

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. Do you have any condition or impairment (including a history of alcohol or substance abuse) that currently interferes, or if left untreated may interfere, with your ability to practice in a competent 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 (<i>last, first, middle, maiden</i>)			
Indiana license number	Expiration date (<i>month, day, year</i>)	ASHA certification number	Expiration date (<i>month, day, year</i>)
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 (<i>month, day, year</i>)	Completion date (<i>month, day, year</i>)	
Name of hospital or facility		
Address (<i>number and street or rural route</i>)		
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 (<i>month, day, year</i>)
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