Maryland Department of Health
Board of Examiners for Audiologists, Hearing Aid Dispensers and Speech-Language Pathologists
4201 Patterson Avenue, Baltimore, Maryland 21215-2299
Phone: 410-764-4725 Fax: 410-358-0273
TTY – Maryland Relay Service 1-800-735-2258

Application for Full License in Audiology

☐ Applicant must check here if the applicant is a veteran or has received training in the military that is being applied to the education requirements for licensure.

Please Read The Application Checklist Before Completing Application Below:

Affix current photo here

1. Name: _____
Last First Maiden/Middle

Other Names: _____

2. Date of Birth: _____ 3. Social Security #_____

4. Residence: _____
Street Apt. #

_____
City State Zip Code

Telephone #: _____ Alternate #: _____

E-Mail: _____

5. Professional Address: _____
Facility or Company's Name

_____
Street Suite #

_____
City State Zip Code

Telephone #: _____ Fax #: _____

Anticipated Date of Employment _____

For Office Use Only

Received _____ CK ( ) MO ( ) Number _____

April 2020

7. Have you previously been licensed in the State of Maryland? _____

If yes, License Number _____ Expiration Date _____

8. Have applicant ever been convicted of a felony or a misdemeanor involving moral turpitude? _____ No _____ Yes

If "Yes" attach full details with copies of all relevant court documents.

9. Education and Employment

A. Education

School	Location	Attended From – To	Credit Hours	Major	Degree & Date
Undergraduate:					
Graduate:					
Au.D:					

Note: If applicant does not have ABA or ASHA certification, a certified official transcript showing credit hours of special study in the area for which license is desired, documentary evidence of education, and other supporting data must accompany application.

B. Applicant holds Board Certification from the American Board of Audiology? ___Yes___ No

Date Originally Granted _____ Expiration Date _____

C. Applicant holds the American Speech-Language-Hearing Association Certificate of Clinical Competence in Audiology? _____ Yes _____ No

Date Originally Granted _____ Expiration Date _____

(1) Clinical training of 1,000 direct on-site supervised hours completed?

_____Yes ____ No

(2) National Examination in Audiology Passed?

_____ Yes ____ No

If answer to C.(1) is "No", applicant must enclose a summary of professional experience including on site direct supervision hours, facility, supervisor, address and telephone numbers.

Note: Applicants that hold either ABA or CCC certification may proceed to item #11.

Photocopy of certification or letter from issuing agency must accompany application.

D. Employment during clinical training (Clinical Fellowship Year or Clinical Externship Year). Provide the title of position, employer, employer's address, dates of employment, and brief description of duties and responsibilities during clinical training,

_____

_____

_____

Applicant must submit a Form AS2 for each place of employment during the clinical training period.

10. Supervision of Clinical Training

A. Submit **Verification of Supervision for Limited Licensure/Clinical Training (AS2)** or copy of ASHA Clinical Training Report.

B. Submit **Verification of Satisfactory Completion of Clinical Training (AS3)**.

For Individuals Holding or Have Held An Audiology License in Another State

11. Are you now or have you ever been licensed in any other state? _____

If "yes", applicant must complete the first part of the attached Licensure Affidavit, AS4. The remainder of the Licensure Affidavit must be completed by the licensure board and the completed form must be returned to the Maryland Board of Examiners.

Currently licensed in the following states: ____ ____ ____ ____ ____ ____ ____

Previously licensed in the following states: ____ ____ ____ ____ ____ ____ ____

Has any disciplinary action ever been taken against any license you have held in any other jurisdiction?

No _____ Yes _____ **If yes, please attach full explanation (typed).**

12. Notary Attestation

I hereby affirm that I have read Sections § 2-101 to § 2-502 of Title 2 of the Health Occupations Article of the Annotated Code of Maryland and fully understand that in receiving a license from the Board, I bind myself to be governed by the Board.

I understand that in submitting this application that the accompanying fee is for administrative purposes and is not refundable. The fee includes licensure fee.

State of _____

City or County of _____

The undersigned, being duly sworn deposes and says that he/she is the person who executed this application, that the statements herein contained are true to the best of his/her knowledge, that he/she has not suppressed any information that might affect this application and that he/she has read and understands this affidavit.

_____

Signature of Applicant Signature of Notary

Subscribed and sworn to before this _____ day of _____

In accordance with Executive Order 01.01.1093-18, the Board is required to advise you as follows regarding the collection of personal information. Personal information requested by the Board is necessary in determining your eligibility for licensure. Such personal information is also intended for use as an additional means of verifying the licensee's identity or to enable the Board to communicate, in a timely manner, with the licensee should the need arise. The licensee has a right to inspect his personal record and to amend or correct the personal data if necessary.

