IOWA BOARD OF SPEECH PATHOLOGY & AUDIOLOGY

SUPERVISED CLINICAL EXPERIENCE PLAN

Nine months full time (or equivalent)

I. Applicant: (type or print)

A. Name:_____
(last) (first) (middle) (date of birth)

B. Address:_____
(street) (city) (state) (zip)

C. Home phone:_____ Office phone:_____

D. Type of license desired: temporary speech pathology___ temporary audiology___

II. Supervised Clinical Experience Setting:

A. Facility Name:_____

B. Address:_____

C. YOUR 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.

Beginning Date:_____ Ending Date:_____

D. Proposed hours of work per week:_____(total).

E. Work experience includes (Check all applicable for this setting).

1. Pediatric population _____
2. Adult population _____
3. Geriatric population _____

III. Supervisor: (type or print). If more than one supervisor will be utilized, please provide necessary information on each one.

A. Name:_____
(last) (first) (middle)

B. Address:_____
(street) (city) (state) (zip)

C. Home phone:_____ Office phone:_____

D. Place of Employment_____
(facility name)

_____
(street) (city) (state) (zip)

E. Iowa License Number: Speech Pathology_____ Audiology_____

F. Iowa License Current to (Date):_____

Revised 02/2025

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

I have discussed this plan with the supervisor herein designated.

_____ _____
(Signature of Applicant) (Date)

V. Plan of Supervision (include type, frequency, duration of contract).

I have read, discussed and approved this plan with the applicant.

_____ _____
(Signature of Supervisor) (Date)

Revised 02/2025