BOARD OF REGISTRATION FOR SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY

Instructions for Speech-Language Pathologist License Application

1. If you do not possess or are ineligible for a Social Security No., contact the Board for instructions.

2. **Licensure by the Board is independent of certification from ASHA.** Accordingly, please ensure your **complete application** with **all supporting documents** is received by the Board's office immediately upon completion of your CFY. The application form must be received by the Board within sixty (60) days after your graduation or within one week after you begin your CFY, whichever comes first. **You may not work** after the end date listed on your Form 2 until licensed by the Board.

3. Regarding Question #1, the address that you note as your mailing address is **public record** and will be released to anyone upon request. You may opt to utilize your business address; if so, please include the business name.

4. **If you are currently licensed in another state or U.S. territory** and currently **maintain your ASHA certification,** you may qualify for **reciprocal licensure:** 1) have your completed application notarized, 2) have ASHA forward your verification to the Board, 3) have each state or territory in which you have been licensed directly forward a verification on your behalf and 4) forward the applicable $68 processing fee made payable to the Commonwealth of Massachusetts. Once all items are received and a criminal background check is successfully completed, your application will be reviewed and processed.

5. For Question #3 and #4, if you hold ASHA certification or have ever held a professional license of any kind in the US, its territories, or in any foreign jurisdiction, a certificate of standing is required from each. Certificates are required for any licensure status including lapsed, expired, etc. Contact that jurisdiction and have the document mailed to you for inclusion with your application. Please maintain the **official statement(s) in the unopened, jurisdiction-sealed envelope(s) to accompany your application.** The document may also be mailed directly to the Board. Your application may only be processed after all items have been received.

6. Please note, if you are not seeking reciprocal licensure, you must have your **PRAXIS score** forwarded to the Board, the Board's score recipient **code is R7421**.

7. Also, if you are not seeking reciprocal licensure, the Board must receive an official school transcript from your graduate program (indicating date that the degree was conferred) and documentation of completion of a minimum of 400 clock hours in envelopes sealed by the school or mailed directly from the school.

8. Regarding Questions #5 through #9, you must include detailed explanations for each affirmative answer. Please include relevant dates, jurisdictions, etc. After your application has been reviewed, additional documentation may be requested

9. Your signature on the application must be notarized as must your signature on the Criminal Offender Record Information ("CORI") acknowledgement form.

10. Include a check or money order fo**r $ 68.00** in U.S. funds made payable to the **Commonwealth of Massachusetts.** The fee is **not** refundable. Please note that your application will not be processed without the fee.

11. Mail the complete application package to: **Board of Speech-Language Pathology & Audiology, 1000 Washington Street, Suite 710, Boston, MA, 02118-6100.**

12. If you have any additional questions, please contact the Board via email: Monique.Brown@state.ma.us by phone: (617) 727-3071.

The Commonwealth of Massachusetts
Division of Professional Licensure
BOARD OF REGISTRATION FOR
SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY
1000 WASHINGTON STREET, SUITE 710
BOSTON, MA 02118-6100
(617) 727-3071
WWW.MASS.GOV/DPL/BOARDS/SP

APPLICATION FOR LICENSURE AS A SPEECH LANGUAGE PATHOLOGIST

BOARD USE ONLY					
$68.00 Received: ❑M.O. or ❑Check #_____	❑ ASHA ____	❑ State ___	❑ Form 1___	❑ Form 2 ___	
Application #: _____	❑ License #: _____	❑ State _____	❑ State ____	❑ Trans ___	❑ Praxis____
❑CORI sent _____	❑ CORI rec'd: _____	❑ State _____	❑ State ___	❑ State ____	❑ Hrs. ____

1. Applicant:

Name: _____
(Last) (First) (Middle)

Address: _____
(Number) (Street)

_____
(City) (State) (Zip Code)

Maiden Name: _____

Phone: _____ _____
(Home) (Other)

Birth Date:_____ Social Security Number:_____
Pursuant to G.L. c. 62C, § 47A, the Division of Professional Licensure is required to obtain your social security number (SSN)and forward it to the Department of Revenue (DOR). DOR will use your SSN to ascertain whether you are in compliance with the Commonwealth's tax laws.

E-mail: _____
Please note: EMAIL will be the primary means of contact for routine correspondences during the application process.

