

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

**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 for Disabled - Maryland Relay Service 1-800-735-2258

**SPEECH-LANGUAGE PATHOLOGY
APPLICATION FOR LIMITED LICENSURE**

TO WHOM IT MAY CONCERN:

Thank you for your interest in the licensing of **speech-language pathologists in the State of Maryland**. The Law which provides for the licensing of speech-language pathologists was enacted on July 1, 1972. Go to the Links Section of the menu for a link to the Board's law.

If, after reviewing the provisions of the law, you find that your employment requires licensure, you must submit this application with the necessary supporting documents. **THE LICENSE MUST BE OBTAINED PRIOR TO THE BEGINNING OF EMPLOYMENT.**

A period of four weeks is usually necessary for processing an application. The Board normally meets on the **third Thursday of each month**. Applications to be approved at the Board Meeting **should** be received in the Board office **one week before the Board Meeting**.

Please Note: The Board's law examination is an open-book examination designed to acquaint you with the Board's law and regulations. Use the link to the Board's law in the Links Section of the menu to complete the examination. **Passing score** on the law examination is **75%**. Please complete the examination and return it to the Board office with your application for licensure. **A license cannot be issued until the law examination is completed and passed.**

SPEECH-LANGUAGE PATHOLOGY
APPLICATION FOR LIMITED LICENSURE CHECKLIST

I. ALL APPLICANTS NEED:

- \$100.00 Fee
- An original current photo
- Application Signed
- Application Notarized
- Law Exam Completed

II. DOCUMENTS NEEDED:

- Official Masters Transcript showing degree awarded (letter from Department
Chair stating that you have **completed** all coursework and clinical
practicum hours if transcript does not show degree awarded)
- Official Undergraduate Transcript
- CFY Plan (Form AS2)

PLEASE NOTE: Your social security number is needed on the application. It will be used for identification purposes and will be released to the Department of Public Safety and Correctional Services to check for any criminal convictions.

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APPLICATION FOR LIMITED LICENSE IN SPEECH-LANGUAGE PATHOLOGY

Application Fee: \$100.00
Make check or money order payable to the Board of
Speech-Language Pathology

**Affix original current
photograph here**

Ms.
Miss

1. NAME

Mrs. _____

Mr. Last First Maiden/Middle
Dr.

2. DATE OF BIRTH _____ 3. SOCIAL SECURITY #

4. RESIDENCE

Street Apt.#

City State Zip
Code

TELEPHONE

5. PROFESSIONAL ADDRESS

Facility or Company's Name

Street Apt.#

City State Zip
Code

TELEPHONE #

BEGINNING DATE OF EMPLOYMENT

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6. HAVE YOU PREVIOUSLY BEEN LICENSED IN MARYLAND?

----- IF
YES, LICENSE NUMBER _____ DATE EXPIRED

7. HAVE YOU EVER BEEN CONVICTED OF A FELONY OR A MISDEMEANOR
INVOLVING MORAL TURPITUDE? _____ YES _____ NO

IF AYES® ATTACH FULL DETAILS

8. EDUCATION AND EMPLOYMENT

A. Education

Degree &	Name &	Attended	Credit	Major
School	Location	From To	Hours	Date
Undergraduate:				

Graduate:

Other:

B. Employment for Clinical Fellowship Year

Date description	Title of position, facility/company name, address, brief of duties and responsibilities
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Note: Form AS-2 (Verification of Supervision for Limited Licensure/Clinical Fellowship Year) must be submitted for each place of employment during the period of limited licensure.

9. Have this Affidavit completed by a Notary Public

STATE OF _____

_____ 1. without official transcript

_____ 2. with official transcript

APPROVED FOR ADDITIONAL CFY
OR CHANGE IN CFY POSITION

BOARD INITIALS & DATE

APPROVED FOR LIMITED LICENSE RENEWAL

BOARD INITIALS & DATE

DISAPPROVED FOR LICENSURE

BOARD INITIALS & DATE

REQUIREMENTS FOR CLINICAL FELLOWSHIP YEAR

CFY TIME REQUIREMENTS:

The CFY must be started within two years after completion of the academic coursework and clinical practicum requirements and must then be completed within 36 months. The CFY is defined as no less than nine months of full-time professional employment (a minimum of 30 hours of work per week). The CFY requirement can also be met with part-time employment.

TIME REQUIREMENTS ARE AS FOLLOWS:

15-19 hours/week must work 18 months
20-24 hours/week must work 15 months
25-29 hours/week must work 12 months
30+ hours/week must work 9 months

At least 80% of the CFY work must be in direct client contact which includes assessment/diagnosis/evaluation, screening, habilitation/rehabilitation, and activities related to client management.

AS2:

An applicant for a Limited License shall submit a Form AS2, Verification of Supervision for Limited License/Clinical Fellowship Year with the application to the Board. The applicant may not begin practicing until the Limited License Application is approved by the Board. **A Limited License authorizes the applicant to practice ONLY in the setting and under the supervision of the person specified on the AS2.**

CFY SUPERVISION REQUIREMENTS:

The CFY must include no less than 36 supervisory activities during the CFY experience. This supervision must include 18 hours of on-site observation of clinical services and 18 other monitoring activities (such as conferences, in-service training, records reviews, etc). **All 18 on-site observation hours must be spent in direct client contact (assessment, diagnosis, evaluation, screening, habilitation and rehabilitation.)**

COMPLETION OF CFY:

Upon completion of the CFY, the Limited Licensee shall submit to the Board an AS3, Verification of Satisfactory Completion of CFY, completed by the supervisor and a copy of the scores on the National exam, if not previously submitted. If the CFY was done in more than one setting, or under more than one supervisor, a separate AS3 must be submitted for each setting or supervisor.

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**VERIFICATION OF SUPERVISION FOR SPEECH-LANGUAGE PATHOLOGY
LIMITED LICENSE CLINICAL FELLOWSHIP YEAR**

1. Applicant (Please type or print)

A. Name: -

Last First Middle/Maiden

B. Address:

Street

City State Zip Code

Phone:

C. Academic Status:

University Degree Date
Conferred

D. Employment Setting:

1. Facility Name:

2. Address:

Street

City State Zip Code

Phone:

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 of Limited Licensure year (please 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: _____

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Form AS2

III. Clinical and Supervisory Responsibility

Applicant Activity	Hours/Week Spent by applicant	Hours/Month spent by Supervisor	
		On-Site Observation	Other monitoring Activities
1. Assessment, diagnosis and/or evaluations			
2. Screening			
3. Habilitation/rehabilitation			
4. Staff meetings			
5. Supervisory conferences			
6. Inservice training			
7. Record keeping			
8. Other (must specify)			
TOTAL			

SIGNATURE OF APPLICANT _____ DATE

SIGNATURE OF SUPERVISOR _____ DATE

Supervisor:

- Holds ASHA CCC-SLP
- Holds MD License in Speech-

- Holds License in Speech-Language Pathology in State of

 Language Pathology

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**VERIFICATION OF SATISFACTORY COMPLETION OF SPEECH-LANGUAGE
 PATHOLOGY CLINICAL FELLOWSHIP YEAR**

I hereby declare that

 Name of Applicant

Address

 -

an applicant for Maryland licensure in speech-language pathology, was employed as a professional in that field from _____ to _____ for _____ 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

() ASHA Certification in Speech-Language Pathology

() A License in Speech-Language Pathology from

State

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