Kentucky Board of Speech-Language Pathology and Audiology
Public Protection Cabinet – Department of Professional Licensing
P.O. Box 1360, Frankfort, Kentucky 40602
500 Mero Street Frankfort, Kentucky 40601 (Overnight Delivery Only)
Phone: (502) 782.4250 | Fax: (502) 564.4818 | SLP.ky.gov| slpa@ky.gov

APPLICATION FOR INTERIM LICENSE

(Please check appropriate box)

☐ **Speech-Language Pathology**

☐ **Audiology (NOTE: An Interim License is NOT available to an applicant who holds a doctorate degree in Au.D. See KRS 334A.185(2).**

INSTRUCTIONS

1. A payment to the Kentucky State Treasurer for the application fee of $50.
2. The applicant shall submit a criminal background investigation performed within the last ninety (90) days by the Department of Kentucky State Police (KSP) and the Federal Bureau of Investigation (FBI), which shall be sent by the KSP and FBI directly to the Board. The applicant is responsible for the payment of any fee to the KSP and FBI.
3. All degrees applicable to Licensure must be documented by a CERTIFIED COPY of the official transcript. The transcript must be sent directly to this office by the school registrar. NO action will be taken on your application until necessary transcripts are received.
4. DO NOT SEND CASH.
5. Mail to Kentucky Board of Speech-Language Pathology and Audiology, P. O. Box 1360, Frankfort, Kentucky, 40602.
6. Please Type or Print All Information.

SECTION 1. GENERAL APPLICANT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Prior Names Used: _____ Mailing Address: _____

County: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Cell Phone: _____

Work Phone: _____ DOB (Month/Day/Year): _____

SECTION 2. GENERAL QUESTIONS

Please answer each of the following questions by putting a check in the appropriate box on the right. You must answer each question with a "YES" or "NO" or "NOt Applicable" ("N/A") if this option is provided. NO other response is acceptable. **All "YES" answers MUST be explained in detail on a separate SIGNED statement and submitted with the application.** Applicants should be aware that answering "YES" to some questions may necessitate special screening procedures by the board. Failure to disclose any of the requested information may result in the denial of your application or other appropriate action.

1. Have you ever applied for licensure as a Speech-Language Pathology Assistant in Kentucky? If YES, please give license number: _____ ☐ YES ☐ NO
   If you were denied a license, please state the reason for denial.

   _____

2. Have you ever had any application for any professional license denied by any licensing authority? If YES, please list where and when. ☐ YES ☐ NO

3. Do you currently hold another professional license or credential? If YES, list the license(s) and state(s). **NOTE: You must request that a letter of good standing be sent directly to the Board from all states in which you hold, or have held, a license.** ☐ YES ☐ NO

4. 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? If YES, explain. ☐ YES ☐ NO

5. Is there any disciplinary action pending against you by any licensing jurisdiction other than Kentucky? If YES, where and when? ☐ YES ☐ NO

6. Are you a member of the military or a military spouse? ☐ YES ☐ NO
If YES, please attach proof of the following: (1) proof of issuance of a valid license, permit, certificate or other document issued by another state that is active or has been expired for < 2 years and that it is in good standing or was upon the date of expiration; DD-214 form or other proof of active or prior military service with an hoNOrable discharge, discharge under honorable conditions, or a general discharge under honorable conditions; proof of marriage to an active duty member of the Armed Forces of the U.S., if applicable; and proof that the military spouse is assigned to a duty station in this state and that the applicant is also assigned to a duty station in this state pursuant to the spouse's active duty military orders.

7. Have you ever violated or been formally charged with a violation of any professional code of ethics? If YES, list where and when. ☐ YES ☐ NO

8. Have you ever been convicted, pled guilty, or pled nolo contendre (NO contest) to a felony conviction, whether or not sentence was imposed or suspended? ☐ YES ☐ NO
If YES, where and when? If YES, attach a certified copy of the court records regarding your conviction, the nature of the offense, date of discharge, if applicable, as well as a statement from the probation or parole officer.

