

Board of Speech-Language Pathology and Audiology

Application for Speech-Language Pathology or Audiology Provisional Licensure With Instructions Attached



**Board of Speech-Language Pathology and Audiology
4052 Bald Cypress Way, Bin # C-06
Tallahassee, FL 32399-3256
(850) 488-0595**

December 2009 Edition

GENERAL INFORMATION

MAILING ADDRESS

Please use the below addresses as they apply.

ORIGINAL APPLICATION, SUPPORTING DOCUMENTS AND FEES TO:

Board of Speech-Language Pathology and Audiology
P. O. BOX 6330
Tallahassee, FL 32314-6330

ADDITIONAL CORRESPONDENCE AND SUPPLEMENTAL DOCUMENTS TO:

Board of Speech-Language Pathology and Audiology
4052 Bald Cypress Way, Bin C06
Tallahassee, FL 32399-3256
TDD 1-800-955-8771

If information is mailed from a source other than the applicant, the applicant's full name must appear on the correspondence or documentation. The information should be addressed to the Board of Speech-Language Pathology and Audiology, 4052 Bald Cypress Way, Bin C-06, Tallahassee, Florida 32399-3256.

If you have further questions you may contact the application reviewers at (850) 245-4161 between the hours of 8:00 AM and 5:00 PM EST. Please do not call to check on your application until at least 30 days from the date you mailed your documentation. If you have Internet access you can verify your license number and address at our website <http://www.doh.state.fl.us/mqa>. Scroll down and click on "Health Care Provider License Lookup".

IMPORTANT NOTICE!

Effective July 1, 2009, section 456.0635, Florida Statutes, provides that health care boards or the department **shall refuse** to issue a license, certificate or registration and shall refuse to admit a candidate for examination if the applicant has been:

- Convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, chapter 893, 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, unless the sentence and any subsequent period of probation for such conviction or pleas ended more than 15 years prior to the date of the application;
- Terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5 years;
- Terminated for cause, pursuant to the appeals procedures established by the state or Federal Government, from any other state Medicaid program or the federal Medicare program, unless the applicant has been in good standing with a state Medicaid program or the federal Medicare program for the most recent 5 years and the termination occurred at least 20 years prior to the date of the application.

BOARD APPEARANCES:

Certain applicants may be required to appear before the Board to discuss their application or may be referred to the Professionals Resource Network (PRN) for an evaluation of competency to practice before a determination of licensure can be made. An appearance, PRN referral or combination of both may be required for a variety of reasons, such as (but not limited to):

- Criminal Convictions
- Previous Discipline
- Previous appearance before a licensing board or regulatory agency
- Drug/alcohol addiction/impairment
- Discrepancies in application information/materials
- Participation in an impaired practitioner program
- Other reasons as deemed necessary by Board staff or the Board Chair

The scenarios listed above are not an automatic appearance before the Board or PRN referral. Appearances and PRN referrals are determined on an individual basis. Should your appearance or referral be required, you will be notified in writing.

SOCIAL SECURITY NUMBER = Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code, Sections 653 and 654; and Sections 456.004(9), 409.2577, and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to assure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for licensee identification pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act), 104 Pub. L 193, Section 317.

ADDRESS NOTE = Your location address will be published on the Internet licensure lookup screen. Our licensure database requires two addresses for each licensee. One is the mailing address and the other is the location address. The "mailing address" is used whenever information is mailed to the applicant/licensee. If you only provide one address, it will be used for both the mailing address and the location address.

ADDRESS CHANGE = If you have a change of address, you must provide signed, written notification to the Board office. Include your full name, old address, and new address, and whether this is your mailing address or your location address.

NAME CHANGE = If you have a legal name change, you must provide signed, written notification to the Board office. Include your full name as you applied, your new name, and a photocopy of the applicable legal document. Your name cannot be changed without valid legal documentation.

