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 2SC32 Frankfort, Kentucky 40601 (Overnight Delivery Only)
Phone: (502) 782.4250 | Fax: (502) 564.4818 | SLP.ky.gov | slpa@ky.gov

CHANGE IN PPE OR SUPERVISION FOR INTERIM SPEECH-LANGUAGE PATHOLOGIST

Name of Interim Licensee: _____

Interim Licensee Number: _____

Email Address: _____ Phone Number: _____

Facility Name: _____Facility Phone:_____

Facility Street Address: _____

Facility City: _____ Facility State: _____ Facility Zip Code: _____

Original Beginning Date of PPE: _____ If applicable, start date of new employment:_____

Original Supervisor of PPE:_____

Original Supervisor's License Number: _____

I do hereby swear and affirm that all information in this document is true and correct to the best of my knowledge:

Licensee Signature: _____Date: _____

NEW SUPERVISOR INFORMATION:

Supervisor Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Place of Employment: _____

KY License Number: _____

DPL-SLPA-03
Rev. July 2026
KRS 334A.035
201 KAR 17.012

Date Granted: _____ Expiration Date: _____

KY Teacher Certification Number: _____

Date Granted: _____ Expiration Date: _____

Beginning Date of Supervision: _____

Agreement to Provide Supervision:

I, the named supervisor for the above-named applicant for licensure, have devised and discussed this plan of activities for postgraduate professional experience with said applicant and accept responsibility for its implementation. Further, I do hereby certify that my Kentucky License or Kentucky Teacher Certification 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'S SIGNATURE: _____ DATE: _____