



SLP/A Licensing
Health Occupations Program
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 St. Paul, MN 55164-0882
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(For MDH Office Use Only)
 Date Received

SLP/Aud Temporary License Application: Clinical Fellowship, Doctoral Externship

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 §§148.5161 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: Temporary License Applicants complete and sign Part I of this form. The licensed speech-language pathologist (SLP) or audiologist (AUD) who will be your Supervisor must complete and sign Part II of this form. When complete, mail this form with an official transcript from the educational institution where you completed your SLP or AUD education and a check or money order in the amount of \$150.00 if applying for speech-language pathology license or \$326.00 if applying for audiology license (or appropriate prorated amount) made payable to the *Treasurer, State of Minnesota* to the Health Occupations Program at the address listed above. If your temporary license period will be less than 18 months, contact us for the correct amount. If you are an audiology clinical fellowship or doctoral externship applicant, and you will dispense hearing aids, your supervisor must have passed the practical examination for hearing instrument dispensers, unless exempt under Minnesota Statute §148.515, Subd. 6 (c).

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: _____
Street City State Zip

Home Telephone:(_____) _____ Email Address: _____

Employment/Business Name: _____

Employment Address: _____
Street City State Zip

Telephone Number:(_____) _____ Fax Number:(_____) _____

Employment Start Date: _____ Position Title: _____

Will you be dispensing hearing instruments during your fellowship or externship: Yes No

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) _____

APPLICANT AFFIRMATION: I hereby make application for Temporary Licensing. I have completed the Master's or doctoral degree educational requirements for licensing as described in Minnesota Statutes, § 148.515, Subd. 2 and Subd. 3. I understand that as a temporary licensee I must practice under the supervision of a speech-language pathologist or audiologist who is licensed by the State of Minnesota or who holds a current certificate of clinical competence from the American Speech-Language Hearing Association (ASHA) or current board certification from the American Board of Audiology (ABA).* I understand that temporary licensing expires eighteen months from issuance and that to continue using a protected title after the expiration of temporary licensing I must apply for and obtain either 1) a renewal of my temporary licensing or 2) full licensing status as a speech-language pathologist or audiologist. I understand that approval of temporary licensing and status as a temporary licensee creates no rights to or expectation of approval of the Minnesota Department of Health for licensing as a speech-language pathologist or audiologist. By signing below, I certify that I have read and will comply with the requirements of Minnesota Statutes, § 148.5161.

Applicant Signature Date

Audiology applicants only: I understand that I must pass the practical exam for hearing instrument dispensing before I am eligible for full audiologist licensing

Audiology Applicant Signature Date

PART II. To be completed by Supervisor

PLEASE PRINT OR TYPE:

Name of Supervisor Minnesota License # OR ASHA /ABA Acct. #

Employment/Business Name: _____

Telephone: (____) _____ Fax Number: (____) _____

Employment Address: _____
Street City State Zip

Employment Start Date: _____

Have you passed the Minnesota practical examination for hearing instrument dispensing or were you exempt under Minnesota Statute Section 148.515, Subd. 6 (c)? Yes No

Hearing Instrument Dispenser Certification # if Certified _____.

The Speech Language Pathology and Audiology Advisory Council of the Minnesota Department Health recommends that the supervisor has at least 1 year of experience. Please carefully read the "Supervisor Affirmation" statement below.

SUPERVISOR AFFIRMATION: I certify that I am a Licensed speech-language pathologist or audiologist in the State of Minnesota or that I hold a current certificate of clinical competence from the American Speech-Language Hearing Association (ASHA) or current board certification by the American Board of Audiology (ABA)* 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 eighteen months 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

If the Supervisor is not licensed by the State of Minnesota, documentation of the Supervisor's current certificate of clinical competence or board certification must be provided by ASHA or ABA prior to approval of temporary licensing.

Waiver

Under the Minnesota Government Data Practices Act, Minnesota Statutes, Chapter 13, all information received as part of an active investigation is confidential data. If my application for temporary licensing as a speech-language pathologist or audiologist is approved, I hereby authorize the Minnesota Department of Health (“Department”) to notify my supervisor in the event the Department receives a complaint against me concerning an act or omission related to the provision of speech-language pathology or audiology services.

By signing below, I waive any privilege afforded to me by the law relating to the disclosure of complaint information and allegations. I further release the Department, its agents or employees from liability for releasing complaint information and allegations to my supervisor. This waiver shall remain in effect until the approved temporary licensing expires, is revoked, or suspended, or until the temporary licensee or approved supervisor listed on this application notifies the Department, in writing, that supervision has been withdrawn.

Applicant Signature

Date

First Name and Last Name (Printed)

Home Address

City, State, and Zip Code

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Revised June 2009