

FORM A-2**VERIFICATION OF CLINICAL EXPERIENCE FOR SLP SUPPORT PERSONNEL – ASSISTANT**

Part of State Form 53764 (R10 / 10-22)
 Approved by State Board of Accounts, 2017

INSTRUCTIONS:

1. Complete **SECTION A** and then forward this form to your previous or current speech-language pathologist (SLP) supervisor(s) for completion of **SECTION B**.
2. Submit proof that you have acquired at least one hundred (100) hours of clinical experience.
3. This form may be duplicated if your one hundred (100) hours of experience have been completed under more than one (1) SLP supervisor.
4. **SECTION B** must be completed by the applicant's previous or current supervisor and sent directly to:

Indiana Professional Licensing Agency
 402 West Washington Street, Room W072
 Indianapolis, IN 46024

SECTION A / APPLICANT INFORMATION

Name of applicant (<i>last, first, middle, maiden or previous name</i>)	Social Security Number *
Name of SLP supervisor (<i>last, first, middle, maiden or previous name</i>)	License number of SLP supervisor
Location of clinical experience	Dates of clinical experience (<i>month, day, year</i>)

SECTION B / CLINICAL EXPERIENCE / SUPERVISOR'S INFORMATION

Total number of hours the above-named applicant served in the clinical experience	Total number of hours obtained with direct face-to-face patient/client contact
Number of hours of direct face-to-face patient/client contact in speech disorders obtained by the above-named applicant	Number of hours of direct face-to-face patient/client contact in language disorders obtained by the above-named applicant
I swear that the above information is true and correct to the best of my knowledge and belief.	
Signature of SLP supervisor	Date signed (<i>month, day, year</i>)
Printed name of SLP supervisor	Daytime telephone number ()