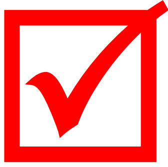

Application Checklist for Speech-Language Pathology and Audiology

Certification of Clinical Competence
U.S. Graduates

If you need assistance, please email the Board at
speechandhearing@dca.ca.gov

1. **Application**
   - Please remember to submit a 2x2 passport quality photograph.

2. **Fees**
   - Please submit a check or money order to the Board in the amount of $60.00, made payable to SLPAHADB.

3. **Verification of Certification Letter from ASHA**
   - Original letter must be mailed from ASHA directly to the Board.

4. **Fingerprints**
   - California applicants are required to use Live Scan for fingerprinting; please submit a copy of the completed form to the Board. Fees are paid directly to the Live Scan operator.

   - Out-of-State applicants are required to submit two fingerprint cards (FD-258) and a check or money order to the Board for $49.00 (DOJ and FBI processing fee). You may request fingerprint cards be mailed to you via email at speechandhearing@dca.ca.gov

   - One (1) check or money order in the amount of $109 ($60 licensing fee and $49 fingerprint processing fees) may be submitted. Please make check or money order payable to SLPAHADB.

NOTE: Except for Audiology students, experience that was completed after June 30, 2003, without holding a RPE temporary license will not be approved. Please refer to the Business and Professions Code section 2532.7(b).

If your certification was issued based on the Mutual Recognition Agreement, you do not qualify for this option. You must apply as a foreign educated applicant.

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.
SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY& HEARING AID DISPENSERS BOARD
2005 EVERGREEN STREET, SUITE 2100, SACRAMENTO, CA 95815
PHONE (916) 263-2666 FAX (916) 263-2668 WWW.SPEECHANDHEARING.CA.GOV

APPLICATION FOR LICENSURE

CERTIFICATE OF CLINICAL COMPETENCE

$60.00

IMPORTANT: You must hold a current Certificate of Clinical Competence (CCC) issued by the American Speech-Language-Hearing Association (ASHA) in order to complete this application. **If your certification was issued under the guidelines of the Mutual Recognition Agreement, you must complete the foreign educated application.**

INSTRUCTIONS: Do not print this application double-sided. Any corrections to this form must be crossed out and initialed. Make check payable to: SLPAHADB

Please check applicable: ☐ Speech-Language Pathologist ☐ Audiologist

PLEASE TYPE OR PRINT NEATLY

1. FULL NAME:	LAST	FIRST	MIDDLE
2. OTHER NAMES YOU HAVE USED (INCLUDING MAIDEN):			
3. ADDRESS:	STREET		
CITY, STATE, ZIP CODE:			
4. RESIDENCE TELEPHONE:		BUSINESS TELEPHONE:	
5. SOCIAL SECURITY NUMBER (SSN) **OR** INDIVIDUAL TAX IDENTIFICATION NUMBER (ITIN):			
6. DATE OF BIRTH: (MM/DD/YYYY)			
7. EMAIL ADDRESS:			
8. ARE YOU, A SPOUSE, OR DOMESTIC PARTNER OF ACTIVE DUTY MILITARY PERSONNEL? YES ☐ NO ☐ If yes, you may qualify for expedited application processing. An applicant for expedited application processing must meet the following requirements: 1) provide evidence that the applicant is married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in California under official active duty orders and; 2) hold a current license in another state, district, or territory of the United States in speech-language pathology or audiology.			
9. ARE YOU AN HONORABLY DISCHARGED VETERAN OF THE ARMED FORCES? YES ☐ NO ☐ If yes, you may qualify for expedited application processing. An applicant for expedited application processing must meet the following requirement: 1) supply satisfactory evidence to the board that the applicant has served as an active duty member of the Armed Forces of the United States and was honorably discharged.			

ATTACH 2" X 2"
PASSPORT QUALITY
PHOTOGRAPH HERE.

MUST BE AN ACTUAL PHOTOGRAPH, NOT A PAPER COPY.

PHOTOGRAPHS MUST BE TAKEN WITHIN 60 DAYS OF THE FILING DATE OF THIS APPLICATION

PRINT YOUR FULL NAME ON THE BACK OF THE PHOTOGRAPH

10. GRADUATE AND UNDERGRADUATE PROGRAMS

INSTITUTION NAME	CITY/STATE	MAJOR FIELD OF STUDY	DEGREE RECEIVED	DATE DEGREE RECEIVED

11. Education:

Master's Degree ☐ Master's Degree Equivalency ☐ Au.D. Degree ☐

12. EMPLOYER:

EMPLOYER'S ADDRESS:

	YES	NO
13. Have you taken the Educational Testing Service (ETS)/National Teacher Examination (NTE) (The Praxis Series) in Speech-Language Pathology or Audiology within the last five (5) years?	☐	☐
14. In what state was your supervised professional experience or Clinical Fellowship Year? State:____ Year________ *If it was completed in California after June 30, 2003, please complete and submit the Required Professional Verification form. Audiologists are exempt under this provision.*		
15. *Audiology Applicants Only*, do you wish to dispense hearing aids? If yes, complete the Hearing Aid Dispenser Written License Examination Application	☐	☐

A YES answer to any of the questions below (16 through 21), requires you to complete and submit the Conviction and Discipline Reporting Form.

