Application for Speech-Language Pathologist or Audiologist Provisional License

Board *of* Speech-Language Pathology & Audiology
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: https://floridasspeechaudiology.gov/
Email: info@floridasspeechaudiology.gov
Phone: (850) 245-4161
Fax: (850) 921-6184

DH-SPA 2, Revised 6/2020, Rule 64B20-2.003, F.A.C.

Are you an active duty member of the United States Armed Services?

Are you a veteran of the United States Armed Services?

Are you the spouse of a veteran of the United States Armed Services?

Are you the spouse of an active member of the United States Armed Services?

If you answered "Yes" to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health's commitment to serving members and veterans of the United States Armed Forces and their families online at http://www.flhealthsource.gov/valor

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Do Not Write in this Space
For Revenue Receipting Only

Select one license type:	
	Provisional Speech-Language Pathologist (3005)- **$180.00**
	Provisional Audiologist (3006)- **$180.00**

Total fee of $180.00 includes the following:

Application Fee (non-refundable)	$75.00
Initial Licensure Fee	$100.00
Unlicensed Activity Fee	$5.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. Requests to withdraw or for a refund must be made in writing. Fees are refundable for up to three years from the date of receipt.

If a physical address is not provided, the license issued will indicate "not practicing."

1. PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

_____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone (Input without dashes)

Physical Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website)

_____ _____ _____
Street (Place of Employment) Suite No. City

_____ _____ _____ _____
State ZIP Country Work/Cell Telephone (Input without dashes)

EQUAL OPPORTUNITY DATA:

We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender:	Male	Race:	Native Hawaiian or Pacific Islander	Hispanic or Latino	White
	Female		American Indian or Alaska Native	Black or African American	Asian
			Two or More Races		

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

Yes No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. SOCIAL SECURITY DISCLOSURE

This information is exempt from public records disclosure.

Pursuant to Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s.) 456.013(1)(a), Florida Statutes (F.S.), authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

Social Security Number: _____
(Input without dashes)

Social Security Information- * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code § 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, F.S. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.

Name: _____

3. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past. Attach additional sheets if necessary.

_____

B. Have you ever held a provisional speech-language pathology or audiology license in Florida? Yes No

If "Yes," provide the provisional license number: _____.

C. Do you hold, or have you ever held a license and/or certificate to practice any profession(s) in any state, U.S. territory, or foreign country? Yes No

D. List all licenses (active, inactive or lapsed). Attach additional sheets if necessary.

License Type	License #	State/Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

If you listed any licenses above, you may be required to submit a license verification. Board staff will attempt to verify your license(s) using available primary-source information (i.e. online verifications), including disciplinary history and method of licensure. If information is not available, you will be notified in writing that official license verification is required.

4. DISASTER

Would you be willing to provide health services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? Yes No

5. EDUCATION HISTORY

List the school(s) you attended.

Accredited School Name/Location	Major/Specialty	Graduation Date (MM/DD/YYYY)	Degree Awarded

All applicants must have an official transcript(s) sent directly from the school to the board office that indicates conferral of a master's degree or doctoral degree with a major emphasis in speech-language pathology or audiology. If you did not graduate from a Council for Higher Education accredited program, verification of the number of hours of supervised clinical practice must also be included on the transcript.

Non-U.S. Education: For the board to consider any education completed outside the U.S. or Canada, documentation must be received which verifies that the institution at which the education was completed was equivalent to an accredited U.S. institution. Documentation must verify that the coursework met the content and credit hour requirement for coursework in the U.S. It is the applicant's responsibility to obtain an evaluation from a recognized educational evaluation service that documents the equivalency of the coursework.

Note: A certified translator who is not related to the applicant must translate any document that is in a language other than English.

Name: _____

This page is to be completed by Speech-Language Pathology Applicants only.

Audiology applicants skip ahead to Section 6.

Under Rule 64B20-2.002(1)(a), Florida Administrative Code (F.A.C.), applicants must have completed 36 semester hours of graduate level courses that provide information about and observations of subjects relevant to the profession as listed in s. 468.1155(2)(b), F.S.

For applicants who did not graduate from an ASHA approved school, use the chart below to identify 36 semester hours of relevant graduate level courses to satisfy this requirement. Attach additional sheets if necessary.

