**Th**e **Commonwealt**h **o**f **Massachusett**s **Departmen**t **o**f **Publi**c **Health**

BOARD OF REGISTRATION FOR

SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY

250 Washington Street

BOSTON, MA 02108

(617) 624-6125

[https://www.mass.gov/orgs/board-of-registration-for-speech-language-pathology-and-audiology](http://www.mass.gov/orgs/board-of-registration-for-speech-language-pathology-and-audiology)

F**OR**M **1**- **SUPERVISE**D **PROFESSIONA**L **PRACTIC**E **PLA**N - **SPEECH-LANGUAG**E **PATHOLOG**Y

**Instructions:**

* **For**m 1 **mus**t **b**e **submitte**d **t**o **th**e **Boar**d **withi**n **seve**n **(7**) **day**s **o**f **beginnin**g **you**r **CFY.**
* **Answe**r **al**l **questions**. **Writ**e **"NO**T **APPLICABLE**" **i**f **n**o **othe**r **respons**e **i**s **appropriate.**
* **I**f **you**r **superviso**r **changes**, **pleas**e **submi**t a **For**m 2 **t**o **complet**e **tha**t **portio**n **o**f **th**e **Supervise**d **Practic**e **plan**. **Also**, **yo**u **mus**t **remi**t a **ne**w **For**m 1 **an**d **For**m 2 **fo**r **eac**h **ne**w **supervisor.**

1. **Speech-Languag**e **Patholog**y **Applicant: I**f **nam**e **ha**s **bee**n **altere**d **sinc**e **applicatio**n **submission**, **Nam**e **o**n **Application**:

**Name:**

**(Last**) **(First**) **(Middle**)

**Address**:

**(Number**) **(Street**)

**(City**) **(State**) **(Zip**)

**(Phone**: **Cell/Home**) **EMAI**L

# Professional Practice Site Information:

**Site**:



**(Compan**y **Name**) **(Division/Department**)

**Address**:



**(Number**) **(Street**)



**(City**) **(State**) **(Zip**)

**Beginnin**g **Date**: **Endin**g **Date**: **Hour**s **pe**r **WeeN**:

**(MM/DD/YYYY**) **(MM/DD/YYYY**)

# Supervisor Information:

**Name**:

**(Last**) **(First**) **(Middle**)

**Address**:

**(Number**) **(Street**)

**(City**) **(State**) **(Zip**)

**Phone**:

**(Business**) **EMAI**L

# Supervisor’s Current Licensure Status:

**Massachusetts License#: Expiration Date:**

**Other State (Specify): License Number: Expiration Date:**

# Supervisor’s Professional Certification(s):

**ASHA/CCC-SLP Certification Number: Expiration Date:**

**Massachusetts Teacher’s Certification Number: Expiration Date:**

# Educational, Supervised Professional Practice, and Examination Requirements:

To be licensed as a Speech-Language Pathologist, an applicant must be of good moral character and meet the educational, clinical, supervised professional practice, and examination requirements specified in the current American Speech-Language-Hearing Association (ASHA) Standards and Implementation Procedures for a Certificate of Clinical Competence in Speech-Language Pathology. Although standards created by ASHA are referenced by the Board, **the Board does not require that applicants obtain or maintain membership in ASHA.** However, ASHA membership/certification of the supervisor may be required if the applicant seeks membership/certification in ASHA once licensed. Please contact ASHA for more information at [www.asha.org.](http://www.asha.org/)

# Statement of the Applicant:

**Applicant, please contact the Board to ensure that your:**

* 1. **Application with $68.00 fee**
  2. **Praxis score [Board code: R7461]**
  3. **Official graduate school transcript including date the degree was conferred**
  4. **Clock hours earned during graduate school**

**have all been received. This will allow faster processing of your application upon receipt of your Form 2.**

**I HAVE DISCUSSED THE PLAN FOR SUPERVISION WITH THE PERSON NAMED AS SUPERVISOR AND AGREE TO ITS IMPLEMENTATION. I UNDERSTAND THAT I MUST NOT WORK AFTER THE END DATE SPECIFIED ON MY FORM 2 UNTIL I AM LICENSED BY THE BOARD. POST CLINICAL FELLOWSHIP WORK WILL SUBJECT BOTH THE APPLICANT AND SUPERVISOR TO DISCIPLINARY ACTION BY THE BOARD.**

**(Applicant’s Signature) (Date)**

# Statement of Supervisor:

I HEREBY CERTIFY THAT ALL STATEMENTS MADE BY ME IN RELATION TO THIS PLAN ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF. I FURTHER CERTIFY THAT I UNDERSTAND THE RESPONSIBILITIES OF A SUPERVISOR AS STATED IN THE RULES AND REGULATIONS OF THE MASSACHUSETTS BOARD OF REGISTRATION FOR SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY. (TITLE 260 OF THE CODE OF MASSACHUSETTS REGULATIONS). I UNDERSTAND THAT THE APPLICANT MUST NOT WORK AFTER THE END DATE SPECIFIED ON THE FORM 2 UNTIL LICENSED BY THE BOARD. POST CLINICAL FELLOWSHIP WORK WILL SUBJECT BOTH THE APPLICANT AND SUPERVISOR TO DISCIPLINARY ACTION BY THE BOARD.

**(Supervisor’s Signature) (Date)**

**Please upload signed form and keep original form on file.**