PROCEDURE FOR REGISTRATION

CFY/AUD Extern

An applicant for registration as a Clinical Fellow shall cause a graduate transcript to be submitted directly from the educational institution to the Board's Administrative Office. The transcript must show that graduation with at least a Master's or Doctorate level degree has been completed and must carry the official seal of the institution.

An applicant for registration as a Clinical Fellow shall successfully complete a minimum of four hundred (400) clock hours of supervised clinical experience (practicum) with individuals having a variety of communications disorders, as required by ASHA. The experience shall have been obtained through an accredited college or university which is recognized by ASHA. The applicant shall cause the Department Chair or other program head to provide directly to the Board's Administrative Office a letter attesting to the standards of the Practicum and the applicant's successful completion.

All supervising licensees must register any and all Clinical Fellows working under their supervision with the Board on a registration form. Registration must be made by the supervising licensee before or within ten (10) days of retaining each Clinical Fellow.

PERIOD OF EFFECTIVENESS

Clinical fellowships are effective for a period of no less than nine (9) months and no more than one (1) year.

The clinical fellowship's period of effectiveness for applicants for licensure who are awaiting national certification and subsequent Board review of their application for licensure may be extended for a period not to exceed three (3) additional months. Such extension will cease to be effective if national certification or Board licensure is denied. At all times while awaiting national certification results and until licensure is received, clinical fellows shall practice only under supervision as set forth in this rule.

Application for licensure or a three (3) month extension of their clinical fellowship should be made thirty (30) days before the expiration of their clinical fellowship registration.

Supervising licensees may only supervise three (3) Registered Clinical Fellows concurrently or two (2) Registered Speech Assistants concurrently. They cannot supervise more than a total of three concurrently.

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
665 Mainstream Dr
Nashville, TN 37243
www.tennessee.gov/health

CFY APPLICATION

_____ NEW _____ EXTENSION _____ 2ND LOCATION/SUPV _____ SUPERVISOR CHANGE

CFY For which profession: AUDIOLOGY SPEECH PATHOLOGY

_____

LAST NAME FIRST NAME MIDDLE INITIAL

Birthdate: _____ SS#: _____

Sex (Circle One): M F U.S. Citizen? (Circle One): Y N

Mailing Address: _____ City/State/ZIP: _____

Phone: (_____) _____ Fax: (_____) _____

Masters Degree Awarded By: _____ Date_____

Practice Site for CFY: _____
_____
_____

CFY Supervisor: _____ TN License Number: _____

Address: _____
_____

Applicant Signature: _____ Date: _____

In order to comply with federal statutes, the Board of Communications Disorders and Sciences is obligated to inform each applicant or licensee from whom it requests a social security number that disclosing such number is mandatory in order for this Board to comply with the requirements of the federal Healthcare Integrity and Protection Data Bank and/or the National Practitioner Data Bank. If the Board is required to make a report about one of its applicants or licensee to either or both of these data banks, it must report that individual's social security number. This application will not be complete if the social security number is omitted. The number will be used for identification purposes and for such purposes as are allowed by the state and federal law.

Witness: I _____ hereby witness the signature of the above Named CFY applicant.
(Print or Type Name)

Signature: _____ Date: _____
(Witness)

CFY Registrant Name: _____
(Print or type)

Name of Supervisor: _____
Last Name First Name Middle Initial

_____ _____
TN License Number of Supervisor **ASHA Certification Number**

Mailing Address: _____

_____

_____

Phone: (_____) _____ **Fax: (_____) _____**

I, _____ have agreed to provide required and

appropriate supervision to _____, registrant for CFY, for the period of

_____ to _____
(Month/Day/Year) **(Month/Day/Year)**

Full Time _____ **Part Time _____**

Signature: _____ **Date: _____**
(Supervisor)

Witness: I, _____ do hereby witness the signature of the above name Supervisor.
(Print or type name)

Signature: _____ **Date: _____**
(Witness)

Please return completed form to: Tennessee Board of Communications Disorders and Sciences
665 Mainstream Dr
Nashville, TN 37243