SJSU | DEPARTMENT OF COMMUNICATIVE DISORDERS AND SCIENCES

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: (select one) ☐ **EDAU 177** ☐ **EDSP 177**

	SPEECH			LANGUAGE			
EVALUATION	PHONOLOGY / ARTICULATION	VOICE / RESONANCE	FLUENCY	REC. / EXP. LANGUAGE	COGNITIVE ASPECTS	SOCIAL ASPECTS	COMM. MODALITIES.
Adult							
Child							
TREATMENT	PHONOLOGY / ARTICULATION	VOICE / RESONANCE	FLUENCY	REC. / EXP. LANGUAGE	COGNITIVE ASPECTS	SOCIAL ASPECTS	COMM. MODAL.ITIES
Adult							
Child							
OBSERVATION	PHONOLOGY / ARTICULATION	VOICE / RESONANCE	FLUENCY	REC. / EXP. LANGUAGE	COGNITIVE ASPECTS	SOCIAL ASPECTS	COMM. MODALITIES.
Adult							
Child							

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

AUDIOLOGY

	HEARING SCREENING	OBSERVATION HEARING SCREENING	AURAL REHABILITATION/ TREATMENT	OBSERVATION AURAL REHABILITATION/ TREATMENT		
Adult					TOTAL HEARING SCREENING HOURS	
Child					TOTAL HEARING SCREENING OBERVATION HOURS	
					TOTAL AURAL REHAB/ TX HOURS:	
					TOTAL OBSERVATION AURAL REHAB/ TX HOURS:	

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

_____
Clinical Supervisor Name (please print)

_____ _____
ASHA Account Number CA License Number

_____ _____
Clinical Supervisor Signature Date Signed