KENTUCKY BOARD OF
SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY
P. O. BOX 1360
FRANKFORT, KY 40602
http://slp.ky.gov

APPLICATION FOR INTERIM LICENSURE
SPEECH-LANGUAGE PATHOLOGY ASSISTANT

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

1. Name: _____ S.S.# _____

2. Name as it appears on transcript: _____

3. Address: _____
Street, Apt. #, P.O. Box City State Zip

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

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

6. Date of birth: _____ 7. Email _____

8. Have you ever applied for licensure as a Speech-Language Pathology Assistant in Kentucky? [ ] Yes [ ] No
If yes, give license number and/or reason for denial: _____

9. 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 as an Speech-Language Pathology-Assistant.

10. 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: _____
_____

11. Have you ever been convicted of a felony? [ ] Yes [ ] No If yes, explain: _____
_____

12. EDUCATION:

School	Names and Locations	Dates Attended		Date of Graduation		Number of Hours or Credits	Degrees Obtained
		From	To	Month	Year		
UNDER-GRADUATE SCHOOL							
GRADUATE SCHOOL							

13. An interim license fee of $50.00 must be attached to this application and mailed to the following address: PO Box 1360, Frankfort, KY 40602. All checks and money orders should be payable to the Kentucky State Treasurer.

AFFIDAVIT

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 _____ DATE _____

Name:_____

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

A. **PPE SETTING:**

School System: _____ School Name(s) _____

Address: _____
Street City State Zip Code
Telephone Number: Home ( ) _____ Work ( ) _____

Beginning Date of PPE: _____/_____/_____ Estimated Ending Date: _____/_____/_____

[ ] Full-Time (1260 hours total, 35 hours per week for 36 weeks)
[ ] Part-Time(1260 hours total, earned over no more than 24 months)
_____ hrs/week _____ # weeks=1260 hours

Interim Speech-Language Pathology Assistants are required to receive no less than 3 hours per full time week of documented direct supervision and no less than 3 hours per full time week of indirect supervision. Direct supervision consists of on-site, in-view observation and guidance as a clinical activity is performed. Indirect supervision includes demonstration, record review, review and evaluation of audio or video taped sessions, or supervisory conferences. Supervision requirements shall be adjusted proportionally for less than full time employment.

B. SUPERVISOR INFORMATION:

Supervisor Name: _____

Address: _____
Street City State Zip Code

Phone: Home ( ) _____ Work ( )_____ Cell ( )_____

Place of Employment: _____

[ ] Kentucky License Number: _____ Date Granted: _____ Expiration Date: _____
[ ] KY Teacher Certification No.: _____ Date Granted: _____

(NOTE: A copy of the supervising SLP's Kentucky Teaching Certificate must be attached if he/she does not hold a current speech-language pathology license in Kentucky.)

C. AGREEMENT TO PROVIDE SUPERVISION

I, _____, do hereby agree to provide supervision as required by KRS 334.035 (2) and as defined by 201 KAR 17:025 Section 2 and 201 KAR 17:027 for _____ 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 the above named individual 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 represent that I have read and understand the laws and regulations related to licensure in Speech-Language Pathology and Audiology.

SUPERVISOR'S SIGNATURE: _____ DATE: _____