

# Clinical Fellowship or Doctoral Externship License Speech Language Pathologist (SLP)/Audiologist (Aud)

## INSTRUCTIONS AND APPLICATION CHECKLIST

- Your application will not be approved until it clears the criminal background study per [Minnesota Statute 144.0572](#).
- It will take Minnesota Department of Health (MDH) **one to two weeks** to review your SLP/Aud Clinical Fellowship/Doctoral Externship application for approval. To ensure that your application is processed in a timely manner, complete all the steps in this checklist.
- MDH will not begin the application review and approval process until we receive: 1) a completed and signed application; 2) all requested documentation; and 3) license fee payment.
- Any applications mailed 30 days after the date of signature on the application will be returned to you to confirm that provided information is still current.
- If a question on the application doesn't apply to you mark your answer as "N/A." Do not leave any questions blank.
- If you are approved for an SLP/Aud Clinical Fellowship/Doctoral Externship, you will receive a letter in the mail from MDH confirming your licensure, along with your license card.

### For Audiology Applicants Only:

- *As of August 1, 2005, all applicants applying for full audiologist licensing must achieve a passing score on the practical exam for hearing instrument dispensing.*
- *If you haven't passed the Minnesota practical examination for hearing instrument dispensing, you must be supervised by a licensed audiologist who is authorized to dispense hearing instruments in order for you to dispense with a Doctoral Externship. The supervisor must complete and sign Part II of this application.*
- *Your supervisor must have passed the practical examination for hearing instrument dispensers, unless exempt under Minnesota Statute, Section 148.515, subd.6(c). If the audiologist that will be your supervisor is not authorized to dispenser, you can only provide audiology services.*
- *For more information about the practical exam, contact (651)201-4200 or [health.hidexam@state.mn.us](mailto:health.hidexam@state.mn.us)*

### Renewing Your SLP/Aud Clinical Fellowship or Doctoral Externship

- You can use this application to apply for a SLP/AUD Clinical Fellowship/Doctoral Externship renewal.
- Per [Minnesota Statute, section 148.5161, subdivision. 5](#), you can renew your Clinical Fellowship/Doctoral Externship license once.
- If you are planning on renewing your Clinical Fellowship/Doctoral Externship, start this process 15 to 30 days before your license expires.
- Per [Minnesota Statute, section 148.5175, subdivision. C](#), clinical fellowship or doctoral externship licensed applicants must submit a letter requesting a renewal. The letter must state the reason for the renewal by showing good cause. Good cause includes but is not limited to inability to take and complete the required practical exam for dispensing hearing instruments.

**APPLICATION CHECKLIST:**

Print this document and check off the instructions as you complete them.

- Criminal Background Study submitted at same time as with licensing application: <https://www.health.state.mn.us/facilities/providers/docs/backgroundstudy.pdf>
- Complete, sign and date Part I of the application.
- Have your supervisor complete and sign Part II.  
**Note: If you have more than one employer and/or supervisor, fill out an application for each additional employer and/or supervisor.**
- Complete, sign, and date the records Waiver & Release form.
- Make a copy of the application and all supporting documents for your records.
- Enclose check or money order for the appropriate amount (see payment information below) and make check payable to: Treasurer, State of Minnesota.  
When MDH receive fee payments, they are deposited immediately. All fees are non-refundable.

Type of License	License Fee (18 Months)		
SLP Temporary	\$150		
Aud Temporary	\$383		

- Contact the school where you completed your degree and request an official transcript to be sent directly to you. If you have recently graduated and a transcript is not yet available to verify your degree, we will accept an unopened/sealed envelope with your letter from the academic department chair or program director documenting that the applicant has completed coursework equivalent to or exceeding a master’s degree with your graduation date or that the applicant is eligible for enrollment in current doctoral externship credit (Minnesota Statute, section 148.5161, subdivision. 3 (d).) on letterhead. We will accept electronic letters from the academic department chair or program director if e-mailed directly to [health.slpa@state.mn.us](mailto:health.slpa@state.mn.us).  
Note: We will not accept a transcript or letter unless it is in an unopened, sealed envelope from your school.
- Mail completed original application, supporting documents, and the fee payment to MDH

**Mail to:**

Mail
Minnesota Department of Health Health Occupations Program Attn: SLP/Aud Licensing PO Box 64882 St. Paul, MN 55164-0882

**Credential Lookup:**

While you are waiting for your Clinical Fellowship/Doctoral Externship approval letter, you can see if your license has been issued on our [Health Occupations Program Credential Lookup](#) web site. This website is updated daily. Your name will appear on our website the day after your license has been issued.

**Once you receive your Clinical Fellowship/Doctoral Externship License approval from MDH:**

Provide your supervisor(s) a copy of your license approval letter. MDH does not notify supervisors or employers when license applications are approved.

**Questions:** If you have any questions about the application process or submitting the required documents, please email [health.slpa@state.mn.us](mailto:health.slpa@state.mn.us) or call (651) 201-4200.



## SLP/A: Clinical Fellowship or Doctoral Externship License

**MINNESOTA GOVERNMENT DATA PRACTICE ACT NOTICE.** This notice is given pursuant to Minnesota Statutes, Section 13.04, Subd. 2, and section 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, sections 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.

### PART I: To be completed by applicant only.

Please print and sign clearly in blue ink.

