Clinical Observation Hours Verification Form

Student Information

(Completed by SLP candidate)

Name of Student: ____ Date: ______________________

Name of School or/and Current Employer: ____

Email: ________________________________ Phone: ________________________________

Site and Supervisor Information

(Completed by site supervisor and SLP candidate)

Site Name: ____

Site Address: ___________________________________ Site Phone: _____________________

Name of Supervisor: _____________________________ Supervisor Phone: _______________

ASHA Certification: _____ CCC-SLP _____ CCC-Dual ASHA #: ________________________

Setting of Observation: ____

Beginning and end dates of observation hours: ____

Total number of observation hours: _________

Site Supervisor Signature: ____
(to verify hours)

Description of observation experiences: (What did you do?)

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Site Supervisor Comments (if applicable):

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Student Comments:

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