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 EXTENSION OF INTERIM LICENSE

(Please check appropriate box)

☐ **Speech-Language Pathology Audiology** ☐ **Speech-Language Pathology Assistant**

GENERAL INFORMATION

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

Prior Names Used: _____ Address:_____

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

Email Address: _____

Work Phone: _____ Cell Phone: _____ DOB (month/Day/Year): _____

Kentucky License Number: _____ Expiration Date of License: _____

Summarize: 1) the reason for request for extension of interim license and 2) the amount of time needed to complete the postgraduate professional experience and 3) the new ending date for PPE: (Provide any documentation that supports your request)

_____

_____

_____

_____

1. Have you ever had an extension of your interim license? ☐ YES ☐ NO

2. If your answer to question 1 is YES, how many times? _____

3. If your answer to question 1 is NO, list dates:_____

4. Is your supervisor aware of the circumstances regarding your request for an extension? ☐ YES ☐ NO

5. Has your supervisor agreed to continue supervision if your application is approved? ☐ YES ☐ NO

DPL-SLPA-02
Rev. July 2026
KRS 334A.033, 334A.035, 334A.183, 334A.185
201 KAR 17:011, 17:025

In affixing my signature to this application, I hereby swear or affirm that all statements and information provided herein are true and correct to the best of my knowledge, information and belief. Any untrue statement knowingly made by me on this application shall constitute grounds for such disciplinary action as the Board may determine appropriate. I represent that I have read and understand the laws and regulations related to licensure in Speech Language Pathology and Audiology.

Signature of Interim Licensee (Required) : _____ Date: _____

I hereby do agree to provide supervision as required by KRS 334A for the above applicant in his/her capacity as speech-language pathologist or speech-language pathologist assistant. I acknowledge that the failure to utilize this person appropriately and to supervise in accordance with KRS 334A of the Kentucky Revised Statutes and the administrative regulations promulgated thereunder, shall be considered as aiding and abetting an unlicensed person to practice speech-language pathology as described by KRS Chapter 334A. Furthermore, I certify that my credentials are current. I represent that I have read and understand the laws and regulations related to licensure in Speech Language Pathology and Audiology.

Signature of Supervisor (Required) : _____ Date:_____