

**STATE OF NORTH CAROLINA**  
**BOARD OF EXAMINERS FOR SPEECH & LANGUAGE PATHOLOGISTS & AUDIOLOGISTS**  
PO BOX 16885, GREENSBORO, NC 27416-0885. [www.ncboeslpa.org](http://www.ncboeslpa.org)  
**SUPERVISED EXPERIENCE YEAR PLAN**

License Application Area: \_\_\_\_\_ Speech-Language Pathology \_\_\_\_\_ Audiology

**I. IDENTIFICATION:**

A. NAME: \_\_\_\_\_  
(Type or Print)

B. HOME ADDRESS:

C. BUSINESS ADDRESS (Employer)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

Telephone: \_\_\_\_\_

C. Preferred Mailing Address: \_\_\_\_\_ Home \_\_\_\_\_ Business

**II. SUPERVISED EXPERIENCE SETTING:**

A. **Exact name/addresses of places of supervised experience (Work Sites):**

\_\_\_\_\_  
-  
\_\_\_\_\_  
-  
\_\_\_\_\_  
-  
\_\_\_\_\_  
-  
\_\_\_\_\_

B. Hours per week to be spent in: Speech-Language Pathology \_\_\_\_\_ Audiology \_\_\_\_\_

C. Beginning Date of Employment: \_\_\_\_\_

**III. SUPERVISOR**

A. Name of supervisor: \_\_\_\_\_ N.C. License # \_\_\_\_\_

B. Supervisor's place of employment and address:

\_\_\_\_\_  
\_\_\_\_\_  
-  
\_\_\_\_\_

**COMPLETE & SIGN FORM ON BACK**

Telephone: \_\_\_\_\_

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**BOARD USE ONLY**

Application Approved: \_\_\_\_\_

Employment: \_\_\_\_\_ Full-time \_\_\_\_\_ Part-time

Beginning Date of SEY: \_\_\_\_\_

Anticipated Completion Date: \_\_\_\_\_

IV. CLINICAL AND SUPERVISORY RESPONSIBILITIES:

The Board shall interpret Section 90-295(4) to mean the supervision which will be satisfactory to the Board **must include four hours per month of direct, on-site observation of the applicant's direct work with patients**, in addition to "other" methods of supervision (e.g. video/audio tape recording review, records review, staff meetings, telephone conferences/correspondence, etc.). **THE APPLICANT MUST BE EMPLOYED A MINIMUM OF TWENTY HOURS PER WEEK TO MAINTAIN AN ACTIVE LICENSE.**

	Hours per week to be spent by <u>applicant</u> in:	Planned hours/month of direct on-site supervision/area:
1. Assessment, diagnosis and/or evaluations	_____	_____
2. Screening	_____	_____
3. Habilitation/rehabilitation/ therapy/counseling	_____	_____
4. Staff meetings	_____	XXXXXXXXXXXXXXXX
5. Record keeping	_____	XXXXXXXXXXXXXXXX
6. Other ( <b>specify</b> )	_____	XXXXXXXXXXXXXXXX
<b>TOTAL:</b>	_____	_____

Number of "other" types of planned supervision activities per month: \_\_\_\_\_

V. TO BE COMPLETED BY THE APPLICANT:

I have met with and discussed this plan with my SEY supervisor. Furthermore, I checked and found that my supervisor holds a valid N.C. license in the area in which I seek licensure. If it is determined at a later date that this statement is not true, I and not the Board, assume full responsibility for a invalid SEY.

SIGNATURE OF APPLICANT \_\_\_\_\_ Date \_\_\_\_\_

VI. TO BE COMPLETED BY THE SUPERVISOR:

I have met with and discussed this plan with the applicant and accept responsibility for its implementation. Furthermore, I certify that my license will be current throughout this SEY and I will fulfill this responsibility even if I am unable to recommend the applicant at the end of the SEY experience.

SIGNATURE OF SUPERVISOR \_\_\_\_\_ Date \_\_\_\_\_

**\*\*\*NOTICE\*\*\***

**Any change in the above plan OR supervisor must be reported to the Board PRIOR to implementing the change or continuing the practice.**

The Board of Examiners has a policy requiring that a supervisor be within approximately fifty miles of the temporary licensee who is under his/her supervision. If there are extenuating circumstances, you may contact the Board's office and request that your particular employment situation be reconsidered.

## **NOTICE TO APPLICANTS FOR TEMPORARY LICENSE**

The Board of Examiners for Speech and Language Pathologists and Audiologists has determined that supervised experience which will meet the Board's approval for a permanent license must be characterized **by a least seventy percent (70%) of work time devoted to clinical activities** (e.g. planning for direct patient services, analysis of data obtained in diagnostic and/or therapeutic services, analysis of data obtained in diagnostic and/or therapeutic contacts, reporting and/or counseling with patients and their families or other professionals). **Not to be included in meeting the 70% requirement are journal groups, administrative activities, staff meetings, inservice training, public relations, or travel.**

**IT IS THE RESPONSIBILITY OF THE APPLICANT OR TEMPORARY LICENSEE TO NOTIFY THEIR IMMEDIATE SUPERIOR AND EMPLOYER, IF DIFFERENT, OF THIS REQUIREMENT. IF THERE IS TO BE ANY CHANGE OF ANY KIND ON THE SUPERVISED EXPERIENCE YEAR PLAN THAT WAS APPROVED, A NEW SEY PLAN MUST BE PROVIDED TO THE BOARD BEFORE THE CHANGE IS MADE.**