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

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.

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 (please note that Rule 220 (c) requires 6 hours quarterly): _________________
   (Some variation is permitted for part time work. 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

TSLP 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**
6/2/13	G - 3	30	*JO*
“	I	20	
“	M	30	

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: ___________________________________

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_______________________