

**DOCUMENTATION OF COMPLETION OF  
PAID CLINICAL EXPERIENCE (PCE) or REQUIRED PROFESSIONAL EXPERIENCE (RPE)**

INSTRUCTIONS

- This Form is to be completed at the end of the PCE or RPE.
- PCE or RPE Fellow should complete Parts I and III.
- PCE or RPE Supervisor must complete Parts II and III.
- AUD graduates Jan. 1, 2007 and after must complete Part IV only.
- Submit this form and documents to the Board office **within 14 days** from the completion of the PCE or RPE.

**PART I – PCE or RPE FELLOW/APPLICANT FOR LICENSURE**

PERSONAL INFORMATION

NAME OF APPLICANT \_\_\_\_\_  
Last First Middle Maiden

ADDRESS OF RECORD: \_\_\_\_\_  
Street City State Zip Code

HOME PHONE: ( ) \_\_\_\_\_ BUSINESS PHONE: ( ) \_\_\_\_\_ FAX: ( ) \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_  
Month/Day/Year [Optional: For Identification, Law Enforcement, Statistical and Administrative Purposes]

CLINICAL EMPLOYMENT

➤ If more than one location, use separate page for each

EMPLOYMENT ADDRESS OF APPLICANT

Name of Facility \_\_\_\_\_  
Street Address \_\_\_\_\_  
City/State/Zip Code \_\_\_\_\_

PCE DATES: BEGINNING \_\_\_\_\_ ENDING \_\_\_\_\_  
Month/Day/Year Month/Day/Year

AREA OF TEMPORARY LICENSE:  SPEECH # \_\_\_\_\_  AUDIOLOGY # \_\_\_\_\_  
WORK STATUS [# HOURS WORKED PER WEEK] \_\_\_\_\_

**PART II - SUPERVISION OF EXPERIENCE**

NAME OF SUPERVISOR \_\_\_\_\_  
Last First Middle Maiden

EMPLOYMENT ADDRESS OF SUPERVISOR

Name of Facility \_\_\_\_\_  
Street Address \_\_\_\_\_  
City/State/Zip Code \_\_\_\_\_

SUPERVISOR

Yes  No Does the Supervisor hold a current Georgia license? If "yes," complete below.  
If "no" see Instructions on page 1.

GEORGIA LICENSE NUMBER \_\_\_\_\_ EXPIRATION DATE \_\_\_\_\_  
ASHA CERTIFICATION NUMBER \_\_\_\_\_ EXPIRATION DATE \_\_\_\_\_  
AREA OF LICENSURE AND/OR CERTIFICATION:  SPEECH  AUDIOLOGY

SUPERVISOR'S EVALUATION OF APPLICANT'S ABILITY

Please: 1) Evaluate Applicant's present ability to function without supervision in each of the areas listed below and 2) Indicate the approximate number of hours per week spent in each of the following areas.

➤ Use a separate sheet, if necessary.

**ASSESSMENT, EVALUATION, DIAGNOSIS** \_\_\_\_\_

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**HABILITATION, REHABILITATION, THERAPY** \_\_\_\_\_

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**PROFESSIONAL RELATIONSHIPS** .....

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**CLINICAL RECORD KEEPING** \_\_\_\_\_

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**OTHER** \_\_\_\_\_

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AMOUNT AND KIND OF CONTACT

TOTAL NUMBER OF DIRECT OBSERVATIONS: \_\_\_\_\_

Briefly describe the **number** and **each type of other monitoring contact** [letters, telephone calls, records observations, videotapes, etc.] made during the PCE or RPE. \_\_\_\_\_

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Yes  No **FROM YOUR ASSESSMENT DURING THE PCE or RPE, DOES THE PCE or RPE FELLOW DEMONSTRATE CLINICAL COMPETENCE IN THE AREA FOR WHICH THE FELLOW IS SEEKING LICENSURE?**

Yes  No **DO YOU RECOMMEND THAT THE PCE or RPE FELLOW'S PERIOD OF PCE or RPE BE APPROVED BY THE BOARD AS MEETING THE REQUIREMENTS FOR LICENSURE?**

**PART III – APPLICANT'S SIGNATURES**

SIGNATURES

**APPLICANT:**  Yes  No I have discussed this report with the Supervisor of my PCE or RPE.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

**SUPERVISOR'S SIGNATURE MUST BE NOTARIZED**

**SUPERVISOR:**  Yes  No I have discussed this report with the PCE or RPE Fellow/Applicant for licensure.

\_\_\_\_\_  
Signature of Supervisor

\_\_\_\_\_  
Date

**PART IV – AUD VERIFICATION OF RPE**

**NAME OF APPLICANT:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**By signing below, I swear and attest that I have completed the required professional experience as defined by Board Rule 609-3-.04**

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date