



# Application for Speech-Language Pathology or Audiology Assistant Certification

Florida Board of Speech-Language Pathology and Audiology  
PO Box 6330  
Tallahassee, FL 32314-6330

Web: [www.floridasspeechaudiology.gov](http://www.floridasspeechaudiology.gov)  
E-mail: [info@floridasspeechaudiology.gov](mailto:info@floridasspeechaudiology.gov)

Do not write in this space.  
For Revenue Receiving Only.

## PART A: PERSONAL INFORMATION

Name: \_\_\_\_\_  
Last / Surname                      First                      Middle

Have you ever changed your name through marriage or through action of the court, or have you ever been known by any other name?  Yes  No If yes, please list all names below: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number : \_\_\_\_\_  
MM/DD/YYYY

The Department of Health is required and authorized under Title 42 USCA § 666(a)(13) to collect Social Security Numbers on applications for professional licensure. Section 456.013(1)(a), Florida Statutes, requires applicants regulated under chapter 456 to provide a Social Security Number. Social Security Numbers are confidential and exempt from public records disclosure.

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

\_\_\_\_\_  
Street/PO Box                      Suite/Apt No.                      City

\_\_\_\_\_  
State                      Zip                      Country                      Home/Cell Number

**Physical Location (Required if mailing address is a PO Box; this cannot be a PO Box and will be posted on the Department Website. If a physical location is not provided, your license will indicate "not practicing."):**

\_\_\_\_\_  
Street                      Suite/Apt No.                      City

\_\_\_\_\_  
State                      Zip                      Country                      Work/Cell Number

**ADDRESS CHANGE:** 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 this is your mailing address or your physical location.

### Email Notification:

If you want to be notified of the status of your application by email, please check the "Yes" box and write your email address on the line provided below. If you choose this form of notification, you will receive information regarding your application file through email. You will be responsible for checking your email regularly and updating your email address with the board office at: [info@floridasspeechaudiology.gov](mailto:info@floridasspeechaudiology.gov)

I want to be notified by email:                      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, mark "No" and do not provide an email address or send electronic mail to our office. Instead, contact the office by phone or in writing.*

## **PART B: APPLICATION TYPE AND FEES**

**License Type:** Indicate the type of license you are applying for:

- Speech-Language Pathology Assistant (3003)       Audiologist Assistant (3004)

**Required Fees:** The total fee due with your application is \$130. This includes a \$75 non-refundable application fee. Fees must be paid in the form of a cashier's check or money order, made payable to: Department of Health.

**Required Documentation:** In addition to this application and the fee, all applicants must submit the following documents to the Board:

**OFFICIAL TRANSCRIPT:** An official transcript(s) must be sent directly from the school to the Board office. The transcript will not be considered official if received from the applicant.

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.

An **audiology assistant** must have earned 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 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.

**VERIFICATION OF EMPLOYMENT:** Under 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.

**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

**PART C: EDUCATIONAL AND PROFESSIONAL HISTORY**

**EDUCATIONAL DATA**

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

**Speech-Language Pathology Applicants Only:** Under Rule 64B20-4.002, F.A.C., applicants must have completed 24 semester hours of courses in specified subjects. In the two charts below please identify the courses that satisfy these requirements. Audiology applicants should skip ahead to the "Licensure Data" section.

Please list fifteen (15) semester hours of courses that provide information about and observation of speech, hearing, language disorders, general phonetics, basic articulation, screening and therapy, basic audiometry, or auditory training. Attach additional sheets if necessary.

Date Completed (month and year)	Title of Course	Credit Hours

Other Courses to be considered: \_\_\_\_\_

**PART C (CONTINUED)**

Please list 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.

Date Completed (month and year)	Title of Course	Credit Hours

Other courses to be considered: \_\_\_\_\_

**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

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 of 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. That form is available on our website for your convenience,

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

**PROFESSIONAL HISTORY**

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.

<b>A.</b> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>B.</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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>C.</b> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>D.</b> Is there a complaint currently pending against you in any jurisdiction, or an investigation of your professional conduct or competency in any profession?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**PART C (CONTINUED)**

**DISCIPLINARY HISTORY**

- A.     Yes    No    Have you ever been denied or is there now any proceeding to deny your application for any healthcare license to practice in Florida or any other state, jurisdiction or country?
  
- B.     Yes    No    Have you ever had disciplinary action taken against your license to practice any healthcare related profession by the licensing authority in Florida or in any other state, jurisdiction or country?
  
- C.     Yes    No    Have you ever surrendered a license to practice any healthcare related profession in Florida or in any other state, jurisdiction or country while any such disciplinary charges were pending against you?
  
- D.     Yes    No    Do you have any disciplinary action pending against your license?

