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) 892.4254 | Fax: (502) 564.4818 | BDN.ky.gov | dn@ky.gov

RENEWAL APPLICATION

LICENSING OPTIONS (CHECK ONE):

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

KRS 334A.170 requires each licensed Speech-Language Pathologist, Audiologist, and Speech-Language Pathology Assistant to biennially renew their license on or before January 31st. Your current license will expire **March 3**. Failure to renew your license shall constitute sufficient cause for termination of licensure. **Licenses not renewed on or before March 2 (includes 30 day grace period) will terminate and you are hereby advised at such time you must CEASE AND DESIST the practice of speech-language pathology and/or audiology in Kentucky.**

INSTRUCTIONS

Complete this form by filling in the information requested below. Incomplete forms **will be** returned.
Attach the appropriate renewal fee: Forms received without the appropriate fee **will be** returned. ***Make check or money order payable to the Kentucky State Treasurer.*** **DO NOT SEND CASH.**

Renewals postmarked on or before Jan. 31: Active -$100.00; Inactive - $20.00; Dual - $200.00
Renewals postmarked Feb. 1 - March 2: Active -$150.00; Inactive - $20.00; Dual - $300.00

Return this form with your check to the address listed above on or before January 31. **Any form, which is returned due to incomplete or incorrect information, will be subject to late penalties if not returned by the deadlines stated above.**
Complete page 2 of this renewal application for Continuing Education credit. Please follow instructions on page 2 of this application when completing Continuing Education section.

SECTION 1: PERSONAL INFORMATION

TO BE COMPLETED BY ALL LICENSEES, Incomplete forms will be returned: (Please Print)

☐ **Check here if name or address has changed. No changes will be made unless marked.**

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

Previous Name: _____

Mailing Address: _____City: _____ State: _____ Zip Code: _____

Business Address: _____City: _____ State: _____ Zip Code: _____

Phone: _____ D.O.B.: _____ Email: _____

SSN (Last 4) : _____

SECTION 2: GENERAL QUESTIONS

1. Have you been charged with, convicted of or pled guilty, to a felony since your last renewal of Kentucky license? If yes, please attach documentation. YES NO

2. Have you had disciplinary action taken against you or pending against your speech-language pathology or audiology license in any other state or jurisdiction since your last renewal? YES NO

SECTION 3: CONTINUING EDUCATION

List hours of Continuing Education obtained, including DATE and HOURS EARNED. **Incomplete forms will be returned and will be subject to late penalties if not returned by stated deadlines.**
Each Speech-Language Pathologist and Audiologist must list thirty (30) hours of Continuing Education obtained during the biennial renewal period. **Two (2) of the hours must be in the area of Ethics.** Please indicate the two hours of Ethics. Dual licensees must list fifty (50) hours of Continuing Education. **Two (2) of these hours must be in the area of Ethics.** All Continuing Education hours shall be earned in the field in which you are licensed. A maximum of four (4) hours may be in a related area for each renewal cycle. Online coursework shall not exceed ten (10) hours per day.
Each Speech-Language Pathologist and Audiologist is responsible for securing documentation to support proof of attendance.
All Continuing Education must be earned by January 31. The "grace period" authorized in 201 KAR 17:030 does not apply to Continuing Education. "Carry over" of hours is not authorized since renewals are on a biennial schedule.

SECTION 4. EDUCATION

Course Name (Required)	*Date(s) M/D/Y (Required)*	*Hours Earned (Required)*

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Total Continuing Education hours earned = _____

Section 4: License Status Selection and Renewal Fees

Please mark the appropriate box:

☐ Remaining on Active status. ($100 Fee required. Continuing education must be listed above.)

☐ Requesting to return to Active status from Inactive status. ($100 Fee required. Continuing education must be listed above.)

☐ First renewal period licensee. ($100 Fee required. No Continuing Education required. Date of initial license: _____)

☐ Currently on an Inactive status. ($20 Fee required. Date Inactive status was initially granted: _____. ** NOTE: Inactive status may be held for no more than 6 years)

☐ Requesting Inactive status. ($20 Fee required. No Continuing Education hours required.)

☐ Requesting Termination. (No fee required. No Continuing Education required.)

I hereby certify that all information provided by me on this form is true and complete to the best of my knowledge. (Signature is required. Forms not signed will be returned and subject to late penalties if not returned by the deadlines states.)

Signature (Required) :_____ Date:_____

SECTION 5: SUPERVISOR RENEWAL RECCOMENDATION

RENEWALS MUST HAVE THIS SECTION COMPLETED BY SUPERVISOR: This section must be completed. Incomplete forms will be returned and subject to **late penalties if not returned by the deadlines stated.** Please check the appropriate box or boxes:

[ ] I am the original supervisor for this licensee.

[ ] I am not the original supervisor for this licensee. I began supervising this individual on _____. **(You MUST complete a Change in Supervision and/or PPE Setting form if one has not been completed and approved by the Board)**

[ ] I recommend that this individual's speech-language pathology assistant license be renewed for the renewal period stated on the front of this application and hereby agree to provide supervision as required by KRS 334.035 (2) and as defined by 201 KAR 17:027 for this licensee 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 this licensee 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 do not recommend that this individual's speech-language pathology assistant license be renewed for the renewal period state on the front of this application. Please explain on a separate sheet of paper and attach to this renewal application

_____ _____

Supervisors Signature Date

_____ _____

Street Address Phone Number

_____ _____

City, State, Zip Code License Number

If you are not the original supervisor & do not hold a KY SLP License, please attach a copy of your KY Teaching Certificate.