SUMMARY OF MATERIALS INCORPORATED BY REFERENCE
201 KAR 17:011E

"Application for Interim Licensure", January 2012, is the form used for applicants for an interim speech-language pathology license and is incorporated by reference.

SUMMARY OF CHANGES TO MATERIALS INCORPORATED BY REFERENCE
201 KAR 17:011E

The following material is incorporated by reference:

(a) The "Application for Interim Licensure", DPL-SLPA-01, July 2026, consisting of four (4) pages, has been amended to add the requirement of a criminal background investigation by the FBI and KSP, and to update the formatting for compliance with the Americans with Disabilities Act.

(b) The "Application for Extension of Interim License", DPL-SLPA-02, July 2026, consisting of two (2) pages, is the new form incorporated by reference used to apply for the extension of an interim license; and

(c) The "Change in PPE or Supervision for Interim SLP", DPL-SLPA- 03, July 202, consisting of one (1) page, is the new form incorporated by reference used for changes in the postgraduate professional experience or supervisor approved in the initial application or for any subsequent report of a change to the board.

201 KAR 17:011E
DIRTY
FILED: JULY 16, 2026

KENTUCKY BOARD OF SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY

COMMONWEALTH OF KENTUCKY
PO BOX 1360
FRANKFORT, KY 40602
http://slp.ky.gov

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

APPLICATION FOR INTERIM LICENSURE

(Please check appropriate block)

☐ Speech-Language Pathology
☐ Audiology

1. Name: _____ S. S. No. _____

2. Name as it appears on your transcr_____

3. Address: _____
Street City State Zip Code

_____
Email Address

4. Phone: Cell: _____ Work_____ Home: _____

5. U.S. Citizen: ☐ Yes ☐ No. If no, have you_____r intention to become a citizen? ☐ Yes ☐ No.

6. Date of Birth: _____

7. Have you ever applied for licensure as a S_____anguage P_____ Assistant in Kentucky? ☐ Yes ☐ No.
If yes, please give license number and r_____r denial: _____

8. Name of other state(s) in which you_____ense: _____

Please submit a letter of good s_____om all states in which you ha_____license in Speech-Language Pathology or Audiology.

9. 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:

_____
_____
_____
_____

10. Have you ever been convicted of a felony? ☐ Yes ☐ No. If yes, explain:

_____
_____
_____
_____

11. Education:

School	Names and Locations	Date Attended		Date of Graduation		Number of Hours or Credits	Degrees Obtained
		From	To	Month	Year		
Undergraduate							
Graduate							

AFFIDAVIT

I do hereby swear or affirm that the above state[illegible]ade by me [illegible]pplication are true, complete, and correct to the best of my knowledge. I represent that I have [illegible]d under[illegible]e laws and regulations related to licensure in Speech Language Pathology and Audiology.

Applicant Signature: Date:

A nonrefundable application fee of $50 (fifty dollars) for i[illegible]nsur[illegible]attached to this form ($100 if dual licensure). Please make check or money order payable to the Kentucky Sta[illegible]rer. DO[illegible]D CASH. Please mail the completed application and the application fee to the address above.

POST[illegible]N OF ACTIVITIES [illegible]
POST[illegible]ATE PROFESSIONAL [illegible]ENCE
This portion o[illegible]plication must be comple[illegible]e supervisor

I. **PPE Setting**

A. Facility Name:

B. Address:

Street City State Zip Code

C. Phone: Work: (____)-

D. Beginning Date of PPE: Estimated Ending Date:

☐ Full-Time 1260 hours total, 35 hours per week for 36 weeks

☐ Part - Time 1260 hours must be earned within 24 months (96 weeks). Part time work of less than 5 hours of work per week cannot be counted toward PPE. (_____ hrs per week X _____# of weeks=1260 hours)

II. **Supervisor**

A. Name: _____ KY License Number: _____

B. Address:

_____
Street City State Zip Code

C. Telephone Number: Cell: ( )- _____ Work: ( )- _____

D. Place / Address of Employment: _____

_____

III. **Plan of Professional Activities**

A. Applicant Activity:

Applicant Activity	Number of Hours per WEEK to be Spent by Applicant
1. Assessment, diagnosis and / [illegible]ation	
2. Screening	
3. Habilitation / Rehabilitation	
4. In-service Training	
5. Record Keeping	
6. Other (Specify):	
TOTAL (equal to hours/week)	

B. Supervisory Activity

Supervisory Activity	On-Site Observations (min. [illegible] hours per segment)	Other monitoring activities (min. of 6 hours per segment)
Segment One		
Segment Two		
Segment Three		
Total On-Site Occasions*		
Total Other Activities		

***Must be minimum of [illegible] in each area**

AFFIDAVIT

I, the named supervisor for the above named applicant for interim licensure, have devised and discussed this plan of activities for post-graduate professional experience with said applicant and accept responsibility for its implementation. Further, I do hereby certify that my Kentucky License 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.