2. Professional Practice Site Information: Applicant must not work after the end date specified on applicant's Form 2 until licensed by the Board. Post clinical fellowship work will subject both the applicant and supervisor to disciplinary action by the Board.

Site: _____
(Company Name) (Division/Department)

Address: _____
(Number) (Street)

_____
(City) (State) (Zip Code)

Phone: _____ _____
(Business) (Fax)

Mail ORIGINAL to the Board and maintain a copy for your files.

3. **National Certification Status**: If you possess a current and valid Certificate of Clinical Competence **(CCC)** from the American Speech-Language Hearing Association **(ASHA),** please have **ASHA send a verification letter to the Board of Speech-Language Pathology and Audiology.**

   ASHA/CCC Certification Number: _____ **Expiration Date**: _____

4. **Licensure Status / Other Certifications**: List all professional licenses and certifications held in the United States or any country of foreign jurisdiction and the state or jurisdiction from which the license or certification was issued. **You must have an official letter of verification of licensure sent directly from each jurisdiction in which you have been licensed. If seeking reciprocal license, you must hold a license in a US jurisdiction and that license must be current as of the application date.**

License / Certification	Number	Expiration Date	Issuing State, Jurisdiction or Foreign Country

5. **Has any disciplinary action been taken against you by a licensing or certification board located in the United States or any country or foreign jurisdiction? No❑ Yes❑** If "Yes", please submit a detailed explanation on a separate page.

6. **Have you voluntarily surrendered a professional license to a licensing or certification board in the United States or any country or foreign jurisdiction? No❑ Yes❑** If "Yes", please submit a detailed explanation on a separate page.

7. **Are you the subject of pending disciplinary action by a licensing or certification board located in the United States or any country or foreign jurisdiction? No❑ Yes❑** If "Yes", please submit a detailed explanation on a separate page.

8. **Have you been the defendant in a malpractice proceeding resulting in a settlement or a judgment against you?**
   No❑ Yes❑ If "Yes", please submit a detailed explanation on a separate page.

9. **Have you ever admitted to or been convicted of a felony or misdemeanor in the United States or any country or foreign jurisdiction other than a traffic violation for which a fine of less than $100 was assessed?**
   No❑ Yes❑ If "Yes", please submit a detailed explanation on a separate page.

10. **Clock Hours**: If you are not applying for reciprocal licensure, please include a copy of the clock hours earned during your graduate program.

11. **Education**: Please fill in the academic institution you have attended. If you are not applying for reciprocal licensure, you must **have an official transcript of your graduate schooling**, with school seal, sent to the Board office (graduate institutions only).

	College or University	Degree Earned	Date of Graduation	Concentration
Graduate:				
Undergraduate:				
Other:				

12. **Pursuant to M.G.L. Ch. 62C, s. 49A**, I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes:

    Yes❑ No❑ If No, please state the details: _____

13. Statement of the Applicant:

I agree to abide by the rules and regulations for licensing of Speech-Language Pathologists as contained in Title 260 of the Code of Massachusetts Regulations (CMR) and I certify, under the pains and penalties of perjury, that the information I have provided pursuant to this application for licensure is truthful and accurate. I understand that the failure to provide accurate information may be grounds for the Board of Registration to deny my application or to suspend or revoke a license issued to me.

_____ _____

Applicant's signature (signed in the presence of a Notary Public) **Date (MM/DD/YYYY)**

Place a 2" by 2" original photo of yourself in this box.

NOTARIZATION

On this ____ day of _____, 20__, before me,_____ the undersigned notary public, personally appeared _____ (name of document signer), proved to me through satisfactory evidence of government issued identification, which was _____, to be the person whose name is signed on the preceding or attached document in my presence.

_____ Notary's signature Seal of Notary

BOARD OF REGISTRATION FOR SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY
CRIMINAL OFFENDER RECORD INFORMATION (CORI)
ACKNOWLEDGEMENT FORM

The Division of Professional Licensure by itself and on behalf of boards of registration pursuant to M.G.L. c. 13, §9 [hereinafter, "Division of Professional Licensure"] is registered under the provisions of M.G.L. c. 6, § 172 to receive CORI for the purpose of screening current and otherwise qualified prospective license applicants and current licensees.

As a license applicant or current licensee, I understand that a CORI check will be submitted for my personal information to the Department of Criminal Justice Information Services ("DCJIS"). I hereby acknowledge and provide permission to the Division of Professional Licensure to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing the Division of Professional Licensure written notice of my intent to withdraw consent to a CORI check.

