IOWA | Department of Inspections, Appeals, & Licensing

Supervised Clinical Experience Plan

Board of Speech Pathology & Audiology

Nine months full time (or equivalent)

Type of license desired: Temporary Speech Pathology_____ Temporary Audiology_____

Applicant name: _____

Date of birth: _____

Address: _____

Home phone: _____

Supervised Clinical Experience Setting

Facility name: _____

Address: _____

Proposed hours of work per week:_____(total)

Dates of supervised clinical experience (SCE), may begin after the temporary license is issued and the board has approved your plan. **Supervision completed before the temporary license is issued will not be accepted**.

Start Date (MM/DD/YY): _____ End Date (MM/DD/YY):_____

Work experience includes (check all applicable for this setting) :

Pediatric population_____ Adult population_____ Geriatric population_____

Supervisor

If more than one supervisor was utilized, please provide necessary information on each one.

Supervisor Name: _____

Address: _____

Home phone:_____

Office phone:_____

Place of employment name: _____

Place of employment address: _____

Iowa license number: Speech Pathology_____ Audiology_____

Iowa license current to (date): _____

Applicant's plan of activity and responsibilities (be specific):

Plan of supervision (include type, frequency, duration of contract):

I, attest that I have completed this form and all the information submitted herein is truthful and accurate. I understand my failure to answer questions contained in this form truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license.

Signature of Applicant: _____ Date: _____

Signature of Supervisor: _____ Date: _____

Department of Inspections, Appeals, and Licensing
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