#### SLP/AUD LICENSE STATUS & HISTORY

This is an application for temporary licensing as a:  Speech-Language Pathologist  
 Audiologist  
 Dual (SLP and Aud)

Do you currently have a Minnesota SLP/Aud License?  No  Yes MN SLP/Aud License # \_\_\_\_\_

Is this a renewal of your Clinical Fellowship/Doctoral Externship license?  No  Yes MN SLP/Aud License # \_\_\_\_\_

#### ADDITIONAL EMPLOYMENT INFORMATION

Do you have more than one SLP/Aud supervisor?  No  Yes If yes how many? \_\_\_\_\_

Do you have more than on SLP/Aud employer?  No  Yes If yes how many? \_\_\_\_\_

Do you have more than one SLP/Aud work location  No  Yes If yes how many? \_\_\_\_\_

\*If you answered “Yes” to any of the additional employment questions, fill out a separate application for each additional supervisor, employer and/or work location.

#### PERSONAL INFORMATION

\_\_\_\_\_  
Last Name First Name Middle

\_\_\_\_\_  
Home Address\* City State ZIP

\_\_\_\_\_  
Home Phone Cell Phone Number

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Date of Birth (mm/dd/yyyy) Social Security Number\*

\*Home Address: PO Box address is not acceptable.

\* SSN Required by Minnesota Statute. 270.72C, subdivision 4

Please designate the address at which you will receive correspondence from the Department regarding your license and which will be public information. If you select “Other,” provide MDH with the address below. **The address you select will be public information.**

Home  Employer  Other

\_\_\_\_\_  
Address City State ZIP

Have you ever used another legal name under which records may be filed concerning your application, including your education training or experience? No  Yes  if yes, please list name(s) used:

\_\_\_\_\_  
Last Name First Name Middle

**EMPLOYMENT INFORMATION**

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Employer/ Facility Name: Please provide the name of the facility where you work. Do not include the name of the staffing agency)

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Street Address	City	State	ZIP
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Employer/Facility Phone	Fax
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Employment Start Date (mm/dd/yyyy)	Position Title
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Will you be dispensing hearing instruments during your fellowship or externship?       No     Yes

**AUDIOLOGY APPLICANTS ONLY: I understand that I must pass the practical exam for hearing instrument dispensing before I am eligible for full audiologist licensing.**

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Applicant Signature	Date
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**APPLICANT AFFIRMATION:** *I hereby make application for Clinical Fellowship/Doctoral Externship Licensing. I have completed the Master’s or doctoral degree educational requirements for licensing as described in Minnesota Statutes, Section 148.515, Subd. 2 and Subd. 3. I understand that as a Clinical Fellowship/Doctoral Externship 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 Clinical Fellowship/Doctoral Externship licensing expires eighteen months from issuance and that to continue using a protected title after the expiration of Clinical Fellowship/Doctoral Externship licensing I must apply for and obtain either 1) a renewal of my Clinical Fellowship/Doctoral Externship licensing or 2)full licensing status as a speech-language pathologist or audiologist.*

*By signing below, I certify that:*

- I have read and will comply with the requirements of Minnesota Statute Section 148.5161
- I have read and will comply with the requirements of Minnesota Statutes, sections 148.511 to 148.5198
- 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;
- 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 (ASHA) and or/American Board of Audiology.

*I understand that approval of Clinical Fellowship/Doctoral Externship license and status as a Clinical Fellowship/Doctoral Externship 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*

*I have read and understand the instructions for this application process.*

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Applicant Signature	Date
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**PART II: To be completed by applicant’s supervisor only.**

Please print and sign clearly in blue ink.

Last Name		First Name		Middle
Supervisor’s MN License #		Employment Business Name		
Street Address		City	State	ZIP
Telephone Number		Employer Telephone Number		
Fax Number		Supervisor’s Email Address		
Date Supervisor Started Employment (mm/dd/yyyy)		Hearing Instrument Dispenser (HID) Certification # (if Certified)		

The Speech-Language Pathology and Audiology Advisory Council at the Minnesota Department of Health recommends that the supervisor has at least one year of experience. Please carefully read the “Supervisor Affirmation” Statement provided 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 applicant who has applied for Clinical Fellowship/Doctoral Externship license. I have read Minnesota Statutes, Section 148.5161 and will provide supervision consistent with subdivision 3. I understand that Clinical Fellowship/Doctoral Externship licensing expires within 18 months of issuance. Furthermore, I understand that I am a 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 Clinical Fellowship/Doctoral Externship licensing*

Supervisor’s Signature	Dater
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**WAIVER AND RELEASE**

To be completed by applicant only. Please print and sign clearly in blue ink.

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 a Clinical Fellowship/Doctoral Externship license as speech-language pathologist or audiologist is approved, I hereby authorize the Minnesota Department of Health to notify my supervisor in the event the Department receives a complaint against me concerning an act or omission related to the practice of speech-language pathologist and/or audiologist services.

By signing below, I waive any privilege afforded to me by 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. The waiver will remain in effect until the approved Clinical Fellowship/Doctoral Externship license expires, is revoked or suspended, or until the Clinical Fellowship/Doctoral Externship licensee or approved supervisor listed on the application notified the Department, in writing, that supervision has been withdrawn.

Last Name		First Name		Middle
Applicant’s Home Address		City	State	ZIP
Applicant Signature		Date		