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 REPORT
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: Speech Pathology____ Audiology____

II. Supervised Clinical Experience Setting:

A. Facility Name:_____

B. Address:_____

C. Actual hours worked per week:_____(total).

D. Dates of supervised clinical experience (SCE). Must match dates approved on plan:

Beginning Date:_____

Ending Date:_____

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 was 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. Was the SCE plan implemented as submitted? Yes_____ No_____

V. If the SCE plan was not implemented as described in the original request, please give explanation below.

VI. Do you recommend that the SCE report be accepted by the board as meeting the requirements for licensure? Yes_____ No_____
List reason for your determination:

VII. I have read and discussed this report with my SCE supervisor and my SCE is completed.

_____ _____
(Signature of Applicant) (Date)

VIII. _____ _____
(Signature of Supervisor) (Date)