FOR LICENSING PURPOSES ONLY:

The Division of Professional Licensure may conduct subsequent CORI checks within one year of the date this Form was signed by me. If subsequent CORI checks are necessary, the Division of Professional Licensure will provide me with written notice of the subsequent CORI checks.

By signing below, I provide my consent to a CORI check and acknowledge that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

_____ _____

Signature Date

Please provide the name of the board of registration and license type for which you are applying or currently hold:

_____ _____

Board of Registration License Type

NOTE: DPL CANNOT ACCEPT THIS TWO-PAGE CORI ACKNOWLEDGMENT FORM UNLESS IT IS EITHER (1) SIGNED IN PERSON AT THE BOARD'S OFFICES IN THE PRESENCE OF A DPL EMPLOYEE WHO HAS VERIFIED THE APPLICANT'S IDENTITY THROUGH ACCEPTABLE IDENTIFICATION, OR (2) SIGNED IN THE PRESENCE OF A NOTARY PUBLIC WHO HAS LIKEWISE VERIFIED IDENTITY AND THEN MAILED OR OTHERWISE DELIVERED TO THE BOARD'S OFFICES AT THE ADDRESS SET FORTH ABOVE.

SUBJECT INFORMATION: (A red asterisk (*) denotes a required field)

_____

*Last Name *First Name Middle Name Suffix

_____

*Maiden Name (or other name(s) by which you have been known)

_____ _____

*Date of Birth Place of Birth

*Last Six Digits of Your Social Security Number: _____ - _____

Sex: _____ Height: ____ ft. ____ in. Eye Color: _____

Driver's License or ID Number: _____ State of Issue: _____

Current and Former Addresses:

_____

Street Number & Name City/Town State Zip

_____

Street Number & Name City/Town State Zip

_____

IDENTITY VERIFICATION SECTION: If this form is submitted by hand at DPL Offices, Section A must be completed. Otherwise, Section B must be completed.

SECTION A: VERIFICATION BY DPL EMPLOYEE: I hereby certify that I verified the identity of the above-referenced subject by reviewing the following form(s) of government-issued identification:[1]

☐ Passport ☐ State-issued driver's license ☐ Military identification ☐ State-issued identification card

VERIFIED BY:

_____

Name of Verifying DPL Employee (Please Print)

_____

Signature of Verifying DPL Employee Date

_____

SECTION B: VERIFICATION BY NOTARY:

On this _____ day of _____, 20____, before me, the undersigned notary public, personally appeared _____ (name of document signer), and proved to me through satisfactory evidence of identification, which was the following:[1]

☐ Passport ☐ State-issued driver's license ☐ Military identification ☐ State-issued identification card

to be the person whose name is signed on the preceding or attached document, and acknowledged to me that (he) (she) signed it voluntarily for its stated purpose.

_____

Notary Public: Notary Commission Expires On

[1] If a subject does not have an acceptable government-issued identification, his or her identity shall be verified by other forms of documentation as determined by DCJIS. 803 CMR 2.09(2).

PLEASE INCLUDE THIS PAGE WITH YOUR APPLICATION

APPLICATION CHECKLIST

□ I have read the regulations governing the profession, i.e. 260 CMR 1.00 et seq.

□ I have answered all questions inclusive of those marked not applicable.

□ I have signed & notarized the entire application form.

□ I I am forwarding the original application form and maintaining a copy for my records.

□ If applicable, I have submitted a "Form1" signed by myself and my CFY supervisor, indicating the start and end dates of my CFY.

□ If applicable, I have requested or enclosed an official ASHA verification with all applicable state(s) verification(s).

□ If applicable, I have requested or enclosed evidence of a minimum of 400 clock hours earned during graduate school.

□ If applicable, I have requested or enclosed an official academic master's degree transcript indicating the date the degree was conferred.

□ If applicable, I have requested that an official PRAXIS score be sent to the Board. The Board's recipient code is R7421.

□ If applicable, I have enclosed or have requested to be sent to the Board sealed, official, certificates of standing from each jurisdiction (outside of MA) in which I have held a professional license or certification.

