

Hearing and Speech Credentialing P.O. Box 47877 Olympia, WA 98504-7877 360.236.4700

Speech Language Pathologist Delegation of Supervision

Name of supervisor of record				License number		
Name of permit holder			Permit Number			
Supervisor's business address						
City	State		Zip		Telephone (enter 10 digit #)	
Delegation to Speech Language Pathologist						
Name of delegated speech language pathologist						
Delegated speech language pathologist's signature					Date	
cicense Number First issue date						
Business Address						
City	State		Zip		Telephone (enter 10 digit #)	
Duration of Training						
From To						
Delegated Supervisor's Attestation						
l, do here					reby certify that	
will work under my supervision						
Name of permit holder						
performing all speech language pathology services during the interim permit period.						
Signature of delegated supervisor				Date		
Approval						
Denial						