	YES	NO
16. Have you ever been the subject of a disciplinary action or have any *pending* disciplinary action taken or charges filed against any speech-language pathology, audiology, hearing aid dispensing, or other healing arts license? Include any disciplinary action taken by any other state or federal government entity? *This includes but is not limited to suspension, revocation, probation, confidential discipline, consent order, letter of reprimand or warning, or any other restriction of actions taken against a license.*	☐	☐
17. Have you had any pending investigations by any state or federal agencies against you?	☐	☐
18. Have you been denied a license to practice speech-language pathology, audiology, hearing aid dispensing, or other healing arts, in any state or country?	☐	☐
19. Have you voluntarily surrendered a license to practice speech-language pathology, audiology, hearing aid dispensing, or other healing arts in another state or country?	☐	☐

		YES	NO
20.	Have you been convicted of, or pled nolo contendere to **any** criminal offense, misdemeanor or felony of any state, the United States, its territories or a foreign country? *(This includes any citation, infraction, misdemeanor and/or felony, excluding violations of minor traffic laws not involving alcohol or drugs which result in fines of $300 or less. Note: Convictions that were later dismissed pursuant to Sections 1203.4, 1203.4a, or 1203.41 of the California Penal Code or equivalent non-California law **must** be disclosed. Convictions that were adjudicated in the juvenile court or convictions under California Health and Safety Code Sections 11357(b),(c),(d),(e), or Section 11360(b) that are two years or older should **not** be reported).* 1203.41. You must also submit a certified copy of any court order dismissing a conviction pursuant to Penal Code Sections 1203.4, 1203.4a, or	☐	☐
21.	Are you required to register as a sex offender pursuant to Section 290 of the Penal Code, or the equivalent in another state or territory, or military or federal law?	☐	☐

You must report to the Board the result of any actions which have been filed or are pending against any speech-language pathology or audiology license you hold at the time of filing this application. Failure to report this information may result in the denial of your application or subject your license to discipline pursuant to Section 480 (c) of the Business and Professions Code.

I hereby certify under penalty of perjury under the laws of the State of California that all statements made herein are true in every respect and that misstatements or omissions of material facts may be cause for denial of this application, or for suspension or revocation of a license.

Applicant's Signature ______________________ Date ____________

Notice: Effective July 1, 2012, the State Board of Equalization and the Franchise Tax Board may share taxpayer information with the Board. You are obligated to pay your state tax obligation and your license may be suspended if your tax obligation is not paid.

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0437
Code assigned by DOJ

Type of Application: (check one) ___Employment _X_License, Certification, Permit ___Volunteer

Job Title or Type of License, Certification or Permit: Speech Pathologist Audiologist Speech Assistant Speech Aide Audiology Aide

PLEASE CIRCLE ONE

Agency Address Set Contributing Agency:

SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS BOARD
Agency authorized to receive criminal history information

06187
Mail Code (five-digit code assigned by DOJ)

2005 Evergreen Street, Suite 2100
Street No. Street or PO Box

N/A
Contact Name (Mandatory for all school submissions)

Sacramento CA 95815
City State Zip Code

( )
Contact Telephone No.

Name of Applicant: ______________________
(Please print) Last First MI

AKA's: ______________________
Last First

CDL No. ______________________

DOB: ____________ SEX: Male Female

Misc. No. **BIL -** Applicant Must Pay At Site
Agency Billing Number (if applicable)

HT: ____________ WT: ____________

Misc. No. ______________________

EYE Color: ____________ HAIR Color: ____________

Home Address: (Applies only if Youth Org/HRA or Public Utility submission)

POB: ______________________

Street or PO Box

SOC: ______________________

City, State and Zip Code

Your Number: 7700 SLP/AU
OCA No. (Agency Identifying No.)

Level of Service DOJ ☒ FBI ☒

If resubmission, list Original ATI No. ____________

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

THIS SECTION IS NOT APPLICABLE
Employer Name

Street No. Street or PO Box

Mail Code (five digit code assigned by DOJ)

City State Zip Code

( )
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: ______________________
Name of Operator

Date ____________

Transmitting Agency

ATI No.

Amount Collected/Billed

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Applicant Submission

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(Please print) Last First MI

AKA's: ______________________________
Last First

CDL No. ______________________________

DOB: ______________ SEX: Male Female

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BCII 8016 (Rev10/98) ORIGINAL-Live Scan Operator; SECOND COPY-Requesting Agency; THIRD COPY-Applicant

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0437
Code assigned by DOJ

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Job Title or Type of License, Certification or Permit: Speech Pathologist Audiologist Speech Assistant Speech Aide Audiology Aide

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Last First

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