APPLICATION INSTRUCTIONS

SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY PROVISIONAL LICENSURE

Please read Chapter 468, Part I, Florida Statutes (F.S.) and Chapter 64B20, Florida Administrative Code (F.A.C.), prior to completing the application forms. You must read the laws and rules in order to determine your eligibility **prior to applying**. The laws and rules can be found on our website at: <http://www.doh.state.fl.us/mqa/speech/index.html>.

Within 30 days of receipt of your application and fees, you will be sent a letter informing you of your application status. If you do not receive notice within 40 days that your application has been received, contact this office at (850) 245-4161.

REQUIRED FEES

The initial licensure, unlicensed activity and application fee is **\$180**. Include a cashier's check or money order made payable to the Department of Health. (Note: The application fee of \$75.00 is non-refundable.)

COMPLETING THE APPLICATION FOR LICENSURE

Questions must be answered fully and truthfully; there are no questions that are not applicable. Obtaining a license by fraudulent misrepresentation is grounds for denial of your application or revocation of your license (Chapter 468.1295(1)(a), F.S.). You must sign and date the application. Original forms must be submitted; photocopies of signatures are not acceptable. It is your responsibility to notify this office in writing if the answers to any of these questions change. Please be advised that illegible applications will be returned to you as incomplete.

EXPERIENCE

One copy of the **Verification of Employment (Form SPA-2A)** is enclosed. You must fill in your name and social security number on the top portion of the form before giving the form to the licensed speech-language pathologist/audiologist who will complete, sign, and return the form to the Board office. If there is a change in supervision, a new **Verification of Employment (Form SPA-2A)** must be completed and signed by the new supervisor and then sent to the Board office. If you change supervisors during your clinical fellowship, each supervisor must complete Form SPA-2B and Form SPA-2C (see "experience" in the application instructions in Section B).

OFFICIAL TRANSCRIPT

You must request that an official transcript(s) be sent directly to the Board office. If the transcript does not reflect that a master's degree or doctoral degree was awarded, a Certificate of Conferral of Master's Degree (SPA-2D) or Doctoral Degree (Form SPA-2E) must accompany your transcript. If you did not graduate from an Educational Standards Board (ESB) approved program; your school must also send verification of 300 clock hours of supervised clinical practice.

FOREIGN EDUCATION

In order for the Board to consider any education completed outside the U.S. or Canada, documentation must be received which verifies that the institution at which the education was completed was equivalent to an accredited U.S. institution. Documentation must also be received which verifies that the coursework met the content and credit hour requirement for coursework in the U.S. It is the applicant's responsibility to obtain an evaluation from a recognized educational evaluation service that documents the acceptability of the coursework.

DOCUMENTS IN A FOREIGN LANGUAGE

A certified translator who is not related to the applicant must translate any document that is in a language other than ENGLISH.

LICENSE / CERTIFICATION VERIFICATION (Form is included with the application or can be obtained from our website.)

This form is required if you answered, "yes" to the question in section 2 of the application. This form is to be completed if you currently hold or have ever held a license or certificate in any state, U.S. territory, or foreign country. You must fill out your name, social security number, address, title of license, and license number in the top section only and mail this form to each state, U.S. territory, or foreign country that issued the license(s) and/or certification(s). That agency must complete and mail the form directly to the Board office. It will not be considered official if the verification form is received from the applicant.

VERIFICATION OF HIV / AIDS COURSE

Chapter 468.1201, F. S. requires completion of a one (1) hour education course on human immunodeficiency virus and acquired immune deficiency syndrome.

VERIFICATION OF PREVENTION OF MEDICAL ERRORS COURSE

Chapter 456.013(7), F.S. requires completion of a two (2) hour education course relating to prevention of medical errors. The course shall include a study of root-cause analysis, error reduction and prevention, and patient safety. (Note: Please refer to rules 64B20-2.001, F.A.C. and 64B20-6.001, F.A.C., for the requirements of this course).

