



**SLP/A 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

**SLP/Aud Temporary License Application: Persons Credentialed by ASHA, ABA or Other States**

MINNESOTA GOVERNMENT DATA PRACTICE ACT NOTICE. This notice is given pursuant to Minnesota Statutes, §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 to 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 licensed. *Once you become licensed, all application data except your Social Security Number and non-designated address become public and will be released to anyone upon request.* Information in your application may, in some circumstances, be disclosed to other Minnesota Department of Health staff, the Speech-Language Pathologist and Audiologist Advisory Council, the Minnesota Attorney General’s Office, and any person to whom the Commissioner must refer your application for verification or to otherwise determine your qualifications. Application data may also be disclosed to an appropriate person or agency to prevent a clear and present danger. If you contest the Commissioner’s decision regarding your license, resulting in a contested case hearing or litigation, your application data becomes accessible to the Minnesota Office of Administrative Hearings, appropriate courts, and those associated with such proceedings, and may become accessible to the public.

**INSTRUCTIONS:** To obtain a Temporary License, complete and sign Part I of this form and mail it to the Health Occupations Program at the above address along with a check or money order for \$50.00 if applying for speech-language pathology temporary license or \$79.00 if applying for audiology temporary license. Make your check or money order payable to Treasurer, State of Minnesota. Include a copy of your current ASHA or ABA certification or a credential from another state in which you are registered, certified or licensed. If you are applying for audiology licensing, you must take and pass the hearing instrument dispenser practical examination before you are eligible for licensing. If you have not taken and passed the examination and you want to dispense hearing instruments with a temporary audiology license, you must be supervised by a licensed audiologist who dispenses hearing instruments, and you must have the supervisor complete Part II of this application.

**PART I. To be completed by Applicant**

PLEASE PRINT OR TYPE:

Application for Temporary Licensing as (check one):  Speech-Language Pathologist  Audiologist  Dual

Applicant Name: \_\_\_\_\_  
Last Name First Name Middle Name

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 name(s) used. \_\_\_\_\_

Home Address: \_\_\_\_\_ Home Telephone: (\_\_\_\_) \_\_\_\_\_  
Street

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

Email Address \_\_\_\_\_ Fax Number \_\_\_\_\_

Employment/Business Name: \_\_\_\_\_ Telephone:(\_\_\_\_) \_\_\_\_\_

Employment Address: \_\_\_\_\_  
Street

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

Employment Start Date: \_\_\_\_\_ Position Title: \_\_\_\_\_

Designated address at which you would like to receive correspondence regarding your license from the MDH/Health Occupations Program and which is public data (check one only):

Home  Employment  Other (please specify) \_\_\_\_\_

**PART I. To be completed by Applicant, Cont'd.**

If applying for temporary Audiologist licensing, have you passed the Minnesota practical examination for hearing instrument dispensing required under Minnesota Statute Section 148.515, Subd. 6 (c)? \_\_\_ Yes \_\_\_ No \_\_\_ N/A. If no, you must obtain a supervisor and complete Part B below in order to dispense hearing instruments with a temporary Audiology license.

**APPLICANT AFFIRMATION OF UNRESTRICTED CREDENTIAL:** I hereby make application for a temporary license. I understand that a temporary license expires 90 days after issuance and that to continue practicing and using a protected title, I must apply for and obtain either 1) a renewal of my temporary license or 2) full licensed status as a speech-language pathologist and/or audiologist. By signing below, I certify that:

- 1) I have read and will comply with the requirements of Minnesota Statutes §§148.511 to 148.5198;
- 2) I am not the subject of a pending investigation or disciplinary action for speech-language pathology or audiology practice in this or any other state or by the American Speech-Language Hearing Association (ASHA), and;
- 3) I have not been the subject of a disciplinary action for speech-language pathology and/or audiology practice in this or any other state or by the American Speech-Language Hearing Association and/or American Board of Audiology.

I understand that approval of a temporary license and status as a temporary licensee creates no rights to or expectation of approval of the Minnesota Department of Health for a license as a speech-language pathologist and/or audiologist.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

**PART II. To be completed by Supervisor**

PLEASE PRINT OR TYPE:

\_\_\_\_\_  
Name of Supervisor

\_\_\_\_\_  
Supervisor's Minnesota Audiology License #  
or Other State Audiology-dispensing #

Employment/Business Name: \_\_\_\_\_

Employment

Address: \_\_\_\_\_  
Street City State Zip

Telephone: (\_\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_\_) \_\_\_\_\_

Employment Start Date: \_\_\_\_\_

Hearing Instrument Dispenser Certification # if Certified \_\_\_\_\_.

**SUPERVISOR AFFIRMATION:** I certify that I am a Licensed audiologist in the State of Minnesota and will be the supervisor of the above-named applicant who has applied for temporary licensing. I have read Minnesota Statutes, § 148.5161 and will provide supervision consistent with Subdivision 3. I understand that temporary licensing expires 90 days from issuance. Furthermore, I understand that I am the responsible supervisor for the above applicant until the Minnesota Department of Health receives my written and signed statement that I wish to cease supervision or until expiration of temporary licensing.

\_\_\_\_\_  
Signature of Supervisor

\_\_\_\_\_  
Date

**Upon request, this information will be made available in alternative format; for example, large print, braille, or cassette tape.**

Revised 6/2009