AUDIOLOGIST APPLICATION FOR LIMITED LICENSURE CHECKLIST

I. ALL APPLICANTS NEED:

_____ $100.00 Fee (make check or money order payable: Board of AUD)

_____ A recent 2x2 passport size photo

_____ Application Signed

_____ Application Notarized

____ Law Exam Completed
Note: To pass the open book examination, all applicants must score at least 75. You can download the examination from the Board's web site at www.mdboardaudhadslp.org. Use the Forms Link to download a copy of the law examination. To complete the examination, use the Law and Regulation Links on the web site. Refer to the law and regulation reference number included with the questions to get the correct answer. If you do not have access to a computer, call the Board office and the examination and a copy of the law and regulations will be mailed to you. A license will **NOT** be issued unless the law examination is passed.

II. DOCUMENTS NEEDED:

____ Official Transcript showing a doctoral degree in audiology from an accredited educational institution. (letter from Department Chair stating that you have **completed** all coursework and clinical practicum if transcript does not show degree awarded). Request college to send the transcript to the Maryland Board.

____ Official Undergraduate Transcript: Request college to send the transcript to the Maryland Board.

____ CFY Plan (Form AS2)

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.

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

LIMITED AUDIOLOGIST APPLICATION

Affix current 2x2 passport size photo

Date _________

1. Name ____
Last First Middle/Maiden

2. Home Address ____
Street Apt.

____
City State Zip Code

3. Home Phone _____________ Alternate#____________ Email _________________

4. Date of Birth ___________________ Social Security #_____________________

5. Have you previously been licensed in the State of Maryland? _______ If yes,
License # ________________ Date Expired ________________

6. Have you ever been convicted of a felony or a misdemeanor involving moral turpitude?
If yes, attach full explanation on a separate sheet of paper.

7. **EDUCATION**
Undergraduate School ____

Address ____
Street City State Zip Code
Attended _______to_______ Major _________________ Date Degree Awarded __________

Graduate School ____

Address ____
Street City State Zip Code

Attended _______to_______ Major _________________ Date Degree Conferred _________

Other____

FOR OFFICE USE

Received ___________________ CH ( ) MO( ) Number _________________________

Revised 9/07

8. **Employment for Clinical Fellowship Year**

Date_______________________ Title of position ____________________________________

Facility/Company Name ____

Address ____
Street City State Zip Code

Brief description of duties

____
____
____

9. Have this Affidavit completed by a Notary Public

I hereby affirm that I have read Sections 2-101 to 2-502 of Title 2 of the Health Occupations Article of the Annotated Code of Maryland and fully understand that in receiving a license from the Board, I bind myself to be governed by the Board.

I understand that in submitting this application that the accompanying fee is for administrative purposes and is not refundable. The fee includes licensure fee.

STATE OF_____________________ CITY OR COUNTY OF ______________________

The undersigned, being duly sworn, deposes and says that he/she is the person who executed this application, that the statements herein contained are true to the best of his/her knowledge, that he/she has not suppressed any information that might affect this application and that he/she has read and understands this affidavit..

________________________________ ________________________________
Signature of Applicant Signature of Notary

Subscribed and sworn to before this __________ day of _________________________________

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In accordance with Executive Order 01.01.1093-18, the Board is required to advise you as follows regarding the collection of personal information:

Personal information requested by the Board is necessary in determining your eligibility for licensure. Such personal information is also intended for use as an additional means of verifying the licensee's identity or to enable the Board to communicate, in a timely manner, with the licensee should the need arise. The licensee has a right to inspect his personal record and to amend or correct the personal data if necessary.

Your Social Security Number is needed on the application. It will be used for identification purposes and may be released to the Department of Public Safety and Correctional Services to check for any criminal convictions.

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.)** Supervision shall include a minimum of two hours of on-site observation of clinical services in direct client contact and two hours of other monitoring activities each month.

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 LIMITED AUDIOLOGIST LICENSE CLINICAL FELLOWSHIP YEAR

1. Applicant (Please type or print)

A. Name: ____
Last First Middle/Maiden

B. Address: ____
Street

____
City State Zip Code

Phone: ________________________ Alternate#______________________

C. Academic Status: ____
College Degree Date Awarded

D. Employment Setting:

1. Facility Name: ____

2. Address: ____
Street

____
City State Zip Code

Phone: _______________________ Fax: ______________________

3. Beginning date of employment: ________________________________
Month Day Year

4. Hours per week spent in Audiology: ________________________________

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: ________________ Alternate #______________________

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. In-service 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-Language Pathology
( ) Holds License in Speech-Language Pathology in State of ____________

Form AS2

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VERIFICATION OF SATISFACTORY COMPLETION OF AUDIOLOGY CLINICAL FELLOWSHIP YEAR

I hereby declare that ____
Name of Applicant

Address ____
Street City State Zip Code

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

____
Street 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 License #________________

( ) ASHA Certification in Speech-Language Pathology Certificate #_____________

( ) 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