Reset Form

APPLICATION FOR LICENSE TO PRACTICE SPEECH-LANGUAGE PATHOLOGY OR AUDIOLOGY

State Form 37911 (R20 / 3-25)
Approved by State Board of Accounts, 2017

SPEECH-LANGUAGE PATHOLOY AND 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 $150.00, 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 the workforce statistical purposes only; disclosure is voluntary.

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

DO NOT WRITE ABOVE THIS LINE

BASIS FOR LICENSURE	TYPE OF LICENSE
Applying for licensure by: ☐ **Examination** ☐ **Endorsement**	**Applying as a:** ☐ **Speech-Language Pathologist** ☐ **Audiologist**

APPLICANT INFORMATION

Name of applicant *(last, first, middle, maiden)*	Social Security Number*
Address *(number and street or rural route, city, state, and ZIP code)*	*City, state, and ZIP code*
Date of birth *(month, day, year)*	Gender** ☐ Male ☐ Female
Telephone number *(daytime)* ( )	Email address

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

MASTER'S DEGREE GRANTED BY

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

EXAMINATION RECORD

EXAMINATION TAKEN	DATE OF MOST RECENT EXAMINATION *(month, day, year)*	WHERE TAKEN
ETS – PRAXIS Series		

AMERICAN SPEECH-LANGUAGE HEARING ASSOCIATION (ASHA) CERTIFICATION

Do you hold an ASHA certification? ☐ Yes ☐ No

Certification number	Date of issuance *(month, day, year)*	Date of expiration *(month, day, year)*

PRE-PROFESSIONAL EDUCATION			
NAME OF SCHOOL	**LOCATION OF SCHOOL**	**DATES ATTENDED** *(month, day, year)*	**DEGREE GRANTED**

DIRECT SUPERVISED CLINICAL EXPERIENCE

Was your supervised clinical experience completed in a:

☐ Educational Institution ☐ Clinical Program Associated with the Institution

How many hours of supervised, direct clinical experience did you receive?

CLINICAL EXPERIENCE COMPLETED:

PROGRAM / INSTITUTION	SUPERVISOR	LOCATION	START DATE *(month, day, year)*	COMPLETION DATE *(month, day, year)*	HOURS COMPLETED

COMPLETION OF CLINICAL FELLOWSHIP (CFY)

Do you hold or have you held a CFY registration in the State of Indiana?

☐ Yes ☐ No

Registration number	Date of issuance *(month, day, year)*	Date of expiration *(month, day, year)*

Was your clinical fellowship completed in:

☐ Nine (9) consecutive months *(30 hours per week)*
☐ Twelve (12) consecutive months *(25 to 29 hours per week)*
☐ Fifteen (15) consecutive months *(20 to 24 hours per week)*
☐ Eighteen (18) consecutive months *(15 to 19 hours per week)*

SUPERVISOR	LOCATION	START DATE *(month, day, year)*	COMPLETION DATE *(month, day, year)*	HOURS WORKED PER WEEK

STATES LICENSED					
LICENSE TYPE	**STATE**	**NUMBER**	**DATE ISSUED** *(month, day, year)*	**EXPIRATION DATE** *(month, day, year)*	**STATUS**

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 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)*