SUPERVISED PROFESSIONAL EXPERIENCE PLAN

Instructions
This section is to be completed and signed by both the applicant for the limited license and the licensed speech-language pathologist who will be supervising the applicant during supervised professional experience. If the applicant will have more than one supervisor then this form must be completed for each supervisor.

Section 1 – Applicant Information

1. Applicant Full Name: _____
   First Middle Last
2. Applicant Mailing Address: _____
3. Applicant Email Address: _____

Section 2 – Supervised Professional Experience Proposed Dates

4. Proposed Beginning Date: _____
   ***NOTE: Applicant may not begin practice prior to a license being issued.**

Section 3 – Supervised Professional Experience Supervisor

5. Supervisor Full Name: _____
   First Middle Last
6. Supervisor Montana License Number: _____

Section 4 – Supervisor and Applicant Responsibilities

	Responsibilities	Estimated Applicant Hours per Month	Estimated Evaluation Time by Supervisor per Month
1.	Assessment, diagnosis/evaluation		
2.	Screening		
3.	Habilitation/Rehabilitation		
4.	Staff meetings		
5.	In-Service training		
6.	Recordkeeping		
7.	Other (specify)		

Section 5 – Declaration

I, the limited licensee applicant have discussed the above plan with my supervisor and agree to its implementation.

_____ _____
Legal Signature of Applicant Date

I, the supervised clinical experience supervisor have discussed the above plan the applicant and accept responsibility for its implementation

_____ _____
Legal Signature of Supervisor Date