Washington State Department of HEALTH

Hearing and Speech Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Speech Language Pathology or Audiology Supervisor Form

To be completed by post-graduate supervisor. Please be advised upon receipt of written request, this form will become a public document.

Applicant Demographics		
First Name	Middle	Last Name
Credential # (if available)	Date of Birth	
Supervisor Name	Supervisor Credential #	
Organization	Position	
Address		
City	State	Zip Code

To be completed by the supervisor:

The above named applicant has applied for license as a Speech Language Pathologist/Audiologist in the state of Washington. We would appreciate your completion of this reference form and return directly to the above address.

Dates of post-graduate supervision From (mm/dd/yyyy)_____ To (mm/dd/yyyy)_____

Total number of hours of post-graduate speech pathology/audiology work you supervised during the entire post-graduate professional work experience (this should be a number and not a percentage): _____

Applicants are required to have thirty-six weeks of full-time professional experience or part-time equivalent per WAC 246-828-04503

To be completed by the supervisor: Please indicate the number of hours completed each week

Week 1		Week 2		Week 3		Week 4		Week 5		Week 6	
Week 7		Week 8		Week 9		Week 10		Week 11		Week 12	
Week 13		Week 14		Week 15		Week 16		Week 17		Week 18	
Week 19		Week 20		Week 21		Week 22		Week 23		Week 24	
Week 25		Week 26		Week 27		Week 28		Week 29		Week 30	
Week 31		Week 32		Week 33		Week 34		Week 35		Week 36	

Comment on the applicant's professional judgment, responsibility, integrity and relationships with professional peers and clients:

Is there any other information about the candidate which you believe should be provided to the Board of Hearing and Speech? ☐ Yes ☐ No

If yes, please explain:

Signature _____ Date (mm/dd/yyyy)_____