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

SPEECH PATHOLOGY

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):

_____

_____

****

SPE SUPERVISOR:
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, SPEECH PATHOLOGY LICENSURE, 410 CAPITOL AVE., MS# 12APP, P.O. BOX 340308, HARTFORD, CT 06134. SHOULD YOU HAVE QUESTIONS, DO NOT HESITATE TO CONTACT THIS OFFICE AT (860)509-8378.