Reset Form

APPLICATION FOR REGISTRATION FOR SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY CLINICAL FELLOWSHIP YEAR

State Form 50320 (R11 / 3-25)
Approved by the State Board of Accounts, 2017

SPEECH-LANGUAGE PATHOLOGY AUDIOLOGY BOARD
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 232-2960
E-mail: pla5@pla.IN.gov
www.pla.IN.gov

INSTRUCTIONS:
1. *The fee for this application is $50.00, payable to the Indiana Professional Licensing Agency, in accordance with 880 IAC 1-1-5.*
2. *Completed application and fees should be mailed to the address listed in the upper right hand corner of this form.*
3. *All fees are non-refundable and non-transferable.*
4. *Please refer to the instructions on our website, www.pla.in.gov, for the licensing requirements.*

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is mandatory and this record cannot be processed without it.
** This information is being requested for workforce statistical purposes only; disclosure is voluntary.

FOR OFFICE USE ONLY	
APPLICATION FEE	
DATE FEE PAID *(month, day, year)*	
RECEIPT NUMBER	
CERTIFICATE NUMBER ISSUED	
DATE OF ISSUE *(month, day, year)*	

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant *(last, first, middle)*

Social Security Number*

Address *(number and street or rural route)*

City, state, and ZIP code

Telephone number *(daytime)*
( )

Email address *(required)*

Gender **
☐ Male ☐ Female

Date of birth *(month, day, year)*

Pursuant to IC 12-32-1-5 and IC 12-32-1-6, I swear under the penalty of perjury that: *(Please select one of the following.)*

☐ I am a United States Citizen. ☐ I am a qualified alien (as defined under 8 U.S.C. § 1641). ☐ I am authorized by the Federal Government to work in the United States.

Are you the spouse of a member of the military who is assigned to a duty station in Indiana? *(Optional)* ☐ Yes ☐ No

Are you an active duty member of the military? *(Optional)* ☐ Yes ☐ No

SCHOOL OF GRADUATION

NAME OF SCHOOL	LOCATION OF SCHOOL	DATE OF GRADUATION *(month, day, year)*

MASTER'S DEGREE GRANTED IN

☐ Speech-Language Pathology ☐ Audiology

* If your clinical fellowship begins prior to the date of graduation, you must submit a letter from the school which indicates that all requirements have been completed and the date the applicant will graduate.

CLINICAL FELLOWSHIP ANTICIPATED STARTING AND COMPLETION DATE

Starting date *(month, day, year)*

Completion date *(month, day, year)*

QUESTIONS

If your answer is "Yes" to any of the following, explain fully in a signed written statement, including all related details, and provide copies of all relevant arrest or court documents. Describe the event including the location, date and disposition. Falsification of any of the following is grounds for permanent revocation of the license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held?	☐ Yes	☐ No
2. Have you ever been denied a license, certificate, registration or permit to practice speech-language pathology or audiology or any regulated health occupation in any state *(including Indiana)* or country?	☐ Yes	☐ No
3. Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice in a competent, ethical, and professional manner?	☐ Yes	☐ No
4. *Except for minor violations of traffic laws resulting in fines, and arrests or convictions that have been expunged by a court,*		
(1) have you ever been arrested;	☐ Yes	☐ No
(2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state;	☐ Yes	☐ No
(3) have you ever been convicted of any offense, misdemeanor, or felony in any state;	☐ Yes	☐ No
(4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or	☐ Yes	☐ No
(5) have you ever pled *nolo contendere* to any offense, misdemeanor, or felony in any state?	☐ Yes	☐ No
5. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended, or subjected to any restrictions, probation or other type of discipline or limitations?	☐ Yes	☐ No
6. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?	☐ Yes	☐ No
7. Have you ever had a malpractice judgment against you or settled any malpractice action?	☐ Yes	☐ No

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Professional Licensing Agency any files, documents, records or other information pertaining to the undersigned requested by the Agency or any of its authorized representatives in connection with processing my application for licensure.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions from any liability with regard to such inspection or furnishing of any information.

I further authorize the Professional Licensing Agency to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions any information which is material to my application, and I hereby specifically release the Agency from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I affirm, under penalties for perjury, that the foregoing representations are true.

Signature of applicant	Date *(month, day, year)*

CLINICAL FELLOW SUPERVISOR'S INFORMATION

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is mandatory and this record cannot be processed without it.

PLEASE TYPE OR PRINT AND ANSWER ALL QUESTIONS.

SUPERVISOR'S INFORMATION

Name *(last, first, middle, maiden)*			
Indiana license number	Expiration date *(month, day, year)*	ASHA certification number	Expiration date *(month, day, year)*
Telephone number ( )		Email address	

CLINICAL FELLOW INFORMATION

I will be supervising the following clinical fellow, at the dates indicated and at the following location(s):

Name of clinical fellow		Social Security Number *	
Starting date *(month, day, year)*		Completion date *(month, day, year)*	
Name of hospital or facility			
Address *(number and street or rural route)*			
City	State	ZIP code	
Telephone number ( )	E-mail address		

LIST ANY ADDITIONAL WORK SITE ADDRESSES ON A SEPARATE SHEET OF PAPER.

AFFIRMATION

I am aware of requirements set forth in 880 IAC 1-1-3.1 and understand and agree that I shall supervise the person for whom this application is submitted.

Signature of applicant	Date signed *(month, day, year)*