Verification of Clinical Fellowship Supervisor-Provisional License

(Speech Pathologist only)

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

INSTRUCTIONS TO THE APPLICANT:
Complete Section 1, then have your supervisor complete Section 2 to verify their credentials to supervise your clinical fellowship. **Please note that your supervisor *must* sign the form before a notary public**. When both parties have completed their sections, attach the completed form to your application for submission it to the Board.

Section 1: APPLICANT

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

TO THE SUPERVISOR: *The person named above is applying for a speech pathologist provisional license in Hawaii. Please complete Section 2 to verify the applicant will complete 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.

Planned Clinical Fellowship Experience Dates		Position Held	Name of Training Site Address, City, State
From	To		
_____/_____ Month Year	_____/_____ Month Year		

Affidavit of the Supervisor: **Please attach a signed affidavit describing the clinical setting and the duties that the applicant will perform under your supervision during the clinical fellowship year ("CFY").**

Please confirm the CFY will meet the following requirements:

☐ YES ☐ NO The CFY will begin after academic coursework and clinical observation and clinical practicum are completed.

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

☐ YES ☐ NO The CFY consists primarily of clinical activities.

I hereby attest that:

1. I will supervise the clinical fellowship of _____ during the calendar period indicated above;
2. I hold an ASHA certificate of clinical competence in speech pathology; and this certification will remain current throughout my supervision of the above applicant's clinical fellowship; and
3. I hold a Speech Pathologist License in Hawaii that is current and in good standing: (Lic. No.) _____

I further certify that the statements and information provided on this verification of clinical fellowship supervision 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 (continued)

Name: _____

Area of ASHA Certification: _____

ASHA Account Number: _____

Effective Date of Certification: _____

Valid Through: _____

HI License #: _____

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.