

RECORD OF SUPERVISED CLINICAL EXPERIENCE FOR SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY

CLINICIAN NAME:

STUDENT ID#:

During the

SEMESTER	YEAR
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semester, the clinician named above satisfactorily completed the designated client contact hours at:

NAME OF SITE(S):

CLINICAL PRACTICA:

☐ EDAU 177

☐ EDSP 177

(select one)

SPEECH				LANGUAGE				
EVALUATION	PHONOLOGY / ARTICULATION	VOICE / RESONANCE	FLUENCY	REC. / EXP. LANGUA GE		COGNITIVE ASPECTS	SOCIAL ASPECTS	COMM. MODALI TIES.
Adult								
Child								
TREATMENT	PHONOLOGY / ARTICULATION	VOICE / RESONANCE	FLUENCY	REC. / EXP. LANGUA GE		COGNITIVE ASPECTS	SOCIAL ASPECTS	COMM. MODALI TIES.
Adult								
Child								
OBSERVATION	PHONOLOGY / ARTICULATION	VOICE / RESONANCE	FLUENCY	REC. / EXP. LANGUA GE		COGNITIVE ASPECTS	SOCIAL ASPECTS	COMM. MODALI TIES.
Adult								
Child								

TOTAL EVALUATION HOURS:	
TOTAL TREATMENT HOURS:	
TOTAL OBSERVATION HOURS:	

AUDIOLOGY						
	HEARING SCREENING	OBSERVATION HEARING SCREENING	Simulation	AURAL REHABILITATION/ TREATMENT	OBSERVATION AURAL REHAB/TREATMENT	TOTAL HEARING SCREENING HOURS
Adult						TOTAL HEARING SCREENING OBSERVATION HOURS
Child						TOTAL AURAL REHAB/ TX HOURS:
						TOTAL OBSERVATION AURAL REHAB/ TX HOURS:
						TOTAL SIMULATION HOURS

By signing this document, I confirm that this student received 25% supervision per case

Clinical Supervisor Name (please print)

ASHA Account Number

CA License Number

Clinical Supervisor Signature

Date Signed