201 KAR 17:030E
DIRTY
FILED: JULY 16, 2026

KENTUCKY BOARD OF SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY
PO BOX 1360
FRANKFORT, KY 40602
http://www.slp.ky.gov
(502) 564-3296

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

RENEWAL APPLICATION

(Please Check Appropriate Box)
[ ] Speech-Language Pathology
[ ] Audiology

KRS 334A.170 requires each licensed Speech-Language Pathologist and Audiologist to biennially renew his or her license on or before January 31st. Your current license will expire **January 31, 2014**. Failure to renew your license shall constitute sufficient cause for termination of licensure. **Licenses not renewed by March 2, 2014 (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.**

PLEASE FOLLOW THESE INSTRUCTIONS AND FILL IN ALL BLANKS:

- Complete this form by filling in the information requested below. Incomplete forms **will be** returned.
- Attach the appropriate renewal fee: Forms rece[illegible]t the appropriate fee **will be** returne[illegible] ***check or money order payable to the Kentucky State Treasurer.*** **DO NOT SEND CA[illegible]**
  Renewals postmarked on or before Jan. 31[illegible]100.00; Inactive - $20.00; [illegible]0.00
  Renewals postmarked Feb. 1 - March 2: Acti[illegible]0; Inactive - $20.00; D[illegible].00
- Return this form with your check to the address listed a[illegible] before Janua[illegible]4. **Any form, which is returned due to incomplete or incorrect information, will be subject to late penalties if [illegible]ed by the [illegible] stated above.**
- Complete the backside of this renewal application for Continuin[illegible] lease follow instructions on the backside of this application when completing Continuing Education section.

E COMPLETED BY ALL LICENSEES, Incomplete forms[illegible]: (Please Print)

[ ] Check here if name or address has changed. No chang[illegible]mad[illegible]arked.

Name: _____ ecurity # _____ License #: SLP _____ AUD_____

Home Address:

_____
Street or Box number City Sta[illegible] Zip Code County

Present Business Address:

_____
Name of Company Street or Box number City State Zip Code

Home Phone: _____ Business Phone: _____ E-Mail: _____

Have you been charged with, convicted of or pled guilty to a felony since your last renewal of Kentucky license?
[ ] Yes (Attach documentation)
[ ] No

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 (Attach documentation including a certified copy of the final disciplinary action taken against you.)
[ ] No

The backside of this application MUST be completed. Incomplete applications WILL be returned.

CONTINUING EDUCATION

List below hours of Continuing Education obtained, including DATE and HOURS EARNED.

Speech-Language Pathologist and Audiologist must list **thirty (30) hours of Continuing Education obtained during the biennial renewal period. Two (2) of these hours must be in the area 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 or related to the field in which you are licensed. No more than four (4) hours may be in "related" areas 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. **Do not attach documentation of Continuing Education hours unless you are being audited.** If you are unsure if you are being audited, you may verify this by looking at the website or contact Marcia Egbert, Board Administrator, at 502-564-3296, ext. 234.

- **All Continuing Education must be earned by January 31, 2014.** Per Kentucky Licensure Law, "grace period," as described in 201 KAR 17:030 relates to payment of licensure fees only and does not apply to Continuing Education. "Carry over" of hours is not permitted as renewals are on a biennial schedule (i.e. licensees have two years to earn all Continuing Education hours).

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

Total CE hours earned = _____

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. No Continuing Education 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 stated.)

Signature: _____ **Date:** _____

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KENTUCKY BOARD OF
SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY
P. O. Box 1360
Frankfort, KY 40602
(502) 564-3296
http://slp.ky.gov

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

RENEWAL APPLICATION FOR SPEECH-LANGUAGE PATHOLOGY ASSISTANTS

KRS 334A.170 requires each licensed speech-language pathologist assistant to biennially renew his or her license on or before January 31th. Your current license will expire **January 31, 2014**. Failure to renew your license shall constitute sufficient cause for termination of licensure. **Licenses not renewed by March 2, 2014 (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.**

PLEASE FOLLOW THESE INSTRUCTIONS A IN ALL BLANKS:

- Complete this form by filling in the information requ . Incomplete forms w rned.
- Attach the appropriate renewal fee: Forms received with ropriate fee **will** d. ***Make check or money order payable to the Kentucky State Treasurer.*** **DO NOT SEND CASH.**
  Renewals mailed on or before January 31 - (must b ked on o anuary 31) – Active $100.00; Inactive license - $20.00
  Renewals mailed January 31 through March 2 - (mus ark efore March 2) – Active $150.00; Inactive license - $20.00
- Complete the backside of this renewal application for continu Each speech-language pathologist assistant must list thirty (30) hours of continuing education with two (2) of those hours in the a ined during this renewal period. DO NOT attach documentation of continuing education hours unless you are requested to do so. cept hours that have not been earned. **You must wait to file your ewal until after all requirements are met.**
  urn this form with your check to the address listed above on y 31, 2014. **Any form, which is returned due to incomplete or incorrect information, will be subject to late penalties if not lines stated above.**

TO BE COMPLETED BY ALL LICENSEES, ete form returned: (Please Print)

[ ] Check here if name or address has changed fro o changes will be ss marked.

