

AMENDED PLAN for SUPERVISED PROFESSIONAL EXPERIENCE

**Ohio Board Of Speech-Language Pathology And Audiology
77 South High Street, Suite 1659, Columbus, Ohio 43215-6108
Phone (614) 466-3145 Fax (614) 995-2286**

Web Site: www.slpaud.ohio.gov

Email Address: board@slpaud.ohio.gov

(To be completed by the Applicant and Supervisor within thirty calendar days upon your start date of employment)
Please Print Legibly in Ink or Type

Please indicate reason: **Supervisor Change** **End-date change** **Hours/Week**

TO BE COMPLETED BY THE APPLICANT:

Please include your Conditional license #		License Number:		
1. Your Name	Last	First	Middle	Maiden
Address / Number		Street		County
City	State	Zip	Phone	E-mail Address
2. Employer / Company Name			Division	
Address / Number		Street		County
City		State	Zip	Phone
Please use the following to determine the ending date for professional experience: <input type="checkbox"/> Full time experience consists of a minimum of thirty (30) hours of professional experience per week, for a minimum of thirty-six (36) weeks. <input type="checkbox"/> Part time experience consists of a minimum of fifteen (15) hours of professional experience, for a minimum of seventy-two (72) weeks. <input type="checkbox"/> Full Time - Secondary plan, a plan that will run concurrently with another plan already on file with the Board. <input type="checkbox"/> Part Time - Secondary plan, a plan that will run concurrently with another plan already on file with the Board. <input type="checkbox"/> PRN position – less than 15 hours per week; will not count towards completion of professional experience.			Please Identify Primary Work Setting: <input type="checkbox"/> College or University – Academic/Faculty/Research <input type="checkbox"/> Community Center (i.e. Speech & Hearing Centers) <input type="checkbox"/> Federal Governmental Agency <input type="checkbox"/> Government Agency (city, county or state) <input type="checkbox"/> Health System/Hospital-Based/Outpatient Facility/Clinic <input type="checkbox"/> Home Health Agency <input type="checkbox"/> Industry (hearing aid mfrs., industrial testing, publisher) <input type="checkbox"/> Medical Office / ENT Office <input type="checkbox"/> Private Practice <input type="checkbox"/> Rehabilitation Center <input type="checkbox"/> Research Center <input type="checkbox"/> School (Preschool/Primary/Secondary) <input type="checkbox"/> Skilled Nursing Fac./Long-Term Care/Assisted Living <input type="checkbox"/> Other – Please Specify: _____	
3. Beginning Date of this Employment				
4. This Plan Beginning Date			This Plan Ending Date	
5. Professional Experience Beginning Date			Date Professional Experience Will Be Complete	

AMENDED PLAN for SUPERVISED PROFESSIONAL EXPERIENCE

(Applicant - Review all statements below before signing)

In order to complete my Supervised Professional Experience required for licensure, I shall abide by the following:

1. Hours of professional experience are defined as those hours of contact with persons served, consultations, record keeping, clinical conferences, in-service training, or any other relevant duties in a professional setting in which bona fide clinical work has been accomplished in the major professional area, speech-language pathology or audiology, in which licensure is being sought.
2. Notify the Board in writing of any change of name, address, employment, or supervisor within thirty (30) days of the change.
3. Display my Conditional License and credential pocket card where I practice, practice in adherence to Chapter 4753 of the Ohio Revised Code (ORC) and Ohio Administrative Code (OAC) and the Code of Ethics, and read the rules governing the supervised professional experience under OAC section 4753-3-07.
4. Not begin practice until a Conditional License has been granted and notify the Board in writing within 30 calendar days if the supervised professional experience is discontinued.
5. Submit this **AMENDED PLAN** within thirty (30) calendar days upon a change in status with my employer, or a change in supervisor, or a change in the previously approved end date for my professional experience.
6. Verify that my supervisor's license is current and remains current throughout the entire Supervised Professional Experience, and verify that my supervisor has completed twenty-four (24) months of full time clinical experience in the last sixty (60) months or the equivalent in the last sixty months, under a valid license or certification by the "American Board of Audiology" or the "American Speech-Language-Hearing Association."
7. Inquire whether my supervisor is supervising no more than four Supervised Professional Experiences and whether the Board has approved supervision of more than four.
8. Review the "Professional Experience Year Report - Clinical Outcomes" with my supervisor to identify goals and the clinical skills on which I will be evaluated.
9. Review the Supervised Professional Experience forms to familiarize myself with the records I will need to keep during the Supervised Professional Experience.
10. Verify that 30 hours of full time work or 15 hours of part time work will be spent in direct patient contact with persons served, in consultations, record keeping, clinical conferences, in-service training, or any other relevant duties in a professional setting in which bona fide clinical work has been accomplished in the major professional area, speech-language pathology or audiology, in which licensure is being sought.
11. Contact the Board office if I need assistance during my supervised professional experience at: Telephone (614) 466-3145, Fax Number (614) 995-2286, or via e-mail at Board@slpaud.ohio.gov.
12. Upon completion of the professional experience year or when there is a change in the professional experience year plan I will submit the **SPE REPORT AND CONTACTS LOG** to the Board within 30 calendar days.

