STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
Board of Speech, Audiology and Hearing
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035

Janet T. Mills
Governor

Anne L. Head
Commissioner

Supervision Form for Speech-Language Pathology Assistant Licensees

This form is required to be submitted by applicants for a speech-language pathology assistant license or to report changes in supervisory relationships to the Board.

Employment Setting **A completed Supervisor form is needed for each place you will be employed.**		
Name of Assistant:	License Number:	
Name of Practice Setting:		
Hours worked per week:		
Address:		
City:	State:	Zip Code:
Work Telephone:	Email:	

Supervisor Information **A completed Supervisor form is needed for each Supervisor you will have.**		
Name of Supervisor:	License Number:	
Name of Practice Setting:		
Hours supervised per week:		
Address:		
City:	State:	Zip Code:
Work Telephone:	Email:	

Supervisor Information

List the names of any other Speech-Language Pathology Assistants currently registered under your supervision and number of hours you supervise them per week:

Name	Hours: full or part time

Please note:

A supervising Speech-Language Pathologist may supervise up to 2 full-time/40 hours per week supervisees, or 4 part-time/20 hours per week supervisees, provided that a supervisor may not supervise a total number of temporary licensees, trainee hearing aid dealers and fitters, speech-language pathology assistants and students in excess of the supervisor's ability to competently supervise such persons and also perform any direct client services for which the supervisor is responsible.

Speech-Language Pathology Assistant

By signing this form, I understand that, upon licensure, I may practice only under the supervision, as defined by 32 M.R.S. §17101(17), of an approved supervising speech-language pathologist as set forth in Chapter 9, Sections 3, 4 and 5 of the Rules of the Board of Speech, Audiology and Hearing and by the laws of the State of Maine. I also understand that if this supervisory relationship changes, it is my responsibility to notify the Board within ten (10) days of the change.

Signature: _____ Date: _____

Speech-Language Pathologist

By signing this form, I agree that, upon licensure of the above named applicant, I will provide supervision pursuant to the laws of the State of Maine and all rules of the Board of Speech, Audiology and Hearing. Further, I understand that I am legally and ethically responsible for the professional activities for this and other speech-language pathology assistant(s) under my supervision. I also understand that if this supervisory relationship changes, it is my responsibility to notify the Board within ten (10) days of the change .

Signature: _____ Date: _____