



APPLICATION FOR REGISTRATION AS A SPEECH-LANGUAGE PATHOLOGY AIDE

State Form 50322 (R2 / 2-06)

Approved by State Board of Accounts, 2006

**SPEECH LANGUAGE PATHOLOGY AUDIOLOGY BOARD
PROFESSIONAL LICENSING AGENCY**
402 West Washington Street, Room W072
Indianapolis, IN 46204
Telephone: (317) 234-2064
E-mail: pla5@pla.IN.gov

***Your Social Security number is being requested by this state agency in accordance with I.C. 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.**

FEE	
DATE FEE PAID (month, day, year)	
RECEIPT NUMBER	
REGISTRATION NUMBER	
DATE ISSUED (month, day, year)	

DO NOT WRITE ABOVE THIS LINE - FOR OFFICE USE ONLY

PLEASE TYPE OR PRINT AND ANSWER ALL QUESTIONS.

APPLICANT INFORMATION

Name of applicant (<i>last, first, middle, maiden</i>)		Social Security number*	
Address (<i>number and street or rural route</i>)			
City		State	ZIP code
Date of birth (<i>month, day, year</i>)	Place of birth (<i>city and state or country</i>)		
Telephone number (<i>daytime</i>) ()		E-mail address	

AIDE REGISTRATION(S) ISSUED

Do you hold or have you held a registration as a speech-language pathology aide? Yes No
If yes, list registration number, date issued, date expired and supervisor's name.

REGISTRATION NUMBER	ISSUE DATE (<i>month, day, year</i>)	EXPIRATION DATE (<i>month, day, year</i>)	SUPERVISOR'S NAME

HIGH SCHOOL, UNDERGRADUATE AND GRADUATE TRAINING

Please list all levels of education you have attended.

NAME OF SCHOOL	LOCATION OF SCHOOL	DATES ATTENDED (<i>month, day, year</i>)	DEGREE GRANTED

(Continued on reverse side)

If your answer is "Yes" to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and disposition. If malpractice, provide name(s) of plaintiffs. Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following questions is grounds for permanent revocation of a registration issued pursuant to this application.

1. Have you ever previously filed an application in the State of Indiana?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. 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 (<i>including Indiana</i>) or country?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are you now being, or have you ever been treated for drug or alcohol abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you ever been convicted of, pled guilty or <i>nolo contendere</i> to:	
A. A violation of any Federal, State or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Any offense, misdemeanor or felony in any state? (<i>Except for minor violations of traffic laws resulting in fines</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you ever had a malpractice judgment against you or settled any malpractice action?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 1-2 and understand that I may practice as a speech-language pathology aide under the direct supervision of the person whose name appears on this application until the expiration of my registration as an aide.

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 for a license to practice as a speech-language pathology aide.

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*)

SPEECH-LANGUAGE PATHOLOGY AIDE SUPERVISOR'S INFORMATION

PLEASE TYPE OR PRINT AND ANSWER ALL QUESTIONS

SUPERVISOR'S INFORMATION

Name (<i>last, first, middle, maiden</i>)		Social Security number *
Indiana license number		Date of expiration (<i>month, day, year</i>)
Address (<i>number and street, or rural route</i>)		
City	State	ZIP code
Telephone number ()	E-mail address	

NAME OF SPEECH-LANGUAGE PATHOLOGY AIDE APPLICANT

Name (<i>last, first, middle, maiden</i>)	Social Security number *
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NAME OF HOSPITAL / FACILITY / COMPANY WHERE THE AIDE WILL BE EMPLOYED

Name of hospital / facility / company		
Address (<i>number and street or rural route</i>)		
City	State	ZIP code
Telephone number (<i>daytime</i>) ()	E-mail address	

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

AIDES CURRENTLY REGISTERED UNDER YOUR LICENSE

How many aides are currently registered under your supervision?
Please list the aides name(s) and registration number(s).

NAME	REGISTRATION NUMBER

SUPERVISION OF THE SPEECH-LANGUAGE PATHOLOGY AIDE

1. Aide's level of academic training.

2. Specify method of supervision.

3. Specify training program.

(Continued on reverse side)

SUPERVISION OF THE SPEECH-LANGUAGE PATHOLOGY AIDE (Continued)

4. Specify all procedures to be performed by the aide.

5. Describe in detail the pertinent educational and work experience for the aide for which authorization is sought.

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 shall be responsible for the direct supervision of the aide for whom this application is submitted in compliance with requirements set forth in IC 25-35.6-1-2(g) and 880 IAC 1-2.

Signature of supervisor

Date signed (*month, day, year*)

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