UNIVERSITY OF ILLINOIS
AT URBANA-CHAMPAIGN

College of Applied Health Sciences
Department of Speech and Hearing Science
Speech-Language Pathology Clinic
2001 South Oak Street, Suite B
Champaign, IL 61820

Student Name:_____ ID #_____

**multiple copies of this form may be needed to record all hours. Total the hours per form at the bottom.*

Students should record observation hours on this form. Clinicians/Supervisors observed must be ASHA certified. If you observe outside of the U of I Clinic, you must obtain the professional's ASHA number. Keep the original and a copy of the form will be placed in your student file upon completion of the 25 hours.

Date	Type of Disorder	Age	DX/TX	Duration	Clinician/Supervisor Signature *If observing in the U of I Clinic, the 475 instructor will sign here*	CCC-SLP/A (ASHA No.)

**Student completes the 3 blanks below*

I certify that_____**has completed**_____**hours of observation**
(Print your name) (list your total for this form)

on_____.
(the date you complete the form)

**Instructor of SHS 475 completes the 3 blanks below*

_____ _____ _____
Name of Instructor **Title** **Date**