# 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. 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 may just submit this page)
(Name of Supervisor being removed from Supervision)

☐ 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.

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

1. _____
2. _____
3. _____

Employment History – Per 36-37-20 you must have a minimum of (3) 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 – Supervisor please read and initial the following statements, certifying that you will abide by them.**

| Requirements for Supervision | Sup. Initials |
|---|---|
| 1. For the first 90 work days of licensed employment, I understand that I am to provide supervision for at least 30 percent of the time each week with at least 20% being direct supervision. | |
| 2. I understand that after the first 90 work days, the amount of supervision can be adjusted if the SLPA has met competencies and skill levels. The minimum supervision must include one hour of direct supervision weekly for full time, two hours monthly for part time and as much indirect supervision as needed to provide quality services. | |
| 3. I understand that I am responsible for ensuring documentation of both indirect and direct supervision and that this documentation must be signed by both parties. The documentation must include: date, activity, direct supervision hours, indirect supervision hours. | |
| 4. For the first 90 work days I understand I must review data on every client seen by the SLPA weekly. | |
| 5. For the first 90 work days I understand that all clients seen by the SLPA must receive direct contact by me at least one session every two weeks. After 90 work days, I understand that all clients seen by the SLPA must receive direct contact by me at least one session every 60 calendar days. | |
| 6. I understand that as the supervising SLP I must be able to be reached throughout the work day. | |
| 7. I understand that all documentation is subject to audit by the SD Board of Speech-Language Pathologists. | |
| 8. I understand that I am not to supervise more than 3 SLPA's at one time. | |

I do hereby affirm that I am the holder of a valid, unrevoked, unsuspended 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 personal investigation into the background experience record of said applicant as to his or her record for honesty and integrity and to the point that it could be proven otherwise, I do hereby swear that the results of said investigation by me were completely satisfactory; also, that I have read the contents of the attached application by above applicant, and that to the best of my knowledge and belief all answers given therein are true and complete. I declare and affirm under the penalties of perjury that this application has been examined by me and to the best of my knowledge and belief, is in all things true and correct.

Signed:_____
Supervisor

Dated:_____
(mm/dd/yyyy)

**Affidavit**

State of_____

County of_____

The SUPERVISOR_____, 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