Application for License as a Speech-Language Pathologist or Audiologist by Evaluation of Credentials

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

DH-SPA 1, Revised 7/2024, Rule 64B20-2.001, F.A.C.

Are you an active-duty member of the United States Armed Services?

Are you a veteran of the United States Armed Services?

Are you the spouse of a veteran of the United States Armed Services?

Are you the spouse of an active member of the United States Armed Services?

If you answered “Yes” to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health’s commitment to serving members and veterans of the United States Armed Forces and their families online at

http://www.flhealthsource.gov/valor.

DH-SPA 1, Revised 7/2024, Rule 64B20-2.001, F.A.C.

Speech-Language Pathology and Audiology Information

Application fees are based on the length of time the initial license will be valid.

Full Initial Licensure Fees are required for licenses issued August 1st of odd-numbered years through December 31st of the following even-numbered year.

Reduced Initial Licensure Fees are required for licenses issued January 1st of odd-numbered years through July 31st of the same odd-numbered year.

All initial licenses expire on December 31st of odd numbered years.

Important Note: If you have a current Certification of Clinical Competence from American Speech-Language-Hearing Association (ASHA) or a current Board Certification in Audiology from the American Board of Audiology (ABA), do not submit this application, and instead submit the application by Endorsement.

This application requires that you provide an official transcript that shows the conferral of a master's degree or a doctorate, a passing score on the national examination, and the submission of documentation from your supervisor(s) regarding your post-graduate clinical experience.

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Do Not Write in this Space
For Revenue Receipting Only

Select one license type:	
☐	Speech-Language Pathologist (3001)
☐	Audiologist (3002)

Select the appropriate fee based on page 3:		
☐	Full Fee	**$280.00**
☐	Reduced Fee	**$180.00**

Total fee includes the following:	
Application Fee (non-refundable)	$75.00
Full Initial Licensure Fee	$200.00
Reduced Initial Licensure Fee	$100.00
Unlicensed Activity Fee	$5.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. Requests to withdraw or for a refund must be made in writing. Fees are refundable for up to three years from the date of receipt.

If a physical address is not provided, the license issued will indicate "not practicing."

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

Physical Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website.)

_____ _____ _____
Street (Place of Employment) Suite No. City

_____ _____ _____ _____
State ZIP Country Work/Cell Telephone

EQUAL OPPORTUNITY DATA:

We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender: ☐ Male ☐ Female

Race: ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native ☐ Two or More Races ☐ Hispanic or Latino ☐ Black or African American ☐ White ☐ Asian

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. SOCIAL SECURITY DISCLOSURE

This information is exempt from public records disclosure.

Pursuant to Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s.) 456.013(1)(a), Florida Statutes, authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

U.S. Social Security Number: _____

Social Security Information- * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code § 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.

Name: _____

3. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past. Attach additional sheets if necessary.

_____

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

C. List all licenses (active, inactive, or lapsed). Attach additional sheets if necessary.

License Type	License #	State/Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

If you listed any licenses above, you may be required to submit a license verification. Board staff will attempt to verify your license(s) using available primary-source information (i.e. online verifications), including disciplinary history and method of licensure. If information is not available, you will be notified in writing that official license verification is required.

4. AVAILABILITY FOR DISASTER

Would you be willing to provide health services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? ☐ Yes ☐ No

If you respond "Yes," your name will be added to a listing that is available to the Department of Health if a disaster is declared. If you live in an area where you may be able to help you will be called on if needed.

5. EDUCATION HISTORY

List the school(s) you attended.

Accredited School Name/Location	Major/Specialty	Graduation Date (MM/DD/YYYY)	Degree Awarded

Name: _____

6. OTHER ITEMS REQUIRED

☐ **Official Transcript(s):** An official transcript must indicate that a master's degree or doctoral degree was conferred and must be sent directly from the school to the board office. 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.

☐ **Non-U.S. Education:** 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 verify 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 equivalency 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.

☐ **National Exam:** Applicants must have an official score report submitted directly to the board office by Educational Testing Services (ETS). A passing score of 600 or greater on the Praxis exam is required. The passing score must have been obtained no more than three years from date of application.

Experience: Pursuant to Rule 64B20-2.004, Florida Administrative Code (F.A.C.), applicants must have their supervisor submit the following forms (each supervisor must submit the following forms):

☐ "Supplementary Evaluation for Every Three Months of the Professional Employment Experience (Form SPA-2B)."

☐ "Supervisory Report for Provisional Licensees (Form SPA-2C)." Visit https://floridasspeechaudiology.gov/applications/evaluation-supervisory-report-provisional-license.pdf to obtain the forms.

Name: _____

This information is exempt from public records disclosure.

