



Ohio Board of Speech-Language Pathology and Audiology

www.slpaud.ohio.gov

77 South High Street, Suite 1659 • Columbus, Ohio 43215-6108

Telephone: (614) 466-3145

E-mail: board@slpaud.ohio.gov

LATE DUAL LICENSE RENEWAL APPLICATION Practice Period: 2015-2016

Dear Dual Licensee:

Pursuant to the Ohio Revised Code section 4753.09, and the Ohio Administrative Code rules 4753-3-10 and 4753-5-01, your dual license to practice as a speech-language pathologist and audiologist in the State of Ohio expired at midnight on December 31, 2014. Your dual license may be renewed through December 31, 2015, by paying the regular renewal fee of \$170.00, plus a late fee of \$150.00.

Please read all instructions carefully and fill in all required fields on the enclosed renewal application to prevent any delays in the processing of your renewal application.

1. Complete the renewal application in its entirety and mail the original.
2. Remit a check, money order, or cashier's check in the EXACT amount indicated on page 1 of the application, made payable to "Treasurer, State of Ohio." All renewal fees are non-refundable.
3. **YOU MUST SIGN, DATE, and MAIL THE ORIGINAL LATE RENEWAL APPLICATION.**
4. Complete and return the attached Employment Verification Form with your late renewal application.
5. All late renewal applications are subject to a continuing education audit. You will be notified if you need to submit proof of continuing education hours.

NAME OR EMPLOYMENT CHANGE

Rule 4753-3-03 of the Administrative Code requires all licensees to notify the board in writing of any change of name, place of business or employment, or mailing address within thirty days of said change.

CONTACT US

You may contact the Board Monday through Friday from 8:00 a.m. to 5:00 p.m. at (614) 466-3145 or board@slpaud.ohio.gov, or by visiting the Board's website at <http://slpaud.ohio.gov>. Please be sure to include your name, license number, and phone number on all correspondence sent to the Board.

CREDENTIAL MAILING ADDRESS

This is the address you wish the Board to correspond with you. This includes renewal and licensure information. Listing an e-mail address will facilitate distribution of our eNewsletter.

BUSINESS ADDRESS

This address is your primary practice address and must be completed if you are practicing with an employer.

Board Members

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Darlene D. Young, Executive Office Administrator
Brandy R. Thomas, Administrative Professional
Connie J. Stansberry, Investigator

You may keep this portion for your records.

***** Complete both sides and return this page to the Board *****

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Renewal Application For Dual Licensure – to Practice during 2015-2016

Please verify your credential numbers. Please cross out and correct information by printing in ink.

Speech-Language Pathology License Number:
Audiology License Number:

Amount Due: **\$320.00 (Renewal Fee: \$170.00 and Late Fee: \$150.00 - Make Check or Money Order payable to “Treasurer, State of Ohio”)**

The following information must be fully completed or your application will be considered incomplete.

Please Print Clearly

Contact & Credential Mailing Information

Name: _____

Credential Mailing Address: _____

City: _____

State: _____

Zip Code: _____

County: _____

Telephone Number: (_____) _____

Email Address: _____

Employment Information

You must check this box if you do not have employer information to report.

Name of Employer: _____

Primary Work Address: _____

City: _____ State: _____ Zip Code: _____

County: (If employment is in Ohio) _____ Work Telephone: _____

Work Email Address: _____

Please indicate your current work status

- Employed full time – at least 30 hours per week
- Employed part time – less than 30 hours per week

- Not employed
- Retired

Please check your primary work setting

- College or University – Academic/Faculty/Research
- Community Center (i.e. Speech & Hearing Centers)
- Federal Governmental Agency
- Government Agency (city, county or state)
- Health System/Hospital-Based/Outpatient Facility/Clinic
- Home Health Agency
- Industry (hearing aid mfrs., industrial testing, publisher)
- Medical Office / ENT Office
- Private Practice
- Rehabilitation Center
- Research Center
- School (Preschool/Primary/Secondary)
- Skilled Nursing Facility/Long-Term Care/Assisted Living
- Other (please specify: _____)

How long have you been licensed to practice?

- Less than 1 year
- 6 to 10 years
- 16 – 20 years
- 1 to 5 years
- 11 to 15 years
- More than 21 years

When do you intend to retire from practice?

- Less than 1 year
- 6 to 10 years
- 16 – 20 years
- 1 to 5 years
- 11 to 15 years
- More than 21 years

Do you intend to let your license expire when you retire?

- Yes
- No

If you plan to maintain your "Active" license status after retirement from your employer, do you intend to continue practicing under your license?

- Yes
- No

Please check one that best describes you in your work setting:

- The majority of my time is spent providing direct therapy/clinical services to patients/clients in my work setting.
- The majority of my time is spent in a supervisory or non-therapy/clinical position in my work setting.

Do you have a certificate of clinical competence in speech-language pathology or audiology that is current and in good standing from the American Speech-Language Hearing Association?

- Yes
- No

Do you hold Board Certification in Audiology from the American Board of Audiology?

- Yes
- No

Please list the highest level of education you have in audiology?

- Master's Degree in Audiology
- Ph.D Degree in Audiology
- Doctor of Audiology Degree, e.g., Au.D.
- Other _____

Please list the highest level of education you have in speech-language pathology?

