



**European Fluency Specialists**  
**Verification of Clinical Activity Form (Initial Application)**

*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 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 Applicant: \_\_\_\_\_

Dates of three-year period: \_\_\_\_\_

Email: \_\_\_\_\_

Signature: \_\_\_\_\_

Date of signature: \_\_\_\_\_

**Supervisor**

I confirm that \_\_\_\_\_ (name of Applicant) 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 Form (Renewal Application)**

*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 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 Applicant: \_\_\_\_\_

Dates of three-year period: \_\_\_\_\_

Email: \_\_\_\_\_

Signature: \_\_\_\_\_

Date of signature: \_\_\_\_\_

**Supervisor**

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

Name and position of supervisor \_\_\_\_\_

Email of supervisor \_\_\_\_\_

Signature of Supervisor \_\_\_\_\_

Date of signature: \_\_\_\_\_