SIGNATURE OF SUPERVISOR: DATE:

_____ _____

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 INTERIM LICENSE

(Please check appropriate box)

[ ] Speech-Language Pathology **[ ] Audiology (NOTE: An Interim License is NOt available to an applicant who holds a doctorate degree in Au.D. See KRS 334A.185(2).**

INSTRUCTIONS

1. A payment to the Kentucky State Treasurer for the application fee of $50.
2. The applicant shall submit a criminal background investigation performed within the last ninety (90) days by the Department of Kentucky State Police (KSP) and the Federal Bureau of Investigation (FBI), which shall be sent by the KSP and FBI directly to the Board. The applicant is responsible for the payment of any fee to the KSP and FBI.
3. All degrees applicable to Licensure must be documented by a CERTIFIED COPY of the official transcript. The transcript must be sent directly to this office by the school registrar. NO action will be taken on your application until necessary transcripts are received.
4. DO NOT SEND CASH.
5. Mail to Kentucky Board of Speech-Language Pathology and Audiology, P. O. Box 1360, Frankfort, Kentucky, 40602.
6. Please Type or Print All Information.

SECTION 1. GENERAL APPLICANT INFORMATION

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

Prior Names Used: _____ Mailing Address: _____

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

Email Address: _____ Cell Phone: _____

Work Phone: _____ DOB (Month/Day/Year): _____

SECTION 2. GENERAL QUESTIONS

Please answer each of the following questions by putting a check in the appropriate box on the right. You must answer each question with a “YES” or “NO” or “NOt Applicable” (“N/A”) if this option is provided. NO other response is acceptable. **All “YES” answers MUST be explained in detail on a separate SIGNED statement and submitted with the application.** Applicants should be aware that answering “YES” to some questions may necessitate special screening procedures by the board. Failure to disclose any of the requested information may result in the denial of your application or other appropriate action.

1. Have you ever applied for licensure as a Speech-Language Pathology Assistant in Kentucky? If YES, please give license number: _____ YES NO
   If you were denied a license, please state the reason for denial.

   _____

2. Have you ever had any application for any professional license denied by any licensing authority? If YES, please list where and when. YES NO

3. Do you currently hold aNOther professional license or credential? If YES, list the license(s) and state(s). **NOTE: You must request that a letter of good standing be sent directly to the Board from all states in which you hold, or have held, a license.** YES NO

4. 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? If YES, explain. YES NO

5. Is there any disciplinary action pending against you by any licensing jurisdiction other than Kentucky? If YES, where and when? YES NO

6. Are you a member of the military or a military spouse? YES NO
If YES, please attach proof of the following: (1) proof of issuance of a valid license, permit, certificate or other document issued by another state that is active or has been expired for < 2 years and that it is in good standing or was upon the date of expiration; DD-214 form or other proof of active or prior military service with an hoNOrable discharge, discharge under honorable conditions, or a general discharge under honorable conditions; proof of marriage to an active duty member of the Armed Forces of the U.S., if applicable; and proof that the military spouse is assigned to a duty station in this state and that the applicant is also assigned to a duty station in this state pursuant to the spouse's active duty military orders.

7. Have you ever violated or been formally charged with a violation of any professional code of ethics? If YES, list where and when. YES NO

8. Have you ever been convicted, pled guilty, or pled nolo contendre (NO contest) to a felony conviction, whether or not sentence was imposed or suspended? YES NO
If YES, where and when? If YES, attach a certified copy of the court records regarding your conviction, the nature of the offense, date of discharge, if applicable, as well as a statement from the probation or parole officer.

9. Have you ever been named as a defendant to a civil suit related to your profession? If YES, please list where and when. YES NO

10. Do you currently have a disability or medical condition that interferes with your ability to to competently and safely perform the essential functions of speech-language pathology? If YES, please explain. YES NO

11. At any time in the last five (5) years have you engaged in the illegal use of any controlled substance on a regular or occasional basis? If YES, please explain. YES NO

_____

12. Are you currently being treated for alcohol or other substance use? If YES, please explain. YES NO

_____

13. Are you under an adjudication or other diversion agreement which suspends or defers sentencing for a crime? If "YES", give details and attach supporting documentation YES NO

_____

SECTION 3. EDUCATION

Undergraduate

School Name/Location: Dates Attended (Mo./Yr to Mo./Yr) Graduation (Mo./Yr) Credit Hrs.

