DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA
Health Systems & Preparedness Administration

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

# Speech-Language Pathology Clinical Fellowship Supervision & Experience Verification Form

## Section 1: Applicant & Supervisor Information

**Applicant Name:** _____

**Supervisor Name:** _____

**Supervisor's License Number:** _____**Issue Date:** _____**State/Jurisdiction:**_____

**Clinical Site Name:** _____ **Site Address:**_____

## Section 2: Clinical Fellowship Time Period & Work Hours

Please select the timeframe that applies to the applicant's fellowship period:

**Fellowship Start Date:** _____ **End Date:** _____

| Selection | Weekly Work Hours | Required Duration |
|---|---|---|
| [ ] | 35 hours per week | ____ months **(Enter Number of Months)** |
| [ ] | 25-29 hours per week | 12 months |
| [ ] | 20-24 hours per week | 15 months |
| [ ] | 15-19 hours per week | 18 months |

**Total Number of Hours Completed:** _____

## Section 3: Supervised Activities & Client Contact

*{According to speech-language pathology clinical fellow regulations, section 8405, at least 80% of the experience must be in direct client contact}.*

Check all that applies to the supervisee's experience:

| **Part A: Direct Client Contact (Minimum 80% of total hours)** | **Yes** | **No** |
|---|---|---|
| Assessment, diagnosis, evaluation, and treatment | | |
| Screening | | |
| Habilitation and rehabilitation | | |
| Activities related to case management | | |
| **Part B: Indirect Supervised Activities (Remaining percentage)** | **Yes** | **No** |
| Writing | | |
| Research | | |
| Planning | | |

## Section 4: Supervisor's Attestation & Signature

In your opinion, has the applicant demonstrated competency in the practice of speech-language pathology sufficient for licensure and the independent practice of speech-language pathology? **Yes** [ ] **No** [ ]

*I certify that the applicant was employed as a professional in the field of audiology 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.*

**Supervisor Signature:** _____ **Date:** _____ **Supervisor's Email:**_____