Dear Dual Licensee:

Pursuant to the Ohio Revised Code section 4753.09, and the Ohio Administrative Code rules 4753-3-10 and 4753-5-01, your dual license to practice as a speech-language pathologist and audiologist in the State of Ohio expired at midnight on December 31, 2016. Your dual license may be renewed through December 31, 2018, by paying the regular renewal fee of $170.00, 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 eNewsletter.

BUSINESS ADDRESS

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

Board Members

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Board Staff

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Brandy R. Thomas, Administrative Professional
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You may keep this portion for your records.
Renewal Application For Dual Licensure – to Practice during 2017-2018

Please verify your credential numbers. Please cross out and correct information by printing in ink.

Speech-Language Pathology License Number:
Audiology License Number:

Amount Due: $320.00 (Renewal Fee: $170.00 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: ____________________________

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

Please check your primary work setting

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

1
How long have you been licensed to practice?
- ☐ Less than 1 year
- ☐ 1 to 5 years
- ☐ 6 to 10 years
- ☐ 11 to 15 years
- ☐ 16 – 20 years
- ☐ More than 21 years

When do you intend to retire from practice?
- ☐ Less than 1 year
- ☐ 1 to 5 years
- ☐ 6 to 10 years
- ☐ 11 to 15 years
- ☐ 16 – 20 years
- ☐ More than 21 years

Do you intend to let your license expire when you retire?
- ☐ Yes
- ☐ No

If you plan to maintain your "Active" license status after retirement from your employer, do you intend to continue practicing under your license?
- ☐ Yes
- ☐ No

Please check 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.

Do you have a certificate of clinical competence in speech-language pathology or audiology that is current and in good standing from the American Speech-Language Hearing Association?
- ☐ Yes
- ☐ No

Do you hold Board Certification in Audiology from the American Board of Audiology?
- ☐ Yes
- ☐ No

Please list the highest level of education you have in audiology?
- ☐ Master’s Degree in Audiology
- ☐ Ph.D Degree in Audiology
- ☐ Doctor of Audiology Degree, e.g., Au.D.
- ☐ Other _______________

Please list the highest level of education you have in speech-language pathology?
- ☐ Master’s Degree in speech-language pathology
- ☐ Ph.D Degree in speech-language pathology
- ☐ Other _______________

Do you hold licensure to practice audiology or speech-language pathology in another state?
- ☐ Yes - List State(s)____________________________
- ☐ No

What year were you born? ________________

What is your gender? Male ______ Female _____
Are you qualified to be a bilingual service provider?

☐ No
☐ Yes - List all language(s) in which you have the knowledge and skills to communicate and provide clinical services under your license: ________________________________

Please circle your answer to the following questions.

1. Do you have experience supervising conditional licensees, CFYs, student permit holders, SLP/AUD Aides, and/or other SLPs/AUDs?  Yes  No

2. 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

3. I have completed 20 clock hours of continuing education, which includes 2 hours related to ethics, as required by §4753-4-01 OAC by December 31, 2016.  Yes  No

4. I am active duty military, a military veteran, or the spouse of an active duty military personnel or military veteran.  Yes  No

Since your last renewal, or license reinstatement:

5. 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

6. 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

7. 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

8. Adjudged by a court to be mentally incompetent?  Yes  No

9. 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

10. 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

11. 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 5-11, 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  Date
EMPLOYMENT VERIFICATION FORM

Please complete the Employment Verification Form verifying your employment from January 1, 2017 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 practice 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?  □ Yes  □ No

JOB DUTIES:  __________________________________________________________________________________________

________________________________________________________________________________________________________

________________________________________________________________________________________________________

B. Were you practicing in Ohio under an expired license, January 1, 2017 through the date you renewed late in 2017?  □ Yes  □ No  (If yes, complete section below. Write “same” if same as section A. If supervisor is not an SLP or Aud., still list their name):

EMPLOYER 1

Employer’s Name:  ________________________________________________

EMPLOYER 2

Employer’s Name:  ________________________________________________

EMPLOYER 3

Employer’s Name:  ________________________________________________

EMPLOYER 4

Employer’s Name:  ________________________________________________
Address: _____________________________________________
Street _______________________________________________
City ___________________________ State _______________
Zip Code ________________

Job Title: __________________________________________
START/END DATE: ____________________________
JOB DUTIES: __________________________________

Supervisor’s Name: ____________________________
Supervisor’s Telephone: ( ) _______________

IF YOU ANSWERED “YES” IN SECTION B, answer the following: (If “NO” skip to Section C)

• How many days did you provide service(s) and/or represent yourself as a speech-language pathologist or audiologist between January 1, 2017 and the date you renewed your license? _______

• Did you supervise a Conditional Speech-Language Pathologist, Speech-Language Pathology Aide, or Audiology Aide? _______

C.  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