

OHIO BOARD OF SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY

77 South High Street, 16th Floor, Columbus, Ohio 43215

Phone: 614/466-3145 Fax: 614/995-2286

Web Site www.slpaud.ohio.gov

Email Address board@slpaud.state.oh.us

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 other wise required by state or federal law".

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

Licensure and regulation of Speech-Language Pathology and Audiology in the State of Ohio are governed by Chapter 4753, Ohio Revised Code and Chapter 4753, Ohio Administrative Code.

APPLICATION FOR SPEECH-LANGUAGE PATHOLOGY OR AUDIOLOGY AIDE

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 "Not Applicable" if no other response is appropriate.
• Use additional pages if necessary.
• Fee payment may be in form of check or money order, payable to "Treasurer, State of Ohio." Do not send cash.
• Mail completed application to above address.

1. License Option:

- [] Initial License (\$50)
[] Amendment of Current License
[] Renewal of License (\$50)
[] Late Renewal (after December 31, 2008) Renewal Fee (\$50) Plus Late Fee (\$150) TOTAL (\$200)

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

3. Full Name: Last First Middle Maiden

4. Social Security Number: Birthdate: Gender: [] F [] M

5. Residence: Number Street Telephone: () County
City State / Zip Code
EmailAddress

6. Employer Telephone: ()
Street
State City State / Zip Code County

Title of Your Position: _____ Hours Per Week: _____

Name of Supervisor: _____

Beginning Date of Practice As An Aide: _____

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

Title of Your Position: _____

Immediate Supervisor _____

Business/Agency Name _____

Address _____

From _____ To _____ Number of Hours Per Week _____

Other Employment:

Title of Your Position: _____

Immediate Supervisor _____

Business/Agency Name _____

Address _____

From _____ To _____ Number of Hours Per Week _____

7-A. Were you employed as a speech-language pathology aide? YES NO

Were you employed as an audiology aide? YES NO

If YES, state employer and describe nature of duties performed: (use additional paper if necessary)

Were you employed as a speech-language pathologist? YES NO

Were you employed as an audiologist? YES NO

If YES, state employer and describe nature of duties performed: (use additional paper if necessary)

7-B. Did you do any additional work as a speech-language pathologist or audiologist? YES NO

If YES, how many hours per week? _____

Give place of employment, nature of duties performed, dates of employment: (use additional paper if necessary)

8. List all education:

High School	Address	Graduation Date
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College or University	Major	Degree	Graduation Date
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9. Special non-degree training (workshops, training courses, etc. - add pages if necessary)

Name	Hours/Days	Where, When, Taught by	Content
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10. Do you hold or have you ever held a license to practice any business activity or profession other than as a speech-language pathology aide or audiology aide? YES NO

If YES, provide

Area of Licensure	License No.	State in which Licensed
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Date License Issued	Expiration Date
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11. Do you hold or have you ever held a license as a speech-language pathology aide or as an audiology aide in any state other than Ohio? YES NO

If YES, provide

Area of Licensure	License No.	State in which Licensed
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Date License Issued	Expiration Date
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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:

13. Have you ever been convicted of a misdemeanor or a felony? YES NO

If YES, provide details of offense, date of conviction, term of sentence, etc.

14. Have you ever been found guilty of unethical practices in the conduct of any business or profession? YES NO

If YES, provide details of offense, dates of action and results.

15. STATEMENT OF APPLICANT

I HAVE READ THE GENERAL INFORMATION AND INSTRUCTIONS AND HAVE ANSWERED ALL QUESTIONS IN COMPLIANCE WITH THE INSTRUCTIONS AND UNDERSTAND THAT THE FEE'S 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 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

Before an application can be considered by the Board of Speech-Language Pathology and Audiology, the following pages must be completed by the licensed individual who will be directly supervising your work.

SPEECH-LANGUAGE PATHOLOGY AIDE OR AUDIOLOGY AIDE PLAN

TO BE COMPLETED BY SUPERVISOR

Supervisor's Name: _____
Last First Middle Maiden

Residence: _____
Number Street Telephone:() County
City State / Zip Code
Email _____

Employer: _____ Telephone:() _____
Street City State / Zip Code County

LICENSURE STATUS

Ohio License Number(s): Audiology A- _____ Speech-Language Pathology SP- _____

Expiration Date of License _____

List place(s) Aide will work:

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

Street City State / Zip Code County

Employment to Start: _____ Employment to End: _____

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

Street 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 per week.
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:

9. **STATEMENT OF SUPERVISOR**

I HAVE READ THE GENERAL INFORMATION AND INSTRUCTIONS AND HAVE ANSWERED ALL QUESTIONS IN COMPLIANCE WITH THE INSTRUCTIONS AND UNDERSTAND THAT THE FEE'S ARE NEITHER 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 SUPERVISOR AND 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 THIS 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 SUPERVISOR

DATE