Washington State Department of Health
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
License Number	First issue date		
Business Address			
City	State	Zip	Telephone (enter 10 digit #)

Duration of Training

From	To

Delegated Supervisor's Attestation

I ________________________________, do hereby certify that
Name of delegated supervisor

________________________________ 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 ________________________________