Your Social Security Number is needed on the application. It will be used for identification purposes and may be released to the Department of Public Safety and Correctional Services to check for any criminal convictions.

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Race/Ethnic Identification

To further its commitment to equal access the Board of Examiners requests applicants to provide, voluntarily, the following information. This information will be used for statistical purposes only by authorized personnel.

Male _____ Female _____

Race/Ethnic Identification – Please Check All That Apply

Are you of Hispanic or Latino origin? ____ Yes ____ No (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

Select one or more of the following racial categories:

1. ___ American Indian or Alaska Native (A person having origins in any of the original peoples of North or South America, including Central America, and who maintains tribal affiliations or community attachment.)

2. ___ Asian (A person having origin in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)

3. ___ Black or African American (A person having origins in any of the black racial groups of Africa.)

4. ___ Native Hawaiian or other Pacific Islander (A person having origins in the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)

5. ___ White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

AUD Full

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Verification of Supervision for Audiology Limited License Clinical Training

1. Applicant (Please Type or Print)

A. Name:_____
Last First Middle/Maiden

B. Address: _____
Street Apt. #

_____
City State Zip Code

Phone: _____ E-Mail: _____

C. Academic Status: _____
University Degree Date Conferred

D. Employment Setting:

1. Facility Name: _____

2. Address: _____
Street Suite #

_____
City State Zip Code

Phone: _____ E-Mail: _____

3. Beginning Date of Employment: _____
Month Day Year

4. How many hours per week spent in Audiology? _____

5. Are you completing a clinical training? _____ Yes _____ No

Form AS2

April 2020

I. Supervisor(s) of Clinical Training (please type or print)

A. Name: _____
Last First Middle/Maiden

B. Address: _____
Street Apt. #

_____
City State Zip Code

Phone: _____ E-Mail _____

C. Place of Employment: _____
Facility Name

_____
Street Suite #

_____
City State Zip Code

Phone: _____ Fax: _____

II. Clinical and Supervisory Responsibility

Applicant Activity	**Hours/Week Spent by Applicant**	**Hours/Month Spent by Applicant**	
		On-Site Observation	**Other Monitoring Activities**
1. Assessment, diagnosis and/or evaluations			
2. Screening			
3. Habilitation/ rehabilitation			
4. Staff Meetings			
5. Supervisory Conferences			
6. In-Service Training			
7. Record Keeping			
8. Other (Must Specify)			
Total			

Signature of Applicant _____ Date _____

Signature of Supervisor _____ Date _____

Supervisor:
( ) Holds ASHA CCC-AUD
( ) Holds MD License in Audiology
( ) Holds License in Audiology in State of _____

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Verification of Satisfactory Completion of Audiology Clinical Training

I hereby declare that _____
Name of Applicant

Address _____

an applicant for Maryland licensure in audiology, was employed as a professional in that

field from _____ to _____ for _____ hours per week.
(mm/dd/yyyy) (mm/dd/yyyy)

The place of employment was _____
Facility Name

_____
Address City State Zip Code

I further declare that the applicant was supervised by _____
Printed Name of Supervisor

At that time the supervisor held:

( ) Maryland License in Audiology
( ) ASHA Certification in Audiology
( ) A License in Audiology from _____
State
whose licensure requirements were equivalent to ASHA certification or ABA certification.

I verify that during the employment period, the applicant reached a satisfactory level of competence in the area in which full licensure is sought.

_____
Signature of Supervisor Title

_____
Current Phone Number Date

Form AS3

April 2020

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Affidavit To Be Completed By Licensure Board

This portion of the form is to be completed by the audiologists. Would you please verify the licensure in your jurisdiction for:

_____
First Name Middle Name Last Name

Date of Birth _____ Social Security Number _____

Graduate of _____ Date _____

This portion of the affidavit to be completed by the Licensure Board.

License No. _____ Date Issued _____

With State Examination _____ Without Examination _____

Is license in good standing? _____ Expiration Date _____

Has the license ever been suspended or revoked? _____ If yes, please explain why:

Attach a separate sheet for explanation

Has it been reinstated? _____

Has any disciplinary action been taken against the license _____If yes, please explain:

Attach a separate sheet for explanation

Is there any derogatory information on file concerning this license _____ If yes, please explain:

Attach a separate sheet for explanation

Signature _____ Date _____

Title _____ AFFIX SEAL OF BOARD HERE

State Board _____ State of _____

Form AS4

April 2020