IDAHO SPEECH, HEARING AND COMMUNICATION SERVICES LICENSURE BOARD
Division of Occupational and Professional Licenses
11341 W. Chinden Blvd., Building #4 Boise ID 83714 or
PO Box 83720, Boise, ID 83720-0063
Phone: (208) 334-3233 Website: https://dopl.idaho.gov
E-mail: shs@dopl.idaho.gov

AUDIOLOGIST
QUARTERLY REPORT

Evaluations are to be completed at quarterly intervals beginning from commencement of supervision. Failure to complete periodic reports may result in revocation of the Provisional Permit. NOTE: For your records, please keep a copy of all quarterly reports submitted.

NAME OF SUPERVISEE: _____ IDAHO STATE PERMIT NO: _____

NAME OF SUPERVISOR: _____ IDAHO STATE LICENSE NO:_____

DATE SUPERVISION BEGAN: _____ENDED: _____

Check Quarter	Due on or Before
☐ JAN., FEB., MARCH	APRIL 10
☐ APRIL, MAY, JUNE	JULY 10
☐ JULY, AUG., SEPT.,	OCT. 10
☐ OCT., NOV., DEC.,	JAN. 10

Please indicate which report you are submitting e.g., #1, #2 etc.
Report # _____ Final Report: Yes____ No _____

1. Total number of cumulative hours under provisional permit: _____

Date of client contact	Individual (I) / Group (G) & # in group / Mentoring activity (M)	Time /session in minutes	Supervisor initials when directly supervised or mentored
Example			
6/2/16	G – 3 (Group with 3 individuals)	30	JO
"	I (Individual)	20	
"	M (Mentoring)	30	
Use the following grid to record your activities.			

1. Evaluation of your supervisee, including Evaluation, Treatment, Management, and Interaction Skills.
   Please feel free to use additional space as needed.

2. Briefly describe the setting in which the candidate's clinical work is being performed.

3. Do you have any reservations regarding the candidate's ability to perform as an audiologist? If so, explain.
   Please feel free to use additional space as needed.

We, the Supervisor and the Supervisee verify that we have discussed this report.

Print Supervisee Name: _____

Signature of Supervisee: _____

Print Supervisor Name: _____

Idaho State License #: _____

Signature of Supervisor: _____