KENTUCKY BOARD OF SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY
COMMONWEALTH OF KENTUCKY
PO BOX 1360
FRANKFORT, KY 40602
http://slp.ky.gov

FOR OFFICE USE ONLY:
Date:_____
[ ]Approved [ ]Denied
[ ]Deferred
Comments: _____
_____
Member Initial _____

CHANGE IN SUPERVISION
FOR A SPEECH-LANGUAGE PATHOLOGY ASSISTANT

1. Name of SLPA: _____ License Number: _____
   Email address: _____
   Home Phone:_____ Cell:_____

2. School System: _____

   School Name: _____ Phone: _____

   Address: _____
   Street City State Zip Code

3. Date of Supervision Change: _____Former Supervisor: _____

   Former Supervisor's License Number:_____ OR Former Supervisor's Teacher Certificate Number: _____

I do hereby swear and affirm that all information on this document is true and correct to the best of my knowledge:	
Licensee Signature:	Date:

4. New Supervisor Information:

   Supervisor Name: _____

   Address: _____
   Street City State Zip Code

   Home : _____ Work: _____ Cell:_____

   Place of Employment:_____

   KY License Number: _____Date Granted: _____Expiration Date:_____

   KY Teacher Certification Number:_____Date Granted: _____ Expiration Date:_____

   Beginning Date of Supervision: _____

5. Agreement to Provide Supervision

I do hereby agree to provide supervision as required by KRS 334.035 (2) and as defined by 201 KAR 17:025 Section 2 and 201 KAR 17:027 for the above named licensee to function as a Speech Language Pathology Assistant. I further agree to accept the responsibility for the practice and activities of the above named individual in his/her capacity as a Speech Language Pathology Assistant. I acknowledge that failure to utilize this person appropriately as a Speech Language Pathology Assistant and to supervise in accordance with the above cited provisions of Chapter 334A of the Kentucky Revised Statutes and the administrative regulations promulgated there under, shall be considered as aiding and abetting an unlicensed person to practice Speech Language Pathology as described in KRS Chapter 334A. I represent that I have read and understand the statutes and regulations related to licensure in Speech Language Pathology and Audiology.

SUPERVISOR'S SIGNATURE: _____ DATE: _____

Form Revised 1/2012