MISSISSIPPI STATE DEPARTMENT OF HEALTH

Speech-Language Pathology/Audiology Aide

Biennial Report

Aide Name: _____

Aide License Number: _____

Supervisor Name: _____

Supervisor License Number: _____

Instructions:

1. **This report is required of all supervising licensees regardless of registration renewal.**

2. **Complete the report in its entirety, sign it, and return it to:**

Mississippi State Department of Health
Professional Licensure – SLP/A Aide
PO Box 1700
Jackson, MS 39215
MSDHProfLicensure@msdh.ms.gov

Section I. List all duties of the registered aide during the past registration period (July 1 – June 30 (even years)

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Section II. **List the type, amount, and date(s) of training provided for the duties listed in Section I.**

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Section III. **Supervision has been provided according to Subchapter 10: Regulations Governing Registration of Speech-Language Pathology Aides/Audiology Aides.**

I, the undersigned, solemnly swear or affirm that I have read the above report and that all statements contained therein or accompanying this report are true. Documentation of the information provided in this report is in the aide's personnel file.

_____
Supervisor Signature

_____
Date

570 East Woodrow Wilson • Post Office Box 1700 • Jackson, MS 39215-1700
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