

# RECORD OF SUPERVISED CLINICAL EXPERIENCE

## FOR SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY

Clinician Name: \_\_\_\_\_ Student ID#: \_\_\_\_\_

has satisfactorily completed the designated client contact hours at:

Name of Site(s): \_\_\_\_\_

Course:  EDAU 177     EDSP 177     EDSP 276     EDSP 278  
 EDAU 277     EDSP 269     EDSP 277    Semester/Year: \_\_\_\_\_

EVALUATION:	SPEECH				LANGUAGE				AGE	# of HRS.
	articulation/ phonology	voice/ res.	fluency	swallowing	rec/exp. language	cognitive aspects	social aspects	comm. modal.	(please check)	
Speech: Adult									<input type="checkbox"/> A <input type="checkbox"/> G	
Language: Adult									<input type="checkbox"/> A <input type="checkbox"/> G	
Speech: Child									<input type="checkbox"/> T <input type="checkbox"/> P <input type="checkbox"/> S	
Language: Child									<input type="checkbox"/> T <input type="checkbox"/> P <input type="checkbox"/> S	
TREATMENT:	articulation/ phonology	voice/ res.	fluency	swallowing	rec/exp. language	cognitive aspects	social aspects	comm. modal.		
Speech: Adult									<input type="checkbox"/> A <input type="checkbox"/> G	
Language: Adult									<input type="checkbox"/> A <input type="checkbox"/> G	
Speech: Child									<input type="checkbox"/> T <input type="checkbox"/> P <input type="checkbox"/> S	
Language: Child									<input type="checkbox"/> T <input type="checkbox"/> P <input type="checkbox"/> S	
Staffing & Misc: _____										
AUDIOLOGY										
Hearing Screening										
Aural Rehabilitation										

**Total hours:** \_\_\_\_\_

\_\_\_\_\_  
 Clinical Supervisor Name (please print)

\_\_\_\_\_  
 ASHA Account Number

\_\_\_\_\_  
 Clinical Supervisor Signature

\_\_\_\_\_  
 CA License

\_\_\_\_\_  
 Date Signed

AGE	
T	0 - 2.11
P	3.0 - 4.11
S	5.0 - 17.11
A	18.0 - 64.11
G	65.0+