KENTUCKY BOARD OF SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY

COMMONWEALTH OF KENTUCKY
PO BOX 1360
FRANKFORT, KY 40602
http://slp.ky.gov

FOR OFFICE USE ONLY:
Date: _____
Amount:_____
Board Review Date:_____
[ ]Approved [ ]Denied
[ ]Deferred
Comments: _____
_____
Member Initial: _____

APPLICATION FOR INTERIM LICENSURE

(Please check appropriate block)

☐ Speech-Language Pathology
☐ Audiology

1. Name: _____ S. S. No. _____

2. Name as it appears on your transcript: _____

3. Address: _____
Street City State Zip Code

_____
Email Address

4. Phone: Cell: _____ Work: _____ Home: _____

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

6. Date of Birth: _____

7. Have you ever applied for licensure as a Speech-Language Pathology Assistant in Kentucky? ☐ Yes ☐ No.
If yes, please give license number and reason for denial: _____

8. 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.

9. 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:

10. Have you ever been convicted of a felony? ☐ Yes ☐ No. If yes, explain:

11. Education:

School	Names and Locations	Date Attended		Date of Graduation		Number of Hours or Credits	Degrees Obtained
		From	To	Month	Year		
Undergraduate							
Graduate							

AFFIDAVIT

I do hereby swear or affirm that the above statements made by me in 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 in Speech Language Pathology and Audiology.

Applicant Signature: _____ Date: _____

A nonrefundable application fee of $50 (fifty dollars) for interim licensure must be attached to this form ($100 if dual licensure). Please make check or money order payable to the Kentucky State Treasurer. DO NOT SEND CASH. Please mail the completed application and the application fee to the address above.

PLAN OF ACTIVITIES FOR
POSTGRADUATE PROFESSIONAL EXPERIENCE
This portion of the application must be completed by the supervisor

I. **PPE Setting**

A. Facility Name: _____

B. Address: _____
Street City State Zip Code

C. Phone: Work: (____)-_____ _____

D. Beginning Date of PPE: _____ Estimated Ending Date: _____

☐ Full-Time 1260 hours total, 35 hours per week for 36 weeks

☐ Part - Time 1260 hours must be earned within 24 months (96 weeks). Part time work of less than 5 hours of work per week cannot be counted toward PPE. (_____ hrs per week X _____# of weeks=1260 hours)

II. **Supervisor**

A. Name: _____ KY License Number: _____

B. Address: _____

Street City State Zip Code

C. Telephone Number: Cell: ( )- _____ Work: ( )- _____

D. Place / Address of Employment: _____

_____

III. **Plan of Professional Activities**

A. Applicant Activity:

Applicant Activity	Number of Hours Each WEEK to be Spent by Applicant
1. Assessment, diagnosis and / or evaluation	
2. Screening	
3. Habilitation / Rehabilitation	
4. In-service Training	
5. Record Keeping	
6. Other (Specify):	
TOTAL (equal to hours/week)	

B. Supervisory Activity

Supervisory Activity	On-Site Observations (min. of 6 hours per segment)	Other monitoring activities (min. of 6 hours per segment)
Segment One		
Segment Two		
Segment Three		
Total On-Site Occasions*		
Total Other Activities		

***Must be minimum of 18 total in each area**

AFFIDAVIT

I, the named supervisor for the above named applicant for interim licensure, have devised and discussed this plan of activities for post-graduate professional experience with said applicant and accept responsibility for its implementation. Further, I do hereby certify that my Kentucky License is current, and will be maintained throughout this period. I represent that I have read and understand the laws and regulations related to licensure in Speech Language Pathology and Audiology.

SIGNATURE OF SUPERVISOR: DATE:

_____ _____