Board of Speech-Language Pathology and Audiology

Application for Speech-Language Pathology or Audiology Provisional Licensure

With Instructions Attached

Board of Speech-Language Pathology and Audiology
4052 Bald Cypress Way, Bin # C-06
Tallahassee, FL 32399-3256
(850) 488-0595

GENERAL INFORMATION

Please read Chapter 468, Part I, Florida Statutes (F.S.) and Title 64B20, Florida Administrative Code (F.A.C.), prior to completing the application forms. You must read the laws and rules in order to determine your eligibility **prior to applying**. The laws and rules can be found on our website at: http://www.doh.state.fl.us/mqa/speech/index.html.

Within 30 days of receipt of your application and fees, you will be sent a letter informing you of your application status including any deficiencies. If you do not receive notice within 40 days that your application has been received, contact this office at (850) 245-4161.

MAILING ADDRESS: Please use the below addresses as they apply. Please include your full name and social security number on any correspondence or documentation.

ORIGINAL APPLICATION with SUPPORTING DOCUMENTS AND FEES TO:
Board of Speech-Language Pathology and Audiology
P.O. BOX 6330
Tallahassee, FL 32314-6330

ADDITIONAL DOCUMENTS SENT SEPARATE FROM THE APPLICATION TO:
Board of Speech-Language Pathology and Audiology
4052 Bald Cypress Way, Bin C06
Tallahassee, FL 32399-3256

APPEARANCES: Certain applicants may be required to appear before the Board to discuss his or her application before a determination of licensure can be made. An appearance may be required for a variety of reasons, such as:

- Criminal or disciplinary history
- Education equivalency
- Impairment
- Other reasons as deemed necessary by the Board

Appearances are determined on a case by case basis. Board office staff does not determine the necessity of an appearance. Should your appearance be required, you will be notified of the exact date, time and location of the meeting at which your appearance is necessary.

If you believe you may be required to appear before the Board it is recommended you submit your application several months in advance of the meeting for which you wish to appear. You may view the Board's meeting dates and locations on its website at: http://www.doh.state.fl.us/mqa/speech/index.html.

ADDRESS NOTE: Your location address will be published on the Internet licensure lookup screen. Our licensure database requires two addresses for each licensee. One is the mailing address and the other is the location address. The "mailing address" is used whenever information is mailed to the applicant/licensee. If you only provide one address, it will be used for both the mailing address and the location address.

ADDRESS CHANGE: If you have a change of address, you must provide written notification to the Board office. Include your full name, old address, and new address, and whether this is your mailing address or your location address.

APPLICATION INSTRUCTIONS

- **REQUIRED FEES:** The total fee is **$180**. Include a cashier's check or money order made payable to the Department of Health. The application fee of $75.00 is non-refundable.

- **COMPLETING THE APPLICATION:** Questions must be answered fully and truthfully; there are no questions that are not applicable. Obtaining a license by fraudulent misrepresentation is grounds for denial of your application or revocation of your license (Section 468.1295(1)(a), F.S.). You must sign and date the application. It is your responsibility to notify this office in writing if the answers to any of these questions change, even if the application is already approved.

- **VERIFICATION OF EMPLOYMENT:** Pursuant to Rule 64B20-2.003, F.A.C., you must also submit the **Verification of Employment Form** (form #SPA-2A). A copy of the form can be obtained from our website. If there is a change in supervision, a new Verification of Employment Form must be completed by the new

supervisor and sent to the Board office.

- **OFFICIAL TRANSCRIPT:** An official transcript(s) must be sent directly from the school to the Board office and must indicate that a master's degree or doctoral degree was conferred. Pursuant to Rule 64B20-2.002, F.A.C., if the transcript does not reflect that a master's degree or doctoral degree was awarded, a Certification of Conferral of Master's Degree (SPA-2D) or Certification of Completing Academic Requirements of Doctoral Program (Form SPA-0002E) must accompany your transcript. If you did not graduate from a Council for Higher Education accredited program, verification of the number of hours of supervised clinical practice must also be included on the transcript.

- **FOREIGN EDUCATION:** In order for the Board to consider any education completed outside the U.S. or Canada, documentation must be received which verifies that the institution at which the education was completed was equivalent to an accredited U.S. institution. Documentation must also be received which verifies that the coursework met the content and credit hour requirement for coursework in the U.S. It is the applicant's responsibility to obtain an evaluation from a recognized educational evaluation service that documents the acceptability of the coursework. Note- A certified translator who is not related to the applicant must translate any document that is in a language other than English.

