



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

AUDIOLOGY LICENSURE

VERIFICATION OF OUT-OF STATE POSTGRADUATE SUPERVISED PROFESSIONAL EXPERIENCE (SPE)

Area Of Experience: Audiology

Name of Applicant: _____

First

Last

Middle

Maiden

Address: _____

No. & Street

City

State

Zip Code

Academic Status: _____

Degree

Date Conferred

Name of University: _____

Address: _____

No. & Street

City

State

Zip Code

SPE Setting: _____

Name

No. & Street

City

State

Zip Code

Beginning Date Of SPE _____

Ending Date _____

Did Applicant Work: Calendar Year _____

Academic Year _____

If calendar year, inclusive dates of employment:

From _____ To: _____ ; From _____ To _____
Mo/Day/Year Mo/Day/Year Mo/Day/Year Mo/Day/Year

Number Of Hours Per Week: _____

SPE Supervisor

Name: _____

Address: _____

License/Certificate # _____ State _____ Date Issued _____

Place of Employment: _____

Address: _____

Business Telephone: _____ Email _____

Supervisor: Please evaluate the level of competency the applicant had achieved at the conclusion of the SPE period in each of the professional skills 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:

Assessment, Diagnosis/Or Eval.	_____
Habilitation, Rehabilitation	_____
Defining Goals And Objectives	_____
Client/Parent Counseling	_____
Professional Relationships	_____
Record Keeping	_____

Briefly describe the applicant's strengths and weaknesses at the conclusion of the SPE period:

Did The Applicant Demonstrate During The Supervised Professional Experience Period That He/She Is Fully Competent To Function Independently And Without Supervision? Yes No , Please Explain:

Did The Applicant Demonstrate 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

Date _____ Supervisor's Signature: _____

Note: This verification should be submitted by the supervisor directly to:

Department of Public Health
 Audiologist Licensing
 410 Capitol Ave., MS#12 APP
 P.O. Box 340308
 Hartford, CT 06134-0308.

If you have any questions regarding this report, please email the department at oplcdph@ct.gov.