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 INTERIM LICENSURE
SPEECH-LANGUAGE PATHOLOGY ASSISTANT

INSTRUCTIONS

1. A license for Interim SLP-A entitles the licensee to work in Kentucky public schools only. See KRS 334A.033.
2. A payment to the Kentucky State Treasurer for the application fee of $50.
3. 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.
4. 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.
5. DO NOT SEND CASH.
6. Mail to Kentucky Board of Speech-Language Pathology and Audiology, P. O. Box 1360, Frankfort, Kentucky, 40602.
7. Please Type or Print All Information.

SECTION 1. GENERAL APPLICANT INFORMATION

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

Prior Names Used: _____ Name as it appears on transcript: _____

Address: _____

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

Email Address: _____ Cell Phone: _____

Work Phone: _____ DOB: _____

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. Do you currently hold an active or inactive license in any other state(s)? YES NO

   If yes, please list the state(s): _____

   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.

2. Do you have an expired license from any other state(s)? YES NO
If yes, please list the state(s): _____

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

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.

SECTION 4. 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 (Required) : _____ Date: _____

SECTION 5. PLAN OF ACTIVITIES FOR POSTGRADUATE PROFESSIONAL EXPERIENCE

This portion of the application must be completed by the supervisor.

PPE Setting

School System: _____ School Name(s): _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

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)

Hours per Week: _____ Number of Weeks: _____

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.

Supervisor Information

Supervisor Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Place of Employment: _____ Kentucky License No._____

Date Granted: _____ Expiration Date: _____

(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.)

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 Signature: _____Date: _____

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POST-GRADUATE PROFESSIONAL EXPERIENCE REPORT AND EVALUATION FORM – INTERIM SLP-A

SECTION 1: LICENSEE INFORMATION

Name of Licensee: _____

Name: _____

Address: Street _____ City: _____ State: _____ Zip Code: _____

Email Address: _____ Phone Number: _____

Academic Status (University): _____ Degree: _____ Date Conferred: _____

KY Interim License Number: _____ Date Licensed: _____

SECTION 2: SUPERVISOR INFORMATION

Name of PPE Supervisor: _____

Address: Street _____ City: _____ State: _____ Zip Code: _____

Email Address: _____ Phone Number: _____

Place of Employment: _____

Credential Information: ☐ KY SLP License #: _____ ☐ Teacher Certification #: _____

SECTION 3: POSTGRADUATE PROFFESIONAL EXEPERIENCE

Setting Details

PPE Setting (School System): _____

Address: _____ City: _____ State: _____ Zip Code: _____

Email Address: _____ Phone Number: _____

Schedule and Hours

Beginning Date of PPE: _____ Ending Date of PPE: _____

___ Full-Time (1260 hours total; 35 hours per week over 36 weeks)

___ Part-Time (1260 hours total earned over no more than 24 months)

___ _____ hours/week X _____# weeks = 1260 hours

___ This report is only for a portion of my PPE **(Please attach explanation)**

Specify how many hours per week were spent in the following activities:

___ Screening

___ Therapy Activities

___ Reports

___ In-service Training

___ Other - specify here:

___ TOTAL HOURS PER WEEK

SECTION 4: SUPERVISION HOURS

Complete Chart A indicting the number of direct and indirect supervision hours completed during each four-week period. A is only for the weeks that this report covers.

