



**PA Supervised Professional Experience Opportunities
Preceptor/Practice Information**

PRECEPTOR NAME: _____

PRACTICE NAME: _____

PRACTICE ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE: _____

COUNTY: _____ PHONE: _____ EMAIL: _____

STATE LICENSE: _____ CERTIFICATION: ASHA ABA

HOW DO YOU PREFER TO BE CONTACTED: Phone Email

DESCRIPTION OF EXPERIENCE OPPORTUNITES:

POPULATION SERVED: Birth to 3 yrs 3 to 17 yrs Adult

SERVICES:

- | | | |
|--|---------------------------------------|---|
| <input type="radio"/> ABR - Adult | <input type="radio"/> ABR - Pediatric | <input type="radio"/> HEARING EVALUATION |
| <input type="radio"/> ASSISTIVE LISTENING DEVICES | | <input type="radio"/> HEARING INSTRUMENT SELECTION |
| <input type="radio"/> AUDITORY (RE) HABILITATION | | <input type="radio"/> HEARING INSTRUMENT DISPENSING |
| <input type="radio"/> COCHLEAR IMPLANT | | <input type="radio"/> INDUSTRIAL AUDIOLOGY |
| <input type="radio"/> AUDITORY PROCESSING EVALUATION | | <input type="radio"/> OTOACOUSTIC EMISSIONS |
| <input type="radio"/> AUDITORY PROCESSING MANAGEMENT | | <input type="radio"/> TINNITUS EVALUATION |
| <input type="radio"/> ECOG | | <input type="radio"/> TINNITUS RETRAINING THERAPY |
| <input type="radio"/> EDUCATIONAL AUDIOLOGY | | <input type="radio"/> RECREATIONAL AUDIOLOGY |
| <input type="radio"/> ENG/VESTIBULAR EVALUATION | | <input type="radio"/> VESTIBULAR REHABILITATION |

OTHER SERVICES: _____

EXTERN DUTIES: _____

START DATE: _____ DURATION OF EXPERIENCE: _____

NUMBER OF POSITIONS AVAILABLE: _____ STIPEND AVAILABLE: _____

APPLICATION PROCESS: _____

SPECIAL REQUIREMENTS: (For example: Do you require the student have experience in specific areas before applying.) _____

RESTRICTED OR OPEN APPLICATIONS: _____

IF AVAILABLE: NAMES OF PREVIOUS EXTERNS AND CONTACT INFORMATION

NAME: _____

CONTACT INFORMATION:

PHONE: _____ CELL PHONE: _____ E-MAIL: _____

PREFERRED METHOD OF CONTACT: PHONE CELL PHONE E-MAIL:

NAME: _____

CONTACT INFORMATION:

PHONE: _____ CELL PHONE: _____ E-MAIL: _____

PREFERRED METHOD OF CONTACT: PHONE CELL PHONE E-MAIL:

NAME: _____

CONTACT INFORMATION:

PHONE: _____ CELL PHONE: _____ E-MAIL: _____

PREFERRED METHOD OF CONTACT: PHONE CELL PHONE E-MAIL:

RETURN PRECEPTOR/PRACTICE INFORMATION TO: Mindy Brudereck, Au.D.
Berks Hearing Professionals, LLC
4997 N. Twin Valley Road, Ste. 2
Elverson, PA 19520
FAX: (610) 286-1991
OR E-MAIL TO: berkshearing@hotmail.com

**The above information will be listed on the official website of the
Pennsylvania Academy of Audiology
www.paaudiology.org**

Membership in the Pennsylvania Academy of Audiology is not required to participate in this program.