Reset Form

APPLICATION FOR REGISTRATION FOR SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY CLINICAL FELLOWSHIP YEAR

State Form 50320 (R9 / 9-17)
Approved by State Board of Accounts, 2017

SPEECH LANGUAGE PATHOLOGY AUDIOLOGY BOARD
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, IN 46204
Telephone: (317) 234-2067
E-mail: pla4@pla.IN.gov
www.pla.IN.gov

INSTRUCTIONS:
1. *The fee for this application is $50.00, payable to the Indiana Professional Licensing Agency, in accordance with 880 IAC 1-1-5.*
2. *Completed application and fees should be mailed to the address listed in the upper right hand corner of this form.*
3. *All fees are non-refundable and non-transferable.*
4. *Please refer to the instructions on our website, www.pla.in.gov, for the licensing requirements.*

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is mandatory and this record cannot be processed without it.
** This information is being requested for workforce statistical purposes only; disclosure is voluntary.

FOR OFFICE USE ONLY	
APPLICATION FEE	
DATE FEE PAID *(month, day, year)*	
RECEIPT NUMBER	
CERTIFICATE NUMBER ISSUED	
DATE LICENSE ISSUED *(month, day, year)*	

APPLICANT

Attach one (1) passport quality photograph taken not earlier than one (1) year prior to the date of application.

DO NOT WRITE ABOVE THIS LINE

PLEASE TYPE OR PRINT AND ANSWER ALL QUESTIONS.

APPLICANT INFORMATION

Name of applicant (*last, first, middle*)		Social Security number *
Date of birth (*month, day, year*)	Place of birth (*city and state or country*)	
Address of applicant (*number and street or rural route*)	City, state, and ZIP code	
Telephone number (*daytime*) ( )	E-mail address *(required)*	
Gender ** ☐ Male ☐ Female	Ethnicity **	Race **

Pursuant to IC 12-32-1-5 and IC 12-32-1-6, I swear under the penalty of perjury that: *(Please select one of the following.)*
☐ I am a United States Citizen. ☐ I am a qualified alien (as defined under 8 U.S.C. § 1641).

Are you the spouse of a member of the military who is assigned to a duty station in Indiana? *(Optional)*
☐ Yes ☐ No

SCHOOL OF GRADUATION

NAME OF SCHOOL	LOCATION OF SCHOOL	DATE OF GRADUATION (*month, day, year*)

MASTER'S DEGREE GRANTED IN

☐ Speech-Language Pathology ☐ Audiology

* If your clinical fellowship begins prior to the date of graduation, you must submit a letter from the school which indicates that all requirements have been completed and the date the applicant will graduate.

CLINICAL FELLOWSHIP ANTICIPATED STARTING AND COMPLETION DATE

Starting date *(month, day, year)*	Completion date *(month, day, year)*

LOCATION OF FELLOWSHIP

Name of hospital or facility		
Address *(number and street or rural route)*		
City	State	ZIP code
Telephone number ( )	E-mail address	

LIST ANY ADDITIONAL WORK SITE ADDRESSES ON A SEPARATE SHEET OF PAPER.

If your answer is "Yes" to any of the following, explain fully in a sworn affidavit, including all related details, and provide copies of all relevant arrest or court documents. Describe the event including the location, date and disposition. Falsification of any of the following is grounds for permanent revocation of the license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held? ☐ Yes ☐ No

2. Have you ever been denied a license, certificate, registration or permit to practice speech-language pathology or audiology or any regulated health occupation in any state *(including Indiana)* or country? ☐ Yes ☐ No

3. Do you have any condition or impairment *(including a history of alcohol or substance abuse)* that currently interferes, or if left untreated may interfere, with your ability to practice in a competent and professional manner? ☐ Yes ☐ No

4. *Except for minor violations of traffic laws resulting in fines, and arrests or convictions that have been expunged by a court,*
   (1) have you ever been arrested; ☐ Yes ☐ No
   (2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state; ☐ Yes ☐ No
   (3) have you ever been convicted of any offense, misdemeanor, or felony in any state; ☐ Yes ☐ No
   (4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or ☐ Yes ☐ No
   (5) have you ever pled *nolo contendre* to any offense, misdemeanor, or felony in any state? ☐ Yes ☐ No

5. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations? ☐ Yes ☐ No

6. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant? ☐ Yes ☐ No

7. Have you ever had a malpractice judgment against you or settled any malpractice action? ☐ Yes ☐ No

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct. I am aware of the requirements set forth in 880 IAC 1-1-3.1 and understand that I may practice under the direct supervision of the person whose name appears on this application until the expiration of my registration. I hereby certify under penalties of perjury that I have completed all requirements for a master's degree as required by IC 25-35.6 -1-5(2).

Signature of applicant	Date signed *(month, day, year)*

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, corporation, association, organization or institution to release to the Professional Licensing Agency any files, documents, records or other information pertaining to the undersigned requested by the Agency, or any of its authorized representatives in connection with processing my application.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm, that I have read the above statements and agree to same.

Signature of applicant	Date signed (*month, day, year*)

CLINICAL FELLOW SUPERVISOR'S INFORMATION

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is mandatory and this record cannot be processed without it.

PLEASE TYPE OR PRINT AND ANSWER ALL QUESTIONS.

SUPERVISOR'S INFORMATION

Name (*last, first, middle, maiden*)			
Indiana license number	Expiration date (*month, day, year*)	ASHA certification number	Expiration date (*month, day, year*)
Address (*number and street or rural route*)			
City		State	ZIP code
Telephone number ( )		E-mail address	

CLINICAL FELLOW INFORMATION

I will be supervising the following clinical fellow, at the dates indicated and at the following location(s):

Name of clinical fellow		Social Security number *	
Starting date (*month, day, year*)		Completion date (*month, day, year*)	
Name of hospital or facility			
Address (*number and street or rural route*)			
City		State	ZIP code
Telephone number ( )		E-mail address	

LIST ANY ADDITIONAL WORK SITE ADDRESSES ON A SEPARATE SHEET OF PAPER.

APPLICATION AFFIRMATION

I am aware of requirements set forth in 880 IAC 1-1-3.1 and understand and agree that I shall supervise the person for whom this application is submitted.

Signature of supervisor	Date signed (*month, day, year*)