Washington State Department of Health
Hearing and Speech Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Speech Language Pathology or Audiology Interim Permit Supervision Form

Applicant Demographics:

First Name	Middle	Last Name
Credential # (If available)	Date of Birth	
Start date (mm/dd/yyyy)	Completion Date of Postgraduate Work Experience (mm/dd/yyyy)	

The interim permit period must consist of at least 36 weeks of full-time postgraduate professional work experience or its part time equivalent, per WAC 246-828-04503 (1)(a).

Postgraduate professional work experience of less than 15 hours per week does not meet the requirement and may not be counted toward the postgraduate professional work experience. Experience of more than 30 hours per week may not be used to shorten the postgraduate professional work experience to less than 36 weeks.

The interim permit expires one year from the date it is issued. The board may extend the interim permit an additional 24 months to accommodate part-time postgraduate professional work experience or upon the request of the interim permit holder due to illness or extenuating circumstances.

The interim permit period is divided into three-month time frames. Please indicate the number of postgraduate professional work experience hours completed each week. Return this form directly to the address above at the end of each three month time frame.

To be completed by the supervisor:

Week 1		Week 2		Week 3		Week 4		Week 5		Week 6	
Week 7		Week 8		Week 9		Week 10		Week 11		Week 12	

As the supervisor for the above named interim permit holder, I certify that the postgraduate professional work experience, as indicated above, has been completed.

Name of Supervisor:

Comments:

Supervisor Signature _____ Date (mm/dd/yyyy) _____

Week 13		Week 14		Week 15		Week 16		Week 17		Week 18	
Week 19		Week 20		Week 21		Week 22		Week 23		Week 24	

As the supervisor for the above named interim permit holder, I certify that the postgraduate professional work experience, as indicated above, has been completed.

Name of Supervisor

Comments

Supervisor Signature _____ Date (mm/dd/yyyy) _____

Week 25		Week 26		Week 27		Week 28		Week 29		Week 30	
Week 31		Week 32		Week 33		Week 34		Week 35		Week 36	

As the supervisor for the above named interim permit holder, I certify that the postgraduate professional work experience, as indicated above, has been completed.

Name of Supervisor:

Comments:

Supervisor Signature _____ Date (mm/dd/yyyy) _____