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 PPE SUPERVISION (SLP Interim only)

1. Name of Interim Licensee: _____ Interim Licensee Number: _____

   Email: _____

   Phone: Home ( )_____ Work ( ) _____ Cell ( )_____

2. PPE Setting:

   Facility Name: _____ Phone: _____

   Address: _____
   Street City State Zip Code

3. Original Beginning Date of PPE: _____ If applicable, start date of new employment: _____

   Original Supervisor of PPE: _____ Original Supervisor's License 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

   Phone: 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, the named supervisor for the above named applicant for licensure, have devised and discussed this plan of activities for post-graduate professional experience with said applicant and accept responsibility for its implementation. Further, I do hereby certify that my Kentucky License or Kentucky Teacher Certification is current, and will be maintained throughout this period. I represent that I have read and understand the laws and regulations related to licensure in Speech Language Pathology and Audiology.

SUPERVISOR'S SIGNATURE: _____ DATE: _____