IDAHO SPEECH, HEARING AND COMMUNICATION SERVICES LICENSURE BOARD
Division of Occupational and Professional Licenses
11341 W. Chinden Blvd., 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

SPEECH LANGUAGE PATHOLOGY PROVISIONAL PERMIT 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. Reports can be emailed or mailed to the address above. Reports are considered to be on-time if postmarked or received before the 10th of the month that the report is due. Please do not staple reports.

Note – When you complete your final Quarterly Report, you can submit it with your SHS Speech-Language Pathologist Application Original License.

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., MAR.	APR. 10
☐ APR., MAY, JUNE	JULY 10
☐ JULY, AUG., SEPT.	OCT. 10
☐ OCT., NOV., DEC.	JAN. 10

Working ☐ **Full Time** or ☐ **Part Time.**
If Part-time, please list approximate # of hours per week _____.

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

1. Total number of hours worked this quarter by the supervisee: _____

   1a. Of the hours in #1, list the hours of Direct Client Contact: _____
   NOTE: direct client contact means assessment/diagnosis/evaluation, screening, treatment, report writing, family/client consultation, and/or counseling.
   1b. Of the hours in #1, list the hours of on-site supervision/observations of Direct Client Contact: _____
   (A total of at least 18 hours is required by the conclusion of the supervision.)
   1c. Of the hours in #1, list the hours of other mentoring activities: _____

Cumulative Report: As hours are accumulated each quarter please provide total hours by adding hours from #1 in all previous quarterly reports whether completed under this or another supervision plan. If this is **your** first quarterly report then merely copy **the** number of hours from #1 above.

2. Cumulative number of hours worked _____/1260

3. Cumulative number of hours of direct client contact _____/1010

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			
6/2/13	G - 3	30	JO
"	I	20	
"	M	30	
Use the following grid to record your activities.			

The sample log sheet may be copied as needed or a spreadsheet containing this information may be substituted.

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 a speech language pathologist? 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. We further verify that we have completed the requirements as outlined in Rule 460.

Print Supervisee Name: _____Signature of Supervisee:_____

Print Supervisor Name: _____Signature of Supervisor: _____

Idaho State License #: _____