



Ohio Board of Speech-Language Pathology & Audiology

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

Telephone (614) 466-3145 • Fax (614) 995-2286

No Change – Late Renewal Application For Aide Licensure to Practice during 2013-2014

Instructions: Complete this form only if you are applying to renew an aide license that has been expired for less than one year from the date of your expiration. In order to process a late renewal application, you should also submit the attached employment verification form. You may use this form until December 31, 2013.

IMPORTANT – This renewal form should only be completed if there are no changes to your aide application and approved aide plan on file with the Board. All changes should be reported on the Board’s prescribed aide application form, which can be downloaded from the Board’s website at <http://slpaud.ohio.gov>; click on the “Forms and Applications” link. If you are unable to download an aide application and need one mailed to you, please contact the Board at the address or phone number noted above.

License Number: _____

Amount Due: **\$200.00** (\$50.00 renewal fee plus a late fee of \$150.00) (Make Check or Money Order payable to “Treasurer, State of Ohio”; credit card payments cannot be processed.)

The following information must be fully completed or your application will be considered incomplete. Incomplete applications will not be processed.

Please Print Clearly

Contact & Credential Mailing Information

Name: _____
First Name Middle Name Last Name

Credential Mailing Address: _____

City: _____ State: _____ Zip Code: _____

County: _____ Telephone Number: (____) _____

Email Address: _____

Employment Information

Name of Employer: _____

Primary Work Address: _____

City: _____ State: _____ Zip Code: _____

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

There are no changes to report from the aide application or approved Aide Plan currently on file with the Ohio Board.

Please check your primary work setting

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

Please circle your answer to the following questions.

Since your last renewal or license reinstatement, have you been:

- | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 1. Convicted of, found guilty of, pled guilty to, or received treatment in lieu of conviction for a felony and/or any offense involving moral turpitude? | Yes | No |
| 2. Adjudged by a court to be mentally incompetent? | Yes | No |
| 3. 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 either question 1-3, 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 of Applicant

Date

Name of Supervisor – Please print

License Number

Signature of Supervisor

Date

Note: All supervisors of record must sign this renewal application. Use additional sheets if necessary.

Name of Supervisor – Please print

License Number

Signature of Supervisor

Date

Name of Supervisor – Please print

License Number

Signature of Supervisor

Date



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www.slpauld.ohio.gov

EMPLOYMENT VERIFICATION FORM

Please complete the Employment Verification Form verifying your employment from January 1, 2013 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: () _____
Job Title: _____ Start Date: _____	Do you supervise as an SLP or AUD? <input type="checkbox"/> Yes <input type="checkbox"/> No
JOB DUTIES: _____ _____ _____	

B. Were you practicing in Ohio under an expired license, January 1, 2013 through the date you renewed late in 2013?

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: _____	Address: _____

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

C. **Ohio Board of Speech-Language Pathology and Audiology**
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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 return to Connie Stansberry, Investigator, at:
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