- **LICENSE /CERTIFICATION VERIFICATION:** You must request that verification of any license to practice any profession that you now hold or have ever held in any state, U.S. territory or foreign country be mailed directly from the other licensing entity to the Board Office. A copy of your license is not considered verification. Some states/countries may require you to send them a License Verification Form. The form is available on our website for your convenience.

- **HIV / AIDS COURSE:** Section 468.1201, F.S. requires completion of a one (1) hour education course on human immunodeficiency virus and acquired immune deficiency syndrome from any Florida health profession Board approved provider.

- **PREVENTION OF MEDICAL ERRORS COURSE:** Section 456.013(7), F.S., requires completion of a two (2) hour education course relating to prevention of medical errors from a Board of Speech-Language Pathology and Audiology approved provider.

To obtain a list of approved providers, please visit CEBroker at www.cebroker.com or call (877) 434-6323 for assistance.

- **APPLICANT HISTORY QUESTIONS – REQUIRED DOCUMENTATION:** If you answer "yes" to any of the questions in the sections regarding criminal, health, or professional history, the required supporting documentation is listed directly on the application. In instances where court documentation is required but cannot be obtained, you must direct the Clerk of Courts to send a letter advising the Board that the documentation is no longer available.

APPLICATION FOR PROVISIONAL LICENSE

Check the box for the profession in which you are applying for licensure:

☐ **Speech-Language Pathologist (3005)** ☐ **Audiologist (3006)**

1. APPLICANT DATA

NAME:	Last	First		Middle	
MAILING ADDRESS:	Number and Street	Apt. #	City	State	Zip Code
PRACTICE LOCATION ADDRESS:	Number and Street	Apt #	City	State	Zip Code
Home Telephone Number	**Business Telephone Number**		**Date of Birth (mm/dd/yyyy)**		

Email Address: _____

Email Notification: If you want to receive notices regarding your application deficiencies by **email only**, please check the "yes" box. If you chose this form of notification, you will receive deficiency notices regarding your application through **email only**. You will be responsible for checking your e-mail regularly and updating your e-mail address with the Board.

I want to be notified by e-mail only: ☐ **Yes** ☐ **No**

Have you ever changed your name through marriage or through action of a court, or have you ever been known by any other name? ☐ Yes ☐ No If YES, list all names below:

2. APPLICANT LICENSURE DATA

Do you hold or have you ever held a license and/or certificate to practice any profession in any state, U.S. territory, or foreign country? ☐ Yes ☐ No

If YES, list all licenses and/or certificates and the issuing state, territory, or foreign country below. Each issuing state, territory, or foreign country must submit a license/certification verification form.

TYPE OF LICENSE/CERTIFICATE	LICENSE NUMBER	ISSUING STATE, TERRITORY, FOREIGN COUNTRY	CURRENT LICENSE STATUS

3. EQUAL OPPORTUNITY DATA

We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniformed Guidelines on Employee Selection Procedure (1978) 43 FR38295 August 25, 1978. This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

RACE: Caucasian [ ] Black [ ] Hispanic [ ] Asian [ ] Native American [ ] Other [ ] _____
SEX: Male [ ] Female [ ]

4. EDUCATIONAL DATA

Undergraduate Degree	Major/Specialty	Accredited School City/State/Country	Date of Graduation
1._____	1._____	1._____	1._____
2._____	2._____	2._____	2._____
3._____	3._____	3._____	3._____

A. I have completed the **Prevention of Medical Errors** course required by Florida Statute, as defined by Rule 64B20-2.001(3), F.A.C. If yes, provide the course and provider information below. If no, send a copy of the certificate once completed. ☐Yes ☐ No

Provider Name:_____
Provider Number:_____
Course Name/Title:_____
Date Completed:_____

B. I have completed the **HIV/AIDS** course required by Florida Statute, as defined by Rule 64B20-2.007, F.A.C. If yes, provide the course and provider information below. If no, send a copy of the certificate once completed. See also Section 468.1201, F.S. ☐Yes ☐ No

Provider Name:_____
Provider Number:_____
Course Name/Title:_____
Date Completed:_____

5. APPLICANT HISTORY – PROFESSIONAL

If you answer "yes" to any question in this section, you must provide the following documentation WITH the application at the time of submission:

1. **A self-explanation including details as to the state(s), license number(s), date(s), and relevant circumstances.**
2. **A copy of the complaint and disposition for each case.**
3. **A copy of any documentation from the state regarding the final actions/outcome of the issue.**

A. Have you ever been denied a license/certificate to practice Speech-Language Pathology and/or Audiology or the renewal thereof in any state, U.S. Territory or foreign country? ☐Yes ☐ No

