DEPAUL

Master of Speech-Language Pathology
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?)

_____

_____

Site Supervisor Comments (if applicable):

_____

_____

Student Comments:

_____

_____