



**VERIFICATION OF EMPLOYMENT  
Form SPA-2A**

**APPLICANT NAME** \_\_\_\_\_

Check one:     Speech-Language Pathology         Audiology

**To The Applicant:** Type or print your name and social security number only.

**SECTIONS I AND II ARE TO BE COMPLETED BY THE SUPERVISING LICENSED SPEECH-LANGUAGE PATHOLOGIST/AUDIOLOGIST VERIFYING THE EMPLOYMENT.**

**To The Supervisor:** Please complete Sections I and II below. Please type or print Section I.

**I. GENERAL INFORMATION**

Supervisor's Name:

Business Phone:

License Number:

Speech-Language Pathology

Audiology

Practice Location Address:

Office or Agency where experience will take place:

**II. CERTIFICATION**

I understand that pursuant to Chapter 468.1155(1), F.S., a provisional license is required prior to the above named applicant initiating the professional employment experience.

I certify that the professional employment shall include assessment, habilitation and rehabilitation activities with the clients; the activities performed by the provisional licensee shall be monitored and evaluated by an individual with an active license in the same area for which provisional licensure is being sought.

I hereby acknowledge receipt of Chapter 468, Part I, F.S., and related rules and further acknowledge that I have read these regulations. I understand that it is my responsibility to keep informed of any changes to Chapter 468, Part I, F.S. and related rules.

I certify that the above information is true and correct to the best of my knowledge.

\_\_\_\_\_  
Supervisor's Signature

\_\_\_\_\_  
Date