



KENTUCKY BOARD OF SPEECH LANGUAGE PATHOLOGY AND AUDIOLOGY

P.O. Box 1360 Frankfort, Kentucky 40602 http://www.slp.ky.gov

APPLICATION FOR EXTENSION OF INTERIM LICENSE

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

- Audiology Speech-Language Pathology Speech-Language Pathology Assistant

Please type or print:

Form with 11 numbered questions regarding license extension, including name, address, phone numbers, and supervisor agreement.

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.

SIGNATURE OF INTERIM LICENSEE 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.

SIGNATURE OF SUPERVISOR DATE