

**APPLICATION FOR RESTORATION FROM INACTIVE LICENSE STATUS IN SPEECH-
LANGUAGE PATHOLOGY AND AUDIOLOGY TO ACTIVE STATUS**

OHIO BOARD OF SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY
77 South High Street, Suite 1659, Columbus, Ohio 43215-6108
Phone: (614) 466-3145

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.

Staple unretouched passport-size
PHOTO taken within last six
months, facial width not less than
three-fourths inch

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

Please Print Legibly in Ink or Type
ALL QUESTIONS MUST BE ANSWERED OR THE BOX CHECKED
(IF NOT APPLICABLE WRITE N/A)

1. Full Name:

_____ Last First Middle Maiden

2. Social Security Number: - -

3. Date of Birth (Month/Day/Year): - -

4. License Number: _____

5. Residence:

_____ Number Street City State Zip Code

County: (If residence is in Ohio) _____

6. Telephone Number: Residence: (_____) _____ - _____ Cell: (_____) _____ - _____

7. Email Address: _____

8. Business/Work Address:

_____ Number Street City State Zip Code

County: (If residence is in Ohio) _____

Business Telephone: (_____) _____ - _____

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9. Since the date your application for inactive status of your license, have you been:
- A. 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
 - B. Adjudged by a court to be mentally incompetent? ____ Yes ____ No
 - C. 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
 - D. 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
 - E. 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 9A – 9E, 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.

The following documents are required:

- \$120.00, Check or Money Order payable to the "Treasurer, State of Ohio"
- Completed Application for Restoration of Inactive License to Active Status
- Completed Employment Verification Form
- Documentation of completion of requisite continuing education hours
- **The Board must receive the completed restoration application and all documentation at least thirty days prior to the date you wish to resume practice.**

Continuing Education Requirements:

- Applicants must submit proof of completing at least twenty contact hours of continuing education in accordance with rule 4753-4-01 of the Administrative Code within the two-year period immediately preceding the application for restoration. Contact hours used to meet this requirement shall not be used to renew the restored license.

In addition:

- A license in inactive status for **less than twelve months** shall be restored to active status when the licensee demonstrates proof he or she completed an additional **ten contact hours** of continuing education during the time the license was in inactive status.
- A license in inactive status for **twelve to twenty-four months** shall be restored to active status when the licensee demonstrates proof he or she completed an additional **twenty contact hours** of continuing education during the time the license was in inactive status.
- A license in inactive status for **twenty-five to forty-eight months** shall be restored to active status when the licensee demonstrates proof he or she completed an additional **forty contact hours** of continuing education during the time the license was in inactive status.
- A license in inactive status for **forty-nine to sixty months** shall be restored to active status when the licensee demonstrates proof he or she completed an additional **fifty contact hours** of continuing education during the time the license was in inactive status.
- In addition to the requirements above, applicants for restoration of an inactive license who have not engaged in the practice of speech-language pathology or audiology for more than five years prior to the date the individual applies to the board for restoration may be subject to additional requirements outlined by the board. Those requirements are contained in rule 4753-3-11 of the Administrative Code.

I HAVE READ THE GENERAL INFORMATION AND INSTRUCTIONS AND HAVE ANSWERED ALL QUESTIONS IN COMPLIANCE WITH THE INSTRUCTIONS. I CONFIRM THAT I HAVE ACCESS TO THE LAWS AND RULES GOVERNING THE PRACTICE FOR WHICH I AM APPLYING FOR, AND I UNDERSTAND THAT THE FEES ARE NON-REFUNDABLE NOR 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

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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 RESTORATION OF MY INACTIVE 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 RESTORATION OF AN INACTIVE LICENSE IN OHIO WILL BE CONSIDERED BASED ON THE TRUTH OF THE INFORMATION PROVIDED AND ACCOMPANYING DOCUMENTATION.

SIGNATURE OF APPLICANT

DATE



Ohio Board of Speech-Language Pathology and Audiology

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Please complete the Employment Verification Form verifying your employment from the date your license became inactive 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 notarized on page 2 and returned to the Board office; even if you did not work during the time your license was inactive. This form must be submitted via U.S. Mail. A fax can only be accepted as a copy of the original.

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: () _____
Your Job Title: _____ Start Date: _____	Do you supervise as an <input type="checkbox"/> SLP or <input type="checkbox"/> Aud? <input type="checkbox"/> Yes <input type="checkbox"/> No
JOB DUTIES: _____ _____ _____	

B. Were you practicing in Ohio and/or in any state, during the time your Ohio license was inactive, and prior to your Restoration Application being submitted and/or approved? Yes No (If yes, fill out the section below. Write "same" if same as section A. If supervisor is not an SLP or Aud., still list their name. List any and all employment since your effective date of inactive status, even if employed outside the state of Ohio; even if not practicing within your Ohio licensure profession):

EMPLOYER 1

EMPLOYER 2

Employer's Name: _____	Employer's Name: _____
Address: _____ Street	Address: _____ Street

