



SLP/Aud Licensing
Health Occupations Program
 P.O. Box 64882
 St. Paul, MN 55164-0882
 Ph: (651)201-3726
 FAX: (651)201-3839

(For MDH Office Use Only)
 Date Received _____

Minnesota Speech-Language Pathologist & Audiologist Licensing Application

Please type or print legibly in black or blue ink (pencil is not acceptable)

- A. I hold or have held a temporary license in the State of Minnesota? ___Yes - #_____. No___.
- B. I have previously held registration/licensing in the State of Minnesota as Speech-Language Pathologist or Audiologist ___Yes - #_____. No___.
- C. My application is for Licensing as (check one only): ___Speech-Language Pathologist; ___Audiologist; ___Dual. If applying for audiology or dual licensing did you take and pass the Hearing Instrument Dispenser practical examination? ___Yes - Date: _____. No___.
- D. I am applying for licensing using method (circle one only): 1-Current CCC; 2-Reciprocity; 3-CCC Eligibility (See instructions.) If applying by method 1, date information was requested from ASHA or ABA: _____.
 If applying by method 2, name of state upon which your reciprocity request is based: _____.
 Date information requested: _____.

GENERAL INFORMATION

1. Name _____
 CHECK ONE: DR ___ MR. ___ MRS. ___ MS. ___ (LAST) (FIRST) (MIDDLE)
2. Have you ever used another name under which records may be filed concerning your application, including your education, training or experience? ___Yes ___No If yes, please list names(s) used.

3. a. Home Mailing address _____
 (STREET ADDRESS. P O BOX IS NOT ACCEPTABLE AS HOME ADDRESS)
 b. _____
 (CITY) (STATE) (ZIP) (COUNTY)
 c. Home Telephone _____ E-Mail Address _____
 (AREA CODE) (NUMBER)
4. a. Current Employer: _____
 b. Employer address: _____
 (STREET ADDRESS. P.O. BOX ALONE IS NOT ACCEPTABLE.)
 c. _____
 (CITY) (STATE) (ZIP) (COUNTY)
 d. Employer Telephone Number _____ Fax Number _____
 (AREA CODE) (NUMBER)
5. Please circle the address at which you would like to receive correspondence from the Department: Home Employer Other (please indicate) _____
 * Please note that this address will be disclosed to anyone requesting it pursuant to Minnesota Statutes, § 13.41, Subd. 2
6. a. Male ___ Female ___ ; b. Date of Birth _____
7. Social Security Number _____ This information is required by M.S. 270.72, Sub4

Applicants Name _____

PROFESSIONAL BACKGROUND

8. Did you complete any part of the clinical fellowship or doctoral externship in Minnesota? ____ Yes ____ No

If yes, indicate dates: _____
(MM/DD/YY) THROUGH (MM/DD/YY)

9. List all employment in which you practiced speech-language pathology or audiology for the last five years. List your current employer first, and then next most recent employer. If the employer is a placement service or provides employment in more than one state, please indicate the employer's address and describe and explain on page 7 the actual states where you worked for that employer. List any employment in which you were self employed. Use page 7 and additional sheets if necessary.

EMPLOYER ADDRESS (STREET OR P.O. BOX, CITY, STATE, ZIP) TELEPHONE NUMBER (INCLUDE AREA CODE) MM/DD/YY-MM/DD/YY

10. Do you hold or have you ever been issued a credential as a Speech-Language Pathologist or Audiologist in another state? ____ Yes ____ No (If you have a teaching credential, check "Yes.")

If yes, please identify the state(s), the current status, the date(s) of issuance and any Identification number(s) used in relation to your permit, license or other credential. Use page 7 and additional sheets if necessary.

<u>State</u>	<u>Current Status</u>	<u>Date of Issuance</u>	<u>I.D. #'s</u>

11. For each state in which you hold or have held a credential as a speech-language pathologist or audiologist (including teacher credentials), you must submit the form "Speech-Language Pathologist or Audiologist Verification of Credential" (included in your application packet). Mail the form to the State credentialing board or agency with any required fees, and request that they send the completed form directly to the Health Occupations Program of the Minnesota Department of Health. The forms must have original signatures. Copies and faxes of signatures are unacceptable. You may photocopy the form, if additional forms are needed. If the verifying agency does not use the verification form, you must request a letter from the appropriate person in the state which provides the following information: your name, date of issuance of your credential, date of expiration of your credential, credential number, current status of your credential, and an affirmative statement about whether any discipline is pending or has been taken against you. Verification letters should be sent to: Minnesota Department of Health, Health Occupations Program, SLPA Licensing, P.O. Box 64882, St. Paul, MN 55164-0882.

