VERIFICATION OF SUPERVISED POST-GRADUATE PROFESSIONAL EXPERIENCE

BOARD OF EXAMINERS FOR SPEECH-LANGUAGE PATHOLOGY
810 North Main #298
Spearfish, SD 57783
(605) 642-1600

Please Type or Print in Blue or Black Ink

Applicant’s Name: _______________________________________________________
                    (Last)                                    (First)                      (M.I.)

**If you are not ASHA certified this form should be mailed in with your application materials**

TO BE COMPLETED BY SUPERVISING SPEECH-LANGUAGE PATHOLOGIST

The above-named individual has applied for licensure as a Speech-Language Pathologist in the State of South Dakota. South Dakota licensing law requires verification of completion of 9 months of full-time supervised post-graduate professional experience in Speech-Language Pathology by a licensed Speech-Language Pathologist. You are being asked to certify the experience of this applicant. Attesting to this applicant’s experience is a vital element of the licensing process. Any misstatements by a licensed Speech-Language Pathologist in completing this form may constitute unethical or unprofessional conduct.

Please return the completed form directly to the Board office. The application for licensure cannot be processed until this completed form is received by the Board.

1. Name, address and phone number of agency where experience was obtained:
    ______________________________________________________________________
    ______________________________________________________________________
    ______________________________________________________________________

2. Name, address and phone number of Speech-Language Pathologist responsible for supervising the applicant’s experience:
    ______________________________________________________________________
     ______________________________________________________________________
     ______________________________________________________________________

3. State where Supervisor is licensed: ______________________________
    Supervisor License #: ____________________________________________
    Date License originally Issued: ________________________________
    Expiration Date of License: ____________________________
    Is the License Current: Yes ☐ No ☐

4. Inclusive dates of applicant’s experience:
    Starting date: ______________ to Completion Date: ______________

5. Applicant’s job title during experience: ____________________________

(Over)

6. Applicant worked: Full-Time ☐ Part-Time ☐
7. The Applicant averaged ______________________
   (Hours/week)
8. Did the applicant receive any disciplinary action while employed? If yes, please explain. 
   Attach a separate sheet if necessary.
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
9. Has the applicant successfully completed a supervised post-graduate professional 
   experience of 9 months while under your supervision? Yes [ ] No [ ]

I declare and affirm under the penalties of perjury that this form has been examined by me, and 
to the best of my knowledge and belief, is in all things true and correct.

___________________________
Printed Name of Supervisor

___________________________
Signature of Supervisor

___________________________
Date (mm/dd/yyyy)