



TERMINATION OF SUPERVISION FOR SPEECH-LANGUAGE PATHOLOGY ASSISTANT

Division 13.4 of Title 16 , California Code of Regulations Section 1399.170.18 requires that at the time of termination of supervision, the supervisor shall submit this original signed form within 14 days of the termination of supervision.

_____	_____
Speech-Language Pathology Assistant's Name	SPA Number
_____	_____
Supervisor's Name	License # or SSN

I, _____ certify that I supervised _____,
in performing the duties and functions of a speech-language pathology assistant in accordance with Section
1399.170.15 of the California Code of Regulations from _____ to _____.

I declare under penalty of perjury under the laws of the State of California that I have read and understand the foregoing and the information submitted on this form is true and correct.

Printed Name of Qualified Supervisor Signature of Qualified Supervisor Date

Mailing Address: Number and Street City State Zip Code

(_____) _____
Qualified Supervisor's Daytime Telephone Number

The **original** of this form must be mailed to:

Speech-Language Pathology & Audiology Board & Hearing Aid Dispensers Board
2005 Evergreen Street, Suite 2100
Sacramento, CA 95815