

Applicants: The supervisor must complete this form **and** send it directly to the DC Board of Rehabilitative Therapies via email (dcboaud@dc.gov).

DC Board of Rehabilitative Therapies

**Verification of Satisfactory Completion of Speech-Language Pathology
Clinical Training**

I hereby declare that _____
Name of Applicant

Address _____

an applicant for DC licensure in speech-language pathology, was employed as a professional in that field from _____ to _____ for _____ hours per week.
(mm/dd/yyyy) (mm/dd/yyyy)

The place of employment was _____
Facility Name

Address City State Zip Code

I further declare that the applicant was supervised by _____
Printed Name of Supervisor

At that time the supervisor held:

- { } DC License in Speech-Language Pathology
- { } ASHA Certification in Speech-Language Pathology
- { } A License in Speech-Language Pathology from _____
State

whose licensure requirements were equivalent to ASHA certification or ABA certification.

I certify that the applicant was employed as a professional in the field of speech-language pathology under supervision and that the information provided above accurately reflects the hours and activities completed in accordance with [DC Municipal Regulations for Speech-Language Pathology](#).

Signature of Supervisor, Current Clinical Director, or HR Department Title

Current Phone Number Date