ONLY FOR LICENSURE BY EXAMINATION

Clinical Fellowship Verification

(ASHA-CCC, ABA Board Certification and AuD applicants may disregard this form)

Access this form via website at: **hawaii.gov/dcca/pvl**

INSTRUCTIONS TO THE APPLICANT: Complete Section 1, **have your supervisor complete Section 2 to verify your clinical fellowship**, then attach the completed form to your application before submitting it to the Board. Please note that your supervisor must sign the form before a notary public.

Section 1: APPLICANT

Check the Type of License you are applying for: ◯ Speech Pathologist ◯ Audiologist

Name (First-Middle)	(Last)	Social Security No.
Address (include apt. no., city, state & zip code)		Phone No.
		Date of Birth

Signature of Applicant: _____ Date: _____

Section 2: SUPERVISOR ONLY

TO THE SUPERVISOR:

The person named above is applying for a speech pathologist/audiologist license (as indicated above) in Hawaii. Please complete Section 2 to verify the applicant completed the clinical fellowship ***under your supervision****, sign the form before a notary public, then return the completed form to the applicant.* ***To correct an error in Section 2, please draw a single line through the incorrect information and initial. DO NOT use correction fluid or write over incorrect information.***

Clinical Fellowship Experience Dates (mo/yr)		Length of Clinical Fellowship	Total Hours	Position Held	Name of Training Institution Address, City, State
From	To				
		yrs. mos.			

Affidavit of Supervisor: Please attach a brief summary of the duties that the applicant performed during the clinical fellowship.

Please respond to each question. The clinical fellowship must have met each standard:

☐ YES ☐ NO Begun after completion of academic coursework and clinical observation and clinical practicum.

☐ YES ☐ NO Consisted of at least thirty-six weeks of full-time professional experience or its part-time equivalent.

☐ YES ☐ NO Consisted of primarily clinical activities.

I hereby attest that:

1. I supervised the clinical fellowship of the individual listed above;
2. I hold an ASHA certificate of clinical competence or board certification in audiology from the ABA in the area of practice for which the certificate is sought; and this certification was current throughout my supervision of the above applicant's clinical fellowship.
3. Number of formal evaluations conducted to evaluate applicants progress in development of professional skills: _____.

I further certify that the statements and information provided on this verification of clinical fellowship and attached documents are true and correct.

_____ Address: _____

Signature of Supervisor _____

Print your name: _____ Phone No.: _____

(CONTINUED ON PAGE 2)

Applicant Name: _____ Date: _____

Section 2: **SUPERVISOR ONLY**

Area of ASHA Certification: _____

ASHA Account Number: _____

Effective Date of Certification: _____

Valid Through: _____

ABA Certificate Number: _____

Issue Date: _____

Current Expiration Date: _____

Subscribed and sworn to before me this

_____ day of _____ , A.D. 20 _____.

_____

Notary Public, State of: _____

My commission expires: _____

Print Name: _____

Doc. Date: _____ No. of Pages: _____

Notary Name: _____ Circuit Court: _____

Doc. Description _____

_____

Notary Signature: _____

Date _____

Print Form

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.