



GOVERNMENT OF THE DISTRICT OF COLUMBIA
Health Professional Licensing Administration
899 North Capitol Street, NE – First Floor
Washington, DC 20002

AUDIOLOGY/SPEECH-LANGUAGE PATHOLOGY APPLICANTS

This form must be returned in a sealed envelope and hand delivered to the office of Health Professional Licensing Administration by the audiology or speech-language pathology applicant. Please note: You must have an application on file.

SUPERVISED PRACTICE FORM TO BE COMPLETED BY AUDIOLOGY OR SPEECH-LANGUAGE PATHOLOGY SUPERVISOR

I _____
(Supervisor's signature) (Supervisor's license number)
understand that this applicant can not work in my facility without a current District of Columbia Supervised Practice Letter or Licensure. I agree to supervise this applicant's practice and understand that during the time of the supervision I may be subject to disciplinary action for any violation of the Act. I understand that this **applicant may work under my supervision for ninety (90) days and that this supervised practice form is not renewable.**

Date of Hire/Employment: _____ **Facility's Name:** _____

Supervisor's name and license number (Please Print):

LAST NAME, FIRST NAME MI LICENSE NUMBER

Applicant's Name (Please Print):

LAST NAME, FIRST NAME MI LICENSE NUMBER

FOR OFFICE USE ONLY

Date supervision form Submitted: _____ Date supervision will end: _____

DC SEAL

HPLA Staff Signature:
