

**ARKANSAS BOARD OF EXAMINERS IN
SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY**

**APPLICATION TO SUPERVISE SPEECH-LANGUAGE
PATHOLOGY ASSISTANT(S)**

1. SLP SUPERVISOR'S NAME

(Last)

(First)

(Middle)

2. MAILING ADDRESS _____

3. AREA OF LICENSURE _____

LICENSE # _____

4. CURRENT EMPLOYER NAME, ADDRESS, AND PHONE #:

EMPLOYMENT HISTORY-(MINIMUM OF TWO (2) YEARS AFTER CFY)

Dates of Employment:

Name & Address of Employer:

FROM _____ TO _____

FROM _____ TO _____

FROM _____ TO _____

(ATTACH EXTRA SHEET IF NECESSARY)

5. NAME OF SLP-ASSISTANT(S)

6. NAME, ADDRESS, AND PHONE # OF FACILITY(S) IN WHICH SLP-
ASSISTANT(S) WILL BE UTILIZED:

7. ARE YOU REGISTERED AS A SLP-SUPERVISOR WITH ANY OTHER
AGENCY? _____ IF YES, INDICATE AGENCY _____

8. LIST WHERE AND WHEN INITIAL TRAINING WAS/WILL BE COMPLETED:

9. Attach a written job description for the SLP assistant which includes:
- (a) specific tasks to be performed under the direction of the supervising SLP;
 - (b) description of the caseload to be served;
 - (c) supervision plan describing how the supervising SLP will provide both direct and indirect supervision and contact with each client each two weeks as required;
 - (d) the service delivery plan including the settings in which services will be provided and the anticipated frequency of service by the supervising SLP and assistant;
 - (e) training plan aimed at assuring that the SLP assistant possesses the competencies to conduct the tasks assigned;
 - (f) describe how supervising SLP will stay in contact with the SLP Assistant:
cell phone _____, pager _____ other _____

AFFIDAVIT OF THE APPLICANT

I have read § 17-100-101 et seq and the Rules and Regulations of the Board and am familiar with the requirements of each. I agree to abide by the rules and regulations of the Board. I understand my responsibility to notify the Board within 21 days of any change in work settings where SLP-Assistants are utilized. I also understand that I must notify the Board office of any change in supervisory arrangements and receive written approval from ABESPA of those changes.

State of: _____

County of: _____

Signature of Supervisor

Subscribed and sworn to before me on this _____ day of _____
in the year _____.

Notary Public

My Commission expires _____ (Date) (Seal)