

Supervised Experience Summary

for the Board of Speech-Language Pathologists and Audiologists

Last updated: 5/6/2025

Fill out upon completion of supervised experience hours. Must be signed by the supervisor who supervised these particular hours. If more than one supervisor, complete a new form for each. Email to dlibsdsip@mt.gov.

SUPERVISEE

Name: _____

Email: _____

License or application number (if known): _____

State issued: _____

SUPERVISOR

Name: _____

License type: _____

License number: _____

State issued: _____

DATES OF SUPERVISION

Start: _____ End: _____

TOTAL HOURS UNDER THIS SUPERVISOR

ex: 110; 690; 1260

LIMITED LICENSEES ONLY: TOTAL HOURS DIRECT CLIENT CONTACT

ex: 1008

We, the undersigned, attest that the information reported on this form is true and complete to the best of our knowledge. We are aware that any false statement or evasive answer could lead to a complaint against our respective licenses on ethical grounds.

Supervisee:

Date:

Supervisor:

Date: