



Application Checklist for Speech-Language Pathology Aide

1. Application

2. Registration Fee

- Check or Money Order to Board for \$10

3. Fingerprints

- If a California resident, must do Livescan; send copy of your form to the Board. Fees paid directly to Livescan Operator.



OFFICE USE ONLY	
RECEIPT #:	
ATS #:	
AMOUNT PAID:	
DATE CASHIERED:	

REGISTRATION OF SPEECH-LANGUAGE PATHOLOGY OR AUDIOLOGY AIDE \$10.00

NOTICE: EFFECTIVE JULY 1, 2012, THE STATE BOARD OF EQUALIZATION, AND THE FRANCHISE TAX BOARD MAY SHARE TAXPAYER INFORMATION WITH THE BOARD. YOU ARE OBLIGATED TO PAY YOUR STATE TAX OBLIGATION AND YOUR LICENSE MAY BE SUSPENDED IF THE STATE TAX OBLIGATION IS NOT PAID.

PLEASE TYPE OR PRINT

1. NAME OF SPEECH-LANGUAGE PATHOLOGIST OR AUDIOLOGIST WHO WILL BE PROVIDING SUPERVISION:

LAST	FIRST	MIDDLE	LICENSE NUMBER
NAME OF BUSINESS			
BUSINESS STREET ADDRESS			
CITY	STATE	ZIP CODE	BUSINESS PHONE NUMBER
EMAIL ADDRESS			

THE FOLLOWING AIDES ARE APPROVED BY THE BOARD TO WORK UNDER MY SUPERVISION:

2. NAME OF AIDE

LAST	FIRST	MIDDLE	BEGINNING DATE OF EMPLOYMENT AS AIDE
HOME ADDRESS		HOME PHONE NUMBER	
CITY	STATE	ZIP CODE	
SOCIAL SECURITY NUMBER		DATE OF BIRTH	
EMAIL ADDRESS:			

A supervisor of a speech-language pathology or audiology aide shall:

- (a) Have legal responsibility for the health, safety and welfare of the patients.
- (b) Have legal responsibility for the acts and services provided by the speech-language pathology or audiology aide, including compliance with the provision of the Act and these regulations.
- (c) **Be physically present while the speech-language pathology or audiology aide is assisting with patients, unless the board has approved an alternative plan of supervision.** A supervisor of industrial audiology aides shall include a proposed plan for alternative supervision with the registration form. An industrial audiology aide may only be authorized to conduct air conduction threshold audiograms when performing outside the physical presence of a supervisor. The supervisor shall review all patients' histories and the audiograms and make any necessary referrals for evaluation and treatment.
- (d) Evaluate, treat, manage and determine the future disposition of patients.
- (e) Appropriately train the speech-language pathology or audiology aide to perform duties to effectively assist in evaluation and/or treatment. A supervisor shall establish and complete a training program for speech-language pathology or audiology aides in accordance with Section 1399.154.4 which is unique to the duties of the aide and the setting in which he or she will be assisting the supervisor.
- (f) Define the services which may be provided by the speech-language pathology or audiology aide. These services shall not exceed the competency of the aide as determined by his or her education, training and experience, and shall not include any treatment beyond the plan established by the supervisor for the patient.

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: _____ Type of Application: (check one) Employment License, Certification, Permit Volunteer
Code assigned by DOJ
Job Title or Type of License, Certification or Permit: _____

Agency Address Set Contributing Agency:

_____ Agency authorized to receive criminal history information _____ Mail Code (five-digit code assigned by DOJ)
_____ Street No. _____ Street or PO Box _____ Contact Name (Mandatory for all school submissions)
_____ City _____ State _____ Zip Code _____ () _____ Contact Telephone No.

Name of Applicant: _____
(Please print) Last First MI

AKA's: _____ CDL No. _____
Last First

DOB: _____ SEX: Male Female Misc. No. **BIL** - _____
Agency Billing Number (if applicable)

HT: _____ WT: _____ Misc. No. _____

EYE Color: _____ HAIR Color: _____ Home Address: (Applies only if Youth Org/HRA or Public Utility submission)

POB: _____ Street or PO Box

SOC: _____ City, State and Zip Code

Your Number: _____
OCA No. (Agency Identifying No.)

If resubmission, list Original ATI No. _____ Level of Service DOJ FBI

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

_____ Employer Name

_____ Street No. _____ Street or PO Box _____ Mail Code (five digit code assigned by DOJ)

_____ City _____ State _____ Zip Code _____ () _____ Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Name of Operator _____ Date _____

_____ Transmitting Agency _____ ATI No. _____ Amount Collected/Billed

