BOARD OF EXAMINERS FOR SPEECH-LANGUAGE PATHOLOGYAND AUDIOLOGY
3700 N CLASSEN BLVD, STE 248
OKLAHOMA CITY, OK 73118

REPORT OF CLINICAL FELLOWSHIP

NAME: _____ CF#: _____
FIRST MIDDLE LAST

HOME ADDRESS: _____
STREET CITY STATE ZIP

PHONE#: _____

COMPANY NAME <u>DURING CF</u>: _____

WORK: _____
STREET CITY STATE ZIP

WORK#: _____

NAME OF SUPERVISOR: _____ LICENSE #: _____

COMPANY NAME <u>AFTER CF</u>: _____

ADDRESS: _____
STREET CITY STATE ZIP

WORK#: _____ WK EMAIL: _____

<u>REQUIRMENTS OF CLINICAL FELLOWSHIP:</u>

1. **START DATE OF CF: _____COMPLETION DATE OF CF: _____**

2. **NUMBER OF WEEKS OF SUPERVISED CF: _____ (MINIMUM 36 WEEKS)**
   (FULL TIME = 36 weeks or more & PART TIME = 72 weeks or more)

3. **HOURS WORKED PER WEEK: _____**
   (FULL TIME = 30+ hours & PART TIME = 15+ hours)

4. **NUMBER OF INSTANCES OF SUPERVISORY MONITORING: _____ (MINIMUM 36)**
   (Supervisory monitoring activities can include correspondence, videotape, audiotape, review of clinical records, phone conferences, evaluation by professional colleagues, consultation with clients and families)

5. NUMBER OF ON-SITE OBSERVATIONS OF DIRECT CLIENT CONTACT OF CF: _____ (MINIMUM 18)

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

* 1 hour =1 on-site observation
* At least 6 on-site observations must have been accrued during each 12-week (each 3rd) period of the Clinical Fellowship
* A MAXIMUM of six (6) on-site observations may be accrued in one (1) day
* On-site observation should include observations of:
  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

( ) I recommend _____ for SLP licensure.
( ) I do not recommend _____ for SLP licensure.

Reasons and Recommendations:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT.

Applicant's Signature: _____ Date: _____

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT.

Supervisor's Signature: _____ Date: _____

ATTACH CHECK HERE:
(PLEASE DO NOT TAPE)