European Fluency Specialists

Verification of Clinical Activity for Applicant

This form is to be filled out by the Applicant himself/herself and countersigned by the Applicant's Supervisor, an EFS registered therapist or a specialist therapist colleague.

Applicant

I have completed a minimum of 120 hours of direct clinical activity in the area of fluency and fluency disorders, providing services in prevention, assessment, intervention, clinical supervision/mentoring fluency trainees, referrals, consulting. This activity covers a caseload including preschool and school-aged children adolescents and adults with disorders of fluency. The clinical work adheres to country-specific clinical guidelines, code of ethics and professional standards and was delivered during the five-year period prior to this date.

Name of Applicant:_____

Dates of five-year period:_____

Email:_____

Signature:_____

Date of signature: _____

Supervisor

I confirm that _____(name of Applicant) has completed a minimum of 120 hours of clinical activity in the five-year time period as stated above.

Name and position of supervisor_____

Signature of Supervisor_____

Email of supervisor_____

Date of signature: _____

European Fluency Specialists

Verification of Clinical Activity for Candidates

This form is to be filled out by the Candidate himself/herself and countersigned by the Candidate's Supervisor, an EFS registered therapist or a specialist therapist colleague.

Candidate

I have completed a minimum of 80 hours of direct clinical activity in the area of fluency and fluency disorders, providing services in prevention, assessment, intervention, clinical supervision/mentoring fluency trainees, referrals, consulting. This activity covers a caseload including preschool and school-aged children adolescents and adults with disorders of fluency. The clinical work adheres to country-specific clinical guidelines, code of ethics and professional standards and was delivered during the three-year period prior to this date.

Name of Candidate:_____

Dates of three-year period:_____

Email:_____

Signature:_____

Date of signature: _____

Supervisor

I confirm that _____(name of Candidate) has completed a minimum of 80 hours of clinical activity in the three-year time period as stated above.

Name and position of supervisor_____

Signature of Supervisor_____

Email of supervisor_____

Date of signature: _____

European Fluency Specialists

Verification of Clinical Activity for Certified Members

This form is to be filled out by the Certified Member himself/herself and countersigned by the Certified Member's Supervisor, an EFS registered therapist or a specialist therapist colleague.

Certified Member

I have completed a minimum of 300 hours of direct clinical activity in the area of fluency and fluency disorders, providing services in prevention, assessment, intervention, clinical supervision/mentoring fluency trainees, referrals, consulting. This activity covers a caseload including preschool and school-aged children adolescents and adults with disorders of fluency. The clinical work adheres to country-specific clinical guidelines, code of ethics and professional standards and was delivered during the three-year period prior to this date.

Name of Certified Member:_____

Dates of three-year period:_____

Email:_____

Signature:_____

Date of signature: _____

Supervisor

I confirm that _____(name of Certified Member) has completed a minimum of 300 hours of clinical activity in the three-year time period as stated above.

Name and position of supervisor_____

Signature of Supervisor_____

Email of supervisor_____

Date of signature: _____