



**KENTUCKY BOARD OF
SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY**

P. O. BOX 1360
FRANKFORT, KENTUCKY 40602
<http://www.slp.ky.gov>

APPLICATION FOR LICENSE

FOR OFFICE USE ONLY:

Date: _____
Amount: _____
Board Review Date: _____
[] Approved [] Denied
[] Deferred
Comments: _____

Member Initial: _____

(Please Check Appropriate Block)

- [] Speech-Language Pathology
[] Audiology

(Please Print or Type)

1. Name: _____ S. S. No. _____
2. Name as it appears on transcript: _____
3. Address: _____
Street City State Zip
Email: _____
4. Phone: Home () _____ Business () _____ Cell () _____
5. U.S. Citizen: [] Yes [] No If no, have you declared your intention to become a U.S. citizen? [] Yes [] No
6. Date of Birth: _____
7. Have you ever applied for permanent or interim license in Speech-Language Pathology or Audiology in Kentucky? [] Yes [] No
If yes, give license number and/or reason for denial: _____
8. Name of other state(s) in which you hold a license. _____
Please submit a letter of good standing from all states in which you have held a license in Speech-Language Pathology or Audiology
9. Have you ever had a license denied, suspended or revoked in any state? [] Yes [] No 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? _____ If yes, explain: _____

11. PROFESSIONAL EXPERIENCE (Begin with Current Position)

Employed: From Mo. ____ Yr. ____ To Mo. ____ Yr. ____ [] Full-Time [] Part-Time _____ hrs./wk Title or Position _____ Name of Employer _____ Address of Employer _____	Describe Your Duties _____ _____ _____ _____ _____
Employed: From Mo. ____ Yr. ____ To Mo. ____ Yr. ____ [] Full-Time [] Part-Time _____ hrs./wk Title or Position _____ Name of Employer _____ Address of Employer _____	Describe Your Duties _____ _____ _____ _____ _____

EDUCATION

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School	Names and Locations	Dates Attended		Date of Graduation		Number of Hours or Credits	Degrees Obtained
		From	To	Month	Year		
UNDER-GRADUATE SCHOOL							
GRADUATE SCHOOL							

NOTE: All degrees applicable to Licensure must be documented by a CERTIFIED COPY of the official transcript. The transcript must be mailed directly to this office by the school registrar. No action will be taken on your application until necessary transcripts are received.

APPLICATION FOR LICENSURE:

12. Do you currently hold the ASHA Certificate of Clinical Competence (CCC)?

☐ Yes Certificate Number: _____

Date Received: _____

Documentation of certification from ASHA must be submitted directly to the Office.

☐ No

(See Item 13)

13. If you do not hold the ASHA Certificate of Clinical Competence (CCC):

a.

• If you hold an Interim License: Was original plan of professional experience (PPE) completed?

☐ Yes

Supervisor's Signature: _____ Number _____

☐ No; attach a statement explaining how your experience fulfills the approved PPE

Supervisor's Signature: _____ License Number _____

• If you do not hold an Interim License:

Submit written evidence from a licensed and/or speech-language pathologist or audiologist supervisor of 1260 hours of full time professional employment or its part time equivalent pertinent to the license sought. Full-time is defined as a minimum of thirty five (35) clock hours of work for at least thirty weeks. A part time equivalent must consist of 1260 hours earned over no more than 24 months.

*In the event that part-time employment is used to fulfill a part of the PPE, 100% of the minimum hours of the part-time work per week requirement must be spent in direct professional experience.

b. Submit documentation of passing score of Praxis Exam in Speech-Language Pathology and/or Audiology, directly from ETS Board.

14. Submit this completed application along with a check or money order payable to the **Kentucky State Treasurer** for the application/licensure fee of \$150 (\$50 application fee/\$100 licensure fee); fee is \$100(licensure fee) if you currently hold an Interim License in Kentucky. If applying for dual licensure the correct fee is \$300 (\$100 application fee/\$200 licensure fee). **DO NOT SEND CASH.** Mail to Kentucky Board of Speech-Language Pathology and Audiology, P. O. Box 1360, Frankfort, Kentucky, 40602.

AFFIDAVIT (Required)

I do hereby swear or affirm that the above statements made by me on 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.

APPLICANT SIGNATURE _____ DATE _____