GUAM BOARD OF ALLIED HEALTH EXAMINERS
HEALTH PROFESIONAL LICENSING OFFICE, DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES
123 Chalan Kareta, Mangilao, GUAM 96913 Telephone: 671-735-7408/7406

SUPERVISORY FORM FOR *LICENSED SLP ASSISTANTS*

___ Initial Supervisory Date: _____: ___ Renewal Date:_____ : ___Updated: Date: _____:
___ SLP-A BACHELOR; or ___ SLP-A MASTER'S

IDENTIFICATION:
NAME: _____ SOCIAL SECURITY #:_____ Lic. #_____
Last First Middle Maiden
Date of Birth: _____ Place of Birth: _____ Sex: ___ M ___ F
Guam Permanent Address: _____
Guam Mailing Address: _____
Work Phone: _____ Cell: _____ Email: _____
Current Employer: _____
Name Address
Supervisor/Administrator: _____ _____
Name Office Location Contact Number

EDUCATIONAL INFORMATION:
College/University: _____ Degree: _____ Date Graduated: _____
Name City/State

PRIMARY SUPERVISOR: _____ ASHA CCC # _____; GUAM SLP Lic # _____;
Name
Agency/Company: _____ Address: _____ Contact # _____ Email _____

SIGNATURE OF PRIMARY SUPERVISOR: _____ Date: _____

(In the event primary supervisor is off-island)
SECONDARY SUPERVISOR: _____ ASHA CCC # _____ GUAM SLP Lic # _____
Name
Agency/Company: _____ Address: _____ Contact # _____ Email _____

SIGNATURE OF SECONDARY SUPERVISOR: _____ Date: _____

ADDITIONAL SUPERVISOR: _____ ASHA CCC # _____ GUAM SLP Lic # _____
Name
Agency/Company: _____ Address: _____ Contact # _____ Email _____

SIGNATURE OF ADDITIONAL SUPERVISOR: _____ Date: _____

ADDITIONAL SUPERVISOR: _____ ASHA CCC # _____ GUAM SLP Lic # _____
Name
Agency/Company: _____ Address: _____ Contact # _____ Email _____

SIGNATURE OF ADDITIONAL SUPERVISOR: _____ Date: _____

SLP_A Signature: _____ DATE:_____