GOVERNMENT OF THE DISTRICT OF COLUMBIA

Health Regulation and Licensing Administration
899 North Capitol Street, NE– 2nd Floor
Washington, DC 20002

AUDIOLOGY/SPEECH-LANGUAGE PATHOLOGY APPLICANTS

This form must be presented in a sealed envelope and hand delivered to the office of Health Regulation and Licensing Administration by the Audiology or Speech-Language Pathology applicant. Please note: You must be fully qualified for licensure and have a licensure application on file to use this form. The supervisor must keep the sealed copy of this form on file at the place of employment. This form is not valid unless signed and approved by the Board of Audiology and Speech-Language Pathology.

SUPERVISED PRACTICE FORM TO BE COMPLETED BY AUDIOLOGY OR SPEECH-LANGUAGE PATHOLOGY SUPERVISOR

I _____
(Supervisor's signature) **(Supervisor's license number)**
understand that this applicant cannot work in my facility without a current District of Columbia Supervised Practice Letter or Licensure. I agree to supervise this applicant's practice and understand that during the time of the supervision I may be subject to disciplinary action for any violation of the Act. I understand that this **applicant may work under my supervision for ninety (90) days and that this supervised practice form is not renewable. I further understand that any person working in the District of Columbia as an Audiologist or Speech-Language Pathologist without a current District of Columbia Supervised Practice Letter or Licensure is in violation of law and may be subject to fine or other action.**

Date of Hire/Employment: _____ **Facility's Name:** _____

Supervisor's name and license number (Please Print):

_____ _____
LAST NAME, FIRST NAME MI LICENSE NUMBER

Applicant's Name (Please Print):

_____
LAST NAME, FIRST NAME MI

FOR OFFICE USE ONLY

Date supervision form Submitted: _____ Date supervision will end: _____

DC SEAL

HRLA/Board Staff Signature:

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