OKLAHOMA BOARD OF EXAMINERS FOR SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY
3700 N Classen Blvd Ste. 248 Oklahoma City, OK. 73118
Oklahoma.gov/OBESPA

REPORT OF CLINICAL FELLOW

Please Print Clearly

LICENSEE'S INFORMATION

1. Licensee's Name: _____
First Last Middle Int.

2. CF License Number: _____

3. Address: _____
P.O. Box, Street Number, Street Name, City, State, Zip Code

4. Licensee's Email Address: _____

5. Licensee's Phone Number: _____

6. Supervisor's Name: _____
First Last Middle Int.

7. Supervisor's License Number: _____

8. Name of Employer During CF: _____

9. Employer Phone Number: _____

10. Employer Address: _____
P.O. Box, Street Number, Street Name, City, State, Zip Code

REQUIREMENTS OF CLINICAL FELLOWSHIP

11. Start date of CF: _____

12. Last date of CF: _____

13. Number of weeks of Supervised CF: _____
(minimum 36 weeks)

14. Hours worked per week:
Full-Time (30hrs or more a week) ☐
OR
Part-Time (30hrs or less a week) ☐

15. Number of Instances of Supervisory monitoring: _____ (minimum 36 instances)
(Supervisory monitoring activities can include correspondence, videotape, audiotape, review of clinical records, phone conferences, evaluation by professional colleagues, consultation with clients and families)

16. Number of On-Site Observations of Direct Client Contact:

_____ (minimum 18)

Please fill out the graph below to show your 18 On-site observations

* 1 hour = 1 observation
* At least 6 observations must have been accrued during each 12-week (each 3rd) period of the Clinical Fellow
* A MAX of 6 observations may be accrued in one day
* Types of observations should include:
  Screening (S), Evaluation/Assessment (E), Habilitation (H), and Rehabilitation (R)

First 12 weeks	Second 12 weeks	Third 12 weeks
Date/Type/# of Hours	Date/Type/# of Hours	Date/Type/# of Hours

The information below must be completed by the Supervising SLP

17. Do you recommend this Clinical Fellow for SLP licensure? (Check the one that is applicable)

☐ ☐

Yes No

Please explain the reason for your recommendation:

_____
_____
_____
_____
_____
_____
_____
_____

18. I certify that the information provided on this form is accurate to the best of my knowledge

_____ _____

Clinical Fellow Signature Date

_____ _____

Supervisor's Signature Date