□ I have enclosed my non-refundable $68.00 Check/Money Order payable to: **Commonwealth of MA.**

□ I have enclosed the two page **CRIMINAL OFFENDER RECORD INFORMATION (CORI) ACKNOWLEDGEMENT FORM, properly signed and notarized.**

□ Once my CFY has ended, I will submit my Form 2 and will not work in any speech capacity until licensed by the Board.

Please Mail ORIGINAL of this and all forms to the Board and maintain a copy for your files.
Board of Speech-Language Pathology and Audiology, 1000 Washington St., Suite 710, Boston, MA 02118-6100

Updated May 26, 2017

The Commonwealth of Massachusetts
Division of Professional Licensure

BOARD OF REGISTRATION FOR
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FORM 1- SUPERVISED PROFESSIONAL PRACTICE PLAN – SPEECH-LANGUAGE PATHOLOGY

Instructions:
- **Form 1 must be submitted to the Board within seven (7) days of beginning your CFY.**
- **Answer all questions. Write "NOT APPLICABLE" if no other response is appropriate.**
- **Use additional pages if necessary.**
- **If your supervisor changes, please submit a Form 2 to complete that portion of the Supervised Practice plan. Also, you must remit a new Form 1 and Form 2 for each new supervisor.**

1. Speech-Language Pathology Applicant: If name has been altered since application submission, Name on Application: _____

Name: _____
(Last) (First) (Middle)

Address: _____
(Number) (Street)

_____
(City) (State) (Zip)

_____ _____
(Phone: Home) EMAIL

2. Professional Practice Site Information:

Site: _____
(Company Name) (Division/Department)

Address: _____
(Number) (Street)

_____
(City) (State) (Zip)

Beginning Date: _____ **Ending Date:** _____ **Hours per Week:** _____
(MM/DD/YYYY) (MM/DD/YYYY)

3. Supervisor Information:

Name: _____
(Last) (First) (Middle)

Address: _____
(Number) (Street)

_____
(City) (State) (Zip)

Phone: (_____) _____ _____
(Business) EMAIL

4. Supervisor's Current Licensure Status:

Massachusetts License#: _____ **Expiration Date:** _____

Other State (Specify): _____ **License Number:** _____ **Expiration Date:** _____

5. Supervisor's Professional Certification(s):

ASHA/CCC-SLP Certification Number: _____ **Expiration Date:** _____

Massachusetts Teacher's Certification Number: _____ **Expiration Date:** _____

6. Educational, Supervised Professional Practice, and Examination Requirements:

To be licensed as a Speech-Language Pathologist, an applicant must be of good moral character and meet the educational, clinical, supervised professional practice, and examination requirements specified in the current American Speech-Language-Hearing Association (ASHA) Standards and Implementation Procedures for a Certificate of Clinical Competence in Speech-Language Pathology. Although standards created by ASHA are referenced by the Board, **the Board does not require that applicants obtain or maintain membership in ASHA.** However, ASHA membership/certification of the supervisor may be required if the applicant seeks membership/certification in ASHA once licensed. Please contact ASHA for more information at www.asha.org.

7. Statement of the Applicant:

Applicant, please contact the Board to ensure that your:

1) **Application with $68.00 fee**
2) **Praxis score [Board code: R7461]**
3) **Official graduate school transcript**
4) **Clock hours earned during graduate school**

have all been received. This will allow faster processing of your application upon receipt of your Form 2.

I HAVE DISCUSSED THE PLAN FOR SUPERVISION WITH THE PERSON NAMED AS SUPERVISOR AND AGREE TO ITS IMPLEMENTATION. I UNDERSTAND THAT I MUST NOT WORK AFTER THE END DATE SPECIFIED ON MY FORM 2 UNTIL I AM LICENSED BY THE BOARD. POST CLINICAL FELLOWSHIP WORK WILL SUBJECT BOTH THE APPLICANT AND SUPERVISOR TO DISCIPLINARY ACTION BY THE BOARD.

_____ _____

(Applicant's Signature) **(Date)**

8. Statement of Supervisor:

I HEREBY CERTIFY THAT ALL STATEMENTS MADE BY ME IN RELATION TO THIS PLAN ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF. I FURTHER CERTIFY THAT I UNDERSTAND THE RESPONSIBILITIES OF A SUPERVISOR AS STATED IN THE RULES AND REGULATIONS OF THE MASSACHUSETTS BOARD OF REGISTRATION FOR SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY. (TITLE 260 OF THE CODE OF MASSACHUSETTS REGULATIONS). I UNDERSTAND THAT THE APPLICANT MUST NOT WORK AFTER THE END DATE SPECIFIED ON THE FORM 2 UNTIL LICENSED BY THE BOARD. POST CLINICAL FELLOWSHIP WORK WILL SUBJECT BOTH THE APPLICANT AND SUPERVISOR TO DISCIPLINARY ACTION BY THE BOARD.

