

**KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
Supervised Professional Experience Documentation**

The **applicant** shall complete Parts 1 and 2 and sign the back of this form.

The **supervisor** shall complete Parts 3 and 4 of this form within 30 days of completion of the supervised postgraduate professional experience.

Part 1 APPLICANT INFORMATION

Applicant Name _____
Last First MI Other last name used
Address _____
Street PO Box City State Zip
Telephone: Work (____) _____ Home (____) _____
Temporary License Number _____ Issue Date _____ Expiration Date _____

Part 2 EMPLOYMENT INFORMATION

Name of Employer _____
Employing Agency _____
Address _____
Street PO Box City State Zip
Business Telephone (____) _____

Part 3 SUPERVISOR INFORMATION

Name of Supervisor _____
Business Address _____
Agency/Business Street/PO Box City State Zip
Business Telephone (____) _____
Kansas License Number _____ Expiration Date _____
Does Supervisor hold ASHA CCC? ____ Yes ____ No
If Yes, in what area? ____ Speech-Language Pathology ____ Audiology ____ Both
Supervisor's ASHA Account Number _____

Part 4 SUPERVISOR'S REPORT

Supervision Period Began On _____ Supervision Period Ended On _____
How many hours per week did the applicant work? ____ 30 or more
____ 25-29
____ 20-24
____ 15-19

Percent of work week applicant spent in direct client contact, i.e., assessment, diagnosis, evaluation, screening, habilitation, or rehabilitation of persons with speech, language or hearing handicaps: _____%

Complete Chart A indicating the number of onsite observation hours and other monitoring activities completed during each month (chronologically). Refer to Chart B for the required number of months and complete Chart A only for the months that this report covers.

(Over)

Chart A: Supervision

Month of Supervision	Number of Onsite Hours	Number of Hours of Other Monitoring Activities
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
Total Hours		Total Number of Activities

Chart B: Time Requirements

Required Number of Months When Working the Following Number of Hours Each Week 15-19 hours/week must work 18 months 20-24 hours/week must work 15 months 25-29 hours/week must work 12 months 30+ hours/week must work 9 months

Based upon your monitoring and evaluation of the applicant, do you find the applicant has satisfactorily completed the supervised postgraduate experience? Yes No

If no, please explain: _____

I have discussed this report with the applicant and attest that the information as reported is correct.

Signature of Supervisor

Date

Applicant: I have read and discussed this report with my supervisor and:
 I concur with the supervisor's report or
 I do not concur with the supervisor's report and I will reply in writing within 30 days of the date of this report.

Signature of Applicant

Date

Mail completed form to: Health Occupations Credentialing
1000 SW Jackson, Suite 200
 Topeka KS 66612-1365