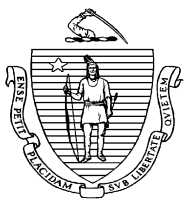


BOARD OF REGISTRATION OF SPEECH LANGUAGE PATHOLOGY & AUDIOLOGY

Instructions for Audiologist License Application

1. If you do not possess or are ineligible for a Social Security Number, contact the Board for instructions.
2. Licensure by the Board is independent of certification from ASHA or ABA. Accordingly, if you are not seeking reciprocal licensure, please ensure your **completed application along with your Form 1** is received by the Board's office within one week after the beginning of your fourth year externship. Please submit all other required documentation as soon as it is available. **You may not work after the end date specified 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 coming from another state or U.S. territory and currently maintain your ASHA or ABA certification**, you may qualify for **reciprocal licensure**: 1) have your completed application notarized, 2) have ASHA or ABA forward your verification to the Board, 3) have each state or territory 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 or ABA 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 documents 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 the date that the degree was conferred) and documentation of your 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 application must be notarized on both pages 5 and 6.
10. Include a check or money order for **\$ 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. The initial fee includes both application processing and your initial licensure.
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: speech.audiology@mass.gov or by phone: (617) 727-3071.



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

APPLICATION FOR AUDIOLOGY LICENSURE

BOARD USE ONLY									
\$68.00 Received:	<input type="checkbox"/> M.O. or	<input type="checkbox"/> Check #	<input type="checkbox"/> ASHA	<input type="checkbox"/> State	<input type="checkbox"/> Form 1	<input type="checkbox"/> Form 2			
Application #:	<input type="checkbox"/> License #:	<input type="checkbox"/> ABA	<input type="checkbox"/> State	<input type="checkbox"/> Trans	<input type="checkbox"/> Praxis				
<input type="checkbox"/> CORI sent	<input type="checkbox"/> CORI rec'd:	<input type="checkbox"/> State	<input type="checkbox"/> State	<input type="checkbox"/> State	<input type="checkbox"/> 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 fourth year externship 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)

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

ASHA/CCC Certification Number: _____ Expiration Date: _____

ABA Certification Number: _____ Expiration Date: _____

1. **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.**

2.

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

3. **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.
4. **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.
5. **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.
6. **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.
7. **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.
8. **Applicant's Certification Track:** Please choose which Professional Organization Standards you followed during your supervised professional practice:

<input type="checkbox"/>	American Speech-Language Hearing Association (ASHA): The current ASHA Standards and Implementation Procedures for a Certificate of Clinical Competency (CCC) in Speech Language. (www.asha.org)
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<input type="checkbox"/>	American Board of Audiology (ABA): The current requirements for Board Certification in Audiology by the ABA. (www.boardofaudiology.org)
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9. **Education:** Please **have an official transcript of your graduate schooling**, with school seal, sent to the Board of Speech-Language Pathology and Audiology from all graduate institutions only. **If you already possess ASHA or ABA certification**, only fill in the academic institutions which you attended.

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

10. 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: _____

11. **Statement of the Applicant:**

I agree to abide by the rules and regulations for licensing of Audiologists as contained in Title 260 of the Code of Massachusetts Regulations (CMR) and attest that all statements herein are truthful and are made under the pains and penalties of perjury.

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:

I understand that the Division of Professional Licensure may conduct a subsequent CORI check within one year of the date this Form was signed by me.

By signing below, I provide my consent to an initial CORI check and a subsequent CORI check, both within one year of the date of this Form, 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).

APPLICATION CHECKLIST

Please include in package with your application

- ☐ 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 am forwarding the original application form and maintain a copy for my records.
- ☐ If applicable, I have requested or enclosed an official ASHA or ABA verification with all applicable state(s) verification(s).
- ☐ If applicable, I have requested or enclosed an official academic AUD transcript indicating date 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 fourth year externship has ended, I will not work in any audiology or speech-language pathology capacity until licensed by the Board.

Mail to: Board of Speech Language Pathology & Audiology, 1000 Washington St., Suite 710,
Boston, MA 02118-6100



The Commonwealth of Massachusetts

Division of Professional Licensure

BOARD OF REGISTRATION OF
SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY
1000 Washington Street, Suite 710
BOSTON, MA 02118-6100
(617) 727-3071
WWW.MASS.GOV/DPL/BOARDS/SP

FORM 1- SUPERVISED PROFESSIONAL PRACTICE PLAN – AUDIOLOGY

- Instructions:**
- Form 1 must be submitted to the Board within seven (7) days of beginning your fourth year externship.
 - 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 fourth year externship. Also, you must remit a new Form 1 and Form 2 for each new supervisor.

