# APPLICATION for SPEECH-LANGUAGE PATHOLOGY or AUDIOLOGY AIDE


**OHIO BOARD OF SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY**
**77 S. High Street, Suite 1659 - Columbus, Ohio 43215-6108**
**Phone: (614) 466-3145 Fax: (614) 995-2286**

Web Site: www.slpaud.ohio.gov Email Address: board@slpaud.ohio.gov


Your Social Security Number is required to facilitate reporting to the Federal Health Integrity & Protection Data Bank (42 U.S.C. Section 1320a-7e9b0, 5 U.S.C. Section 552a and 45 C.F.R. pt. 61) and for accurate identification under the Federal and State Child Support Enforcement law (42 U.S.C. Section 666 and O.R.C. Section 3123.50.) It may also be used for reporting to the National Practitioner Data Bank U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/ enforcement purposes in compliance with O.R.C. Chapter 4730, 4731, 4760 or 4762, or as otherwise required by state or federal law. In compliance with O.R.C. 1347, notice is hereby given that in making application for licensure the applicant is also requesting that Confidential Personal Information be accessed.

TAPE
un-retouched headshot
PHOTO
taken within the
last six-months;
OR
send photo via email to
board@slpaud.ohio.gov

Chapter 4753, Ohio Revised Code and Chapter 4753, Ohio Administrative Code
governs licensure and regulation of Speech-Language Pathology and Audiology in the State of Ohio

**Instructions:**

- Read application carefully before completing.
- Type or print in blue or black ink.
- Do not use abbreviations in your responses.
- All questions must be answered. Write "N/A" (not applicable) if not other response is appropriate.
- Use additional pages if necessary.
- Fee Payment may be in the form of check or money order, payable to "Treasurer – State of Ohio"
- Supervisor(s) must complete Aide Plan (pages 5-6) of this application.
- Mail completed application with payment to address above.

1. **Select License Option**:
   [ ] Initial License (**$50**)
   [ ] Amendment of Current License
   [ ] Renewal of License with Supervisor Change (**$50**)

2. Area of Licensure: [ ] Speech-Language Pathology Aide [ ] Audiology Aide

3. Full Name: _____
   Last First Middle (Maiden)

4. Social Security Number: ☐☐☐-☐☐-☐☐☐☐

5. Date of Birth (Month/Day/Year): ☐☐-☐☐-☐☐☐☐ Gender: ☐M ☐F

6. **Residence**: _____
   Number Street City State Zip Code

   County (If in Ohio): _____

   Telephone: ( ) _____ Email Address: _____

7. **Employer:** _____

Address: _____
Number Street City State Zip Code

County (If in Ohio): _____

Telephone: ( ) _____ Email Address: _____

**Position Title**: _____ Hours/Week _____

Name of Supervisor: _____ Beginning Date of Practice as an Aide _____

8. **List all other employment experience in the last three years**:

**Position Title**: _____ Hours/Week _____

Employer: _____ Name of Supervisor: _____

Address: _____

Dates of Employment: From: _____ To: _____

**Position Title**: _____ Hours/Week _____

Employer: _____ Name of Supervisor: _____

Address: _____

Dates of Employment: From: _____ To: _____

**Position Title**: _____ Hours/Week _____

Employer: _____ Name of Supervisor: _____

Address: _____

Dates of Employment: From: _____ To: _____

8A. [ ] yes [ ] no Were you employed as a Speech-Language Pathology or Audiology Aide?

If yes, state employer and describe nature of duties performed. (Use additional paper if needed)

_____

_____

9. **List all Education**

| High School | Address | Graduation Date |
|---|---|---|
| _____ | | |
| College or University | Major / Degree | Graduation Date |
| _____ | | |

10. **Special Non-Degree Training** (workshops, training courses). Use additional paper if needed

| Name | Hours/Days | Content | Where, When, Taught By |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

11. Do you hold or have you ever held a license to practice any business activity or profession other than speech-language pathology aide or audiology aide?

[ ] yes [ ] no If yes, provide:

| Name of State | Area of Licensure | License No. |
|---|---|---|
| Date of License | Status | Expiration Date |

12. Have you ever had a license to practice any business activity or profession denied, suspended, or revoked?

[ ] yes [ ] no If yes, provide detailed information. (Use additional pages if needed)

13. Have you ever been found guilty of unethical practices in the conduct of any business profession?

[ ] yes [ ] no If yes, provide detailed information. (Use additional pages if needed)

14. 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 of in any other state, commonwealth, territory, province, or country, (other than minor traffic violations)?

[ ] yes [ ] no If yes, you are required to forward a certified copy of the court records regarding your conviction, the nature of the offense, date of discharge, and if applicable, a statement from the probation or parole officer.

15. Have you ever been arrested, charged and/or convicted, pled guilty or no contest, or been grated 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 If yes, you are required to forward a certified copy of the court records regarding your conviction, the nature of the offense, date of discharge, and if applicable, a statement from the probation or parole officer.

16. 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 If yes, you are required to submit a statement explaining the nature of the expunged conviction.

17. Are you now or have you in the last 5 years been addicted to or used in excess, any drug or chemical substance including alcohol?

