

SUPERVISOR'S AFFIDAVIT

SOUTH DAKOTA BOARD OF EXAMINERS FOR SPEECH-LANGUAGE PATHOLOGY
810 North Main Street #298
Spearfish, SD 57783
Ph. 605-642-1600

This form must accompany each application for a Speech-Language Pathology Assistant license. Pursuant to ARSD 20:79:04:05, this form must be submitted before the SLPA practices. Please return with your completed application.

Section I – To Be Completed by Applicant

Applicant Name: _____
(Last) (First) (M.I.) (Maiden)

Applicant Address: _____
(Mailing Address) (City) (State) (Zip)

Applicant Phone Number: (____)_____

Applicant Email Address: _____

I am:

- Adding to my existing list of Supervisors
- Removing: _____ (If no replacement is being named you
(Name of Supervisor being removed from Supervision) may just submit this page)
- Replacing: _____
(Name of Supervisor being replaced from Supervision)
- I am not employed at this time. I understand that I must complete another form listing my current supervisor before I begin employment in the field.

I do hereby declare and affirm, under the penalties of perjury, that the information provided herein is true and correct. I further declare and affirm that I will submit and conform myself and my actions to comply with all provisions of South Dakota Codified Law and the Administrative Rules of South Dakota governing the practice of Speech-language Pathology in South Dakota.

Signature: _____ Date: _____
Speech-language Pathology Assistant applicant (mm/dd/yyyy)

Affidavit

State of _____

County of _____

That _____, being duly sworn, declares all statements made in this application are true and correct to the best of his or her knowledge.

Subscribed and sworn before me this _____ day of _____.

My commission expires _____

Signature of Notary Public

Section II – To Be Completed by Supervisor

Supervisor Name: _____
 (Last) (First) (M.I.)

Business Address: _____
 (Mailing Address) (City) (State) (Zip)

Business Phone #: (_____) _____

SLP License No.: _____ Area of Licensure: _____

Name of the SLPA(s) that you will/do have under your Supervision (include the applicant's name).
 Note: Per SDCL 36-37-20 you may only supervise a maximum of three (3) SLPA's at one time.

1. _____
2. _____
3. _____

Employment History – Per SDCL 36-37-20 you must have a minimum of two (2) years' experience as a licensed SLP. Attach a separate sheet if necessary.

Name of Employer:	Address:	Dates of Employment:
		From _____ To _____
		From _____ To _____

Requirements of Supervision – Supervising SLP needs to read and initial the following statements, thereby certifying that the supervising SLP will abide by them.

Requirements for Supervision	Sup. Initials
1. I attest that I meet the requirements of SDCL 36-37-20 and have at least two years of experience as a licensed speech-language pathologist.	
2. I understand that pursuant to SDCL 36-37-20, I may not supervise more than three speech-language pathology assistants at one time.	
3. I understand that I am responsible for the extent, kind, and quality of service provided by the speech-language pathology assistant I am supervising.	
4. I agree that clients receiving services from a speech-language pathology assistant will receive prior written notification that services are to be provided, in whole or in part, by a speech-language pathology assistant and that the speech-language pathology assistant may never represent themselves as an SLP.	
5. I agree that within the first two working weeks of supervising the speech-language pathology assistant that I will develop and document a written supervision plan complying with ARSD 20:79:04:03 and 20:79:04:04. I will continue to review the plan and ensure the speech-language pathology assistant practices within their scope as outlined in ARSD 20:79:04.	
6. I understand that as the supervising SLP I must be able to be reached throughout the work day. The speech-language pathology assistant may not practice if I am not immediately available in-person or by telecommunication technology.	
7. I understand that all documentation is subject to audit by the SD Board of Speech-Language Pathologists.	

I do hereby declare and affirm, under the penalties of perjury, that I am the holder of a valid, non-revoked, non-suspended Speech-Language Pathology license issued to me under SDCL Chapter 36-37. That I fully understand and accept my responsibilities as Supervisor for the above-named applicant who will work and train under my personal supervision, and for whose proper technical training and ethical conduct I am to be solely responsible. I further affirm that I have made a thorough investigation into the background experience record of said applicant and do hereby swear that the results of said investigation were satisfactory. I further affirm that I have examined the contents of the attached application by the above applicant, and that to the best of my knowledge and belief, all answers provided are true and correct. I further declare and affirm that I will submit and conform myself and my actions to comply with all provisions of South Dakota Codified Law and the Administrative Rules of South Dakota governing the practice of Speech-language Pathology in South Dakota.

Signature: _____
Supervisor

Date: _____
(mm/dd/yyyy)

Affidavit

State of _____

County of _____

That _____, being duly sworn, declares all statements made in this application are true and correct to the best of his or her knowledge.

Subscribed and sworn before me this _____ day of _____, _____.

My commission expires _____

Signature of Notary Public