SUMMARY OF MATERIALS INCORPORATED BY REFERENCE
201 KAR 17:032

The "Application for Interim Licensure", January 2012, was created for applications for interim licensure, generally, and is incorporated by reference.

SUMMARY OF CHANGES TO MATERIALS INCORPORATED BY REFERENCE
201 KAR 17:032

The administrative regulation was amended to remove the materials incorporated by reference because the "Application for Interim License", form DPL-SLPA-01, is incorporated by reference in 201 KAR 17:011.

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 transc[illegible] _____

3. Address: _____
Street City State Zip Code

_____
Email Address

4. Phone: Cell: _____ Work[illegible] _____ Home: _____

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

6. Date of Birth: _____

7. Have you ever applied for licensure as a S[illegible]anguage P[illegible] Assistant in Kentucky? ☐ Yes ☐ No.
If yes, please give license number and [illegible]f denial: _____

8. Name of other state(s) in which you [illegible]ense: _____

Please submit a letter of good s[illegible]om all states in which you ha[illegible]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:

_____
_____
_____
_____

Form Revised 1/2012

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]nsu[illegible]ttached to this form ($100 if dual licensure). Please make check or money order payable to the Kentucky St[illegible]rer. DO[illegible]D CASH. Please mail the completed application and the application fee to the address above.

N OF ACTIVITIES
POST[illegible]ATE PROFESSIONAL[illegible]ENCE
This portion [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)

_____ _____

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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 Ac	of Hours WEEK to be t by Applicant
1. Assessment, diagnosis and 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	O ons (min urs ment)	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 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:

_____ _____