

IDAHO SPEECH, HEARING AND COMMUNICATION SERVICES LICENSURE BOARD
Idaho Bureau of Occupational Licenses
700 West State Street, Boise, 83702 or
PO Box 83720, Boise, ID 83720-0063
Phone: (208) 334-3233 Fax: (208) 334-3945
Website: www.ibol.idaho.gov E-mail: shs@ibol.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: _____

<u>Check Quarter</u>	<u>Due on or Before</u>
<input type="checkbox"/> JAN., FEB., MARCH	APRIL 10
<input type="checkbox"/> APRIL, MAY, JUNE	JULY 10
<input type="checkbox"/> JULY, AUG., SEPT.,	OCT. 10
<input type="checkbox"/> 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: _____

AUD Quarterly Report
(Continued)

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.			

AUD Quarterly Report
(Continued)

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.

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 _____