



Paul R. LePage
Governor

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
Board of Speech, Audiology and Hearing
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035

Anne L. Head
Director

TERMINATION OF SUPERVISION FORM

Chapter 9, Section 3(5)(B) of the Board's Rules requires that supervisors of speech-language pathology assistants notify the Board of the termination of any supervisory relationship no later than ten (10) days after the termination.

Therefore, upon any change in supervision, please complete the following form and send to the Office by mail or courier. Upon receipt of the fully-completed form, you will be removed as the supervising speech-language pathologist and the speech-language assistant's registration will be terminated.

Name of Speech-Language Pathology Assistant:		Registration Number:	
Name of Supervisor:		Maine License Number:	
Name of Practice Setting:			
Mailing Address:			
City:	State:	Zip Code:	
<p>I, _____ certify that I supervised _____ <small>supervisor's name</small> <small>speech-language pathology assistant's name</small></p> <p>in performing the duties and functions of a speech-language pathology assistant in accordance with the laws and rules of the Board from _____ to _____ <small>month/day/year</small> <small>month/day/year</small></p>			
<p>By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief.</p> <p>Signature of Supervisor: _____ Date: _____</p>			



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TTY USERS CALL MAINE RELAY 711
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