STATE BOARD OF EXAMINERS IN SPEECH, LANGUAGE, AND HEARING
P O BOX 2649
HARRISBURG, PA 17105
717-783-1389

www.dos.state.pa.us/speech st-speech@pa.gov

Application instructions for Licensure in Audiology, Speech Language Pathology, or Teacher of the Hearing Impaired based on Master's Degree, Clinical Fellowship Year and Praxis Examination

1. Complete pages 1 and 2. An original signature is required; a faxed copy will not be accepted.

2. Attach $20.00 application fee payable to Commonwealth of PA.

3. Request the school to submit an official transcript conferring master's degree in Speech-Language Pathology, Audiology or Teacher of the Hearing Impaired directly to the Board in an official school sealed envelope.

4. Complete top section of page 3. Send to Institution. Verification of Supervised Professional Experience (CFY) **9 full months must be completed** and must be received directly from the qualified training supervisor in an official institution sealed envelope. Form must have the seal of the institution or if the institution does not have a seal the form must be notarized.

5. Complete page 4 only if you will have a Pennsylvania Employer. Complete top section of page 4. Provide this form to the Pennsylvania Employer. This form must be submitted directly to the Board office to the address listed above in an official sealed envelope. (This form must be mailed in a sealed envelope that includes the employer's return address matching the employer name listed in the paragraph on page 4.)

6. Request the examination results be sent from the NTE (1-800-772-9476) directly to the Board in an official sealed envelope. (Use code 8053 for Pennsylvania when requesting scores.)

7. Request letter(s) of good standing to be forwarded directly in an official sealed envelope, to the Pennsylvania State Board from any other state in which you have ever held a license to practice.

8. Attach a Curriculum Vitae listing all periods of employment or any other activities (i.e. child rearing, etc.) from graduation to the date of the application. The list must be in chronological order and include dates of employment/activities and must provide a list of duties..

9. If a different name is used on documentation submitted to the Board, a copy of a legal name change document (marriage certification, court order, divorce decree) showing change of name is required.

PLEASE NOTE: If the application process has not been completed within one year from the date it was received, applicants will be required to submit an updated application and another application fee.
PAGES 1 AND 2 AND LETTERS OF GOOD STANDING MUST BE UPDATED EVERY SIX MONTHS.

STATE BOARD OF EXAMINERS IN SPEECH, LANGUAGE, AND HEARING

Phone: 717-783-1389
Fax: 717-787-7769

Regular Mailing Address
P O Box 2649
Harrisburg, PA 17105-2649

Courier Delivery Address
2601 North Third Street
Harrisburg, PA 17110

APPLICATION FOR LICENSURE BASED ON EDUCATION, CLINICAL FELLOWSHIP YEAR AND PRAXIS EXAMINATION

Attach $20.00 application fee (non-refundable) payable to the Commonwealth of PA. (Please note- A processing fee of $20.00 will charged for any check or money order returned unpaid by the bank, regardless of the reason for non-payment.)

Type of License- Check one:

___ Audiology ___ Speech Language Pathology ___ Teacher of the Hearing Impaired

Last Name First Middle Maiden Name

Street Address Email address

City State Zip Code

Date of Birth Social Security Number

Home Telephone Work Telephone

Name of Pennsylvania employer-if not employed in Pennsylvania, please write “unemployed”

Name of Educational Institution Date Graduated (month/year) Degree Earned

The following questions must be answered, please check the appropriate box		Yes	No
1.	Have you ever been licensed to practice Audiology, Speech Language Pathology, or Teacher of the Hearing Impaired in any other state? **If yes, please list all states below** _____		
2.	Has any disciplinary action been taken against your license in any state, territory or jurisdiction?		
3.	Have you ever withdrawn an application, had an application denied or refused, or agreed not to apply for licensure in another jurisdiction?		
4.	Have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.		
5.	Have you ever been found guilty of immoral or unprofessional conduct or violated standards of professional practice or conduct?		
6.	Are you now, or have you within the past five years, been actively addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? (Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Board's Health Monitoring Program.)		
7.	Do you have any mental or physical condition that would prevent you from practicing as a Speech Language Pathologist, Audiologist, or Teacher of the Hearing Impaired with reasonable skill?		