NOTE: Applicants who are applying for licensing by reciprocity must request that the credentialing state also provide a copy of the state statute or administrative rule which describes the qualifications for your credential at the time your credential was issued.

Date you requested the verifications described above: _____.

Applicants Name _____

12. Is action being taken against you or has action ever been taken against you or your legal authorization to practice speech-language pathology or audiology in this or another state either through denial of application, revocation, suspension, restrictions, limitations, conditions, reprimand, civil penalty, or any other means (including Stipulation and Consent Orders and Determinations)? _____ Yes _____ No

If yes, please explain the reason for the action, action taken and name the state, address of Credentialing authority in possession of your record, dates, and party or parties involved in the action. Use page 7 and additional sheets if necessary.

13. Do you now hold or have you ever been issued a credential (e.g. a permit, registration, certification or license) to dispense hearing instruments in this or another state? _____ Yes _____ No

If yes, please identify the state(s), the current status, the date(s) of issuance and any identification number(s) used in relation to your credential. Use Page 7 and additional sheets if necessary.

<u>STATE</u>	CURRENT STATUS	DATE OF ISSUANCE	I.D. #s
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

14. Is action being taken against you or has action ever been taken against you or your legal authorization to dispense hearing instruments in this or another state either through denial of application, revocation, suspension, restrictions, limitations, conditions, reprimand, civil penalty, or any other means (including Stipulation and Consent Orders and Determinations)? _____ Yes _____ No

If yes, please explain the reason for the action, action taken, and name the state, address of credentialing authority in possession of your record, dates, and party or parties involved in the action. Use page 7 and attach additional sheets if necessary.

15. For each state in which you hold or have ever been issued a credential (e.g. a permit, registration, certification or license) to dispense hearing instruments (**not including MN**), you must submit a letter from the appropriate person in the state, which provides the following information: your name and date of birth, date credential issued, credential number, current status of your credential and a statement about any disciplinary action pending or taken against you, if any.

16. Have you been convicted, within the last five years, of a felony or misdemeanor which relates to hearing instrument dispensing or which involved an essential element of dishonesty? _____ Yes _____ No

If yes, give a statement supplying full details including the crime(s) of which you were convicted, date(s), name(s) and location of court(s) and case number(s). Use page 7 and additional sheets if necessary.

17. Have you ever been subject to a state or federal court order or judgment issued to manage your activities in dispensing hearing instruments? (Include conciliation court orders) _____ Yes _____ No. If yes, please explain on Page 7.

18. Have you ever violated a state or federal court order or judgment issued to manage your activities in dispensing hearing instruments? _____ Yes _____ No. If yes, please explain on Page 7.

19. Do you have any criminal charges pending against you? _____ Yes _____ No.
If yes, provide a statement giving full details on page 7.

If you answered yes to question(s) 17 through 19 please explain on Page 7 and use additional sheets if necessary.

20. Have you been convicted, within the last five years, of a felony or misdemeanor which related to the practice of speech-language pathology or audiology or which involved an essential element of dishonesty? _____ Yes _____ No

If yes, provide a statement giving full details on page 7, including the crime(s) of which you were convicted, date(s), name(s) and location of court(s) and case number(s).

21. Have you engaged in, or aided and abetted another in engaging in, or had someone act on your behalf in any of the following conduct?