7. EXAMINATION HISTORY

Have you taken and passed the PRAXIS examination? ☐ Yes ☐ No

If "Yes," list the date(s) taken: _____.
(MM/YYYY Format)

8. HEALTH HISTORY

Physical and Mental Health Disorders Impacting Ability to Practice

A. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or would impair your ability to practice? ☐ Yes ☐ No

B. In the last two years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental or physical disorder that impaired your ability to practice? ☐ Yes ☐ No

Substance-Related Disorders Impacting Ability to Practice

C. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or would impair your ability to practice? ☐ Yes ☐ No

D. During the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol or drug) disorder or, if you were previously in such a program, did you suffer a relapse? ☐ Yes ☐ No

E. During the last five years, have you been enrolled in, required to enter, or participated in any substance-related (alcohol or drug) recovery program or impaired practitioner program for treatment of drug or alcohol abuse? ☐ Yes ☐ No

If a "Yes" response was provided to any of the questions in this section, provide the following documents directly to the board office:

☐ **A letter from a Licensed Health Care Practitioner,** who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

☐ **A written self-explanation,** identifying the medical condition(s) or occurrence(s); and current status.

9. DISCIPLINE HISTORY

A. Have you ever been denied or is there now any proceeding to deny your application for any health care license to practice in Florida or any other state, jurisdiction, or country? ☐ Yes ☐ No

B. Have you ever been denied a license/certificate to practice speech-language pathology and/or audiology or renewal thereof in any state, U.S. territory, or foreign country? ☐ Yes ☐ No

C. Have you ever had disciplinary action taken against your license to practice any health care related profession by the licensing authority in Florida or in any other state, jurisdiction, or country? ☐ Yes ☐ No

D. Have you ever had any license/certificate to practice 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

E. Have you ever surrendered a license to practice any health care related profession in Florida or in any other state, jurisdiction, or country while any such disciplinary charges were pending against you? ☐ Yes ☐ No

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

G. Do you have any disciplinary action pending against your license? ☐ Yes ☐ No

If you responded "Yes" to questions in this section, complete the following:

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

If you responded "Yes" to questions above, you must provide the following:

☐ **A written self-explanation**, describing in detail the circumstances surrounding the disciplinary action.

☐ A copy of the **Administrative Complaint** and **Final Order**.

H. 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

If you responded "Yes," you must provide the following:

☐ **A written self-explanation**, describing in detail the circumstances surrounding the litigation.

☐ A copy of the **Complaint** and **any Orders**.

10. CRIMINAL HISTORY

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? You must include all misdemeanors and felonies, even if adjudication was withheld. Pursuant to s. 943.0585(6)(b), Florida Statutes, and s. 943.059(6)(b), Florida Statutes, an applicant seeking to be licensed by the Department of Health must disclose expunged and sealed criminal history records.

Reckless driving, driving while license suspended or revoked (DWLSR), 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:

☐ **A written self-explanation**, describing in detail the circumstances surrounding each offense; including date, city and state, charges and final results.

☐ **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.

☐ **Completion of Sentence Documents**. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

Name: _____

11. CRIMINAL AND MEDICAID / MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), Florida Statutes.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under chapter (ch.) 409, Florida Statutes (relating to social and economic assistance), ch. 817, Florida Statutes (relating to fraudulent practices), ch. 893, Florida Statutes (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 2.

   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 subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), Florida Statutes)? ☐ Yes ☐ No

   c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), Florida Statutes, has it been more than five 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," provide supporting documentation)? ☐ Yes ☐ No

2. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to 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

If you responded "No" to the question above, skip to question 3.

   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 s. 409.913, Florida Statutes? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 4.

   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

If you responded "No" to the question above, skip to question 5.

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

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

Name: _____

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

   a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? ☐ Yes ☐ No

   b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **A written self-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.

☐ **Supporting documentation** including court dispositions or agency orders where applicable.

Documents in sections 8, 9, 10, and 11 may be submitted to the board office via the online upload system at https://mqaonline.doh.state.fl.us/datamart/voservicesportal/, via email at MQA.SpeechLanguage@flhealth.gov, or mailed to:

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

12. APPLICANT SIGNATURE

I, the undersigned, state that I am the person referred to in this application for licensure in the state of Florida. I have carefully read the questions in the application and have answered them completely, without reservation of any kind, and I state that my answers and all statements made by me herein and in support of the application are true and correct.

I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to s. 456.067, Florida Statutes.

Florida law requires me to immediately inform the board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed.

I acknowledge that the practice of speech-language pathology and audiology in Florida is governed by ch. 456 and 468, Part 1, Florida Statutes, and Rule chapter 64B20, F.A.C. I understand that I am under a continuing obligation to understand and keep informed of any changes to ch. 456 and 468, Part 1, Florida Statutes, and Rule chapter 64B20, F.A.C.

Section 456.013(1)(a), Florida Statutes, 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 MQA.SpeechLanguage@flhealth.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
License Verification Request

Part I: To be completed by applicant (Florida requires verification of all your current and previously held licenses.)

Name: _____

Address: _____

Name original license was issued under: _____

License Number: _____ State: _____

I hereby authorize release of any information regarding my licensure status to the Florida Board of Speech-Language Pathology & Audiology.

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

Part II: To be completed by state licensing agency

All verifications must be in English and include the following criteria:

* Typed on an official state form or letterhead
* Include an official board seal
* Signature and title of state board official

The following information must be included in all verifications:

* Licensee name
* License number
* State or jurisdiction of licensure
* Licensure status
* Is license in good standing?
* Date of issuance/expiration
* Licensure method (examination or endorsement)
* Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)?
* If this license has ever been encumbered, please provide certified copies of documentation regarding the action with the completed license verification.