



CLINICAL FELLOWSHIP AGREEMENT
*For Updating changes in Clinical Fellowship information
 of a current Temporary SLP licensee.*

A.R.S. § 36-1905 requires that a Sponsor (Supervisor) of a Clinical Fellow:

1. Directly train and supervise a temporary licensee,
2. May not sponsor more than two temporary licensees at one time, and
3. Is equally liable with the trainee for violations of law and rule during the training activities of the Clinical Fellow.

CLINICAL FELLOW (TSLP Licensee) INFORMATION:

NAME:		ARIZONA TSLP LICENSE NUMBER:	
HOME ADDRESS:			
CITY:	STATE:	ZIP CODE:	
CONTACT PHONE:		E-MAIL:	

CLINICAL FELLOWSHIP SUPERVISOR (SPONSOR) INFORMATION:

SUPERVISOR NAME:		
BUSINESS ADDRESS:		
CITY:	STATE:	ZIP CODE:
CONTACT PHONE:		E-MAIL:
VALID ARIZONA SPEECH-LANGUAGE PATHOLOGIST LICENSE NUMBER: (THIS IS NOT THE ASHA MEMBERSHIP/CERTIFICATE NUMBER)		

CLINICAL FELLOWSHIP SITE:

BUSINESS SITE NAME:		
SITE PHYSICAL ADDRESS:		
CITY:	STATE:	ZIP CODE:
CONTACT PHONE:		E-MAIL:

Continue completing the next page →

TSLP LICENSEE LAST NAME:	FIRST NAME:	MI:
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CLINICAL FELLOWSHIP LEGAL AGREEMENT:

I agree to train and supervise _____
under this Clinical Fellowship agreement. (INITIAL)_____ (APPLICANT'S/CLINICAL FELLOW'S NAME - PLEASE PRINT)

I agree to complete a minimum of 36 supervisory activities, including at least 18 monitoring activities,
and 18 onsite observations with no more than 6 onsite observations in 24 hours. (INITIAL)_____

I will submit a copy of the clinical fellowship report to the Department within 30 days of completion of
the clinical fellowship. (INITIAL)_____

I will provide the Department and the clinical fellow written notice of termination within 72 hours of
terminating the clinical fellowship if it is terminated before the completion of the clinical fellowship.
(INITIAL)_____

During this clinical fellowship period I understand that I am assumed to be equally liable for the
applicant's fellowship activities as mandated in A.R.S. § 36-1905. (INITIAL)_____

I hold a valid Arizona Speech-Language Pathologist license and I understand that I cannot sponsor
more than two people at one time. (INITIAL)_____

CF SUPERVISOR/SPONSOR'S SIGNATURE

DATE

TSLP LICENSEE SIGNATURE

DATE

Please do not write in this box, for ADHS use only ~ Thanks!

Clinical Fellowship Verified by : _____ Date Verified: _____

Cross Verified CF Supervisor's License in ASPEN Verified Agreement with CF Supervisor via Phone / E-mail