BRITISH COLUMBIA | Ministry of Children and Family Development

Registry of Autism Service Providers

Supervision Verification Record - SLP/OT

The personal information collected on this form is collected under the authority of the *Freedom of Information and Protection of Privacy Act* for the purpose of administering the *Supply Act*. The *Freedom of Information and Protection of Privacy Act* protects the personal information collected from unauthorized use and disclosure. If you have any questions about the collection, use or disclosure of this information, please call the Autism Funding Branch, Toll Free: 1 877 777-3530 or in Greater Victoria: 250 387-3530, PO Box 9776 Stn Prov Govt, Victoria BC V8W 9S5.

Complete this form to support the Registry of Autism Service Providers (RASP), Speech-Language Pathologist or Occupational Therapist Application. Both portions of the form must be completed and signed by the Applicant and a Supervisor.

Applicant Information

First Name | Last Name

Daytime Phone | Alternate Phone | Email Address

☐ Speech-Language Pathologist ☐ Occupational Therapist

Supervisor Information

First Name | Last Name

Position | Daytime Phone | Email Address

Letter of Verification

The applicant and their supervisor should complete each section. For each item, it should be indicated if the minimum requirement was met.

Applicant Requirements

	Minimum Requirements	
Service Provision	60 hours direct service	
Time Span	12 months for at least one client	
Number of Clients	3 different children with ASD under the age of six	
Direct Hours of Service	6 hours per child	

Supervisor Requirements

	Minimum Requirements	
Direct Supervision	6 hours total	
Total Supervision	35 hours	
Length of Supervision Period	12 months	
Direct Supervision per Child	1 hour per child	

Supervision Record

The table below contains the details of service provision and supervision for the applicant.

For the 'Code for Child' enter a non-identifiable code (such as initials) that the supervisor and the supervisee agree upon to identify a child.

Client #	Code for Child	Age at Start of Service	Time Span of Service (in months)	Service Provision			Supervision	
				Start Date	End Date	Hours of Direct	Hours of Direct	Hours of Indirect
1								
2								
3								
4								
5								
6								
					Total:			

Acknowledgements

Applicant

I verify that the information above is accurate.

Name of Applicant	SIGNATURE	DATE SIGNED (YYYY-MMM-DD)

Supervisor

I observed this applicant providing clinically competent services to clients with ASD and I verify that the information above is accurate.

Name of Supervisor	SIGNATURE	DATE SIGNED (YYYY-MMM-DD)

Submission Information

Please print, sign and then mail your completed Supervision Record and Verification Letter along with your RASP Service Provider Application (CF0901).

Submit completed forms to: RE: Autism Service Provider Application
c/o
Autism Information Services British Columbia
3688 Cessna Drive
Richmond BC V7B 1C7 Telephone: 1 844 878 4700