Reset Form

APPLICATION FOR REGISTRATION AS SPEECH-LANGUAGE PATHOLOGY SUPPORT PERSONNEL

State Form 53764 (R10 / 10-22)
Approved by State Board of Accounts, 2017

SPEECH-LANGUAGE PATHOLOGY 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 $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 LICENSE ISSUED (*month, day, year*)	

DO NOT WRITE ABOVE THIS LINE

Type of application (*please check one only*)
☐ Aide ☐ Associate ☐ Assistant

APPLICANT INFORMATION

Name of applicant (*last, first, middle*)	Social Security Number *
Date of birth (*month, day, year*)	Gender ** ☐ Male ☐ Female
Address of applicant (*number and street or rural route*)	City, state, and ZIP code
Telephone number (*daytime*) ( )	E-mail 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? ☐ Yes ☐ No

SUPERVISOR(S) INFORMATION

Name of supervisor	Supervisor's License Number
Name of supervisor	Supervisor's License Number
Name of supervisor	Supervisor's License Number

EDUCATION

Please list all levels of education you have attended.

NAME OF SCHOOL	LOCATION OF SCHOOL	DATES ATTENDED (*month, day, year*)	DEGREE GRANTED

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 judgement 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 Board, 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)*

FORM SLP-1
VERIFICATION OF SPEECH-LANGUAGE SUPPORT PERSONNEL SUPERVISOR'S INFORMATION

Part of State Form 53764 (R10 / 10-22)
Approved by State Board of Accounts, 2017

INSTRUCTIONS:

1. *Complete **SECTION A** and forward this form to your field supervisor.*
2. ***SECTION B** must be completed by a speech-language pathologist licensed by the board.*
3. *List any additional work site addresses on a separate sheet of paper.*

SECTION A / APPLICANT INFORMATION	
Name of applicant (*last, first, middle, maiden or previous name*)	Social Security Number *

Level of supervisor (*please check one only)*

☐ Aide ☐ Associate ☐ Assistant

SECTION B / SUPERVISOR'S INFORMATION			
Name of supervisor (*last, first, middle, maiden or previous name*)			Number of years of clinical experience
Indiana license number	Date of expiration (*month, day, year*)	ASHA certification number	Date of expiration (*month, day, year*)

NAME OF SCHOOL / HOSPITAL / FACILITY / COMPANY WHERE THE SUPPORT PERSONNEL WILL BE EMPLOYED		
Name of school / hospital / facility / company		
Address (*number and street or rural route*)		
City	State	ZIP Code
Telephone number ( )	E-mail address	

ADDRESS OF LOCATION WHERE SERVICES WILL BE PROVIDED		
Address of location (*number and street or rural route*)		
City	State	ZIP Code

SUPPORT PERSONNEL CURRENTLY REGISTERED UNDER YOUR LICENSE	
Please list the support personnel name(s) and registration number(s) currently registered under your license.	
NAME	**REGISTRATION NUMBER**

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 Board, 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)*

FORM A-1
VERIFICATION OF SLP SUPPORT PERSONNEL FIELD EXPERIENCE – ASSOCIATE

Part of State Form 53764 (R10 / 10-22)
Approved by State Board of Accounts, 2017

INSTRUCTIONS:

*1. Complete **SECTION A** and forward this form to your field supervisor.*
*2. **SECTION B** must be completed by an official of the institution that has granted you the academic credit for this supervised field experience.*
3. Return this form to:

Indiana Professional Licensing Agency
402 West Washington Street, Room W072
Indianapolis, IN 46024

SECTION A / APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden or previous name*)	Social Security Number *

My minimum one hundred (100) hour supervised field experience was completed under the auspices of the following educational institution:

_____ located at _____
Name of Institution *City and State*

I completed the supervised field experience between the following dates:

_____ _____
Date began (month / year) *Date completed (month / year)*

I completed the supervised field experience at the following location:

_____
Specific location of field experience

SECTION B / VERIFICATION OF COMPLETION OF THE ONE HUNDRED (100) HOUR FIELD EXPERIENCE

As an official of the school named above, I certify that the above-named applicant has completed at least the following experience during the completion of the supervised field experience:

(1) Applicant has completed at least a one hundred (100) hour field experience that enabled the applicant to develop the core technical skills needed to assist in the treatment of communication disorders.

As an official of the school named above, I certify that the above-named applicant was valuated throughout the field experience and the applicant's performance was satisfactory.

I further certify that the supervision for this field experience was conducted by either a program faculty member or a supervisor working under the supervision of a program faculty member. The applicant's supervisor(s) held the following position(s), degree(s), license(s), and / or certification(s) – *(Provide name(s) and qualification(s) below):*

Program faculty member	
Alternate supervisor	
Site supervisor	
Position held at the institution	Name of institution
Name (*last, first, middle, maiden or previous name*)	

SUPERVISION OF SPEECH-LANGUAGE PATHOLOGY SUPPORT PERSONNEL

1. Support personnel's level of academic training.

2. Specify method of supervision.

3. Specify training program

4. Specify all procedures to be performed by the support personnel.

5. Describe in detail the pertinent educational and work experience for the support personnel for which authorization is sought.

APPLICATION AFFIRMATION

I hereby swear or affirm under penalties of perjury, that the statements made in this application are true, complete, and correct. I shall be responsible for the direct supervision of the support personnel for whom the application is submitted in compliance with requirements set forth in IC 25-35.6-1-2 (g) and 880 IAC 1-2.1.

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

FORM A-2
VERIFICATION OF CLINICAL EXPERIENCE FOR SLP SUPPORT PERSONNEL – ASSISTANT

Part of State Form 53764 (R10 / 10-22)
Approved by State Board of Accounts, 2017

INSTRUCTIONS:

1. *Complete **SECTION A** and then forward this form to your previous or current speech-language pathologist (SLP) supervisor(s) for completion of **SECTION B.***
2. *Submit proof that you have acquired at least one hundred (100) hours of clinical experience.*
3. *This form may be duplicated if your one hundred (100) hours of experience have been completed under more than one (1) SLP supervisor.*
4. ***SECTION B** must be completed by the applicant's previous or current supervisor and sent directly to:*

Indiana Professional Licensing Agency
402 West Washington Street, Room W072
Indianapolis, IN 46024

SECTION A / APPLICANT INFORMATION	
Name of applicant (*last, first, middle, maiden or previous name)*	Social Security Number *
Name of SLP supervisor (*last, first, middle, maiden or previous name*)	License number of SLP supervisor
Location of clinical experience	Dates of clinical experience (*month, day, year*)

SECTION B / CLINICAL EXPERIENCE / SUPERVISOR'S INFORMATION	
Total number of hours the above-named applicant served in the clinical experience	Total number of hours obtained with direct face-to-face patient/client contact
Number of hours of direct face-to-face patient/client contact in speech disorders obtained by the above-named applicant	Number of hours of direct face-to-face patient/client contact in language disorders obtained by the above-named applicant
I swear that the above information is true and correct to the best of my knowledge and belief.	
Signature of SLP supervisor	Date signed *(month, day, year)*
Printed name of SLP supervisor	Daytime telephone number ( )