Hearing and Speech Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Speech-Language Pathology Assistant Work Experience Verification

In accordance with WAC 246-828-617 (1) and (2)

Instructions To Applicant: Please fill out this section completely and include completed form with application. Please use one form for each employer.

I, ____ am applying for certification to practice as a speech-language pathology assistant in Washington State and authorize you to release information as required on this form. I authorize the Department of Health to contact my employer if further information is needed.

Signature of applicant: ____

Applicant's address: ____

____

Employer Name: ____

Employment Dates: ____

Instructions To Employer: Please fill out the following sections completely.

By my signature below, I attest that the above-named applicant has completed supervised patient/client/student work experience within a one-year time frame under the supervision of a licensed speech-language pathologist or speech-language pathologist certified as an educational staff associate by the superintendent of public instruction.

1. During their employment, the applicant has completed:

   ☐ 100 or more hours, with at least 50 of those hours under direct supervision

   Or

   ☐ ________ hours, with ________ hours under direct supervision

2. The applicant was supervised by a speech-language pathologist:

   From: ________________ To: ________________ Number of hours: ________________

   From: ________________ To: ________________ Number of hours: ________________

   From: ________________ To: ________________ Number of hours: ________________

Employer signature: ____ Title: ________________________________

Printed Name: ____ Date: ________________________________

Employer's mailing address: ____

Phone: ____