

IDAHO STATE BOARD OF SPEECH AND HEARING SERVICES

Bureau of Occupational Licenses

700 West State Street, Boise ID 38702

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Boise, ID 83720-0063

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**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

JAN., FEB., MARCH

APRIL, MAY, JUNE

JULY, AUG., SEPT.,

OCT., NOV., DEC.,

Due on or Before

APRIL 10

JULY 10

OCT. 10

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: _____

AUD Quarterly Report
(Continued)

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

Print Supervisee Name: _____

Signature of Supervisee: _____

State of _____, County of _____, ss.

Subscribed and sworn before me this _____ day of _____, 20____.

(seal)

Notary Public Official Signature
My Commission Expires _____

Print Supervisor Name: _____

Idaho State License #: _____

Signature of Supervisor: _____

State of _____, County of _____, ss.

Subscribed and sworn before me this _____ day of _____, 20____.

(seal)

Notary Public Official Signature
My Commission Expires _____