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 a Limited License as a Speech-Language Pathologist

**Please Read The Application Checklist Before Completing Application Below:**

**1.** Name _____
Last First Middle/Maiden

**Affix current 2x2 passport size photo**

**2.** Home Address _____
Street Apt.

_____
City State Zip Code

**3.** Home Phone_____Alternate #_____

Email _____

**4.** Date of Birth_____Social Security # _____

**5.** Have you previously been licensed in the State of Maryland?_____If yes,

License #_____ Date Expired _____

**6.** Have you ever pled guilty, nolo contendere, or been convicted of or received probation before judgment of any criminal act (excluding minor traffic violations)?_____No_____Yes

If "Yes" you must submit (1) a complete explanation discussing your case(s), subsequent employment, rehabilitation, and/or good conduct, if any, and (2) certified copies of your court documents showing the outcome and underlying facts and circumstances of your case(s) must be submitted for review.

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**FOR OFFICE USE ONLY**

Received_____ CHRC Complete _____

CH ( ) MO ( ) Number_____Date _____

Revised October, 2020

**7. Education**

Graduate School _____

Address_____
Street City State Zip Code

Attended_____to_____Major_____Date Degree Conferred _____

Undergraduate School _____

Address_____
Street City State Zip Code

Attended_____to_____Major_____Date Degree Awarded _____

**8. Department Chair Letter In Lieu of Official Transcript (for recent graduates)**

This section is to be completed by applicants that are recent graduates (up to 60 days after graduation) that are submitting proof of the education requirements with a letter issued by the Department Chair. Department Chair letter must include a statement that the student has completed all coursework and all clinical requirements, the degree conferred date, and the institution's accreditation.

I hereby affirm that I have read Section 2-310.2 of Title 2 of the Health Occupations Article of the Annotated Code of Maryland and Code of Maryland Regulations 10.41.03.03A(2)(a) and that I understand a Master's degree in speech-language pathology is the minimum educational requirement to hold a limited license in speech-language pathology. I hereby agree that I am solely responsible for ensuring that the Board receives an official transcript of my Master's degree within 60 days of the issuance of the limited license. I hereby affirm that I will be subject to the grounds for discipline, specifically Section 2-314(10) "Commits any unprofessional act in the practice of … speech-language pathology." if the Board does not receive an official transcript within 60 days of the issuance of a limited license.

_____ _____
Signature of Applicant Printed Name of Applicant

**9. Employment for Clinical Fellowship Year**

Date_____Title of Position _____

Facility/Company Name _____

Address_____
Street City State Zip Code

Brief description of duties during clinical fellowship year:

_____

_____

_____

_____

_____

**10. Continuing Education Required to Renew A Full License**

This section is to be completed by applicants who are applying for a limited license in speech-language pathology.

I hereby affirm that I understand that pursuant to COMAR 10.41.03.06 the Board has established continuing education requirements to renew a full speech-language pathology license.

I hereby affirm that I understand that the continuing education requirements supersede any private professional association's requirements to maintain a certification or similar title.

I further affirm that I understand that completing continuing education is not a requirement to hold a limited license in speech-language pathology or to renew a limited license in speech-language pathology. However, I affirm that continuing education activities completed during the time a limited license is held may be eligible for the renewal requirements if certain conditions are met.

I hereby affirm that I will be subject to the grounds for discipline, specifically § 2-314(10), "Commits any unprofessional act in the practice of … speech-language pathology" if the minimum continuing education requirements are not completed in the appropriate time frame.

I hereby affirm that I understand that information regarding the continuing education requirements to renew a license is posted to the Board's website.

_____ _____

Signature of Applicant Printed Name of Applicant

**11. Affidavit To Be Completed by a Notary Public**

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*** _____ ***County/City 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 required 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.

Please be advised that the disclosure of your Social Security Number (SSN) is mandatory in order to process your application.

Any license application received at the Maryland Board of Examiners for Audiologists, Hearing Aid Dispensers and Speech-Language Pathologists without a SSN **will not** be processed. An application without a SSN is considered **incomplete**.

The Board is required by federal and Maryland law to collect this information for the following purposes:

Verification of identity with respect to final adverse actions related to your license or certificate (42 U.S.C. § 1320a-7e(b))

Administration of the Child Support Enforcement Program (Md. Family Law Code Ann., § 10-119.3)

Identification by the Maryland Department of Assessments and Taxation of new businesses in Maryland (Md. Health Occ. Code Ann., § 1-210)

Accordingly, the Board, in order to meet all statutory requirements for the issuance of a license, must have a valid Social Security Number on file for every applicant/licensee.

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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, Peurto 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.)

SLP Limited

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**Verification of Supervision for Speech-Language Pathologist**
**Limited License Clinical Fellowship Year**

******Applicant, please check if any of the following apply regarding the submission of this form:***

___ Change in Employment Site ___ Additional Site ___ Change of Supervisor
___ Additional Supervisor ___ Change in Hours

**1. Applicant (Please type or print)**

A. Name:_____
Last First Middle/Maiden

B. Address:

_____
Street

_____
City State Zip Code

Phone:_____Alternate # _____

C. Academic Status:

_____
College Degree Date Conferred

D. Employment Setting:

1. Facility Name: _____

2. Address:_____
Street

_____
City State Zip Code

Phone:_____Fax _____

3. Beginning Date of Employment: _____
Month Day Year

4. Hours per Week spent in Speech-Language Pathology: _____

5. Are you completing a CFY?_____Yes_____No

II. Supervisor During Limited Licensure Year (Print or Type)

A. Name:

_____

Last First Middle/Maiden

B. Address:

_____

Street

_____

City State Zip Code

C. Place of Employment:

_____

Facility Name

_____

Street

_____

City State Zip Code

Phone:_____Alternate #: _____

*III.* Clinical and Supervisory Responsibility – ***80% of total time should be in items 1, 2 and 3***

| **Applicant Activity** | **Hours/Week Spent by Applicant** | **Hours/Month Spent by Supervisor** | |
|---|---|---|---|
| | | **On-Site Observation (at least 4 hour per month)** | **Other Monitoring Activities (optional)** |
| 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 MD License in Speech-Language Pathology with License # _____

( ) Holds ASHA CCC-SLP # _____

**Form AS2**

Revised October, 2020

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# Verification of Satisfactory Completion of Speech-Language Pathologist Clinical Fellowship Year

I hereby declare that,_____,
Name of Applicant
an applicant for Maryland licensure in speech-language pathology, was employed as a professional in that field from_____to_____for _____
(mm/dd/yyyy) (mm/dd/yyyy)
hours per week.

The place of employment was:

_____
Facility Name

_____
Address City State Zip Code

I further declare that the applicant was supervised by:

_____
Name of Supervisor

At that time the CFY supervisor held:

( ) Maryland License in Speech-Language Pathology License, License #_____

( ) ASHA Certification in Speech-Language Pathology Certificate # _____

( ) A License in Speech-Language Pathology from State of _____
whose licensure requirements were equivalent to ASHA certification.

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

_____ _____
Signature of Supervisor Typed or Printed Name

_____ _____ _____
Title Date Current Phone Number

**Form AS3**

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