



**STATE BOARD OF EXAMINERS FOR SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY**

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**Faxed to: (512) 834-6677, Attention: Speech**

**Alternate Supervision of an Assistant Request Plan**

§741.64(g) A licensed speech-language pathology supervisor shall assign duties and provide appropriate supervision to the licensed assistant. (5) An exception to paragraph (3) of this subsection may be requested. The supervising speech-language pathologist shall submit the prescribed Alternate Supervision Request Plan form for review by the board's designee. Within 15 working days of receipt of the request, the board's designee shall approve or not approve the plan. The plan shall be for not more than one year's duration.

If more information is requested by the board designee, the applicant has 15 business days to respond. If no response is received within the 15 business day, the request will be null and void.

**Please include a fax number. Request confirmations will only be faxed.**

**Please review to be sure all information is completed correctly. Incomplete forms will be returned and will delay your approval. The completed form can be faxed to the board office:**

**Speech-Language Pathologist or Audiologist Information:** (If employed at more than one location, please provide information on separate sheet.)

|   |            |
|---|------------|
| Name:   | License #: |
| Employer:   |            |
| Address:  |            |
| City/State/Zip:   |            |
| Phone Number:   |            |
| <b>Fax Number</b><br>(Confirmation will be faxed to this #.): |            |
| E-mail Address:   |            |

|   |  |
|---|--|
| Number of hours/week you are employed   |  |
| Total number of cases for which you would be responsible for (i.e., all cases to be seen by you and <i>all</i> supervised Interns/Assistants) |  |

**Speech-Language Pathology Assistant Information: (Please complete a separate plan for each additional assistant.)**

|                                |                        |
|--------------------------------|------------------------|
| Name:                          | Assistant's License #: |
| Number of hours/week employed: |                        |
| Location:                      |                        |

**OTHER CURRENT INTERNS/ASSISTANTS SUPERVISED:**

Do you *currently* supervise any Interns/Assistants?     Yes     No

If yes, provide the following for each Intern/Assistant supervised and indicate if the individual is an Intern or Assistant

|                                |  |
|--------------------------------|--|
| Name:                          | Intern <input type="checkbox"/> Assistant <input type="checkbox"/><br>License #: |
| Number of hours/week employed: |  |
| Location                       |  |

|                                |  |
|--------------------------------|--|
| Name:                          | Intern <input type="checkbox"/> Assistant <input type="checkbox"/><br>License #: |
| Number of hours/week employed: |  |
| Location:                      |  |

|                                |  |
|--------------------------------|--|
| Name:                          | Intern <input type="checkbox"/> Assistant <input type="checkbox"/><br>License #: |
| Number of hours/week employed: |  |
| Location:                      |  |

|   |  |
|---|--|
| Name:   | Intern <input type="checkbox"/> Assistant <input type="checkbox"/><br>License #: |
| Length of time the asst has been practicing under your supervision: |  |
| Number of hours/week employed:                                      |  |
| Location:   |  |

**Time Frame of Requested Plan**

Dates Supervisor will be out:

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Dates Alternate Plan:

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## Proposed Supervision Plan

Explain how you will provide adequate supervision for the proposed assistant(s). (Additional sheet(s) may be used.)

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## Justification

Explain why the alternate supervision plan is necessary for you to supervise the proposed assistant(s). (Additional sheet(s) may be used.)

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Signature \_\_\_\_\_

\_\_\_\_\_ Date

Please review to be sure all information is completed correctly. Incomplete forms will be returned and will delay your approval.

**Faxed to: (512) 834-6677, Attention: Speech**

**A faxed confirmation is required prior to beginning the alternate supervision plan.**

**This process can take up to 15 business days.**



PRIVACY NOTIFICATION: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.dshs.state.tx.us/> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004) DSHS Publication #: F76-13408