Course Title	Date Completed (MM/YYYY)	Credit Hours

Other courses to be considered: _____

_____

List 300 clock hours of supervised experience which can be found in your transcripts including at least 200 hours in the area of speech-language pathology or audiology, as appropriate.

Course Title	Date Completed (MM/YYYY)	Credit Hours

Other courses or information to be considered: _____

_____

Name: _____

This information is exempt from public records disclosure.

6. HEALTH HISTORY

Physical and Mental Health Disorders Impacting Ability to Practice

A. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or would impair your ability to practice? Yes No

B. In the last two years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental or physical disorder that impaired your ability to practice? Yes No

Substance-Related Disorders Impacting Ability to Practice

C. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or would impair your ability to practice? Yes No

D. During the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol or drug) disorder or, if you were previously in such a program, did you suffer a relapse? Yes No

E. During the last five years, have you been enrolled in, required to enter, or participated in any substance-related (alcohol or drug) recovery program or impaired practitioner program for treatment of drug or alcohol abuse? Yes No

If a "Yes" response was provided to any of the questions in this section, provide the following documents directly to the board office:

A letter from a Licensed Health Care Practitioner, who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

A written self-explanation, identifying the medical condition(s) or occurrence(s); and current status.

Name: _____

7. DISCIPLINE HISTORY

A. Have you ever been denied or is there now any proceeding to deny your application for any health care license to practice in Florida or any other state, jurisdiction, or country? Yes No

B. Have you ever been denied a license/certificate to practice speech-language pathology and/or audiology or renewal thereof in any state, U.S. territory, or foreign country? Yes No

C. Have you ever had disciplinary action taken against your license to practice any health care related profession by the licensing authority in Florida or in any other state, jurisdiction, or country? Yes No

D. Have you ever had any license/certificate to practice revoked, suspended, or otherwise acted against (including probation, fine, reprimand, or surrender in lieu of disciplinary action) in a disciplinary proceeding in any state, U.S. territory, or foreign country? Yes No

E. Have you ever surrendered a license to practice any health care related profession in Florida or in any other state, jurisdiction, or country while any such disciplinary charges were pending against you? Yes No

F. Is there a complaint currently pending against you in any jurisdiction, or an investigation of your professional conduct or competence in any profession? Yes No

G. Do you have any disciplinary action pending against your license? Yes No

If you responded "Yes" to questions in this section, complete the following:

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				Y N
				Y N
				Y N

If you responded "Yes" to questions above, you must provide the following:

A written self-explanation, describing in detail the circumstances surrounding the disciplinary action.

A copy of the **Administrative Complaint** and **Final Order**.

H. Are you now or have you ever been a defendant in civil litigation in which the basis of the complaint against you was alleged negligence, malpractice, or lack of professional competence? Yes No

If you responded "Yes," you must provide the following:

A written self-explanation, describing in detail the circumstances surrounding the litigation.

A copy of the **Complaint** and **any Orders**.

Name: _____

8. CRIMINAL HISTORY

Have you **ever** been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld.

Reckless driving, driving while license suspended or revoked (DWSLR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question. Yes No

If you responded "Yes" to this question, complete the following:

Offense	Jurisdiction	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				Y N
				Y N
				Y N

If you responded "Yes" to this question, you must provide the following:

A written self-explanation, describing in detail the circumstances surrounding each offense; including date, city and state, charges and final results.

Final Dispositions and **Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.

Completion of Sentence Documents. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

Name: _____

9. CRIMINAL AND MEDICAID / MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), F.S.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under chapter (ch.) 409, F.S. (relating to social and economic assistance), ch. 817, F.S. (relating to fraudulent practices), ch. 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? Yes No

   If you responded "No" to the question above, skip to question 2.

   a. If "Yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence, and completion of any subsequent probation? Yes No

   b. If "Yes" to 1, for the felonies of the third degree, has it been more than ten years from the date of the plea, sentence, and completion of subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), F.S.)? Yes No

   c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), F.S., has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation? Yes No

   d. If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed (if "Yes" provide supporting documentation)? Yes No

2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? Yes No

   If you responded "No" to the question above, skip to question 3.

   a. If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended? Yes No

3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to s. 409.913, F.S.? Yes No

   If you responded "No" to the question above, skip to question 4.

   a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? Yes No

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? Yes No

   If you responded "No" to the question above, skip to question 5.

   a. Have you been in good standing with a state Medicaid program for the most recent five years? Yes No

   b. Did termination occur at least 20 years before the date of this application? Yes No

Name: _____

5. Are you currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities (LEIE)? Yes No

   a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? Yes No

   b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? Yes No

If you responded "Yes" to any of the questions in this section, you must provide the following:

A written self-explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation.