***If you answered "Yes" to any of the above, please explain the circumstances surrounding the disciplinary action(s); attach additional sheets, as necessary:***

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***If you answered "Yes" to any of the above, please attach a copy of the **Administrative Complaint** and **Final Order** for each disciplinary action.***

**Failure to disclose information in this section may result in a denial of your application**

## PART D: CRIMINAL HISTORY

### GENERAL DISCLOSURE

When you answer this question, you must include all misdemeanors and felonies even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses.

If you answer "Yes" to this question you must provide a written explanation that describes the surrounding circumstances, the date, city, state, the charge, and the result. Include the final disposition and arrest record provided by the Clerk of the Court in the arresting jurisdiction. If the documentation is unavailable, you must provide a letter from the Clerk of the Court. You may obtain documentation on completion of your sentence from the Department of Corrections. It must include start and end date, and state that you met whatever conditions were imposed.

- A.  Yes  No 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?
- B.  Yes  No Have charges ever been brought against you by any branch of the United States Armed Services?

***If you answered "Yes" to any of the above, please explain the circumstances surrounding each offense and any corrective actions you have taken; attach additional sheets, as necessary:***

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***If you answered "Yes" to any of the above, please attach a copy of the **Arrest Record, Final Disposition, and Completion of Sentencing Documents** for all charges.***

**Failure to disclose information in this section may result in a denial of your application.**

### CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

If you are applying for licensure, certification, registration, or as a candidate for examination, you may be excluded if your felony conviction occurred within a certain timeframe established by state law. If you answer "Yes" to any of the questions in this section, provide a written explanation for each answer and include the county, state, and date of each termination or conviction. Provide the board office with copies of supporting documentation, including court dispositions or agency orders. If you fail to disclose information in this section, your application could be denied.

1.  Yes  No 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 or prevention and control) or a similar felony offense(s) in another state or jurisdiction?

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

## PART D (CONTINUED)

- a.  Yes  No If "Yes" to 1, have you successfully completed a drug court program for a felony offense that resulted in the plea being withdrawn or charges dismissed?
- b.  Yes  No If "Yes" to 1, for felonies of the first or second degree, has it been more than 15 years before the date of application?
- c.  Yes  No If "Yes" to 1, for felonies of the third degree, has it been more than 10 years before the date of application, except for felonies of the third degree under Section 893.13(6), Florida Statutes?
- d.  Yes  No If "Yes" to 1, for felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years before the date of application?
2.  Yes  No 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)?

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

- a.  Yes  No 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?
3.  Yes  No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?

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

- a.  Yes  No If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent 5 years?
4.  Yes  No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?

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

- a.  Yes  No Have you been in good standing with a state Medicaid program for the most recent five years?
- b.  Yes  No Did the termination occur at least 20 years before the date of this application?
5.  Yes  No 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?

**PART E: HEALTH HISTORY**

**Health History**

- A.      Yes    No    Do you have any condition that currently impairs your ability to practice your profession with reasonable skill and safety?
- B.      Yes    No    Are you using medications, other drugs, narcotics, or intoxicating chemicals that impair your ability to practice your profession with reasonable skill and safety?

*If you answered "Yes" to either of the above questions, please provide a letter from a licensed health care practitioner, who is qualified by skill and training to address your condition, which explains the impact your condition may have on your ability to practice your profession with reasonable skill and safety, and stating either that you are safe to practice your profession without restriction or indicating what restrictions are necessary. If necessary, you may attach additional sheets. Documentation must be current within the last year. If you fail to disclose the information requested in this section, your application may be denied.*

## PART F:

### EQUAL OPPORTUNITY DATA:

We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 CFR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

**Sex:**  Male  Female      **Race:**  White  Black  Asian/Pacific  
Islander  Hispanic  Other \_\_\_\_\_

### AVAILABILITY FOR DISASTER:

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

**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.

### APPLICANT STATEMENT

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 changes in circumstances or conditions occur which might affect the Board's decision concerning my eligibility for examination or licensure. Such supplement is required by section 456.013(1), F.S. 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 reservation of any kind, and I declare that my answers and all statements made by me herein and in support of this application are true and correct. Should I furnish any false information on or in support of this application, I understand that such action shall constitute cause for denial, suspension, or revocation of any license to practice in the state of Florida in the profession for which I am applying. I hereby acknowledge that practice as a licensed Massage Therapist in Florida is governed by Chapters 456 and 480, F.S., and Rule Chapter 64B7, F.A.C. I understand that I am under a continuing obligation to understand and keep informed of any changes to Chapters 456 and 480, F.S., and Rule Chapter 64B7, F.A.C.

**Applicant Signature:** \_\_\_\_\_  
(This field cannot be typed. You must print the application and sign it).

**Date:** \_\_\_\_\_  
(MM/DD/YYYY)

**All applications filed with the department are valid for one (1) year from the date of receipt.**