

# **Board of Speech-Language Pathology and Audiology**

## **Application for Speech-Language Pathology or Audiology Assistant Certification With Instructions Attached**



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

# Important 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 to determine your eligibility for licensure. You may find the laws and rules on the website <http://floridasspeechaudiology.gov/>

Within 30 days of receipt of your application and fees, the board office will notify you of your status and if any documents are missing. You can follow the progress of your application through our website at <http://ww2.doh.state.fl.us/mqaservices/login.asp>. Applications are reviewed in date order of receipt.

**MAILING ADDRESS:** Please use the below addresses as they apply. Please include your full name 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 do 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 the website at: <http://floridasspeechaudiology.gov/>

**Criminal History**

Any applicant who has ever been found guilty of, or pled guilty or no contest to/nolo contendere, any charge other than a minor traffic offense must list each offense on the application. Failure to disclose criminal history may result in denial of your application. Each application is reviewed on its own merits.

**Applicants with criminal convictions are required to submit the following documents:**

**Final Dispositions/Sanctions** –Final disposition records for offenses can be obtained at the clerk of the court in the arresting jurisdiction. If the records are not available, you must have a letter on court letterhead sent from the Clerk of the Court attesting to their unavailability.

**Completion of Probation/Parole** –Probation records for offenses can be obtained at the clerk of the court in the arresting jurisdiction. If the records are not available, you must have a letter on court letterhead sent from the Clerk of the Court attesting to their unavailability.

**Self Explanation** –Applicants who have listed offenses on the application must submit a letter in your own words describing the circumstances of the offense.

### **Disciplinary History**

Any applicant who has ever been denied, had disciplinary action, or surrendered a license to practice in any healthcare profession, in any state, jurisdiction, or country must provide a self explanation of all occurrences of denial, disciplinary action or surrendering of a license. The State Board(s) of Speech involved must also submit copies of the **administrative complaint** and **final order** directly to the Florida Board. Applicants are responsible to ensure that the proper documentation is sent to the Florida Board. Any action taken against your license by a state licensing board must be reported on this application

**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 **\$130.00**. 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:** Every question on the application must be answered. Be sure to answer all questions honestly. The Board may deny your application if you provided false information on your application. 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.

**OFFICIAL TRANSCRIPT:** An official transcript(s) must be sent directly from the school to the Board office.

A **Speech-Language Pathology Assistant** must have earned a bachelor's degree and have at least 24 semester hours in the following subject areas:

a) Nine (**9**) semester hours in courses that provide fundamental information applicable to normal human growth and development, psychology, and normal development and use of speech, hearing and language.

b) Fifteen (**15**) semester hours in courses that provide information about and observation of speech, hearing, language disorders, general phonetics, basic articulation, screening and therapy, basic audiometry, or auditory training.

A **Speech-Language Audiology Assistant** must submit proof of a high school diploma or its equivalent.

**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.

**FORM 1269 ACTIVITY PLAN / SUPERVISORY PLAN:** This form must be completed by the **Speech-Language Pathologist/Audiologist Supervisor** and must be submitted once you find employment in accordance with **Rule 64B20-4.004, F.A.C.** The form is attached to this application. Assistants must be under the direct supervision of a licensed Speech Pathologist or Audiologist who has met all the requirements of Section 468.1185, F.S. Direct supervision requires the physical presence of the licensee in the same facility when the assistant is carrying out assigned responsibilities, in order for the licensee to be available for consultation and direction. The supervising licensee shall make provisions for emergency situations including the designation of another licensee who has agreed to be available to provide direct supervision to the assistant when the supervising licensee is not available. In the event that a supervising licensee is not on the premises, the assistant may only perform duties not involving direct client contact (**64B20-4.004 Supervision of Speech-Language Pathology Assistants and Audiology Assistants**)

**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 <http://floridasspeechaudiology.gov/applications/license-verification.pdf> 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](http://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 ASSISTANT CERTIFICATION

FEE = \$130

Check the box for the profession you are applying for:  **Speech-Language Pathologist (3003)**  
 **Audiologist (3004)**

Print clearly in black ink or type all information.

