DEPARTMENT OF HEALTH

Clinical Fellowship or Doctoral Externship - Supervisor Form

To be completed by supervisor only. Please print and sign clearly in blue ink.

Last Name	First Name	Middle
Supervisor's MN License #	Employment Name	
Street Address	City State	ZIP
Telephone Number	Employer Telephone Number	
Fax Number	Supervisor's Email Address	
Date Supervisor Started Employment (mm/dd/yyyy)	Hearing Instrument Dispenser (HID) Certification # (if Certified)	

The Speech-Language Pathology and Audiology Advisory Council at the Minnesota Department of Health recommends that the supervisor has at least one year of experience. Please carefully read the "Supervisor Affirmation" Statement provided below.

SUPERVISOR AFFIRMATION. *I certify that I am a licensed speech-language pathologist or audiologist in the State of Minnesota or that I hold a current certificate of clinical competence from the American Speech- Language Hearing Association (ASHA) or current board certification by the American Board of Audiology (ABA)* and will be the supervisor of the applicant who has applied for Clinical Fellowship/Doctoral Externship license. I have read Minnesota Statutes, Section 148.5161 and will provide supervision consistent with subdivision 3. I understand that Clinical Fellowship/Doctoral Externship licensing expires within 18 months of issuance. Furthermore, I understand that I am a responsible supervisor for the above applicant until the Minnesota Department of Health receives my written and signed statement that I wish to cease supervision or until expiration of Clinical Fellowship/Doctoral Externship licensing*

Supervisor's Signature	Date

WAIVER AND RELEASE

To be completed by applicant only. Please print and sign clearly in blue ink.

Under the Minnesota Government Data Practices Act, Minnesota Statutes, Chapter 13, all information received as part of an active investigation is confidential data. If my application for a Clinical Fellowship/Doctoral Externship license as speech-language pathologist or audiologist is approved, I hereby authorize the Minnesota Department of Health to notify my supervisor in the event the Department receives a complaint against me concerning an act or omission related to the practice of speech-language pathologist and/or audiologist services.

By signing below, I waive any privilege afforded to me by law relating to the disclosure of complaint information and allegations. I further release the Department, its agents or employees from liability for releasing complaint information and allegations to my supervisor. The waiver will remain in effect until the approved Clinical Fellowship/Doctoral Externship license expires, is revoked or suspended, or until the Clinical Fellowship/Doctoral Externship licensee or approved supervisor listed on the application notified the Department, in writing, that supervision has been withdrawn.

Last Name	First Name	Middle
Applicant's Home Address	City State	ZIP
Applicant Signature	Date	