

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

CLINICIAN NAME: _____ STUDENT ID#: _____

During the SEMESTER YEAR 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. LANGUAGE	COGNITIVE ASPECTS	SOCIAL ASPECTS	COMM. MODALITIES.	TOTAL EVALUATION HOURS:	
Adult									
Child									
TREATMENT	PHONOLOGY / ARTICULATION	VOICE / RESONANCE	FLUENCY	REC. / EXP. LANGUAGE	COGNITIVE ASPECTS	SOCIAL ASPECTS	COMM. MODALITIES.	TOTAL TREATMENT HOURS:	
Adult									
Child									
OBSERVATION	PHONOLOGY / ARTICULATION	VOICE / RESONANCE	FLUENCY	REC. / EXP. LANGUAGE	COGNITIVE ASPECTS	SOCIAL ASPECTS	COMM. MODALITIES.	TOTAL OBSERVATION HOURS:	
Adult									
Child									
AUDIOLOGY								TOTAL HEARING SCREENING HOURS:	
	HEARING SCREENING	OBSERVATION HEARING SCREENING	AURAL REHABILITATION / TREATMENT	OBSERVATION AURAL REHAB/TREATMENT	TOTAL HEARING SCREENING OBSERVATION HOURS:				
Adult									
Child								TOTAL AURAL REHAB/ TX HOURS:	
								TOTAL OBSERVATION AURAL REHAB/ TX HOURS:	
By signing this document, I confirm that this student received 25% supervision per case								TOTAL SIMULATION HOURS	

Clinical Supervisor Name (please print)

ASHA Account Number

CA License Number

Clinical Supervisor Signature

Date Signed