Yes No

- a. _____ intentionally submitted false or misleading information to the Commissioner or the advisory council;
- b. _____ failed, within 30 days, to provide information in response to a written request by the Commissioner or advisory council;
- c. _____ performed services of a speech-language pathologist or audiologist in an incompetent or negligent manner.
- d. _____ violated, aided or abetted another person in violating any provision of Minnesota Statute, §§148.511 to 148.5198;
- e. _____ failed to perform services with reasonable judgment, skill or safety due to the use of alcohol or drugs, or other physical or mental impairment;
- f. _____ failed to cooperate in an investigation conducted by the Health Department;
- g. _____ advertised in a manner that is false or misleading;
- h. _____ engaged in conduct likely to deceive, defraud, or harm, the public; or demonstrated a willful or careless disregard for the health, welfare, or safety of a client;
- i. _____ failed to disclose to the consumer any fee splitting or any promise to pay a portion of a fee to any other professional other than fee for services rendered by that professional to the client;
- j. _____ engaged in abusive or fraudulent billing practices, including violations of federal Medicare or Medicaid laws, Food and Drug Administration regulations or state medical assistance laws;

Applicants Name _____

(Question number 21 continued)

Yes No

- k. ___ ___ obtained money, property, or services from a consumer through use of undue influence, high pressure sales tactics, harassment, duress, deception or fraud;
- l. ___ ___ performed services for a client who had no possibility of benefiting from the services;
- m. ___ ___ failed to refer a client for medical evaluation or to other health care professionals when appropriate, or when a client indicated symptoms associated with diseases that could be medically or surgically treated;
- n. ___ ___ used the term doctor of audiology, doctor of speech-language pathology, A.u.D., or SLP.D., without having obtained the degree from an institution accredited by the North Central Association of Colleges and Secondary Schools or the American Speech-Language-Hearing Association.
- o. ___ ___ failed to comply with the requirements of section 148.5192 regarding supervision of speech-language pathologist assistants.
- p. ___ ___ if applying as an audiologist, failed to comply with the standards of practice for hearing instrument dispensing listed in 148.5195, Subd. 3, (20)

If you answered yes to any part of Question number 21 please give full details on Page 7 and additional sheets if necessary.

APPLICANT AFFIRMATION: The information I have provided in this application is true and accurate to the best of my knowledge and belief. I have read and will comply with the requirement of Minnesota Statutes, §148.5811 through 148.5198.

SIGNATURE

DATE

RECORDS WAIVER AUTHORIZATION AND RELEASE

I HEREBY AUTHORIZE THE COMMISSIONER OF THE MINNESOTA DEPARTMENT OF HEALTH or the Commissioner's designee to obtain, and authorize the person to whom this authorization is presented to release, any and all information contained in the license, registration, permit or other credentialing records in this or any other state where I have practiced speech-language pathology or audiology or where I have dispensed or have authorization to dispense hearing instruments.

This authorization also allows the Commissioner or the Commissioner's designee to make summaries or photocopies of all or any portion of any records pertaining to my authority to practice speech-language pathology or audiology or to my dispensing of or authorization to dispense hearing instruments in this or any other state. A photocopy of this authorization may be considered to be as valid as the original.

MINNESOTA GOVERNMENT DATA PRACTICE ACT NOTICE. This notice is given pursuant to Minnesota Statute, §13.04, Subd. 2, and §13.41, Subd. 2. The Commissioner of the Minnesota Department of Health (Commissioner) will use information provided in this application to determine if you meet Minnesota Statutes, §148.511 through 148.5198 requirements for licensing. You are not legally required to supply the requested information. However, **FAILURE TO PROVIDE INFORMATION OR THE SUBMISSION OF FALSE OR MISLEADING INFORMATION MAY DELAY THE PROCESSING OF YOUR APPLICATION OR MAY BE GROUNDS FOR DENYING YOUR APPLICATION.** All data, except your name and address, submitted by you or on your behalf are considered private until you are registered. "Private" data are not public. Private data are accessible to you. *When you become registered the application data, except social security number, becomes public and will be released to persons who request the public data..* Information submitted to the Commissioner in this licensing application may, in some circumstances, be disclosed to other persons or entities including the Minnesota Department of Health and its staff, the Speech-Language Pathologist and Audiologist Advisory Council and its staff; staff of the Attorney General's Office; and persons whom they contact including any person to whom the Commissioner must refer the application or parts thereof for verification purposes or for otherwise determining your qualifications, to persons you designate, and to persons who request the public data. In addition, if the matter of your licensing becomes contested and thereby results either in a contested case hearing or litigation, the data submitted by you or on your behalf may also become accessible to the Minnesota Office of Administrative Hearings, appropriate courts, and those associated with such proceedings, and thereby become public data.

Dated this _____ day of _____, _____ (year).

Signature

Name typed or printed

Address (street address)

City, State, Zip Code.