Name: _____ ocial Security # _____ License #: SLPA _____

Home Address:

_____
Street or Box number City State Zip Code County

Present Business Address:

_____
Name of Company Street or Box number City State Zip Code

Home Phone: _____ Business Phone: _____ E-Mail: _____

Please mark the appropriate box:

[ ] Requesting to change to active status from inactive status. **(Fee required, Continuing education must be listed on back side)**
[ ] Remaining on active status. **(Fee required, Continuing Education must be listed on back side)**
[ ] First renewal period. **Fee required, Date of initial license:** _____
[ ] Currently on an Inactive Status. **(Fee required, No Continuing Education required)**
[ ] Requesting an Inactive Status. **(Fee required, No Continuing Education hours required)**
[ ] Requesting Termination. **(No fee required, No Continuing Education required)**

The backside of this application MUST be completed. Incomplete applications WILL be returned.

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CONTINUING EDUCATION

- List below hours of Continuing Education obtained, including DATE and HOURS EARNED.
- Each Speech-Language Pathology Assistant must list **thirty (30) hours of Continuing Education obtained during the biennial renewal period. Two (2) of these hours must be in the area of Ethics.**
- All Continuing Education hours shall be earned in or related to the field in which you are licensed. No more than four (4) hours may be in "related" areas each renewal cycle. Online coursework shall not exceed ten (10) hours per day.
  Each Speech-Language Pathology Assistant is responsible for securing documentation to support proof of attendance. **Do not attach documentation of Continuing Education hours unless you are being audited.** If you are unsure if you are being audited, you may verify this by looking at the website or contact Marcia Egbert, Board Administrator, at 502-564-3296, ext. 234.
- **All Continuing Education must be earned by January 31, 2014.** Per Kentucky Licensure Law, "grace period," as described in 201 KAR 17:030 relates to payment of licensure fees only and does not apply to Continuing Education. "Carry over" of hours is not permitted as renewals are on a biennial schedule (i.e. licensees have two years to earn all Continuing Education hours).

Course Name (Required)	Date(s) M/D/Y (Required)	30 Hours Earned (Required)

I hereby certify that all information provided by me on th tru rrect to the best of my knowledge. (Signature is required. Forms not signed will be returned and subject to late penaltie y the deadlines stated.)

ture: _____ Date: _____

TO BE COMPLETED BY SUPERVISOR: Th mpleted. **Incomplete forms will be returned and subject to late penalties if not returned by the deadlines stated.** Please appr or boxes:

[ ] I am the original supervisor for this licensee.

[ ] I am not the original supervisor for this license supervising this indi _____.
(Must complete a Change in Supervision a Setting form if one has ompleted and approved by the Board)

[ ] I recommend that this individual's speech pathology assistant license be re e renewal period stated on the front of this application and hereby agree to provid n as required by KRS 334.035 (2) a by 201 KAR 17:027 for this licensee to function as a speech-language patho nt during the period of this license. I fur 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** _____

Citv, State, Zip Code _____ **License Number and/or KY Teaching Certificate Number**
If you are not the original supervisor & do not hold a KY SLP License, please attach a copy of your KY Teaching Certificate.

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.

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

APPLICATION FOR RENEWAL BY REINSTATEMENT

Licensing Options (check one):

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

INSTRUCTIONS

1. A payment by check or money order made payable to the Kentucky State Treasurer for:
   a. For an SLP, SLP-A, or AUD, a biennial renewal fee of $100, plus a delinquency fee of $150, for a total payment of $250; or
   b. For dual licensure for an SLP and AUD: a biennial renewal fee of $200, plus a delinquency fee of $300, for a total payment of $500.
   c. DO NOT SEND CASH.
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. Mail to Kentucky Board of Speech-Language Pathology and Audiology, P. O. Box 1360, Frankfort, Kentucky, 40602.
5. Please Type or Print All Information

SECTION 1: GENERAL APPLICANT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: ____ License Number: _____

Mailing Address: Street_____ City: _____ State: _____ Zip Code: _____

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

Telephone Number: _____ Email Address: _____ D.O.B. _____

SSN (Last 4): _____ Present Place of Employment: _____

Present Place of Employment E-mail Address: _____

Expired KY license number: _____ Telephone Number: _____

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)? 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.** YES NO

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

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? 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. YES NO

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? 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. YES NO

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? 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

14. **Date of expiration of your Kentucky License:**

15. List all places of employment and dates since your license expired in Kentucky:

SECTION 3: CONTINUING EDUCATION

You must attach evidence of completion of (30) thirty hours of continuing education in the past twenty-four (24) months in accordance with 201 KAR 17:090, Section 6. If you do not have these hours, you may attach a letter requesting an extension (up to one year) to fulfill the minimum CEU requirement.

SECTION 4: AFFADAVIT

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: FOR APPLICATIONS FOR REINSTATEMENT OF SLIP-ASSISTANT LICENSE

THIS SECTION MUST BE COMPLETED BY THE SLP-A SUPERVISOR IF APPLYING FOR REINSTATEMENT OF SLP – ASSISTANT LICENSE. Incomplete forms will be returned. Please check the appropriate box or boxes:

Licensee's Name: _____ Telephone Number: _____

School System: _____ Business Telephone Number: _____

School Name(s): _____

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

☐ I am the original supervisor for this licensee.

☐ I am not the original supervisor for this licensee. I began supervising this individual on _____.

☐ I recommend that this individual's speech-language pathology assistant license be reinstated 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 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 reinstated. Please explain on a separate sheet of paper and attach to this reinstatement application.

Supervisor's Comments: _____

_____

I hereby certify that all information provided on this form is true and correct to the best of my knowledge.

Supervisor's Signature: _____ Date: _____

Street Address: _____ Phone Number: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ License # and/or KY Teaching Certificate Number: _____