State of New Hampshire

OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
DIVISION OF LICENSING AND BOARD ADMINISTRATION
Allied Health
7 Eagle Square, Concord, NH 03301-4980
Phone: 603-271-2152

SUPERVISED PRACTICE PLAN FOR AUDIOLOGISTS

TO BE COMPLETED BY APPLICANT

General Information

Name: _____
(Last) (First) (Middle Initial)

Address: _____
(Street) (City) (State) (Zip)

Telephone Business (____)_____ Home (_____) _____

Training Program Responsibilities

Diagnostics_____

Aural Rehabilitation _____

Identification and Evaluation of Learning Impairment_____

Record Keeping _____

Staff Meetings _____

In-Service Training_____

Employment Information

Employer _____
(Company Name) (Division or Department)

Address_____
(Street) (City) (State) (Zip)

Beginning date of employment _____

Date Supervised Training Program to start _____

Date Supervised Program to end _____

Average number of hours per week_____

TO BE COMPLETED BY SUPERVISOR

Name:_____

(Last) (First) Middle Initial)

Address: _____

(Street) (City) (State) (Zip)

Telephone Business: (_____) _____ Home (_____) _____

Registration#_____

Methods	Sessions / Month	Length / Session	Activity
On-site Observations			
Remote Observations (audio, videotape)			
Conference (Phone)			
Review of Records 1. Therapy plans 2. Diagnostic reports			
Staff Meetings			
Case Staffing (Placement Meetings)			

Recommendation of Supervisor

l. Has the applicant fulfilled professional employment responsibilities? Yes No
If no, please describe:

_____

_____

I hereby: ( ) recommend ( ) do not recommend

_____ for licensure in the area of audiology.
(Applicant's Name)

_____ _____
(Signature of Supervisor) (Date)

This Plan Must Be Completed, Signed, And Returned To The Board Office Within Thirty (30) Calendar Days Of The Start Of Your Supervised Training Program.