KENTUCKY BOARD OF
SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY
P.O. BOX 1360
FRANKFORT, KENTUCKY 40602
http://slp.ky.gov

APPLICATION FOR LICENSE
SPEECH-LANGUAGE PATHOLOGY ASSISTANT

FOR OFFICE USE ONLY:
Date:_________________
Amount: ______________
[ ]Approved [ ]Denied
[ ]Deferred
Comments: _____________
____
Member Initial:__________

1. Name: ____ S.S. #: __________________________

2. Name as it appears of transcript: ____

3. Address: ____
Street City State Zip Code

4. Telephone: Home ( ) ____________________ Work ( ) ___________________ Cell ( ) ____________________

5. U. S. Citizen: [ ] Yes [ ] No If no, have you declared your intention to become a citizen? [ ] Yes [ ] No

6. Date of Birth: ____________________ 7. Email ____

8. Have you ever applied for licensure in Speech-Language Pathology in Kentucky? [ ] Yes [ ] No
If yes, give license number and/or reason for denial: ____

9. Name of other state(s) in which you hold a license. ____
Please submit a letter of good standing from all states in which you have held a license in Speech-Language Pathology or Audiology

10. Have you ever had a license denied, suspended or revoked in any state or have you ever received a reprimand as a result of unethical, immoral or illegal conduct by any licensure board or agency? [ ] Yes [ ] No If yes, explain: _________________
____

11. Have you ever been convicted of a felony? [ ] Yes [ ] No If yes, explain: ____
____

12. Professional Experience (Begin with Current Position)

	Describe Your Duties
Employed: From Mo. _____ Yr. _____ To Mo. _____ Yr. ______ [ ] Full-Time [ ] Part-Time _____________hrs./wk Title or Position ____ Name of Employer _______________________________________ Address of Employer _____________________________________	____ ____ ____ ____ ____
Employed: From Mo. _____ Yr. _____ To Mo. ______ Yr. _____ [ ] Full-Time [ ] Part-Time _____________hrs./wk Title or Position ____ Name of Employer _______________________________________ Address of Employer _____________________________________	Describe Your Duties ____ ____ ____ ____ ____

Name ____

EDUCATION

School	Names and Locations	Dates Attended		Date of Graduation		Number of Hours or Credits	Degrees Obtained
		From	To	Month	Year		
UNDER-GRADUATE SCHOOL							
GRADUATE SCHOOL							

NOTE: All degrees applicable to Licensure must be documented by a CERTIFIED COPY of the official transcript. The transcript must be mailed directly to this office by the school registrar. No action will be taken on your application until necessary transcripts are received.

13. Work Setting – School System: ____________________________ School Name(s): ____________________________________

    Address: ____
    Street City State Zip Code

14. Licensees must provide a Postgraduate Professional Experience Report completed by each Speech-Language Pathologist who has provided supervision during your interim licensure period.

15. Licensees must submit the Postgraduate Professional Experience Evaluation Form completed by each Speech-Language Pathologist who has provided supervision during your interim licensure period.

16. An initial licensure fee of $75.00 must be attached to this application and mailed to the following address: P.O. Box 1360, Frankfort, Kentucky, 40602. All checks or money orders should be made payable to the ***Kentucky State Treasurer***. **DO NOT SEND CASH.**

AFFIDAVIT

I do hereby swear or affirm that the above statements made by me on this application are true, complete and correct to the best of my knowledge. I represent that I have read and understand the laws and regulations related to licensure as a Speech-Language Pathology Assistant.

APPLICANT'S SIGNATURE: ____ DATE: _________________

AGREEMENT TO PROVIDE SUPERVISION

I, ________________________________, do hereby agree to provide supervision as required by KRS 334.035 (2) and as defined by 201 KAR 17:027 for ____________________________________ to function as a speech-language pathology assistant during the period of this license.

I further agree to accept responsibility for the practice and activities of the above named individual in his/her capacity as a speech-language pathology assistant.

I acknowledge that the failure to utilize this person appropriately as a speech-language pathology assistant and to supervise in accordance with the above cited provisions of Chapter 334A of the Kentucky Revised Statues and the administrative regulations promulgated thereunder, shall be considered as aiding and abetting an unlicensed person to practice speech-language pathology as described in KRS Chapter 334A. I represent that I have read and understand the laws and regulations related to licensure as a Speech-Language Pathology Assistant.

____
Supervisors Signature

____
Date

____
Street Address

____
Phone Number

____
City, State, Zip Code

____
SLP License or Certificate Number(You must attach a copy of your Kentucky Teaching Certificate if you do not hold a Kentucky SLP License)

Revised 7/12/2011