

**APPLICATION FOR STUDENT PERMIT IN SPEECH-LANGUAGE PATHOLOGY**

**OHIO BOARD OF SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY**

**77 South High Street, Suite 1659, Columbus, Ohio 43215-6108**

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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.



Un-retouched passport-size PHOTO taken within last six months, facial width not less than three-fourths inch (per OAC 4753-3-01) taped here.

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.

**If Completing By Hand Please Print In Ink  
ALL QUESTIONS MUST BE ANSWERED  
(IF NOT APPLICABLE WRITE N/A)**

Check All That Apply:  Initial Application  Change in Supervision or Practice Setting

1 Year Extension of Current Permit – Submit statement of reason for extension with application

1. Full Name: \_\_\_\_\_  
Last First Middle Maiden

**Name, as to appear on certificate** \_\_\_\_\_  
First Middle Last

2. Social Security Number: \_\_\_\_\_

3. Birth date (mm/dd/yy): \_\_\_\_\_

4. Gender:  M  F

5. Residence \_\_\_\_\_  
Number Street

\_\_\_\_\_  
City State Zip Code

6. Telephone Numbers: Residence: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

7. Email Address: \_\_\_\_\_

8. County of Residence: \_\_\_\_\_

9.  Yes  No Have you practiced in Speech Pathology other than in an educational clinical experience? If YES, describe nature of duties performed:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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Student Permit Plan

(C) Credit for student clinical experience may be granted when supervision is conducted in accordance with requirements of the American Speech-Language- Hearing Association and this board. Minimum supervision of the student permit holder will consist of twenty-five percent direct supervision of treatment activities and twenty five percent of direct supervision of diagnostic activities. Direct supervision must be in real time and must never be less than twenty-five percent of the student permit holder's total contact with each client or patient and must take place periodically throughout the experience. The supervisor will be accessible to the student permit holder during all client contact.

Please check all appropriate boxes and answer all questions completely. If not applicable write 'N/A'

18. [ ] I authorize the Board to share my application information/application status with the OMNIE Project.

19. [ ] I will not begin practice until my permit has been issued by the Board.

20. [ ] I have completed no less than twenty five hours of observation and seventy-five hours of student clinical experience to be consistent with the population to be served and work setting.

21. Name of the Ohio speech-language pathology graduate program recommending student for permit:

University Name \_\_\_\_\_

22. Practice setting: \_\_\_\_\_

University Designee Name Printed \_\_\_\_\_

University Designee Signature \_\_\_\_\_

Date \_\_\_\_\_

23. I will be practicing under this permit for:

Company or School Name: \_\_\_\_\_

Complete Mailing Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Number of hours working per week \_\_\_\_\_

24. I will be supervised by: \_\_\_\_\_  
(Print Name)

Number of hours of Supervision per week \_\_\_\_\_

**Important: Minimum supervision of the student permit holder will consist of twenty-five percent direct supervision of treatment activities and must be in real time and must never be less than twenty-five percent of the student permit holder's total contact with each client or patient and must take place periodically throughout the experience. The supervisor will be accessible to the student permit holder during all client contact.**

[ ] Yes [ ] No The supervisor will be accessible to the student permit holder during all client contact.

\_\_\_\_\_ Number of permit holders and/or conditional license holders supervised or planned for supervision.

Pursuant to OAC 4753-3-10, supervisors of must have a current Ohio license in speech-language pathology and have at least 24 months of full-time clinical experience and may not supervise more than one student permit holder unless approved by the board.

To request Board approval for concurrent supervision of more than one permit holder, the supervisor submits to the Board a current resume and cover letter of request/explanation. Additionally required is a letter to the Board from the employer listing all supervisees and attesting that the supervisor's duties have been adjusted to allow sufficient time for supervision as specified by OAC 4753-3-07 and 4753-10-03.



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**The following documents are required for Student Permit:**

1. \$50.00, nonrefundable application fee, payable to the "Treasurer, State of Ohio"
2. Completed Permit Application and Student Permit Plan, Photograph, Supervisor Request to Concurrently Supervise More Than One Permit Holder (if applicable), Supervisor Adjustment of Duties Letter (if applicable), Statement of Reason for Extension of Permit (if applicable).
3. Graduate transcript received **directly from the university or a letter from the graduate program indicating one year (three semesters or four quarters) of full-time study in a speech language pathology graduate program at an Ohio college or university.**

**IMPORTANT INFORMATION:**

\*Sealed envelope of transcript issued to students cannot be accepted for permit.

I HAVE READ THE GENERAL INFORMATION AND INSTRUCTIONS AND HAVE ANSWERED ALL QUESTIONS IN COMPLIANCE WITH THE INSTRUCTIONS. **I CONFIRM THAT I HAVE READ THE LAWS AND RULES, OAC & ORC §4573, GOVERNING THE PRACTICE WHICH I AM APPLYING FOR**, AND I UNDERSTAND THAT THE FEES ARE NON-REFUNDABLE OR TRANSFERABLE.

UNDER PENALTIES PROVIDED BY LAW FOR FRAUD, DECEPTION OR MISREPRESENTATION IN OBTAINING OR ATTEMPTING TO OBTAIN A PERMIT, 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 TRUE, CORRECT AND COMPLETE IN EVERY RESPECT.

I FURTHER UNDERSTAND THAT MY APPLICATION FOR A PERMIT IS AN ONGOING PROCESS AND I WILL NOTIFY THE OHIO BOARD OF SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY, WITHIN **FIVE (5) DAYS**, IN WRITING, OF ANY CHANGES TO THE FOREGOING INFORMATION OR ACCOMPANYING DOCUMENTS.

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

**SIGNATURE** OF APPLICANT \_\_\_\_\_

DATE \_\_\_\_\_