_____ _____

(Supervisor's Signature) **(Date)**

The Commonwealth of Massachusetts

Division of Professional Licensure

BOARD OF REGISTRATION FOR
SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY
1000 WASHINGTON STREET, SUITE 710
BOSTON, MA 02118-6100
(617) 727-3071
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FORM 2 - SUPERVISED PROFESSIONAL PRACTICE REPORT – SPEECH-LANGUAGE PATHOLOGY

Instructions: ·**Form 2** must be **submitted to the Board within One (1)** day of the completion of the Professional Practice. Upon completion, fax Form 2 to 617-727-9932 or scan and e-mail to Monique.Brown@state.ma.us and mail original to Board.
·**If your supervisor changed, please submit a Form 1 to correlate with that portion of the Supervised Practice year. Also, you must forward a new Form 1 and Form 2 for all other supervisor(s).**

IMPORTANT NOTE: Post clinical fellowship work will subject both you and your supervisor to disciplinary action by the Board.

1. Speech-Language Pathology Applicant: If name has changed since application your initial submission, **Name on Application:** _____

Name: _____
(Last) (First) (Middle)

Address: _____
(Number) (Street)

_____
(City) (State) (Zip)

Phone: ( ) _____ _____
(Home) EMAIL:

2. Professional Practice Site Information:

Site: _____
(Company Name) (Division/Department)

Address: _____
(Number) (Street)

_____
(City) (State) (Zip)

Beginning Date: _____ **Ending Date:** _____ **Hours per Week:** _____
(MM/DD/YYYY) (MM/DD/YYYY)

- If the ending date is different from ending date specified in your Form 1, please indicate here _____ and attach a letter of explanation signed by both the applicant and the supervisor. Additional documentation may be required.

3. Supervisor Information:

Name: _____
(Last) (First) (Middle)

Address: _____
(Number) (Street)

_____
(City) (State) (Zip)

Phone: ( ) _____ _____
(Business) EMAIL

4. Supervisor's Current Licensure Status:

Massachusetts License#: _____ **Expiration Date:** _____

Other State (Specify): _____ **License Number:** _____ **Expiration Date:** _____

5. Supervisor's Professional Certification(s):

ASHA/CCC-A Certification Number: _____ **Expiration Date:** _____

Massachusetts Teacher's Certification Number: _____ **Expiration Date:** _____

6. Educational, Supervised Professional Practice and Examination Requirements:

To be licensed as a Speech-Language Pathologist, an applicant must be of good moral character and meet the educational, clinical, supervised professional practice, and examination requirements specified in the current American Speech-Language-Hearing Association (ASHA) Standards and Implementation Procedures for a Certificate of Clinical Competence in Speech-Language Pathology. Although standards created by ASHA are referenced by the Board, **the Board does not require that applicants obtain or maintain membership in ASHA**. However, ASHA membership/certification of the supervisor may be required if the applicant seeks membership/certification in ASHA once licensed. Please contact ASHA for more information. www.asha.org

7. Professional Practice Plan completion:

Has the applicant successfully fulfilled the Professional Practice Plan responsibilities as specified in Form 1?
❑Yes ❑No If no, please explain _____

_____

_____

_____

8. Recommendation of Supervisor:

I hereby ❑ **recommend** **OR** ❑ **do not recommend** for licensure as a SPEECH-LANGUAGE PATHOLOGIST**.**

APPLICANT AND SUPERVISOR UNDERSTAND THAT THE APPLICANT MUST NOT WORK AFTER THE END DATE SPECIFIED ON THE FORM 2 UNTIL LICENSED BY THE BOARD. POST CLINICAL FELLOWSHIP WORK WILL SUBJECT BOTH THE APPLICANT AND SUPERVISOR TO DISCIPLINARY ACTION BY THE BOARD.

_____ _____

Applicants's Signature **Date**

_____ _____

Supervisor's Signature **Date**