UNDER PENALTIES PROVIDED BY LAW FOR FRAUD, DECEPTION OR MISREPRESENTATION IN OBTAINING OR ATTEMPTING TO OBTAIN A LICENSE, I HAVE EXAMINED AND READ THE GENERAL INFORMATION AND INSTRUCTIONS ON THIS PLAN. MY SIGNATURE BELOW ACKNOWLEDGES THAT I UNDERSTAND AND AGREE TO FOLLOW ALL STATEMENTS CONTAINED HEREIN AND ABIDE BY THE PROVISIONS UNDER OHIO REVISED AND ADMINISTRATIVE CODE CHAPTERS 4753 GOVERNING THE PRACTICE OF SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY IN THE STATE OF OHIO. I FURTHER ATTEST THAT ALL STATEMENTS AND INFORMATION SUBMITTED ON THIS PLAN ARE STRICTLY TRUE, CORRECT AND COMPLETE IN EVERY RESPECT.

SIGNATURE OF APPLICANT

DATE

AMENDED PLAN for SUPERVISED PROFESSIONAL EXPERIENCE

TO BE COMPLETED BY THE SUPERVISOR:

1. Conditional Licensee's Name _____				
Last	First	Middle	License #	
2. Supervisor's Name _____				
Last	First	Middle	License #	
Supervisor's Address / Number		Street	County	
City	State	Zip	Phone	E-Mail Address

(Supervisor - Review all three statements below and verify that ALL are true before signing)

In order to meet requirements for supervising during the professional experience, I have:

1. A current license from the Ohio Board of Speech-Language Pathology and Audiology, and I will maintain current licensure throughout the supervised professional experience.
2. Twenty-four (24) months of full time clinical experience as a licensed speech-language pathologist or audiologist or the equivalent within the last sixty (60) months under a valid license or certification by the "American Board of Audiology" or the "American Speech-Language-Hearing Association."
3. Agreed to supervise the conditional licensee's professional experience.

Supervised Professional Experience Performed Outside Ohio – If Applicable

Professional experience, when completed outside the state of Ohio, shall be acceptable for licensure only when done under the supervision of a person who during the professional experience, is licensed in the state in the professional area in which licensure is sought; or in states without licensure who during the professional experience is certified by the "American Board of Audiology" or the "American Speech-Language-Hearing Association" in the professional area in which licensure is sought.

UNDER PENALTIES PROVIDED BY LAW FOR FRAUD, DECEPTION OR MISREPRESENTATION IN OBTAINING OR ATTEMPTING TO OBTAIN A LICENSE, I HAVE READ AND UNDERSTAND THE GENERAL INFORMATION AND INSTRUCTIONS ON THIS PLAN. BY SIGNING THIS DOCUMENT, I ALSO AGREE TO SUPERVISE THE PRACTICE OF SPEECH-LANGUAGE PATHOLOGY EXPERIENCE OF THE CONDITIONAL LICENSEE IDENTIFIED ON THIS PLAN.

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.

SIGNATURE OF SUPERVISOR

DATE