The medical errors course must be taken from a provider approved by the Board of Speech-Language Pathology and Audiology or the American Speech-Language Hearing Association (ASHA). To obtain a list of approved providers, please visit CEBroker at www.cebroke.com or call (877) 434-6323 for assistance.

APPLICANT HISTORY QUESTIONS – REQUIRED DOCUMENTATION:

If you answer “yes” to any of the questions in sections 4-7 regarding criminal, health, or professional history, the required supporting documentation is listed directly on the application. In instances where certified court documentation is required but cannot be obtained, you must direct the Clerk of Courts to send a letter advising the Board that the documentation is no longer available.

For Section 7- Chapter 456.0635 (2):

A – B: If yes, please provide an explanation on a separate sheet. You must also submit CERTIFIED copies of all pertinent court/arrest documents, including arrest report, official charges, restoration of civil rights (if applicable) and current disposition.

C – D: If yes, provide an explanation on a separate sheet. You must also direct the Medicaid program to submit all pertinent documentation directly to the Board office.

E – G: If yes, provide an explanation on a separate sheet. You must also direct the state Medicaid program or the federal Medicare program to submit all pertinent documentation directly to the Board office.

**Application Checklist for Provisional License
Speech-Language Pathologist or Audiologist**

| Provisional | |
|---|--|
| Application <i>(documents mailed by applicant)</i> | |
| | Complete the Confidential and Exempt From Public Records Disclosure Form |
| | Answer all questions <ul style="list-style-type: none"> ➤ <i>Applicant Licensure Status (section 2) - If you answered yes, please request the issuing state, territory, or foreign country to complete the license/certification verification form (included in the application packet).</i> ➤ <i>Applicant History (section 4 and 5) General or Professional - If you answered yes, please provide certified court and/or treating physician documents.</i> |
| | Attach a recent 2x2 color photo <i>(above shoulders)</i> |
| | Sign and date application |
| | Fees <i>(check/money order for application, licensure and unlicensed activity fees)</i> |
| | Proof of 1-hour HIV/AIDS course <i>(offered by any healthcare profession)</i> |
| | Proof of 2-hours prevention of medical errors course <i>(from an approved Board of Speech-Language Pathology and Audiology continuing education provider)</i> |
| | Verification of Employment Form <i>(may be mailed by supervising licensee)</i> |
| Transcript <i>(documents must be mailed from the originating Source)</i> <i>(Note: Foreign transcripts must be translated into English and evaluated by an approved Evaluating Credentialing Agency.)</i> | |
| ◆ Speech-Language Pathologist | |
| | Master's Degree or completion of the academic requirements of a Doctoral degree program. |
| | Complete the program requirements by academic course work, practicum experience, or laboratory or research activity, as verified by the program. |
| ◆ Audiologist | |
| | Doctoral Degree or completion of the academic requirements of a Doctoral degree program. |
| | Proof of completion of the academic requirement of a doctoral degree program <i>(Certification of Completion of academic requirements of a Doctoral Program form included in application packet).</i> |

| | |
|--|--|
| | Complete the program requirements by academic course work, practicum experience, or laboratory or research activity, as verified by the program. |
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APPLICATION FOR PROVISIONAL LICENSURE

Check the box for the profession in which you are applying for:

Speech-Language Pathologist (3005) Audiologist (3006)

Print clearly in black ink or type all information.