[ ] yes [ ] no If yes, give details of the circumstance. (Use additional pages if necessary)

_____

_____

18. Are you now being treated or have you in the last 5 years been treated for a drug or alcohol addiction or participated in a rehabilitation program?

[ ] yes [ ] no If yes, give details of the circumstance. (Use additional pages if necessary)

_____

_____

**Military Service:**

If you are a current or former member (or spouse) of the armed forces of the United States, the national guard or a reserve component, you are eligible for expedited processing of your licensure application, and may be entitled to other benefits. Please visit the board's website at: www.slpaud.ohio.gov for additional information about benefits and resources.

19. [ ] yes [ ] no I am a member or former member of the armed forces of the United States, the national guard or a reserve component.

20. [ ] yes [ ] no I am the spouse of a member or former member of the armed forces of the United States, the national guard or a reserve component.

You may be required to submit documentation of military status if requested by the Board, such as an ID card (DD form, or Certificate of Release or Discharge from Active Duty (DD Form 214).

STATEMENT OF APPLICANT

***I HAVE READ THE GENERAL INFORMATION AND INSTRUCTIONS AND HAVE ANSWERED ALL QUESTIONS IN COMPLIANCE WITH THE INSTRUCTIONS. I CONFIRM THATI HAVE ACCESS TO THE LAWS AND RULES GOVERNING THE PRACTICE FOR WHICH I AM APPLYING FOR, AND I UNDERSTAND THAT APPLICATION FEES ARE NON-REFUNDABLE / NON-TRANSFERABLE.***

***UNDER PENALTIES PROVIDED BY LAW FOR FRAUD, DECEPTION OR MISREPRESENTATION IN OBTAINING OR ATTEMPTING TO OBTAIN A LICENSE, I HEREBY CERTIFY THAT I AM THE PERSON REFERRED TO IN THE APPLICATION, THAT I HAVE EXAMINED THE STATEMENTS AND INFORMATION PROVIDED THEREIN AND ALL THE ACCOMPANYING DOCUMENTS AND THAT ALL THE STATEMENTS AND INFORMATION IS STRICTLY TRUE, CORRECT AND COMPLETE IN EVERY RESPECT.***

***I FURTHER UNDERSTAND THAT MY APPLICATION FOR A LICENSE IS AN ONGOING PROCESS AND I WILL NOTIFY THE OHIO BOARD OF SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY, WITHIN THIRTY (30) DAYS, IN WRITING, OF ANY CHANGES TO THE FOREGOING INFORMATION OR ACCOMPANYING DOCUMENTS.***

***I ALSO UNDERSTAND THAT THE ISSUANCE OF A LICENSE IN OHIO WILL BE CONSIDERED BASED ON THE TRUTH OF THE INFORMATION PROVIDED AND ACCOMPANYING DOCUMENTATION.***

_____

SIGNATURE OF APPLICANT DATE

# SPEECH-LANGUAGE PATHOLOGY (OR) AUDIOLOGY AIDE PLAN

## TO BE COMPLETED BY EACH SUPERVISOR

***Before an application can be considered by the Board the following 2-pages must be completed by the licensed individual who will be directly supervising your work***

**Supervisor's Name**: _____
First Middle Last

Residence: _____
Number Street City State / Zip Code

Telephone: ( ) _____ Email: _____

Name of Employer: _____

Address: _____
Number Street City State / Zip Code

**Supervisor Licensure Status**:

Ohio License Number:
Audiology A-_____ Speech-Language Pathology SP-_____ Expiration Date: _____

List place(s) Aide will work:

(1) _____ Telephone: ( ) _____
Place of Employment

_____
Address City State / Zip Code County

Employment to Start: _____ Employment to End: _____

(2) _____ Telephone: ( ) _____
Place of Employment

_____
Address City State / Zip Code County

Employment to Start: _____ Employment to End: _____

ON A SEPARATE SHEET OF PAPER, answer questions one through four:

1. Provide a description of the training the Aide has received to prepare for the performance of the planned activities.
2. Provide a detailed description of the activities to be performed by the Aide.
3. Provide a description of the direct and indirect supervision you will provide and how you will be available.
4. Provide the amount of time per week you will spend in direct supervision of the aide. _____ Hours / week.

## SPEECH-LANGUAGE PATHOLOGY (OR) AUDIOLOGY AIDE PLAN

## TO BE COMPLETED BY EACH SUPERVISOR

5. Will you provide direct, comprehensive, documented and immediate supervision to the aide? [ ] YES [ ] NO

6. Will you review 100% of the records generated by the aide? [ ] YES [ ] NO

7. Will you maintain the legal and ethical responsibilities for all assigned activities provided by the aide; to make all decisions relating to the diagnosis, treatment, management and future disposition of the patient/client(s) served; and to have the responsibility for the health, safety and welfare of the patient/client(s) served by the aide?

[ ] YES [ ] NO

8. List all other licensed aides under your supervision:

_____
_____
_____
_____
_____
_____

List all other aide applications in process:

_____
_____
_____
_____
_____
_____

STATEMENT OF SUPERVISOR

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_____

SIGNATURE OF SUPERVISOR DATE