Supporting documentation including court dispositions or agency orders where applicable.

Documents in sections 6, 7, 8, and 9 may be submitted to the board office via the online upload system at https://mqaonline.doh.state.fl.us/datamart/voservicesportal/, via email at info@floridasspeechaudiology.gov, or mailed to:

Board *of* Speech-Language Pathology & Audiology
4052 Bald Cypress Way Bin C-06
Tallahassee, FL 32399-3256

10. APPLICANT SIGNATURE

I, the undersigned, state that I am the person referred to in this application for licensure in the state of Florida. I have carefully read the questions in the application and have answered them completely, without reservation of any kind, and I state that my answers and all statements made by me herein and in support of the application are true and correct.

I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to s. 456.067, F.S.

Florida law requires me to immediately inform the board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed.

I acknowledge that the practice of speech-language pathology and audiology in Florida is governed by ch. 456 and 468, Part 1, F.S., and Rule ch. 64B20, F.A.C. I understand that I am under a continuing obligation to understand and keep informed of any changes to ch. 456 and 468, Part 1, F.S., and Rule ch. 64B20, F.A.C.

Section 456.013(1)(a), F.S., provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant Signature _____ Date _____
You may print this application and sign it or sign digitally. MM/DD/YYYY

If you have a change of address, you must provide written notification to the board office. Include your full name, old address, new address, and whether you are changing your mailing address or your physical location address.

Complete verifications must be sent directly from the licensing agency to the board office at info@floridasspeechaudiology.gov, or mailed to:

Board *of* Speech-Language Pathology & Audiology
4052 Bald Cypress Way Bin C-06
Tallahassee, FL 32399-3256

Board *of* Speech-Language Pathology & Audiology

Verification of Employment (SPA-2A)

Applicant Name: _____

Select the appropriate license type:			
	Speech-Language Pathologist		Audiologist

License Number: _____

The remainder of this form is to be completed by the supervising licensed speech-language pathologist/audiologist verifying the employment.

Supervisor Name: _____

Select the appropriate license type:			
	Speech-Language Pathologist		Audiologist

License Number: _____

Business Address: _____

Business Telephone: _____

Office or Agency where experience will take place: _____

Certification:

I understand that pursuant to chapter (ch.) 468.1155(1), Florida Statutes (F.S.), a provisional license is required prior to the above-named applicant initiating the professional employment experience.

I certify that the professional employment shall include assessment, habilitation, and rehabilitation activities with the clients. The activities performed by the provisional licensee will be monitored and evaluated by an individual with an active license in the same area for which provisional licensure is being sought.

I acknowledge receipt of ch. 468, Part I, F.S., and related rules and further acknowledge that I have read these regulations. I understand that it is my responsibility to keep informed of any changes to ch. 468, Part I, F.S., and related rules.

I certify that the above information is true and correct to the best of my knowledge.

Supervisor Signature: _____ Date: _____
MM/DD/YYYY

Complete verifications must be sent directly from the licensing agency to the board office at info@floridasspeechaudiology.gov, or mailed to:

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4052 Bald Cypress Way Bin C-06
Tallahassee, FL 32399-3256

Board *of* Speech-Language Pathology & Audiology
License Verification Request

Part I: To be completed by applicant (Florida requires verification of all your current and previously held licenses.)

Name: _____

Address: _____

Name original license was issued under: _____

License Number: _____ State: _____

I hereby authorize release of any information regarding my licensure status to the Florida Board of Speech-Language Pathology & Audiology.

Applicant Signature: _____ Date: _____
MM/DD/YYYY

Part II: To be completed by state licensing agency

All verifications must be in English and include the following criteria:

* Typed on an official state form or letterhead
* Include an official board seal
* Signature and title of state board official

The following information must be included in all verifications:

* Licensee name
* License number
* State or jurisdiction of licensure
* Licensure status
* Is license in good standing?
* Date of issuance/expiration
* Licensure method (examination or endorsement)
* Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)?
* If this license has ever been encumbered, please provide certified copies of documentation regarding the action with the completed license verification.