| 1. APPLICANT DATA | | | | |
|--|---------------------------|--------|---|---------------------|
| NAME: | Last | First | Middle | |
| MAILING ADDRESS: | Number and Street | Apt. # | City | State Zip Code |
| PRACTICE LOCATION ADDRESS: | Number and Street | Apt # | City | State Zip Code |
| Home Telephone Number | Business Telephone Number | | Date and Place of Birth | |
| Have you ever changed your name through marriage or through action of a court, or have you ever been known by any other name? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, list <u>all</u> names below: | | | | |
| 2. APPLICANT LICENSURE STATUS | | | | |
| Do you hold or have you ever held a license and/or certificate to practice any profession in any state, U.S. territory, or foreign country? <input type="checkbox"/> yes <input type="checkbox"/> no | | | | |
| If YES, list <u>all</u> licenses and/or certificates and the issuing state, territory, or foreign country below. Each issuing state, territory, or foreign country must submit the license/certification verification form enclosed. | | | | |
| TYPE OF LICENSE/CERTIFICATE | | | ISSUING STATE, TERRITORY, FOREIGN COUNTRY | |
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Board of Speech-Language Pathology and Audiology
 4052 Bald Cypress Way, Bin C06, Tallahassee, FL 32399-3256
 Telephone: (850) 245-4161 FAX: (850) 921-6184 Web Site <http://www.doh.state.fl.us/mqa>

APPLICANT NAME: _____

| 3. EDUCATIONAL DATA | | | | |
|--------------------------------|-----------------|-----------------|-----------------------|--------------------|
| Graduate/Under graduate Degree | Major/Specialty | Accredited City | School /State/Country | Date of Graduation |
| 1. _____ | 1. _____ | 1. _____ | | 1. _____ |
| 2. _____ | 2. _____ | 2. _____ | | 2. _____ |
| 3. _____ | 3. _____ | 3. _____ | | 3. _____ |

4. APPLICANT HISTORY – CRIMINAL *(Attach additional sheets if necessary)*
If you answer “yes” to questions A-B below, you must provide the following WITH the application at the time of submission:

- 1. An explanation (in your own words) regarding the charges on a separate sheet.**
- 2. You must also submit CERTIFIED copies of all pertinent court and arrest documents, including arrest report, official charge documentation, restoration of civil rights (if applicable) and current disposition. This should include sentencing due to the arrest and proof of successful completion of your sentencing.**

A. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? yes no
You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question. The fact that a plea, conviction or disposition of a criminal case is on appeal does not affect your obligation to disclose the plea or conviction under this question.

B. Have ever been arrested or criminally or civilly charged with any intentional or negligent action related to use or misuse of drugs, alcohol, or illegal substances? yes no

5. APPLICANT HISTORY – HEALTH HISTORY
If you answer “yes” to questions A-G below, you must provide the following WITH the application at the time of submission:

- 1. A complete description of all treatments and diagnosis you received for any condition or impairment you experienced, were treated for, or which you were diagnosed.**
- 2. A list of all medications you have been prescribed, that you have taken or that you are taking to treat each diagnosed condition.**
- 3. A statement from your treating physician for each condition you were or are being treated for including all DSM III/DSM IV, Axis I, II, and III diagnosis and codes. If there is no Axis to report, the treating physician(s) must indicate that in their statement.**

