Reset Form

APPLICATION FOR LICENSE TO PRACTICE SPEECH-LANGUAGE PATHOLOGY OR AUDIOLOGY

State Form 37911 (R16 / 8-16)
Approved by State Board of Accounts, 2016

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
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. *All fees are non-refundable and non-transferable.*
3. *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.

APPLICANT

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

FOR AGENCY USE ONLY		
Application fee	Date fee paid (*month, day, year*)	Receipt number
License number	Date of issuance (*month, day, year*)	

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden*)	Social Security number*
Address (*number and street or rural route, city, state, and ZIP code*)	
Date of birth (*month, day, year*)	Place of birth (*city and state or country*)
Telephone number (*daytime*) ( )	E-mail address
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

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*)

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

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?	☐ 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 contendre* 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

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*)

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*)

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
Email: 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:

☐ Examination ☐ Endorsement ☐ Certificate of Clinical Competence From ASHA (CCC's)

☐ Other _____

Type of examination:	Date of examination(s) (*month, day, year*)
☐ ETS-PRAXIS Series ☐ State Constructed Examination (*Attach subjects, scores and average*)	

Has the license been subject to any disciplinary action? ☐ Yes ☐ No
(*Please attach certified copies of any disciplinary action taken by your board.*)

FORM COMPLETED BY:

Name	PLEASE AFFIX BOARD SEAL
Title	
State Board	
Date (*month, day, year*)	