Kentucky Board of Speech-Language Pathology and Audiology
Public Protection Cabinet – Department of Professional Licensing
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POST-GRADUATE PROFESSIONAL EXPERIENCE REPORT AND EVALUATION FORM – INTERIM SLP-A

SECTION 1: LICENSEE INFORMATION

Name of Licensee: _____

Name: _____

Address: Street _____ City: _____ State: _____ Zip Code: _____

Email Address: _____ Phone Number: _____

Academic Status (University): _____ Degree: _____ Date Conferred: _____

KY Interim License Number: _____ Date Licensed: _____

SECTION 2: SUPERVISOR INFORMATION

Name of PPE Supervisor: _____

Address: Street _____ City: _____ State: _____ Zip Code:_____

Email Address: _____ Phone Number: _____

Place of Employment: _____

Credential Information: ☐ KY SLP License #: _____ ☐ Teacher Certification #: _____

SECTION 3: POSTGRADUATE PROFFESIONAL EXEPERIENCE

Setting Details

PPE Setting (School System): _____

Address: _____ City: _____ State: _____ Zip Code: _____

Email Address: _____ Phone Number: _____

Schedule and Hours

Beginning Date of PPE: _____ Ending Date of PPE: _____

☐ Full-Time (1260 hours total; 35 hours per week over 36 weeks)

☐ Part-Time (1260 hours total earned over no more than 24 months)

☐ _____ hours/week X _____# weeks = 1260 hours

☐ This report is only for a portion of my PPE **(Please attach explanation)**

Specify how many hours per week were spent in the following activities:

___ Screening

___ Therapy Activities

___ Reports

___ In-service Training

___ Other - specify here:

___ TOTAL HOURS PER WEEK

SECTION 4: SUPERVISION HOURS

Complete Chart A indicting the number of direct and indirect supervision hours completed during each four-week period. A is only for the weeks that this report covers.

Weeks of PPE	***Number of Direct Supervision Hours (minimum of 3 hours per week)***	***Number of Indirect Supervision Hours (minimum of 3 hours per week)***
Week 1-4		
Week 5-8		
Week 9-12		
Week 13-16		
Week 17-20		
Week 21-24		
Week 25-28		
Week 29-32		
Week 33-36		
Week 37-40		
Week 41-44		
Week 45-48		
Week 49-52		
Week 53-56		
Week 57-60		

Week 61-64	_____	_____
Week 65-68	_____	_____
Week 69-72	_____	_____
Week 73-76	_____	_____
Week 77-80	_____	_____
Week 81-84	_____	_____
Week 85-88	_____	_____
Week 89-92	_____	_____
Week 93-96	_____	_____
TOTAL HOURS	_____	_____

SECTION 5: SUPERVISOR EVALUTION

EVALUATION PORTION TO BE COMPLETED BY SUPERVISOR: Please use the following scale to rate each skill after completion of each segment (each segment = 1/3 of PPE) 3 = Strongly Agree; 2 = Agree; 1= Disagree

	SEGMENT 1 period covered ____to ____	***SEGMENT 2 period covered ____to ____***	***SEGMENT 3 period covered ____to ____***
Appropriately implements screening procedures	_____	_____	_____
Follows documented treatment plans effectively	_____	_____	_____
Appropriately and consistently documents student progress	_____	_____	_____
Maintains student records in a timely and efficient manner	_____	_____	_____
Complies with program administrative and other regulatory policies such as due process documentation	_____	_____	_____
Demonstrates competent communication skills, including listening, speaking, nonverbal communication and writing	_____	_____	_____
Evaluates own strengths and weaknesses	_____	_____	_____
Maintains confidentiality	_____	_____	_____
Effectively controls student behavior	_____	_____	_____
Reinforces target communication skills effectively	_____	_____	_____
Is reliable and dependable	_____	_____	_____
Keeps supervisor informed about student's progress and needs	_____	_____	_____
Consistently follows schedule approved by supervisor	_____	_____	_____
Seeks supervisory assistance when needed	_____	_____	_____
Appropriately collaborates with other professionals	_____	_____	_____

As the interim SLPA Licensee, I hereby certify that all information on this form is true and complete to the best of my knowledge.

INTERIM SLPA LICENSEE SIGNATURE: DATE:

_____ _____

As the Speech Language Pathology Assistant Postgraduate Professional Experience Supervisor, I certify that has engaged in only those activities in the SLP Assistant's scope of responsibilities. I further certify that these activities have been successfully completed and supervised as specified in KRS 334A.

☐ YES ☐ NO (If no, please attach letter of explanation)

I recommend that _____ receive full licensure as a Speech-Language Pathology Assistant. I have discussed this report with the interim licensee. Furthermore, I certify that my credentials were current throughout this PPE. I have completed and attached the required report/evaluation form. I represent that I have read and understand the laws and regulations related to licensure in Speech Language Pathology and Audiology.

SUPERVISOR SIGNATURE: _____ DATE: _____