



Washington State Department of

Health

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: _____