ARKANSAS BOARD OF EXAMINERS
IN SPEECH-LANGUAGE
PATHOLOGY AND AUDIOLOGY

Renee Mallory
SECRETARY OF HEALTH

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Speech-Language Pathology Assistant Supervisor Application

SLPA

Name:

Email Address: Phone:

ABESPA License Number (if known):

Supervisor (Primary)

Name:

Email Address: Phone:

ABESPA License Number: ASHA Account Number:

CCC award date:

Workplace Setting

Facility Name:

Address:

City and State: Zip Code:

Supervisor (Secondary, if applicable)

Name:

Email Address: Phone:

ABESPA License Number: ASHA Account Number:

CCC award date:

Additional Workplace Setting (Secondary, if applicable)

Facility Name:

Address:

City and State: Zip Code:

Supervisor's Agreement

I, _____ have agreed to provide required and appropriate supervision to_____, registrant for SLPA. I have also completed the required SLP Assistants/Supervision training Modules on _____.

_____ _____

Signature of Primary Supervisor Date

_____ _____

Signature of Secondary Supervisor Date