_____ _____ _____ _____

Degree 1: _____ Degree 2: _____

Degree 3: _____ Degree 4: _____

School Name/Location: Dates Attended (Mo./Yr to Mo./Yr) Graduation (Mo./Yr) Credit Hrs.

_____ _____ _____ _____

Degree 1: _____ Degree 2: _____

Degree 3: _____ Degree 4: _____

Graduate

School Name/Location: Dates Attended (Mo./Yr to Mo./Yr) Graduation (Mo./Yr) Credit Hrs.

_____ _____ _____ _____

Degree 1: _____ Degree 2: _____

Degree 3: _____ Degree 4: _____

School Name/Location: Dates Attended (Mo./Yr to Mo./Yr) Graduation (Mo./Yr) Credit Hrs.

_____ _____ _____ _____

Degree 1: _____ Degree 2: _____

Degree 3: _____ Degree 4: _____

Attach additional sheets for schools if needed.

NOTE: Pursuant to 201 KAR 17:011. Section 1(b) An applicant shall have an equivalent education if the Applicant holds a bachelor's degree from a regionally accredited college or university and has completed all coursework and clinical practicum requirements leading to a doctorate or master's degree from a university program accredited by the Council for Academic Accreditation of the American Speech Language Hearing Association. A signed letter from the department chair or a director of graduate studies confirming all coursework and clinical hours have been met shall be provided if an official transcript is not yet available.

SECTION 4. AFFIDAVIT

I do hereby swear or affirm that the above statements made by me in this application are true, complete, and correct to the best of my knowledge. I represent that I have read and understand the laws and regulations related to licensure in Speech Language Pathology and Audiology.

Signature (Required) : _____ Date: _____

SECTION 5. PLAN OF ACTIVITIES FOR POSTGRADUATE PROFESSIONAL EXPERIENCE
(This portion of the application must be completed by the supervisor)

I. PPE Setting

A. Facility Name: _____

B. Address: _____

C. Cell Phone:_____ Work Phone:_____

D. Beginning Date of PPE: _____ Estimated Ending Date of PPE: _____

Full-Time 120 hours total, 35 hours per week for 36 weeks.

Part time 1260 hours must be earned within 24 months (96 weeks). Part time work of less than five (5) hours per week cannot be counted towards PPE. (_____ hrs per week X _____ # of weeks = 1260 hours)

II. Supervisor

A. Name:_____ KY License Number: _____

B. Address:_____

C. Cell Phone:_____ Work Phone:_____

D. Place / Address of Employment: _____

III. Plan of Professional Activities

A. Applicant Activity:

Number of Hours Each WEEK to be Spent by Applicant

1. Assessment, diagnosis and/or evaluation _____
2. Screening _____
3. Habilitation / Rehabilitation _____
4. In-service Training _____
5. Recording Keeping _____
6. Other (Specify) _____

Supervisory Activity (Must be a minimum of 18 total in each area.)

Segment One:

On-Site Observations (Minimum of 6 hours per segment): _____

Other Monitoring Activities (Minimum of 6 hours per segment): _____

Segment Two:

On-Site Observations (Minimum of 6 hours per segment): _____

Other Monitoring Activities (Minimum of 6 hours per segment): _____

Segment Three:

On-Site Observations (Minimum of 6 hours per segment): _____

Other Monitoring Activities (Minimum of 6 hours per segment): _____

Total On-Site Occasions*:

On-Site Observations (Minimum of 6 hours per segment): _____

Other Monitoring Activities (Minimum of 6 hours per segment): _____

Total Other Activities:

On-Site Observations (Minimum of 6 hours per segment): _____

Other Monitoring Activities (Minimum of 6 hours per segment): _____

AFFIDAVIT

I, the named supervisor for the above-named applicant for interim licensure, have devised and discussed this plan of activities for post-graduate professional experience with said applicant and accept responsibility for its implementation. Further, I do hereby certify that my Kentucky License 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 Signature: _____ Date: _____

Printed Name of Supervisor: _____

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 | Website: SLP.ky.gov| Email: 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

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:_____

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 | Website: SLP.ky.gov| Email: 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: _____