

Department of Health and Human Services
 Division of Public Health - Licensure Unit
 P.O. Box 94986 - Lincoln, Nebraska 68509-4986
 Telephone #: 402-471-2299

APPLICATION FOR CERTIFICATION OF SUPERVISION OF AN AUDIOLOGY OR SPEECH-LANGUAGE PATHOLOGY ASSISTANT

This application must be completed by the supervising audiologist or speech-language pathologist.
 The audiologist or speech-language pathologist supervisor may provide supervision for **no more than two (2) Audiologist or Speech-Language Pathology Assistants at one time.**

SECTION A - Supervising Audiologist or Speech-Language Pathologist Information

| | | | |
|---|---|---------------------------------------|---|
| 1 | Name: | | |
| 2 | Present Address: | Street/PO/Route: | |
| | | City: | State: Zip: |
| 3 | Nebraska license number: | Audiologist: <input type="checkbox"/> | Speech-Language Pathologist: <input type="checkbox"/> |
| 4 | Area in which the Assistant is working: | | |
| | Audiology: <input type="checkbox"/> | | Speech-Language Pathology: <input type="checkbox"/> |

SECTION B - Name of Audiology or Speech-Language Pathology Assistant

Name: _____

Are you supervising other audiology or speech-language pathology assistants? Yes No

| If yes, list name of assistant(s) and number of hours per week that you supervised each assistant: | <u>Name:</u> | <u>Hours per day</u> | <u>Days per week</u> |
|--|--------------|----------------------|----------------------|
| | | | |
| | | | |
| | | | |
| | | | |

SECTION C - Practice Site(s) Location(s) where Audiology or Speech-Language Pathology Assistant will be working:

| | | | |
|-----------------|-------|--------|------|
| Facility Name | | | |
| Street Address: | | | |
| | City: | State: | Zip: |
| Telephone – | | | |
| Facility Name | | | |
| Street Address: | | | |
| | City: | State: | Zip: |
| Telephone – | | | |

CERTIFICATION FEE: One-time fee of **\$25** Make payable to the "Licensure Unit"
License expires upon termination of the Audiology or Speech-Language Pathology Assistant

SECTION D - Usage Plan - Indicate which of the following duties the audiology or speech-language pathology assistant will perform.

| | |
|--------------------------|---|
| <input type="checkbox"/> | (1) Implement programs and procedures designed by licensed audiologist(s) or speech-language pathologist(s). |
| <input type="checkbox"/> | (2) Maintain records of implemented procedures which document a patient's responses to treatment. |
| <input type="checkbox"/> | (3) Provide input for interdisciplinary treatment planning, inservice training and other activities directed by a licensed audiologist or speech-language pathologist. |
| <input type="checkbox"/> | (4) Prepare instructional material to facilitate program implementation as directed by a licensed audiologist or speech-language pathologist. |
| <input type="checkbox"/> | (5) Follow plans developed by licensed audiologist(s) or speech-language pathologist(s) that provide specific sequences of treatments to individuals with communicative disorders or dysphagia. |
| <input type="checkbox"/> | (6) Chart or log patient responses to the treatment plan. |
| <input type="checkbox"/> | (7) Provide aural rehabilitation. |

Describe how you will use an alternate supervisor when you are unable to provide supervision and the method of supervision the alternate supervisor will use:

SECTION E – ATTESTATION

Attestation of the supervising audiologist or speech-language pathologist: I attest as follows:

1. I will provide supervision for no more than two (2) audiology or speech-language pathology assistants at one time;
2. I will provide direct onsite supervision for the first two (2) treatment sessions of each patient's care;
3. I will provide direct onsite supervision of at least twenty (20) percent of all subsequent treatment sessions per quarter;
4. I will provide a minimum of ten (10) hours of in-service training;
5. I will provide semi-annual performance evaluations and review them with the audiology or speech-language pathology assistant that I am supervising;
6. I will provide an alternate supervisor if I am unable to supervise the audiology or speech-language pathology assistant;
7. I will be responsible for all aspects of patient treatment;
8. The audiology or speech-language pathology assistant that I am supervising will not perform the functions listed in Neb. Rev. Stat. §38-524;
9. The audiology or speech-language pathology assistant that I am supervising will not perform aural rehabilitation unless s/he has the additional training required by Neb. Rev. Stat. §38-522; and
10. All statements in this application are true and complete.

Signature of Supervisor

Date

