

RECORD OF SUPERVISED CLINICAL EXPERIENCE

FOR SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY

Clinician Name: _____ Student ID#: _____

For _____ the clinician named above has satisfactorily completed the designated client contact hours at:
SEMESTER & YEAR

Name of Site(s): _____

Course: EDAU 177 EDAU 277 EDSP 177 EDSP 269 EDSP 276 EDSP 277 EDSP 278

SPEECH				LANGUAGE				AGE	# of HRS.	
EVALUATION:	PHONOLOGY / ARTICULATION	VOICE / RESONANCE	FLUENCY	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:	PHONOLOGY / ARTICULATION	VOICE / RESONANCE	FLUENCY	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		
MISCELLANEOUS:										
Indirect Hours										
Client Conferences										
SWALLOWING										
<input type="checkbox"/> Evaluation Age: <input type="checkbox"/> T <input type="checkbox"/> P <input type="checkbox"/> S <input type="checkbox"/> A <input type="checkbox"/> G HRS: <input style="width: 30px;" type="text"/>				<input type="checkbox"/> Treatment Age: <input type="checkbox"/> T <input type="checkbox"/> P <input type="checkbox"/> S <input type="checkbox"/> A <input type="checkbox"/> G HRS: <input style="width: 30px;" type="text"/>				TOTAL HOURS		
AUDIOLOGY										
Hearing Screening							Age: <input type="checkbox"/> T <input type="checkbox"/> P <input type="checkbox"/> S <input type="checkbox"/> A <input type="checkbox"/> G			
Aural Rehabilitation							Age: <input type="checkbox"/> T <input type="checkbox"/> P <input type="checkbox"/> S <input type="checkbox"/> A <input type="checkbox"/> G			

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+

Total hours:	
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