B. Have you ever had a license/certificate to practice a profession revoked, suspended, or otherwise acted against (including probation, fine, reprimand or surrender in lieu of disciplinary action) in a disciplinary proceeding in any state, U.S. Territory or foreign country? ☐Yes ☐ No

C. Are you now or have you ever been a defendant in civil litigation in which the basis of the complaint against you was alleged negligence, malpractice or lack of professional competence? ☐Yes ☐ No

D. Is there a complaint currently pending against you in any jurisdiction, or an investigation of your professional conduct or competency in any profession? ☐Yes ☐ No

6. APPLICANT HISTORY – CRIMINAL

If you answer "yes" to the question below, you must provide the following WITH the application at the time of submission:

1. **A self-explanation regarding the charges on a separate sheet.**
2. **Copies of all pertinent court and arrest documents, including arrest report, official charge documentation and current disposition. This should include sentencing due to the arrest and proof of successful completion of your sentencing. These documents can be obtained from the clerk of court in the county the offense occurred.**

A. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question. ☐Yes ☐ No

7. APPLICANT HISTORY – 456.0635(2), F.S.

Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer YES to any of the following questions, please provide a written explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation to the address below. Supporting documentation includes court dispositions or agency orders where applicable.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? (If you responded "no", skip to #2.) ☐ Yes ☐ No

a. If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation? ☐ Yes ☐ No

b. If "yes" to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes). ☐ Yes ☐ No

c. If "yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation? ☐ Yes ☐ No

d. If "yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? (If "yes", please provide supporting documentation). ☐ Yes ☐ No

2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? ☐ Yes ☐ No

a. If "yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended? ☐ Yes ☐ No

3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If "No", do not answer 3a.) ☐ Yes ☐ No

a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? ☐ Yes ☐ No

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? ☐ Yes ☐ No

a. Have you been in good standing with a state Medicaid program for the most recent five years? ☐ Yes ☐ No

b. Did the termination occur at least 20 years before the date of this application? ☐ Yes ☐ No

5. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities? ☐ Yes ☐ No

6. If "yes" to any of the questions 1 through 5 above, on or before July 1, 2009, were you enrolled in an educational or training program in the profession in which you are seeking licensure that was recognized by this profession's licensing board or the Department of Health? (If "yes", please provide official documentation verifying your enrollment status.) ☐ Yes ☐ No

8. SOCIAL SECURITY NUMBER AND HEALTH HISTORY:

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

Florida Department of Health
Board of Speech-Language Pathology and Audiology
Provisional License Application

Name:_____
Last **First** **Middle**

Social Security Number:_____

APPLICANT HISTORY – HEALTH

If questions A-F are answered YES, explain in full on a separate sheet of paper. Your statement must include, but is not limited to, the date(s), location(s), specific circumstances, practitioners and/or treatment involved. If you have been under treatment for emotional/mental illness, chemical dependency, etc., you must request that each practitioner, hospital, and program involved in your treatment submit a full, detailed report of such to the Board office, to include: treatment received, medications, and dates of treatment and, if applicable, all DSM III R/DSM IV/DSM IV-TR Axis I and II diagnosis(es) code(s), and admission and discharge summary(s).

A. In the last five years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the within the last five years?	☐ Yes ☐ No
B. In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?	☐ Yes ☐ No
C. During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice within the last five years?	☐ Yes ☐ No
D. In the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice?	☐ Yes ☐ No
E. In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder, if you were previously in such a program, did you suffer a relapse within the last five years?	☐ Yes ☐ No
F. During the last five years, have you been treated for or had a recurrence of a diagnosed related (alcohol/drug) disorder that has impaired your ability to practice within the past five years?	☐ Yes ☐ No

***This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCA § 666 (a)(13). For all professions regulated under Chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013 (1)(a), Florida Statutes.**

9. APPLICANT STATEMENT:

I hereby authorize all hospitals, institutions, or organizations, personal physicians, employers (past or present), business and professional associates (past or 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 and when any material change in circumstances or conditions occur which might affect the Board's decision concerning my eligibility for licensure. Section 456.013(1)(a), F.S., requires such supplement. Failure to do so may result in disciplinary action by the Board including denial of licensure.

I have carefully read the questions in the foregoing application and have answered them completely without reservations of any kind, and I declare that my answers and all statements made by me herein are true and correct. Should I furnish any false information on this application, I hereby 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 that I have read Chapter 468, Part I, F.S., Chapter 456, F.S. and related rules. I understand that it is my responsibility to keep informed of any changes to Chapter 468, Part I, F.S., Chapter 456, 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 TO PRACTICE THE PROFESSION.

Applicant's Signature:_____ **Date:**_____