1. Audiology Applicant: If name has been altered since application submission, **Name on Application:** _____

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

Address: _____
(Number) (Street)

(City) (State) (Zip)

Phone: () _____ () _____
(Home) (Other)

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)

(Other)

4. Supervisor's Current Licensure Status:

Massachusetts License#: _____ Expiration Date: _____

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

5. Supervisor's Professional Certification(s):

ASHA or ABA Certification Number: _____ Expiration Date: _____

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

6. Audiology Applicant's Certification Track: Please choose which Professional Organization Standards you will be following:

<input type="checkbox"/>	American Speech-Language-Hearing Association: The current ASHA Standards and Implementation Procedures for a Certificate of Clinical Competence in Audiology. www.asha.org
<input type="checkbox"/>	American Board of Audiology: The current requirements for Board Certification in Audiology by the American Board of Audiology. www.boardofaudiology.org .

To be licensed as an Audiologist, an applicant must be of good moral character and meet the educational, clinical, supervised professional practice, and examination requirements specified in the applicant's chosen professional organization standards. Although standards created by professional organizations are referenced by the Board, **the Board does not require that licensees obtain or maintain membership in said organizations.** However, membership/certification of the supervisor may be required if the applicant seeks membership/certification in the chosen professional organization. Please contact the professional organizations for more information.

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 immediate 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 FOURTH YEAR EXTERNSHIP WORK WILL SUBJECT BOTH THE APPLICANT AND SUPERVISOR TO DISCIPLINARY ACTION BY THE BOARD.

(Applicant's Signature)

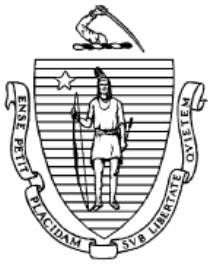
(Date)

8. Statement of Supervisor:

I HEARBY 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 FOURTH YEAR EXTERNSHIP 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 OF
SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY
1000 Washington Street, Suite 710
BOSTON, MA 02118-6100
(617) 727-3071
WWW.MASS.GOV/DPL/BOARDS/SP

FORM 2 - SUPERVISED PROFESSIONAL PRACTICE REPORT – AUDIOLOGY

Instructions: •Form 2 must be submitted to the Board within One (1) day of the completion of the fourth year externship.. Upon completion, fax Form 2 to 617-727-9932 or scan and e-mail to speech.audiology@mass.gov and mail original to Board.

•If your supervisor changed, please submit a Form 1 to correlate with that portion of the fourth year externship. Also, you must forward a new Form 1 and Form 2 for all other supervisor(s).

IMPORTANT NOTE: Post fourth year externship work will subject both you and your supervisor to disciplinary action by the Board.

1. Audiology 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)

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 or ABA Certification Number: _____ Expiration Date: _____

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

6. Audiology Applicant's Certification Track: Please choose which Professional Organization Standards you followed:

<input type="checkbox"/>	American Speech-Language-Hearing Association: The current ASHA Standards and Implementation Procedures for a Certificate of Clinical Competence in Audiology. www.asha.org
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<input type="checkbox"/>	American Board of Audiology: The current requirements for Board Certification in Audiology by the American Board of Audiology. www.boardofaudiology.org
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To be licensed as an Audiologist, an applicant must be of good moral character and meet the educational, clinical, supervised professional practice, and examination requirements specified in the applicant's chosen professional organization standards. Although standards created by professional organizations are referenced by the Board, **the Board does not require that applicants obtain or maintain membership in said organizations.** However, membership/certification of the supervisor may be required if the applicant seeks membership/certification in the chosen professional organization. Please contact the professional organizations for more information.

7. Professional Practice Plan completion:

Has the applicant successfully fulfilled the Professional Practice Plan responsibilities as specified in Form 1?

☐ Yes ☐ No In no, please explain _____

8. Recommendation of Supervisor:

I hereby ☐ recommend **OR** ☐ do not recommend for licensure as an AUDIOLOGIST.

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 FOURTH YEAR EXTERNSHIP WORK WILL SUBJECT BOTH THE APPLICANT AND SUPERVISOR TO DISCIPLINARY ACTION BY THE BOARD.

Applicant's Name & Signature

Date

Supervisor's Signature

Date

Mail **ORIGINALS** 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