

Certificate of Receipt of Services

Important: We are presently updating our records regarding speech pathology services in the Philippines. Kindly fill out the form. "Referent" will be used to refer to the speech pathologist and "referee" be used for the person filling out this form.

Name of speech pathologist: (First name, Middle Initial, Last name)

| Type of Reference: ☐ Clinic Administrator ☐ Section Chief | | Others. Please specify |
|---|-------------|---------------------------------|
| What kind of setting is your or | ganization? | |
| ☐ Clinic | ~ | Home-based |
| ☐ Hospital | | School |
| □ Others | | |
| What are the designated roles does of the referent in your organization? | | |
| ☐ Clinician / Consultant | | Clinic Mentor |
| ☐ Clinical Supervisor | | Department Head / Section Chief |
| ☐ Administrator | | Home Care Provider |
| □ Others | | |
| How long have you been working with the referent? How did you avail of services? Please briefly describe the referent's client load and work arrangement with your organization. | | |
| | | |
| Name of the Referee | | |
| Name of the Organization | | |
| Address | | |
| Contact Numbers | | |
| Email | | |
| Date Accomplished | | |

By clicking this, I certify that the foregoing statements are true and correct to the best of my knowledge and belief, and understand willfully that false statement is sufficient cause for rejection of this application.

Thank you for completing this form. For inquiries, please email PASP.Membership@gmail.com.