A. In the last five years, have you been declared legally incompetent? yes no

B. In the last five years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the within the last five years? yes no

C. In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment? yes no

D. During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice within the last five years? yes no

E. In the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice? yes no

APPLICANT NAME: _____

| | |
|--|--|
| F. In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder, if you were previously in such a program, did you suffer a relapse within the last five years? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| G. During the last five years, have you been treated for or had a recurrence of a diagnosed related (alcohol/drug) disorder that has impaired your ability to practice within the past five years? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| <p>6. APPLICANT HISTORY – PROFESSIONAL</p> <p><i>If you answer “yes” to questions A- E of this section, you must provide the following documentation WITH the application when it is filed:</i></p> <ol style="list-style-type: none"> 1. Complete details as to the state(s), license number(s), date(s), and relevant circumstances on attached sheets. 2. A copy of the complaint and disposition for each case. 3. A copy of any documentation from the state regarding the final actions/outcome of the issue. | |
| A. Have you ever been denied a license/certificate to practice Speech-Language Pathology and/or Audiology or the renewal thereof in any state, U.S. Territory or foreign country? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| B. Have you ever been denied the right to take a Speech-Language Pathology and/or Audiology licensure examination? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| C. Have you ever had a license/certificate to practice a profession revoked, suspended, or otherwise acted against (including probation, fine or reprimand) in a disciplinary proceeding in any state, U.S. Territory or foreign country? <i>Concerning the answer to question C., the surrender of a license or certificate of registration because of, or in response to, charges or an investigation constitutes “otherwise acted against” within the meaning of the question.</i> | <input type="checkbox"/> yes <input type="checkbox"/> no |
| D. Are you now or have you ever been a defendant in civil litigation in which the basis of the complaint against you was alleged negligence, malpractice or lack of professional competence? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| E. Is there a complaint currently pending against you in any jurisdiction, or an investigation of your professional conduct or competency in any profession? | <input type="checkbox"/> yes <input type="checkbox"/> no |

| | |
|---|--|
| <p>7. APPLICANT HISTORY –CHAPTER 456.0635(2)</p> <p>Pursuant to Chapter 456.0635(2), Florida Statutes the following questions (A – G) are being asked. If you answer yes to any of the following questions, you must explain on a separate sheet providing accurate details and submit copies of all supporting documentation. Please see instructions for additional information and required documentation.</p> | |
| A. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, Chapter 817, or Chapter 893, Florida Statutes; or 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396? (If no, do not answer B.) | <input type="checkbox"/> yes <input type="checkbox"/> no |
| B. Has it been more than 15 years prior to the date of this application since the sentence and completion of any subsequent period of probation for each such conviction? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| C. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If no, do not answer D.) | <input type="checkbox"/> yes <input type="checkbox"/> no |
| D. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| E. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state or federal government, from any other state Medicaid program or the federal Medicare program? (If No, do not answer F or G.) | <input type="checkbox"/> yes <input type="checkbox"/> no |
| F. Have you been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| G. Did the termination occur at least 20 years prior to the date of this application? | <input type="checkbox"/> yes <input type="checkbox"/> no |

APPLICANT NAME: _____**8. CERTIFICATION**

I hereby authorize all hospitals, institutions, or organizations, personal physicians, employers (past or present), business and professional associates (past or present), and all government agencies and instrumentalities (local, state, federal, or foreign) to release to the Department of Health any information, files, or records requested by the Department in connection with the processing of this application. I further authorize the Department to release to the organizations, individuals, and groups listed above any information which is material to my application.

I understand that it is my duty and responsibility as an applicant for licensure to supplement my application after it has been submitted if and when any material change in circumstances or conditions occur which might affect the Board's decision concerning my eligibility for licensure. Chapter 456.013(1)(a), F.S., requires such supplement. Failure to do so may result in disciplinary action by the Board including denial of licensure.

I have carefully read the questions in the foregoing application and have answered them completely without reservations of any kind, and I declare that my answers and all statements made by me herein are true and correct. Should I furnish any false information on this application, I hereby agree that such act shall constitute cause for denial, suspension, or revocation of any license to practice in the State of Florida the profession for which I am applying.

I hereby acknowledge receipt of Chapter 468, Part I, F.S., and related rules and further acknowledge that I have read these regulations. I understand that it is my responsibility to keep informed of any changes to Chapter 468, Part I, F.S. and related rules.

I UNDERSTAND THAT I AM NOT PERMITTED TO PRACTICE THE PROFESSION FOR WHICH I AM APPLYING UNTIL I AM ISSUED A LICENSE TO PRACTICE THE PROFESSION.

Applicant's Signature:

Date:



CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS
DISCLOSURE*

**Florida Department of Health
Board of Speech-Language Pathologist and Audiologist Provisional
Application**

Name: _____
Last **First** **Middle**

Social Security Number: _____

* This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCA § 666 (a)(13). For all professions regulated under Chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013 (1)(a), Florida Statutes.