1. APPLICANT DATA					
<b>NAME:</b>	Last	First	Middle		
<b>MAILING ADDRESS:</b>	Number and Street	Apt. #	City	State	Zip Code
<b>PRACTICE LOCATION ADDRESS:</b>	Number and Street	Apt #	City	State	Zip Code
Home Telephone Number	Business Telephone Number		Date of Birth (mm/dd/yyyy)		
<b>Email Address:</b> _____					
<b>Email Notification:</b> If you want to receive notices regarding your application deficiencies by <b>email only</b> , please check the "yes" box. If you chose this form of notification, you will receive deficiency notices regarding your application through <b>email only</b> . You will be responsible for checking your e-mail regularly and updating your e-mail address with the Board.					
<b>I want to be notified by e-mail only:</b> <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>					
Have you ever changed your name through marriage or through action of a court, or have you ever been known by any other name? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If YES, list <u>all</u> 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? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>					
If YES, list <u>all</u> 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.					
<b>TYPE OF LICENSE/CERTIFICATE</b>	<b>LICENSE NUMBER</b>	<b>ISSUING STATE, TERRITORY, FOREIGN COUNTRY</b>	<b>CURRENT LICENSE STATUS</b>		
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.					
<b>RACE:</b> Caucasian [ ]    Black [ ]    Hispanic [ ]    Asian [ ]    Native American [ ]    Other [ ] _____					
<b>SEX:</b> Male [ ]    Female [ ]					

<b>4. EDUCATIONAL DATA</b>			
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:

- A self-explanation including details as to the state(s), license number(s), date(s), and relevant circumstances.**
- A copy of the complaint and disposition for each case.**
- 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.) | <input type="checkbox"/> Yes <input type="checkbox"/> 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?   | <input type="checkbox"/> Yes <input type="checkbox"/> 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).  | <input type="checkbox"/> Yes <input type="checkbox"/> 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?   | <input type="checkbox"/> Yes <input type="checkbox"/> 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).   | <input type="checkbox"/> Yes <input type="checkbox"/> 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)?  | <input type="checkbox"/> Yes <input type="checkbox"/> 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?   | <input type="checkbox"/> Yes <input type="checkbox"/> 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.)   | <input type="checkbox"/> Yes <input type="checkbox"/> 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?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| a. Have you been in good standing with a state Medicaid program for the most recent five years?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Did the termination occur at least 20 years before the date of this application?  | <input type="checkbox"/> Yes <input type="checkbox"/> 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?  | <input type="checkbox"/> Yes <input type="checkbox"/> 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.)   | <input type="checkbox"/> Yes <input type="checkbox"/> No |



**CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE\***

**Florida Department of Health  
Board of Speech-Language Pathology and  
Audiology Assistant Certification Application**

**Name:** \_\_\_\_\_  
Last
First
Middle

**Social Security Number:** \_\_\_\_\_

<b>APPLICANT HISTORY – HEALTH</b>	
<p>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).</p>	
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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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.**



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:** \_\_\_\_\_

# Board of Speech-Language Pathology and Audiology Assistant Activity and Supervisory Plan

This form is to be used for new assistants, supervisory updates, and deletions of a supervisory relationship.

Both the assistant and supervisor are required to review the laws and rules for the profession. The laws and rules can be found on the Board's website at: [www.doh.state.fl.us/mqa/speech](http://www.doh.state.fl.us/mqa/speech)

- Check one:**
- New Assistant (applying for licensure)
  - Change in Supervisor (new supervisor)
  - Deletion of Supervisory Relationship

- Check one:**
- Speech-Language Pathology
  - Audiology

Assistant's Information:	Supervisor's Information:
Name: _____	Name: _____
Address: _____ _____	Business Name: _____
Phone: _____	Business Address: _____ _____
Email: _____	Business Phone: _____
Supervision will be: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	Email: _____
License Number: _____	License Number: _____
	Anticipated Start Date: _____

**Supervisor's Signature:**

I \_\_\_\_\_ have reviewed, with my assistant, Chapter 468, Part I, Chapter 456, Florida Statutes, and Title 64B20, Florida Administrative Code (F.A.C.). I understand my responsibilities as a registered supervisor of an assistant and understand that any violation of the laws or rules may result in disciplinary action against my license. I also understand that the assistant shall engage **only** in those services that are listed in Rule 64B20-4.003, F.A.C.

**Supervisor's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Assistant's Signature:**

I \_\_\_\_\_ have reviewed, with my supervisor, Chapter 468, Part I, Chapter 456, Florida Statutes, and Title 64B20, Florida Administrative Code (F.A.C.). I understand my responsibilities as a registered assistant and understand that any violation of the laws or rules may result in disciplinary action against my license. I also understand that I shall engage **only** in those services that are listed in Rule 64B20-4.003, F.A.C.

**Assistant's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

The **supervisor** must return this form to:

Board of Speech-Language Pathology and Audiology  
4052 Bald Cypress Way, Bin C06  
Tallahassee, FL 32399-3256