IF YOU HAVE ANSWERED YES TO ANY QUESTIONS 2 THROUGH 7, PLEASE ATTACH AN 8 ½ X 11 SHEET OF PAPER PROVIDING A DETAILED EXPLAINATION OF THE CIRCUMSTANCES AND THE OUTCOME. INCLUDE CERTIFIED COPIES FROM THE COURT IF YOU ANSWERED YES TO #4.

VERIFICATION

I verify that this form is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way and that the statements in this application are true and correct to the best of my knowledge, information and belief. I am aware of the criminal penalties for tampering with public records or information pursuant to 18 Pa. C.S. § 4911 and I understand that false statements are made subject to the penalties of 18 Pa. C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension or revocation of my license.

_____ _____

APPLICANT'S SIGNATURE DATE

Note that disclosing your social security number on this application is mandatory in order for the State Board of Examiners in Speech-Language and Hearing to comply with the requirements of the federal Social Security Act pertaining to child support enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. § 4304.1(a). In order to enforce domestic child support orders, the Commonwealth's licensing boards must provide to the Department of Public Welfare information prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is mandatory in order for this board to comply with the reporting requirements of the federal Healthcare Integrity and Protection Data Bank. Reports to the HIPDB must include the licensee's social security number.

STATE BOARD OF EXAMINERS IN SPEECH, LANGUAGE, AND HEARING

Regular Mail
P O BOX 2649
HARRISBURG, PA 17105
717-783-1389

Courier Delivery
2601 N THIRD ST
HARRISBURG, PA 17110

VERIFICATION OF SUPERVISED PROFESSIONAL EXPERIENCE (CFY)
9 FULL MONTHS MUST BE COMPLETED

APPLICANT – Complete top section and send to institution where supervised professional experience (CFY) was completed.

Last name First Middle Maiden Name

Street Address Social Security Number

City State Zip Code

INSTITUTION – *Complete bottom section and return directly to the Board Office at the above address in an official institution sealed envelope*. Form must be completed by qualified training supervisor as defined in Section 45.2 of the regulations.

Name of Institution

Street Address

City State Zip Code

Year of Supervised Professional Experience (YSPE or CFY):

_____ _____

Beginning- Month Day Year Ending- Month Day Year

List number of months of Supervised Professional Experience (CFY) by specialty. Total must be at least 9 full months and 1080 hours.

Specialty	Number of Months	Hours per Week Worked
Speech Language Pathology	_____	_____
Audiology	_____	_____
Teacher of the Hearing Impaired	_____	_____

_____

Supervisor's Signature PA license number

(Seal of Institution or Notary)

_____

Supervisor's Title Date

If institution does not have seal, the form must be notarized.

STATE BOARD OF EXAMINERS IN SPEECH, LANGUAGE, AND HEARING

Regular Mail
P O BOX 2649
HARRISBURG, PA 17105
717-783-1389

Courier Delivery
2601 N THIRD ST
HARRISBURG, PA 17110

CURRENT PENNSYLVANIA EMPLOYER

APPLICANT – Complete top section and send to Pennsylvania employer. If you have more than one employer, make copies of this page and send a copy to each one. If you do not have a current Pennsylvania employer, you are not required to submit this page.

Last Name First Middle Maiden Name

Date of Birth Social Security Number

EMPLOYER – Complete bottom section and submit directly to the Board office to the address listed above in an official sealed envelope. (Form must be mailed in a sealed envelope that includes the employer's return address matching the employer name listed in the below paragraph).

In accordance with Sections 16 and 17 of the Speech-Language and Hearing Licensure Act of December 21, 1984, PL 1253, 63 P.S. § 1716 and 1711, I the undersigned, being duly authorized, certify that _____, is the name
(Name of corporation, partnership, trust, association, company or organization must be listed here)
of a corporation, partnership, trust, association, company, or organization, which engages in the practice of Speech Language Pathology, Audiology, or Teaching of the Hearing Impaired by the employment of individuals licensed under the provisions of this act, submits itself to the rules and regulations of the State Board of Examiners in Speech, Language, and Hearing and the provisions of the Act which the Board considers applicable.

VERIFICATION

I verify that the statements on this page are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 PA C.C § 4904 (relating to unsworn falsification to authorities) and may result in the suspension or revocation of my license. (Notarization not required.)

Pennsylvania Employer's Signature Title Date

Mailing Address of Place of Employment City State, Zip Code

Print or type name of Pennsylvania Employer