



# APPLICATION FOR LICENSE TO PRACTICE SPEECH-LANGUAGE PATHOLOGY OR AUDIOLOGY

State Form 37911 (R17 / 9-17)

Approved by State Board of Accounts, 2017

SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY BOARD

PROFESSIONAL LICENSING AGENCY

402 West Washington Street, Room W072

Indianapolis, IN 46204

Telephone: (317) 234-2067

E-mail: [pla4@pla.IN.gov](mailto:pla4@pla.IN.gov)

[www.pla.IN.gov](http://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](http://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	
LICENSE NUMBER	
DATE ISSUED (month, day, year)	

**APPLICANT**

Attach one (1) passport-quality photograph taken not earlier than one (1) year prior to the date of application.

**DO NOT WRITE ABOVE THIS LINE**

### APPLICANT INFORMATION

Name of applicant (last, first, middle)		Social Security number *
Date of birth (month, day, year)	Place of birth (city and state or country)	
Address of applicant (number and street or rural route)		City, state, and ZIP code
Telephone number (daytime) (      )	E-mail address	
Gender ** <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity **	Race **
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.) <input type="checkbox"/> I am a United States Citizen. <input type="checkbox"/> I am a qualified alien (as defined under 8 U.S.C. § 1641).		
Are you the spouse of a member of the military who is assigned to a duty station in Indiana? (Optional) <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you an active duty member of the military? (Optional) <input type="checkbox"/> Yes <input type="checkbox"/> No	

APPLYING FOR LICENSURE AS: (Please check one)       Speech-Language Pathologist       Audiologist

### 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	HOW MANY TIMES HAVE YOU SAT FOR THIS EXAMINATION?
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)
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### 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)       Fifteen (15) consecutive months (20 to 24 hours per week)  
 Twelve (12) consecutive months (25 to 29 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

**LIST ALL PLACES YOU LIVED SINCE GRADUATION**

GENERAL LOCATION	DATES (month, day, year)

**LIST ALL PLACES OF EMPLOYMENT SINCE GRADUATION FROM YOUR MASTER'S DEGREE PROGRAM**

NAME AND ADDRESS OF EMPLOYER	RESPONSIBILITIES	DATES OF EMPLOYMENT (month, day, year)

If your answer is "Yes" to any of the following, explain fully in a sworn affidavit, 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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; (2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state; (3) have you ever been convicted of any offense, misdemeanor, or felony in any state; (4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or (5) have you ever pled <i>nolo contendere</i> to any offense, misdemeanor, or felony in any state?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you ever had a malpractice judgment against you or settled any malpractice action?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**APPLICATION AFFIRMATION**

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

Signature of applicant	Date signed (month, day, year)
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**AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize, request and direct any person, firm, 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 a license to practice speech-language pathology or audiology.

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 such information.

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

**AFFIRMATION**

I hereby swear or affirm, that I have read the above statements and agree to same.

Signature of applicant	Date signed (month, day, year)
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**VERIFICATION OF SPEECH-LANGUAGE PATHOLOGIST OR AUDIOLOGIST LICENSURE**

**INSTRUCTIONS:** Type or print the top portion of the verification and send a copy to each state where you hold or have held a license. Request each state to complete and send directly to:

Professional Licensing Agency  
 402 West Washington Street, Room W072  
 Indianapolis, IN 46204  
 Telephone: (317) 234-2067  
 E-mail: pla4@pla.IN.gov

Name (last, first, middle, maiden)		Social Security number *	
Address (number and street, rural route)			
City		State	ZIP code
Date of birth (month, day, year)	Telephone number (daytime) (       )		E-mail address
I hereby authorize the State of _____ to furnish the Professional Licensing Agency with the information below.			
Signature		Date signed (month, day, year)	

**TO BE COMPLETED BY THE STATE BOARD**

License number	Date of issuance (month, day, year)	Date of expiration (month, day, year)
License issued based upon: <input type="checkbox"/> Examination <input type="checkbox"/> Endorsement <input type="checkbox"/> Certificate of Clinical Competence From ASHA (CCC's) <input type="checkbox"/> Other _____		
Type of examination: <input type="checkbox"/> ETS-PRAXIS Series <input type="checkbox"/> State Constructed Examination (Attach subjects, scores and average)		Date of examination(s) (month, day, year)
Has the license been subject to any disciplinary action? (Please attach certified copies of any disciplinary action taken by your board.)		<input type="checkbox"/> Yes <input type="checkbox"/> No

**FORM COMPLETED BY:**

Name	<b>PLEASE AFFIX BOARD SEAL</b>
Title	
State Board	
Date (month, day, year)	