

# SUPERVISED PROFESSIONAL EXPERIENCE (SPE) REPORT

## Ohio Board of Speech-Language Pathology and Audiology

77 South High Street, Suite 1659  
Columbus, Ohio 43215-6108

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Upon completion of the Professional Experience Year - *or* - when there is a change in the Professional Experience Year Plan,  
**Conditional licensee must submit the following to the Board within 30 calendar days:**

- **Supervised Professional Experience Report**
- **Supervised Professional Experience Contacts Log**

**NO FEES ARE REQUIRED UPON COMPLETION OF THE SUPERVISED PROFESSIONAL EXPERIENCE PLAN**

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**PLEASE PRINT LEGIBLY IN INK OR TYPE**

**ALL QUESTIONS MUST BE ANSWERED OR THE BOX CHECKED**

(IF NOT APPLICABLE WRITE N/A)

Conditional Licensee: \_\_\_\_\_ License No: \_\_\_\_\_

Licensee Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Practice Site: \_\_\_\_\_

Supervisor Name: \_\_\_\_\_ License No: \_\_\_\_\_

**Supervised Professional Experience time covered in this report:**     Full-time     Part-time     PRN

Starting Date: \_\_\_\_\_ Ending Date: \_\_\_\_\_

- YES \_\_\_ NO \_\_\_ This Conditional licensee demonstrates competence in the area of evaluation.  
YES \_\_\_ NO \_\_\_ This Conditional licensee demonstrates competence in the area of intervention.  
YES \_\_\_ NO \_\_\_ This Conditional licensee demonstrates competence in the area of interaction and personal qualities.

**Report of Partial Experience Completion** (please check appropriate box):

- I recommend that this experience count toward the completion of this Conditional licensee's SPE.  
 I **do not** recommend that this experience count toward the completion of this Conditional licensee's SPE.  
**Attach a letter of explanation and supporting documentation (if not recommended).**

**Report for Completed Professional Experience** (please check appropriate box):

- I recommend that this experience count toward the completion of this Conditional licensee's SPE, and recommend this Conditional licensee for licensure in the area in which licensure is sought.  
 I **do not** recommend that this experience count toward the completion of this Conditional licensee's SPE.  
**Attach a letter of explanation and supporting documentation (if not recommended).**

# SUPERVISED PROFESSIONAL EXPERIENCE CONTACTS LOG

**IMPORTANT: PLEASE READ THE FOLLOWING BEFORE COMPLETING THE CONTACTS LOG**

**The SPE Contacts Log may be completed by or under the direction of the supervisor**

**The Contacts Log should reflect that the supervisor and the Conditional licensee met the following requirements during the professional experience:**

- Weekly Hours Required: FULL-TIME: (36) weeks (minimum of 30-hours each week)  
PART-TIME: (72) weeks (minimum of 15-hours each week)
- On-site Conference Tracking: 18 total; (2-per month, with 6-onsites held during each third of the professional experience)
- Monthly Evaluation Conference: once each month (may be held in conjunction with an on-site conference).
- A summary of the licensee's clinical strengths and goals must be documented at least once during each third of the professional experience.

The tasks under the "Other Supervisory Activities" column may include but are not limited to:

1. Conferring with the licensee concerning clinical treatment strategies;
2. Monitoring changes in communication behaviors of person(s) served;
3. Evaluating the applicant's clinical records, including: diagnostic reports, treatment records, correspondence, plans of treatment, and summaries of clinical conferences;
4. Monitoring the licensee's participation in case conferences;
5. Evaluating the licensee's performance by professional colleagues and employers;
6. Evaluating the licensee's work by person(s) served and their parents; and
7. Monitoring the licensee's contributions to professional meetings and publications, as well as participation in professional growth opportunities
8. Other supervisory activities.

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**\*\*\* SIGNATURES ARE REQUIRED \*\*\***

**Please submit signed original to the Board Office – must be received within 30-days.**

I / We hereby attest and confirm:

I have read the general information and instructions, and have answered all questions in compliance with the instructions.

Under penalties provided by law for fraud, deception or misrepresentation in obtaining or attempting to obtain a license, I hereby certify that I am the person referred to in the Supervision Contacts log, that I have examined the statements and information provided herein and all the accompanying documents, and that all the statements and information are strictly true, correct and complete in every respect.

I further understand that I will notify the Ohio Board of Speech-Language Pathology and Audiology, within thirty (30) days, in writing, of any changes to the forgoing information or accompanying documents.

**THIS SECTION MUST BE COMPLETED: Indicate the number of weeks to credit under this Report and Contacts Log**

\_\_\_\_ # of **Full-time Weeks** (minimum of 30-hours) - as of \_\_\_\_\_  
Date

\_\_\_\_ # of **Part-time Weeks** (minimum of 15-hours) - as of \_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Licensee Date

\_\_\_\_\_  
Signature of Supervisor Date

***SPE Report and Contacts Log cannot be approved unless signed by Conditional Licensee and current supervisor of record.***

# SUPERVISED PROFESSIONAL EXPERIENCE CONTACTS LOG

## ONSITE CONFERENCES / MONTHLY EVALS / QUARTERLY SUMMARIES

PLEASE PRINT LEGIBLY IN INK OR TYPE

<u>DATE</u>	<u>ON-SITE HOURS</u>	<u>OTHER SUPERVISORY ACTIVITIES</u> <small>See Activity Code numbers Listed above</small>	<u>SUMMARY OF CLINICAL STRENGTHS &amp; GOALS</u> <small>Document clinical strengths &amp; goals at least once during each third of the PEY</small>	<u>Monthly Evaluation Conference Held</u>  <small>Place check mark in appropriate boxes</small>	<u>SUMMARY OF FEEDBACK</u> <small>Print or type summary of feedback provided. Monthly evaluation may be in conjunction with one of the on-site conferences and may be summarized together.  Retain all documentation of supervision in case additional information is requested.</small>
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[2]					
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FIRST PERIOD OF PEY

# SUPERVISED PROFESSIONAL EXPERIENCE CONTACTS LOG

<u>DATE</u>	<u>ON-SITE HOURS</u>	<u>OTHER SUPERVISORY ACTIVITIES</u> <small>See Activity Code numbers Listed above</small>	<u>SUMMARY OF CLINICAL STRENGTHS &amp; GOALS</u> <small>Document clinical strengths &amp; goals at least once during each third of the PEY</small>	<u>Monthly Evaluation Conference Held</u>  <small>Place check mark in appropriate boxes</small>	<u>SUMMARY OF FEEDBACK</u>  <small>Print or type summary of feedback provided. Monthly evaluation may be in conjunction with one of the on-site conferences and may be summarized together.  Retain all documentation of supervision in case additional information is requested.</small>
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[8]					
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SECOND PERIOD OF PEY

# SUPERVISED PROFESSIONAL EXPERIENCE CONTACTS LOG

DATE	ON-SITE HOURS	OTHER SUPERVISORY ACTIVITIES <small>See Activity Code numbers Listed above</small>	SUMMARY OF CLINICAL STRENGTHS & GOALS <small>Document clinical strengths &amp; goals at least once during each third of the PEY</small>	<u>Monthly Evaluation Conference Held</u>  Place check mark in appropriate boxes  ✓	SUMMARY OF FEEDBACK  Print or type summary of feedback provided. Monthly evaluation may be in conjunction with one of the on-site conferences and may be summarized together.  Retain all documentation of supervision in case additional information is requested.
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THIRD PERIOD OF OF PEY