- Master's Degree in speech-language pathology
- Ph.D Degree in speech-language pathology
- Other _____

Do you hold licensure to practice audiology or speech-language pathology in another state?

- Yes - List State(s) _____
- No

What year were you born? _____

What is your gender? Male _____ Female _____

Please circle your answer to the following questions.

1. Do you have experience supervising conditional licensees, CFYs, student permit holders, SLP/AUD Aides, and/or other SLPs/AUDs? **Yes No**

2. This is my first renewal; therefore, I am not required to attest to completing continuing education pursuant to Ohio Administrative Code (OAC) §4753-4-01(A)(5). **Yes No**

3. I have or will have completed 40 clock hours of continuing education, as required by §4753 OAC by December 31, 2014. **Yes No**

4. I am active duty military, a military veteran, or the spouse of an active duty military personnel or military veteran. **Yes No**

Since your last renewal, or license reinstatement:

5. Have you ever been arrested, charged and/or convicted, pled guilty, or no contest or been granted intervention in lieu of conviction for any **misdemeanor or other criminal offense** in the State of Ohio or in any other state, commonwealth, territory, province, or country, (other than minor traffic violations)? Yes No

6. Have you ever been arrested, charged and/or convicted, pled guilty, or no contest or been granted intervention in lieu of conviction for any **felony or other criminal offense** in the State of Ohio or in any other state, commonwealth, territory, province, or country, or United States federal court? Yes No

7. Have you ever had a misdemeanor or felony conviction expunged that is substantially related to the practice of speech-language pathology or audiology? Yes No

8. Adjudged by a court to be mentally incompetent? Yes No

9. Denied a license to practice speech-language pathology and audiology or another healthcare profession by any state (including Ohio) or U.S. territory? Yes No

10. Disciplined in any state (including Ohio) or U.S. territory in which you currently hold or have ever held a license to practice speech-language pathology and audiology or another healthcare profession? Yes No

11. Do you currently have any open complaints/disciplinary actions pending or were you disciplined in your work setting? Yes No

If you answered yes to any of questions 5-11, you are required to provide details on a separate sheet of paper including the location(s) where the action(s) occurred. You must also include copies of any court and/or licensing board orders.

I, the undersigned, hereby certify that the information is true. I am aware that misrepresentation on this application may result in disciplinary action in accordance with Ohio Revised Code section 4753.10.

Signature

Date



EMPLOYMENT VERIFICATION FORM

Please complete the Employment Verification Form verifying your employment from January 1, 2015 through the present. If you were employed by more than one employer during this time period, verification may be included on additional pages. This form along with any additional pages must be signed and dated on page two and returned to the Board office, even if you did not work during the specified time. This form may be submitted via mail, fax or e-mail denoted in the letterhead.

YOUR NAME (First, M.I., Last): _____ **License #:** _____

A. Are you currently employed? Yes No

CURRENT EMPLOYER

Employer's Name: _____	
Address: _____ Street _____ City _____ State _____ Zip Code _____	Supervisor's Name and Title: _____
	Supervisor's Telephone: () _____
	Do you supervise as an SLP or AUD? <input type="checkbox"/> Yes <input type="checkbox"/> No
Job Title: _____	
Start Date: _____	
JOB DUTIES: _____ _____ _____	

B. Were you practicing in Ohio under an expired license, January 1, 2015 through the date you renewed late in 2015?

Yes No (If yes, fill out section below. Write "same" if same as section A. If supervisor is not an SLP or Aud., still list their name):

EMPLOYER 1

EMPLOYER 2

Employer's Name: _____	Employer's Name: _____
----------------------------------	----------------------------------

Address: <hr/> Street	Address: <hr/> Street
City _____ State _____ Zip Code _____	City _____ State _____ Zip Code _____
Job Title: _____ START/END DATE: _____ JOB DUTIES: _____ <hr/> <hr/> <hr/> Supervisor's Name: _____ Supervisor's Telephone: () _____	Job Title: _____ START/END DATE: _____ JOB DUTIES: _____ <hr/> <hr/> <hr/> Supervisor's Name: _____ Supervisor's Telephone: () _____

**C. Ohio Board of Speech-Language Pathology and Audiology
77 South High Street, Suite 1659
Columbus, Ohio, 43215-6108**

I attest that I **was practicing** **was not practicing in Ohio while my license was expired and that this information is true and accurate.** Pursuant to Ohio Revised Code 4753.02 no person shall practice, offer to practice, or aid and abet the practice of the profession of speech-language pathology or audiology, or use in connection with the person's name, or otherwise assume, use, or advertise any title or description tending to convey the impression that the person is a speech-language pathologist or audiologist unless the person is licensed or permitted under this chapter.

I have read and answered all questions on this form truthfully. Under penalties provided by law for fraud, deception or misrepresentation in obtaining, or attempting to obtain licensure or to retain licensure, I hereby certify that I am the person referred to on this form, that I have examined the statements and information provided therein and that all the statements and information is true, correct and complete in every respect.

Licensee Name (Printed)	Title	Signature
Primary Telephone Number	E-mail	Date

Please attach this completed form with your late renewal application to:
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