Texas Department of Licensing and Regulation
PO Box 12057 ● Austin, Texas 78711-2157
(800) 803-9202 ● (512) 463-6599 ● FAX (512) 475-2871
www.tdlr.texas.gov ● cs.speech@tdlr.texas.gov

SPEECH-LANGUAGE PATHOLOGY
ALTERNATE SUPERVISION PLAN INSTRUCTIONS

All information provided must be typed or printed in black ink. This form must be completed and returned if a supervisor

1. ASSISTANT'S/INTERN'S NAME - Write the assistant's/intern's legal name in the space provided. (Last Name, First Name, Middle Name, Suffix) Examples of a suffix include Jr., Sr., and II. (Mr. is not a suffix.)
2. ASSISTANT'S/INTERN'S TEXAS LICENSE # – Indicate the Texas Assistant/Intern in Speech-Language Pathology license number.
3. SUPERVISOR'S NAME – Write the supervisor's legal name in the spaces provided. (Last Name, First Name, Middle Name, Suffix) Examples of a suffix include Jr., Sr., and II. (Mr. is not a suffix.)
4. SUPERVISOR'S TEXAS LICENSE # - Write the Texas Speech-Language Pathologist license number.
5. SUPERVISOR'S EMAIL ADDRESS – Write the supervisor's email address. Please provide the email address so the department may email license information and required notices to you. Your email address is confidential pursuant to the Texas Public Information Act, and the department will not share it with the public.
6. DATES COVERED BY THE ALTERNATE SUPERVISION PLAN – List dates the supervisor will be unable to provide supervision.
7. NUMBER OF ASSISTANTS/INTERNS YOU ***CURRENTLY*** SUPERVISE – Write the number of assistants/interns you currently supervise.
8. TOTAL NUMBER OF CASES – Write the total number of all cases to be seen by you and *all* supervised assistants/interns).
9. ASSISTANTS/INTERNS CURRENTLY SUPERVISED – Provide the requested information for each assistant/intern you currently supervise.
10. PROPOSED SUPERVISION PLAN - Explain how you will provide adequate supervision for the proposed assistant(s)/intern(s). List the requested information for each assistant/intern you currently supervise.
11. JUSTIFICATION - Explain why the alternate supervision plan is necessary for you to supervise the proposed assistant(s)/intern(s).
12. STATEMENT OF SUPERVISOR – Please read carefully sign.

Reminder:

111.50. Assistant in Speech-Language Pathology License--Licensing Requirements
(g) A licensed speech-language pathologist department-approved supervisor shall assign duties and provide appropriate supervision to the licensed assistant.
(3) The licensed speech-language pathologist department-approved supervisor shall provide a minimum of eight (8) hours per month of supervision, at least four (4) hours of which are direct, and at least two (2) hours of which is in person and onsite supervision where the licensed assistant is providing the therapy. This paragraph applies whether the licensed assistant's practice is employed full- or part-time. For the purposes of this paragraph the telehealth and telepractice provisions allowed by Subchapter V may be used for up to six (6) hours of supervision without applying for the exception referenced under §111.213. When determining the amount and type of supervision, the department-approved supervisor must consider the skill and experience of the licensed assistant as well as the services to be provided. The supervision hours established in this paragraph may be exceeded as determined by the department-approved supervisor.
(4) Supervisory records shall be maintained for a period of three years by the licensed speech-language pathologist that verify regularly scheduled monitoring, assessment, and evaluation of the licensed assistant's and client's performance. Such documentation may be requested by the department.

111.213. Limitations on the Use of Telecommunications Technology by Speech-Language Pathologists.
(a) The limitations of this section apply to the use of telecommunications technology by speech-language pathologists.
(b) Supervision of a licensed assistant and/or intern in speech-language pathology shall not be undertaken through the use of telecommunications technology unless an exception to this prohibition is secured pursuant to the terms of this section. **(this does not apply to the 6 hours allowed in §111.50(g)(3)**.
(c) An exception to subsection (b) shall be requested by the speech-language pathologist submitting the prescribed alternate supervision request form for review by the department. The department shall approve or not approve the plan. The plan shall be for not more than one year's duration.
(d) If the exception referenced in subsection (c) is approved and the reason continues to exist, the licensed supervising speech-language pathologist shall annually resubmit a request to be evaluated by the department. The department shall approve or not approve the plan.

111.40. Intern in Speech-Language Pathology License--Licensing and Internship Requirements.
(h) Internship Requirements. The internship shall:
(6) be divided into three segments with no fewer than thirty-six (36) clock hours of supervisory activities to include:
(A) six hours of in person observations per segment by the department-approved supervisor(s) of the intern's direct client contact at the worksite in which the intern provides screening, evaluation, assessment, habilitation, and rehabilitation; and
(B) six hours of other monitoring activities per segment with the department-approved supervisor(s) which may include correspondence, review of videotapes, evaluation of written reports, phone conferences with the intern, evaluations by professional colleagues; or
(C) an alternative plan as approved by the department.

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SPEECH-LANGUAGE PATHOLOGY ALTERNATE SUPERVISION PLAN

DO NOT WRITE ABOVE THIS LINE	
All information provided must be typed or printed in <u>black ink</u>. **Form can be submitted by: Email, Fax or Mail**	
ASSISTANT'S/INTERN'S INFORMATION	
1. Assistant's/Intern's Name:	2. Intern License #:
SUPERVISOR'S INFORMATION	
3. Supervisor's Name:	4. Supervisor's Texas License #:
5. Supervisor's Email:	
DATES / CASES COVERED	
6. Dates Covered by the Alternate Supervision Plan:	7. Number of Assistants/Interns you ***currently*** supervise:
8. Total number of cases for which you would be responsible for (i.e., all cases to be seen by you and *all* supervised Interns/Assistants):	
ALL ASSISTANTS/INTERNS CURRENTLY BEING SUPERVISED	
9. List the requested information for each Assistant/Intern you currently supervise:	
• **Name**:	• Intern ☐ Assistant ☐ • License #:
• Length of time the assistant/intern has been practicing under your supervision:	
• Number of hours/week employed:	
• Location:	
• **Name**:	• Intern ☐ Assistant ☐ • License #:
• Length of time the assistant/intern has been practicing under your supervision:	
• Number of hours/week employed:	
• Location:	
• **Name**:	• Intern ☐ Assistant ☐ • License #:
• Length of time the assistant/intern has been practicing under your supervision:	
• Number of hours/week employed:	
• Location:	
• **Name**:	• Intern ☐ Assistant ☐ • License #:
• Length of time the assistant/intern has been practicing under your supervision:	
• Number of hours/week employed:	
• Location:	

PROPOSED SUPERVISION PLAN

10. Explain how you will provide adequate supervision for the proposed assistant(s). (Additional sheet(s) may be used.) List the requested information for each Assistant/Intern you currently supervise:

JUSTIFICATION

11. Explain why the alternate supervision plan is necessary for you to supervise the proposed assistant(s). (Additional sheet(s) may be used.)

I certify that I have read and will comply with all applicable provisions of the Speech-Language Pathology and Audiology Act; Texas Occupation Code, Chapter 401 and Chapter 51; Texas Administrative Code, Chapter 111; and the Speech-Language Pathology and Audiology Administrative Rules, I understand that providing false information on this application may result in denial of this application and/or revocation of the license I am requesting and the imposition of administrative penalties.

Signature of Supervisor _____ Date _____