Weeks of PPE	***Number of Direct Supervision Hours (minimum of 3 hours per week)***	***Number of Indirect Supervision Hours (minimum of 3 hours per week)***
Week 1-4		
Week 5-8		
Week 9-12		
Week 13-16		
Week 17-20		
Week 21-24		
Week 25-28		
Week 29-32		
Week 33-36		
Week 37-40		
Week 41-44		
Week 45-48		
Week 49-52		
Week 53-56		
Week 57-60		
Week 61-64		

Week 65-68	_____	_____
Week 69-72	_____	_____
Week 73-76	_____	_____
Week 77-80	_____	_____
Week 81-84	_____	_____
Week 85-88	_____	_____
Week 89-92	_____	_____
Week 93-96	_____	_____
TOTAL HOURS	_____	_____

SECTION 5: SUPERVISOR EVALUTION

EVALUATION PORTION TO BE COMPLETED BY SUPERVISOR: Please use the following scale to rate each skill after completion of each segment (each segment = 1/3 of PPE) 3 = Strongly Agree; 2 = Agree; 1= Disagree

	SEGMENT 1 period covered ____to ____	***SEGMENT 2 period covered ____to ____***	***SEGMENT 3 period covered ____to ____***
Appropriately implements screening procedures	_____	_____	_____
Follows documented treatment plans effectively	_____	_____	_____
Appropriately and consistently documents student progress	_____	_____	_____
Maintains student records in a timely and efficient manner	_____	_____	_____
Complies with program administrative and other regulatory policies such as due process documentation	_____	_____	_____
Demonstrates competent communication skills, including listening, speaking, nonverbal communication and writing	_____	_____	_____
Evaluates own strengths and weaknesses	_____	_____	_____
Maintains confidentiality	_____	_____	_____
Effectively controls student behavior	_____	_____	_____
Reinforces target communication skills effectively	_____	_____	_____
Is reliable and dependable	_____	_____	_____
Keeps supervisor informed about student's progress and needs	_____	_____	_____
Consistently follows schedule approved by supervisor	_____	_____	_____
Seeks supervisory assistance when needed	_____	_____	_____
Appropriately collaborates with other professionals	_____	_____	_____

As the interim SLPA Licensee, I hereby certify that all information on this form is true and complete to the best of my knowledge.

INTERIM SLPA LICENSEE SIGNATURE: DATE:

_____ _____

As the Speech Language Pathology Assistant Postgraduate Professional Experience Supervisor, I certify that has engaged in only those activities in the SLP Assistant's scope of responsibilities. I further certify that these activities have been successfully completed and supervised as specified in KRS 334A. I recommend that _____ receive full licensure as a Speech-Language Pathology Assistant. [ ] YES [ ] NO (Note: If no, please attach letter of explanation)

I have discussed this report with the interim licensee. Furthermore, I certify that my credentials were current throughout this PPE. I have completed and attached the required report/evaluation form. I represent that I have read and understand the laws and regulations related to licensure in Speech Language Pathology and Audiology.

SUPERVISOR SIGNATURE: DATE:

_____ _____

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CHANGE IN SUPERVISION

☐ **INTERIM SLP-ASSISTANT** ☐ **SLP- ASSISTANT**

SECTION 1: SPLA LICENSEE INFORMATION

Name of SLPA Licensee: _____ SLP-A Licensee Number: _____

Email Address: _____ Telephone Number: _____

School System & School Name: _____ Facility Phone Number: _____

Address: Street _____ City: _____ State: _____ Zip Code: _____

Date of Supervision Change: _____ Former Supervisor: _____

Former Supervisor's License Number: _____

Or Former Supervisor's Teacher Certificate Number: _____

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

Licensee Signature: _____ Date: _____

SECTION 2: SUPERVISOR INFORMATION

Supervisor Name:
_____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Work Number: _____

Place of Employment: _____

KY License Number: _____ Date Granted: _____ Expiration Date: _____

KY Teacher Certification Number:_____ Date Granted: _____ Expiration Date: _____

Beginning Date of Supervision: _____

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 the above-named licensee to function as a Speech Language Pathology Assistant. I further agree to accept the responsibility for the practice and activities of the above-named individual in his/her capacity as a Speech Language Pathology Assistant. I acknowledge that 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 Statutes and the administrative regulations promulgated there under, 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 statutes and regulations related to licensure in Speech Language Pathology and Audiology.

SUPERVISOR'S SIGNATURE: _____ DATE: _____