STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

SPEECH AND LANGUAGE PATHOLOGY / AUDIOLOGY LICENSURE

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

AREA OF EXPERIENCE: SPEECH AND LANGUAGE PATHOLOGY

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 <u>HOURS</u> PER WEEK: _____

<u>SPE SUPERVISOR</u>

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

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DATE_____ SUPERVISOR'S SIGNATURE:_____

NOTE: This verification should be submitted by the supervisor directly to the Department of Public Health, 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 oplc.dph@ct.gov.