



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

SINGLE SLP OR AUD LATE RENEWAL APPLICATION **Practice Period: 2015-2016**

Dear Licensee:

Pursuant to the Ohio Revised Code section 4753.09 and Ohio Administrative Code rules 4753-3-10 and 4753-5-01, your license to practice as a speech-language pathologist or audiologist in the State of Ohio expired at midnight on December 31, 2014. Your single license may be renewed through December 31, 2015, by paying the regular renewal fee of \$120.00, 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 newsletter.

BUSINESS ADDRESS

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

Board Members

Amy Thorpe Wiley, M.Ed., CCC-SLP, Chairperson
Karen K. Mitchell, Au.D., Vice Chairperson
Tammy H. Brown, M.A., CCC-A, ABA, FAAA
Carrie Spangler, Au.D., CCC-A, FAAA

Lisa A. Froehlich, Ph.D., CCC-SLP
Linda L. Wellman, Ph.D., CCC-SLP
Helen L. Mayle, Public Member
Angela N. King, Public Member

Board Staff

Gregg B. Thornton, Esq., Executive Director
Darlene D. Young, Executive Office Administrator
Brandy R. Thomas, Administrative Professional
Connie J. Stansberry, Investigator

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

Ohio Board of Speech-Language Pathology & Audiology
77 South High Street, Suite 1659 • Columbus, Ohio • 43215-6108
(614) 466-3145

Late Renewal Application – to Practice during 2015-2016

Which license are you renewing (check one): **Speech-Language Pathology:** _____ **Audiology:** _____

Your License Number: _____

Amount Due: **\$270.00 (Renewal Fee: 120.00 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: _____

1. Please indicate your current work status

- Employed full time– at least 30 hours per week Not employed
 Employed part time– less than 30 hours per week Retired

2. How long have you been licensed to practice?

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

3. How many more years do you intend to continue practicing before retiring?

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

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

- Yes No

5. If you checked “No” and plan to maintain your “Active” license status after retirement from your employer, do you intend to continue practicing under your license?

- Yes No

6. 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 specify:_____) |

7. Please select the 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.
 Not applicable

8. Do you have a Certificate of Clinical Competence that is current and in good standing from the American Speech-Language-Hearing Association?

- Yes – CCC-SLP No
 Yes – CCC-AUD
 Yes – CCC-AUD

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

- Yes No Not Applicable

10. Are you credentialed as a “Fellow of the American Academy of Audiology” (FAAA)?

- Yes No Not Applicable

11. Please list the highest level of education you have in speech-language pathology or audiology, e.g., Masters, Au.D., Ph.D., etc.

Specify highest degree in your area of licensure: _____

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

- Yes No

13. What is your gender?

- MALE FEMALE

14. Do you have experience supervising conditional licensees, CFYs, student permit holders, SLP/AUD Aides, and/or other SLPs/AUDs?

- Yes No

15. 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

16. If this is not your first renewal, have you completed or will you complete 20 clock hours of continuing education, as required by Ohio Revised Code Chapter 4753 by December 31, 2014.

Yes No

17. Since your last renewal, restoration, or license reinstatement 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

18. Since your last renewal, restoration, or license reinstatement 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

19. Since your last renewal, restoration, or license reinstatement 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

20. Since your last renewal, restoration, or license reinstatement have you been adjudged by a court to be mentally incompetent?

Yes No

21. Since your last renewal, restoration, or license reinstatement have you been 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

22. Since your last renewal, restoration, or license reinstatement have you been 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

23. 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 17-23, 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.

24. If you need more than one renewal card mailed to you, please indicate the number: _____

25. Have you served in the military?

Yes No

26. Has your spouse served in the military?

Yes No

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: () _____
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, 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:

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