STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
SUPERVISED PROFESSIONAL EXPERIENCE (SPE) PLAN

_____SPEECH PATHOLOGY (PLEASE CHECK ONE)
_____AUDIOLOGY
_____BOTH

NAME:_____
FIRST LAST MIDDLE MAIDEN

ADDRESS:_____
NO. & STREET CITY STATE ZIP CODE

I. PROFESSIONAL CLINICAL EMPLOYMENT RESPONSIBILITIES:

ACTIVITY	**HOURS PER WEEK**
EVALUATION	_____
THERAPY	_____
PARENT PROGRAMS	_____
INSERVICE TRAINING	_____
STAFF MEETINGS	_____
OTHER (SPECIFY)	_____

TOTAL HOURS PER WEEK: AUDIOLOGY_____ SPEECH PATHOLOGY_____

II. SUPERVISED PROFESSIONAL EXPERIENCE SETTING:

NAME:_____

ADDRESS:_____
NO. & STREET CITY STATE ZIP CODE

WILL APPLICANT WORK (PLEASE CHECK ONE)_____ CALENDAR YEAR _____ACADEMIC YEAR

PREFERRED BEGINNING DATE OF EMPLOYMENT_____

III. SUPERVISION:

METHODS	SESSIONS PER MONTH	HOURS PER SESSION	ACTIVITY
ON SITE OBSERVATIONS	_____	_____	_____
CONFERENCES	_____	_____	_____
REVIEW OF RECORDS	_____	_____	_____
STAFF MEETINGS	_____	_____	_____
CASE STAFFINGS	_____	_____	_____
REMOTE OBSERVATIONS (AUDIO-VIDEO ETC.)	_____	_____	_____

IV. TO BE COMPLETED BY THE SPE APPLICANT

I, THE SPE APPLICANT, HAVE SEEN AND DISCUSSED THE PLAN FOR SUPERVISION, AS DESCRIBED ON THIS APPLICATION, WITH THE PERSON LISTED BELOW, AND AGREE TO ITS IMPLEMENTATION:

_____ _____

SIGNATURE DATE

V. TO BE COMPLETED BY THE SPE SUPERVISOR:

I, THE SPE SUPERVISOR, HAVE DISCUSSED THE PLAN FOR SUPERVISION WITH THE SPE APPLICANT AND ACCEPT RESPONSIBILITY, AS DESCRIBED IN THE SPE GUIDELINES:

_____ _____

SIGNATURE DATE

CT LICENSE NO.:_____ _____

PLEASE TYPE OR PRINT NAME

BUSINESS ADDRESS:_____

NO. & STREET CITY STATE ZIP CODE

TELEPHONE NO.:_____

WHERE YOU CAN BE REACHED MON. - FRI. 8:30 a.m. - 4:30 p.m.

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NOTE: This form must be submitted directly to Department of Public Health, Speech Pathology/Audiology Licensure, 410 Capitol Ave., MS# 12APP. P.O., Box 340308, Hartford, CT 06134 by the SPE Supervisor. Connecticut General Statutes require a minimum of thirty-six (36) weeks and one thousand eighty (1,080) hours full-time (thirty [30] or more hours per week) or a minimum of forty-eight (48) weeks and one thousand four hundred forty (1,440) hours part-time (at least fifteen [15] but less than thirty [30] hours per week), under the supervision of a Connecticut-licensed Speech Pathologist/Audiologist. Each area of licensure, speech pathology and/or audiology, requires a separate plan; individuals seeking dual licensure must file both plans.

The beginning date of the SPE will be approved by this office upon receipt of an acceptable plan. Upon approval of the plan, the beginning date can be established a maximum of six (6) weeks retroactively. Written notice of approval, and of the approved starting date, will be given at this time.

Supervision must include a minimum of two (2) sessions of on-site observations per month, totaling a minimum of two (2) hours per month. There must be a minimum of four (4) additional sessions per month in the remaining modalities of supervision, to total a minimum of two (2) additional hours per month.

Should significant change in the plan be contemplated, a new plan must be filed and approved by the Department prior to implementing the change. Such changes would include a change from full-time to part-time work or vice versa, a change in supervisor or a change in employer or work setting.

Should you have questions regarding the completion of this plan, do not hesitate to contact this office at (860) 509-8378.