

SPEECH-LANGUAGE PATHOLOGIST **APPLICATION FOR LIMITED LICENSURE CHECKLIST**

I. ALL APPLICANTS NEED:

___ \$100.00 Fee (make check or money order payable: Board of SLP)

___ 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.mdboardaudhadsplp.org. Use the Forms Link to download a copy of the law examination. To complete the examination, refer to the law and regulation reference number included with the questions. Use the web site law and regulations links to get the correct answer. If you do not have access to a computer, you may contact the Board and request a copy of the examination and law and regulations. A license will **NOT** be issued unless the law examination is passed.

II. DOCUMENTS NEEDED:

___ Official Masters Transcript showing degree awarded (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 Board.

___ Official Undergraduate Transcript. Request college to send the transcript to the 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.

**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 SPEECH-LANGUAGE PATHOLOGIST 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

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 _____

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 _____

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.

VERIFICATION OF SUPERVISION FOR SPEECH-LANGUAGE PATHOLOGIST
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: _____ Alternate # _____

C. Academic Status: _____
College Degree Date Conferred

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 Speech-Language Pathology: _____

5. Are you completing a CFY? _____ Yes _____ No

Form AS2

II. Supervisor of Limited Licensure year (please print or type)

A. Name: _____
Last First Middle/Maiden

**VERIFICATION OF SATISFACTORY COMPLETION OF SPEECH-LANGUAGE
PATHOLOGIST 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

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 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