Application for Renewal of a Speech-Language Pathologist or Audiologist Provisional License

Board of Speech-Language Pathology & Audiology
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: https://floridasspeechaudiology.gov/
Email: info@floridasspeechaudiology.gov
Phone: (850) 245-4161
Fax: (850) 921-6184

Florida HEALTH
Medical Quality Assurance

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This application should be submitted 90 days prior to the expiration of a current provisional license.

Select one license type:	
☐	Speech-Language Pathologist (3005)
☐	Audiologist (3006)

License Number: _____ Expiration Date: _____ MM/DD/YYYY

1. PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

_____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone (Input without dashes)

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

☐ Yes ☐ No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. APPLICANT BACKGROUND

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense withheld since your last application to the department? You must include all misdemeanors and felonies, even if adjudication was withheld.

Reckless driving, driving while license suspended or revoked (DWSLR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question. ☐ Yes ☐ No

If you responded "Yes" to this question, complete the following:

Offense	Jurisdiction	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

If you responded "Yes" to this question, you must provide the following:

☐ **Final Dispositions** and **Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.

Name: _____ License Number: _____

3. APPLICANT SIGNATURE

I hereby authorize all hospitals, institutions, or organizations, personal physicians, employers (past and present), business and professional associates (past and present), and all government agencies and instrumentalities (local, state, federal, or foreign) to release to the Department of Health any information, files, or records requested by the department in connection with the processing of this application. I further authorize the department to release to the organizations, individuals, and groups listed above any information, which is material to my application.

I understand that it is my duty and responsibility as an applicant for licensure to supplement my application after it has been submitted if any when any material change in circumstances or conditions occur which might affect the board's decision concerning my eligibility for examination or licensure as required by section 456.013(1), Florida Statutes (F.S.). Failure to do so may result in disciplinary action by the board including denial or licensure.

I have carefully read the questions in this application and have answered them completely without reservation of any kind, and I state under penalty of perjury that my answers and all statements made by me in this application are true and correct. Should I furnish any false information on this application, I agree that such act shall constitute cause for denial, suspension, or revocation of any license to practice in the state of Florida the profession for which I am applying.

I hereby acknowledge receipt of ch. 468, Part I, F.S., and related rules and further acknowledge that I have read these regulations. I understand that it is my responsibility to keep informed of any changes to ch. 468, Part, I, F.S. and related rules.

I understand that I am not permitted to practice the profession for which I am applying until I am issued a license or certificate to practice the profession.

Section 456.013(1)(a), F.S., provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant Signature _____ Date _____
You may print this application and sign it or sign digitally. MM/DD/YYYY

If you have a change of address, you must provide written notification to the board office. Include your full name, old address, new address, and whether you are changing your mailing address or your physical location address.

Complete verifications must be sent directly from the licensing agency to the board office at info@floridasspeechaudiology.gov, or mailed to:

Board *of* Speech-Language Pathology & Audiology
4052 Bald Cypress Way Bin C-06
Tallahassee, FL 32399-3256

Board *of* Speech-Language Pathology & Audiology

Verification of Employment (SPA-2A)

Applicant Name: _____

Select the appropriate license type:			
☐	Speech-Language Pathologist	☐	Audiologist

License Number: _____

The remainder of this form is to be completed by the supervising licensed speech-language pathologist/audiologist verifying the employment.

Supervisor Name: _____

Select the appropriate license type:			
	Speech-Language Pathologist		Audiologist

License Number: _____

Business Address: _____

Business Telephone: _____

Office or Agency where experience will take place: _____

Certification:

I understand that pursuant to section 468.1155(1), Florida Statutes (F.S.), a provisional license is required prior to the above-named applicant initiating the professional employment experience.

I certify that the professional employment shall include assessment, habilitation, and rehabilitation activities with the clients. The activities performed by the provisional licensee will be monitored and evaluated by an individual with an active license in the same area for which provisional licensure is being sought.

I acknowledge receipt of chapter 468, Part I, F.S., and related rules and further acknowledge that I have read these regulations. I understand that it is my responsibility to keep informed of any changes to chapter 468, Part I, F.S., and related rules.

I certify that the above information is true and correct to the best of my knowledge.

Supervisor Signature: _____ Date: _____
MM/DD/YYYY