IOWA BOARD OF SPEECH PATHOLOGY & AUDIOLOGY
Iowa Department of Public Health/Professional Licensure
Lucas State Office Building, 5th Floor
321 E. 12th Street
Des Moines, IA 50319-0075

SUPERVISED CLINICAL EXPERIENCE PLAN
Nine months full time (or equivalent)

I. Applicant: (type or print)

A. Name:_____
(last) (first) (middle) (birth)

B. Address:_____
(street) (city) (state) (zip)

C. Home phone:_____ Office phone:_____

D. Type of license desired: temporary speech pathology___temporary audiology___

II. Supervised Clinical Experience Setting:

A. Facility Name:_____

B. Address:_____

C. YOUR SUPERVISED CLINICAL EXPERIENCE (SCE) MAY BEGIN AFTER THE TEMPORARY LICENSE IS ISSUED AND THE BOARD HAS APPROVED YOUR PLAN. Supervision completed before the temporary license is issued will not be accepted.

Beginning Date:_____ Ending Date:_____

D. Proposed hours of work per week:_____(total).

E. Work experience includes (Check all applicable for this setting).

1. Pediatric population_____
2. Adult population_____
3. Geriatric population_____

III. Supervisor: (type or print). If more than one supervisor will be utilized, please provide necessary information on each one.

A. Name:_____
(last) (first) (middle)

B. Address:_____
(street) (city) (state) (zip)

C. Home phone:_____ Office phone:_____

D. Place of Employment_____
(facility name)

_____
(street) (city) (state) (zip)

E. Iowa License Number: Speech Pathology_____ Audiology_____

F. Iowa License Current to (Date):_____

IV. Applicant's plan of activity and responsibilities: (be specific).

I have discussed this plan with the supervisor herein designated.

_____ _____

(Signature of Applicant) (Date)

V. Plan of Supervision (include type, frequency, duration of contract).

I have read, discussed and approved this plan with the applicant.

_____ _____

(Signature of Supervisor) (Date)