The Commonwealth of Massachusetts

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

**FORM 2 - SUPERVISED PROFESSIONAL PRACTICE REPORT – SPEECH-LANGUAGE PATHOLOGY**

**Instructions: ·Form 2 must be submitted to the Board within One (1) day of the completion of the Professional Practice. Please email Form 2 to** **speech.audiology@mass.gov.**

**·If your supervisor changed, please submit a Form 1 to correlate with that portion of the Supervised Practice year. Also, you must**

**forward a new Form 1 and Form 2 for all other supervisor(s).**

|  |
| --- |
| **IMPORTANT NOTE: Post clinical fellowship work will subject both you and your supervisor to disciplinary action by the Board.****1. Speech-Language Pathology Applicant**: If name has changed since application your initial submission, **Name on Application:** **Name:**  |
|  | (Last) | (First) | (Middle) |
| **Address:** |  |
|  | (Number) | (Street) |  |
|  | (City) | (State) | (Zip) |
| **Phone:** |  ( )  |   |  |
|  | (Home) | EMAIL: |  |

# Professional Practice Site Information:

|  |
| --- |
| **Site:**  |
| (Company Name) | (Division/Department) |  |
| **Address:**  |
| (Number) | (Street) |  |
| (City) | (State) | (Zip) |

|  |  |  |
| --- | --- | --- |
| **Beginning Date:**  | **Ending Date:**  | **Hours per Week:** |

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

* + If the ending date is different from ending date specified in your Form 1, please indicate here and attach a letter of explanation signed by both the applicant and the supervisor. Additional documentation may be required.

# Supervisor Information:

|  |  |
| --- | --- |
| **Name:** |  |
|  | (Last) | (First) | (Middle) |
| **Address:** |  |
|  | (Number) | (Street) |  |
|  | (City) | (State) | (Zip) |
| **Phone:** |  ( )  |   |  |
|  | (Business) | EMAIL |  |

1. **Supervisor’s Current Licensure Status:**

|  |  |
| --- | --- |
| **Massachusetts License#:** |  **Expiration Date:**  |
| **Other State (Specify):**  | **License Number:**  | **Expiration Date:** |

# Supervisor’s Professional Certification(s):

|  |  |
| --- | --- |
| **ASHA/CCC-A 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. [www.asha.org](http://www.asha.org/)

# Professional Practice Plan completion:

**Has the applicant successfully fulfilled the Professional Practice Plan responsibilities as specified in Form 1?**

|  |  |  |
| --- | --- | --- |
| * **Yes**
 | * **No**
 | **If no, please explain** |

# Recommendation of Supervisor:

I hereby  **recommend OR**  **do not recommend** for licensure as a SPEECH-LANGUAGE PATHOLOGIST**.**

APPLICANT AND SUPERVISOR 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.

|  |  |  |
| --- | --- | --- |
| **Applicant’s Signature** |  | **Date** |

|  |  |  |
| --- | --- | --- |
| **Supervisor’s Signature** |  | **Date** |

**Scan and email completed form to** **speech.audiology@mass.gov.**