CYPRESS FAIRBANKS
INDEPENDENT SCHOOL DISTRICT
Learn ● Empower ● Achieve ● Dream

Special Education - Instructional Support Center/South
10300 Jones Rd. Houston, Texas 77065-4208
Ph: 281-897-6400 Fax: 281-897-6403

_____
Name of Previous Employer

_____
Address (Street & Number)

_____
City State Zip

To Whom It May Concern:

I have been employed by the Cypress-Fairbanks Independent School District and need a record of my experience so I may receive credit for salary purposes.

I have listed my experience on the attached form. Please have the authorized person complete and verify each year of service and return to me.

Your cooperation will be greatly appreciated.

Sincerely,

_____
Signature

_____
Address (Street & Number)

_____
City State Zip

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GUIDELINES FOR AWARDING CREDIT FOR PRIOR SPEECH THERAPY SERVICE OUTSIDE OF PUBLIC SCHOOLS

Following are criteria which must be met for Cypress-Fairbanks ISD to accept or credit prior speech therapy toward total years of experience:

- Full-time, full-year, direct speech therapy services
- Service provided in a hospital, clinic, private school/practice or other private facility
- Experience must be verifiable by the completed original verification of service outside of public schools form
- Credit will not be given for substitute therapy services, clinical practicum, or service as an aide, student assistant or teaching fellow
- Credit for experience may not be granted from more than one entity in any given academic year
- While speech therapy service records should be completed using **calendar** years, a year of service is defined as the employment period between July 1 and the following June. Credit for outside public school experience will be awarded accordingly.

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Dear Speech/Language Pathologist:

The attached form is to be used to request your prior speech therapy experience record for service outside of the public school setting.

Please complete the top information, Columns #1, #2, and #3, **only**. Columns #4, #5, and #6 are to be completed by the authorized representative at the clinic, hospital or private facility. No more than one year of experience is to be listed per line. Speech Therapy Verification Forms should be completed using the actual beginning and ending work dates.

Ditto marks are not acceptable, each line must be completed. Signatures must be originals, no stamped signatures will be accepted.

Mail this form to your previous employer requesting they complete Column #4, #5 and #6. Authorized personnel would be a Director, Owner, or Payroll Manager. This person is verifying your actual work experience, and must sign each line of service. They would also print their name, title and date the form. An example is shown below:

(1)		(2)	(3)	(4)	(5)	(6)
Dates of Employment		% of Day Employed 50% = Half Day 100% = Full Day	Age Level of Clients	Number of Days Worked	Name of Clinic, Hospital or Private Facility	Authorized Signature
From Month/Yr	To Month/Yr					
1/18/2013	11/29/2014	100%	2-14	85	Tx Childrens Hospital	
2/15/2014	12/31/2015	100	2-14	100	Tx Childrens Hospital	
2/15/2014	12/31/2015	100	2-14	187	Tx Childrens Hospital	

Have the completed form returned to your home address. Once you receive the returned form, please send to my attention at the address listed above.

Please call if you have any questions regarding this process and I will be happy to assist you.

Thank you,

Kelly Mock, M.S. CCC-SLP

Coordinator for Speech Language Pathology

EMPLOYMENT VERIFICATION FORM - SPEECH LANGUAGE PATHOLOGIST

For Service Outside of Public Schools

Last Name | First | Middle Initial | Social Security Number | Professional License Number

Instructions:

Verification of Speech Pathology work conducted for a private or government entity. Do not list substitute therapy, clinical practicum service as an aide, student assistant or teaching fellow. Use a separate line for each year of employment. Use a separate form for each employer. **Number of days worked is total of days for the year, not during work week.**

Credit for experience may not be grated for more than one entity in any given academic year.

(1)		(2)	(3)	(4)	(5)	(6)
Dates of Employment		% of Day Employed 50% = Half Day 100% = Full Day	Age Level of Clients	Number of Days Worked	Name of Clinic, Hospital or Private Facility	Authorized Signature
From Month/Yr	To Month/Yr					

Printed Name and Title of Authorized Signature

Date

Address of Clinic, Hospital or Private Facility

Phone number