Documentation of Supervision of Services Provided by Limited License Speech Language Pathologist

Student Name:	Date of Birth:	Diagnosis:
Name of Supervised: Name of Supervising SLP:	School Year:	
Date of Initial face-to-face Contact:		

Review of IEP/Evaluations *(at minimum at the beginning of the school year or the beginning of treatment for new students):*	
Date:	Date:
Direct Observation:	
Date:	Date:
Date:	Date:
Review of Medicaid Documentation:	
Date:	Date:
Date:	Date:
Conference with supervising speech pathologist:	
Date:	Notes:
Other Relevant Data:	
Date:	Notes:

Supervisor's Signature:_____Date:_____