9. Have you ever been named as a defendant to a civil suit related to your profession? If YES, please list where and when. ☐ YES ☐ NO

10. Do you currently have a disability or medical condition that interferes with your ability to to competently and safely perform the essential functions of speech-language pathology? If YES, please explain. ☐ YES ☐ NO

11. At any time in the last five (5) years have you engaged in the illegal use of any controlled substance on a regular or occasional basis? If YES, please explain. ☐ YES ☐ NO

_____

12. Are you currently being treated for alcohol or other substance use? If YES, please explain. ☐ YES ☐ NO

_____

13. Are you under an adjudication or other diversion agreement which suspends or defers sentencing for a crime? If "YES", give details and attach supporting documentation ☐ YES ☐ NO

_____

SECTION 3. EDUCATION

Undergraduate

School Name/Location: Dates Attended (Mo./Yr to Mo./Yr) Graduation (Mo./Yr) Credit Hrs.

_____ _____ _____ _____

Degree 1: _____ Degree 2: _____

Degree 3: _____ Degree 4: _____

School Name/Location: Dates Attended (Mo./Yr to Mo./Yr) Graduation (Mo./Yr) Credit Hrs.

_____ _____ _____ _____

Degree 1: _____ Degree 2: _____

Degree 3: _____ Degree 4: _____

Graduate

School Name/Location: Dates Attended (Mo./Yr to Mo./Yr) Graduation (Mo./Yr) Credit Hrs.

_____ _____ _____ _____

Degree 1: _____ Degree 2: _____

Degree 3: _____ Degree 4: _____

School Name/Location: Dates Attended (Mo./Yr to Mo./Yr) Graduation (Mo./Yr) Credit Hrs.

_____ _____ _____ _____

Degree 1: _____ Degree 2: _____

Degree 3: _____ Degree 4: _____

Attach additional sheets for schools if needed.

NOTE: Pursuant to 201 KAR 17:011. Section 1(b) An applicant shall have an equivalent education if the Applicant holds a bachelor's degree from a regionally accredited college or university and has completed all coursework and clinical practicum requirements leading to a doctorate or master's degree from a university program accredited by the Council for Academic Accreditation of the American Speech Language Hearing Association. A signed letter from the department chair or a director of graduate studies confirming all coursework and clinical hours have been met shall be provided if an official transcript is not yet available.

SECTION 4. 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.

Signature (Required) : _____ Date: _____

SECTION 5. 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: _____

C. Cell Phone:_____ Work Phone:_____

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

☐ **Full-Time** 120 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 five (5) hours per week cannot be counted towards PPE. (_____ hrs per week X _____ # of weeks = 1260 hours)

II. Supervisor

A. Name:_____ KY License Number: _____

B. Address:_____

C. Cell Phone:_____ Work Phone:_____

D. Place / Address of Employment: _____

III. Plan of Professional Activities

A. 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. Recording Keeping _____
6. Other (Specify) _____

Supervisory Activity (Must be a minimum of 18 total in each area.)

Segment One:

On-Site Observations (Minimum of 6 hours per segment): _____

Other Monitoring Activities (Minimum of 6 hours per segment): _____

Segment Two:

On-Site Observations (Minimum of 6 hours per segment): _____

Other Monitoring Activities (Minimum of 6 hours per segment): _____

Segment Three:

On-Site Observations (Minimum of 6 hours per segment): _____

Other Monitoring Activities (Minimum of 6 hours per segment): _____

Total On-Site Occasions*:

On-Site Observations (Minimum of 6 hours per segment): _____

Other Monitoring Activities (Minimum of 6 hours per segment): _____

Total Other Activities:

On-Site Observations (Minimum of 6 hours per segment): _____

Other Monitoring Activities (Minimum of 6 hours per segment): _____

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.

Supervisor Signature: _____ Date: _____

Printed Name of Supervisor: _____