

**SPEECH-LANGUAGE PATHOLOGIST FULL LICENSURE**  
**APPLICATION CHECKLIST**

**I. ALL APPLICANTS NEED:**

\_\_\_ \$150.00 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.mdboardaudhadslp.org](http://www.mdboardaudhadslp.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 question. Use the law and regulation Links on the web site 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:**

\_\_\_ Letter of confirmation of CCC from ASHA **or**

\_\_\_ Copy of ASHA-CCC (a copy of ASHA card is not acceptable)

\_\_\_ Short Resume (if you have been practicing more than 5 years)

\_\_\_ License affidavit from ALL states in which you are now licensed or have ever been licensed

**OR IF YOU DO NOT HAVE CCC:**

\_\_\_ Official Masters Transcript

\_\_\_ Official Undergraduate transcript

\_\_\_ Clinical Fellowship Year Plan (Form AS2)

\_\_\_ Clinical Fellowship Year Verification (Form AS3)

\_\_\_ Praxis Exam Scores

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-LANGUGAE PATHOLOGIST FULL LICENSE APPLICATION**

Date \_\_\_\_\_

**Affix current 2x2 passport  
size photo**

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, please explain. Attach a separate sheet with the 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 Awarded \_\_\_\_\_

Note: If you do not have ASHA Certification, a certified official transcript showing credit hours in speech-language pathology must accompany this application

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**FOR OFFICE USE**

Received \_\_\_\_\_ CH( ) MO ( ) Number \_\_\_\_\_

8. Do you hold the American Speech-Language Hearing Association Certificate of Clinical Competence in Speech-Language Pathology? Date originally granted \_\_\_\_\_

(A) Clinical Fellowship Year completed? \_\_\_\_ Yes \_\_\_\_ No

(B) Praxis Examination in Speech-Language Pathology Passed? \_\_\_\_ Yes \_\_\_\_ No

*If you answer no to #8(A) or (B) enclose a professional resume. If you hold a CCC, proceed to # 11. A photocopy of ASHA Certificate or Letter from ASHA must accompany the application*

**9. Employment during Clinical Fellowship Year – submit AS2 for each place of employment during the period of limited licensure**

Date \_\_\_\_\_ Title of position \_\_\_\_\_

Facility/Company name \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip Code

Brief description of duties

**10. Supervision of Clinical Fellowship Year**

A. Submit Verification of Supervision for Limited Licensure Clinical Fellowship Year (From AS2) or copy of ASHA CFY

B. Submit Verification of Satisfactory Completion of Clinical Fellowship Year (Form AS3)

**11.** Are you now or have you ever been licensed in any other state? \_\_\_\_\_ If yes, please complete the first page of the Licensure Affidavit ( AS4). Request the State licensure Board to return the completed form to the Maryland Board office.

I am licensed in the following states \_\_\_\_\_

I was licensed in the following states \_\_\_\_\_

**12.** Has any disciplinary action ever been taken against your license in any other jurisdiction? \_\_\_\_ Yes \_\_\_\_ No *If yes, please explain. Attach a separate sheet.*

**13. 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.

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

1. Applicant (Please type or print)

A. Name: \_\_\_\_\_  
Last First Middle/Maiden

B. Address: \_\_\_\_\_  
Street Apt.

\_\_\_\_\_  
City State Zip Code

Phone: \_\_\_\_\_ Alternate# \_\_\_\_\_ Email \_\_\_\_\_

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 Speech-language Pathology? \_\_\_\_\_

5. Are you completing a CFY? \_\_\_\_\_ Yes \_\_\_\_\_ No



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**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

