Augmentative Communication Evaluation Team Qualifications

SPEECH LANGUAGE PATHOLOGIST

NAME:

DEGREE:

UNIVERSITY NAME AND LOCATION:

ASHA CERTIFICATE OF CLINICAL COMPETENCE IN SPEECH LANGUAGE PATHOLOGY AWARD DATE:

ABESPA LICENSE NUMBER:

SIGNATURE:_____ **DATE:**_____

PHYSICAL THERAPIST

NAME:

DEGREE:

UNIVERSITY NAME AND LOCATION:

ALABAMA LICENSE NUMBER:

SIGNATURE:_____ **DATE:**_____

OCCUPATIONAL THERAPIST

NAME:

DEGREE:

UNIVERSITY NAME AND LOCATION:

ALABAMA LICENSE NUMBER:

SIGNATURE:_____ **DATE:**_____

By signing this form you certify that you do not have a financial relationship with nor will you receive any other gain from the manufacture of the recommended device/equipment.

(continued)

OTHER

ROLE:

NAME:

DEGREE:

UNIVERSITY NAME AND LOCATION:

ALABAMA LICENSE NUMBER:

SIGNATURE:_____ **DATE:**_____

OTHER

ROLE:

NAME:

DEGREE:

UNIVERSITY NAME AND LOCATION:

ALABAMA LICENSE NUMBER:

SIGNATURE:_____ **DATE:**_____

OTHER

ROLE:

NAME:

DEGREE:

UNIVERSITY NAME AND LOCATION:

ALABAMA LICENSE NUMBER:

SIGNATURE:_____ **DATE:**_____

By signing this form you certify that you do not have a financial relationship with nor will you receive any other gain from the manufacture of the recommended device/equipment.