

# 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.mdboardaudhadspl.org](http://www.mdboardaudhadspl.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 Doctoral Transcript: Request college to send the transcript to the Maryland Board.

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

\_\_\_\_\_ Clinical Training Plan (Form AS2)

**Note:** Form AS-2 (Verification of Supervision for Limited Licensure/Clinical Training) 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 \_\_\_\_\_

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**FOR OFFICE USE**

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

**8. Employment for Clinical Training**

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 TRAINING

### **CLINICAL TRAINING REQUIREMENTS:**

The clinical training must be started within two years after completion of the academic coursework and clinical practicum requirements and must then be completed within 24 months.

To complete a clinical training, the applicant shall be employed as a professional in the field of audiology under appropriate on-site supervision for not less than 9 months with a minimum of 36 hours of work per week. This requirement may also be met with part-time employment as follows:

- (a) 14-16 hours a week for a period of 24 months;
- (b) 17-20 hours a week for a period of 18 months;
- (c) 21-24 hours a week for a period of 15 months;
- (d) 25-35 hours a week for a period of 12 months.

At least 80% of the applicant's employment during the clinical training shall be in direct contact which includes:

- (a) Assessment/diagnosis/evaluation;
- (b) Screening;
- (c) Habilitation/rehabilitation; and
- (d) Activities related to client management.

### **AS2:**

An applicant for a Limited License shall submit a Form AS2, Verification of Supervision for Limited License/Clinical Training 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.**

### **CLINICAL TRAINING SUPERVISION REQUIREMENTS:**

An individual serving as a supervisor:

- (a) Shall hold a valid license issued by the Board in audiology, or if the supervisor is employed by a facility whose employees qualify for an exemption from licensure the Certificate of Clinical Competence of the American Speech-Language-Hearing Association in Audiology or Board Certification in Audiology from the American Board of Audiology;
- (b) Shall have been in practice for a minimum of 3 years after completion of the clinical training;
- (c) Shall supervise not more than three limited licensees at one time; and
- (d) May not have been formally disciplined by the Board within the previous 5 years.

On-site direct supervision is required.

### **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 SATISFACTORY COMPLETION OF AUDIOLOGY  
CLINICAL TRAINING**

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