLICANT DEMONSTRATED CONFORMANCE WITH ACCEPTED STANDARDS OF PROFESSIONAL PRACTICE DURING HIS/HER SUPERVISED PROFESSIONAL EXPERIENCE:
___________YES, __________ NO, PLEASE EXPLAIN:_______________________________________

____

____

DO YOU RECOMMEND, BASED ON THE APPLICANT'S DEMONSTRATED LEVEL OF COMPETENCY DURING THE SUPERVISED PROFESSIONAL EXPERIENCE PERIOD, THAT HE/SHE BE ISSUED A LICENSE TO FUNCTION INDEPENDENTLY?
__________YES, __________NO, PLEASE EXPLAIN:____

____

____

****
I HAVE DISCUSSED THIS REPORT WITH MY SPE SUPERVISOR:

SIGNATURE:_______________________________________ DATE___________________________
APPLICANT

****
I HAVE DISCUSSED THIS REPORT WITH THE ABOVE NAMED APPLICANT:

SIGNATURE:_______________________________________ DATE___________________________
SUPERVISOR

NOTE: THE ORIGINAL REPORT MUST BE SUBMITTED BY THE SUPERVISOR DIRECTLY TO THE DEPARTMENT OF PUBLIC HEALTH, AUDIOLOGIST LICENSURE, 410 CAPITOL AVE., MS# 12 APP, P.O. BOX 340308, HARTFORD, CT 06134. SHOULD YOU HAVE QUESTIONS, DO NOT HESITATE TO CONTACT THIS OFFICE AT oplc.dph@ct.gov.