



KENTUCKY BOARD OF
SPEECH LANGUAGE PATHOLOGY AND AUDIOLOGY

P.O. Box 1360
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<http://www.slp.ky.gov>

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

POSTGRADUATE PROFESSIONAL EXPERIENCE
REPORT AND EVALUATION FORM for Interim SLP-A

I. Name of Interim Licensee:

Last First Middle Maiden
Address: _____
Street City State Zip Code
Academic Status: _____
University Degree Date conferred
Email address: _____
Phone Numbers: Home () _____ Work () _____ Cell () _____
Kentucky Interim License Number _____ Date Licensed _____

II. Name of PPE Supervisor:

Last First Middle Maiden
Address: _____
Street City State Zip Code
Email address: _____
Phone: Home () _____ Work () _____ Cell () _____
Place of Employment _____
Credential Information: [] Kentucky SLP License # _____ [] Teacher Certification # _____

III. PPE Setting: _____

School System

Address: _____
Street City State Zip Code
Phone: Work () _____

IV. 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**)

V. 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

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

Chart A: PPE Supervision

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		

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.

SIGNATURE OF INTERIM SLPA LICENSEE _____ 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. I recommend that _____ receive full licensure as a Speech-Language Pathology Assistant.

[] YES [] NO (Note: If no, please attach letter of explanation)

IX. 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.

SIGNATURE OF SUPERVISOR _____ DATE _____