



Application Checklist for Speech-Language Pathology and Audiology *Registration of Aide*

**If you need assistance, please email the Board at
speechandhearing@dca.ca.gov**

1. Application

- Please remember to submit a 2x2 passport quality photograph.
- If you have multiple supervisors, a separate application with the \$10 fee must be submitted for each supervisor.

2. Fees

- Please submit a check or money order to the Board in amount of \$10, made payable to SLPAHADB.

3. Fingerprints

- California applicants are required to use Live Scan for fingerprinting; please submit a copy of the completed form to the Board. Fees are paid directly to the Live Scan operator.
- Out-of-State applicants are required to submit two fingerprint cards (FD-258) and a check or money order to the Board for \$49.00(DOJ and FBI processing fee). You may request fingerprint cards be mailed to you via email at speechandhearing@dca.ca.gov
 - One (1) check or money order in the amount of \$59 (\$10 licensing fee and \$49 fingerprint card processing fees) may be submitted. Please make check or money order payable to SLPAHADB.



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

INSTRUCTIONS: Do not print this application double-sided. You must complete **Part A** and your supervisor must complete **Part B**. Any corrections to this form must be crossed out and initialed.

Please check applicable: Speech-Language Pathology Aide Audiology Aide

PART A – Personal Information

1. FULL LEGAL NAME:	LAST	FIRST	MIDDLE
2. OTHER NAMES YOU HAVE USED (INCLUDING MAIDEN):			
3. STREET ADDRESS:			
CITY, STATE, ZIP CODE:			
4. RESIDENCE TELEPHONE:		BUSINESS TELEPHONE:	
5. SOCIAL SECURITY NUMBER (SSN) OR INDIVIDUAL TAX IDENTIFICATION NUMBER (ITIN):			
6. DATE OF BIRTH: (MM/DD/YYYY)			
7. EMAIL ADDRESS:			
8. ARE YOU, A SPOUSE, OR DOMESTIC PARTNER OF AN ACTIVE DUTY MILITARY PERSONNEL OR HAVE BEEN HONORABLY DISCHARGED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
IF YES, YOU MAY QUALIFY FOR EXPEDITED APPLICATION PROCESSING. AN APPLICANT FOR EXPEDITED APPLICATION PROCESSING MUST MEET THE FOLLOWING REQUIREMENTS: 1) PROVIDE EVIDENCE THAT THE APPLICANT IS MARRIED TO, OR IN A DOMESTIC PARTNERSHIP OR OTHER LEGAL UNION WITH, AN ACTIVE DUTY MEMBER OF THE ARMED FORCES OF THE UNITED STATES WHO IS ASSIGNED TO A DUTY STATION IN CALIFORNIA UNDER OFFICIAL ACTIVE DUTY ORDERS AND; 2) HOLD A CURRENT LICENSE IN ANOTHER STATE, DISTRICT, OR TERRITORY OF THE UNITED STATES IN HEARING AID DISPENSING.			
9. ARE YOU AN HONORABLY DISCHARGED VETERAN OF THE ARMED FORCES? YES <input type="checkbox"/> NO <input type="checkbox"/>			
IF YES, YOU MAY QUALIFY FOR EXPEDITED APPLICATION PROCESSING. AN APPLICANT FOR EXPEDITED APPLICATION PROCESSING MUST MEET THE FOLLOWING REQUIREMENT: 1) SUPPLY SATISFACTORY EVIDENCE TO THE BOARD THAT THE APPLICANT HAS SERVED AS AN ACTIVE DUTY MEMBER OF THE ARMED FORCES OF THE UNITED STATES AND WAS HONORABLY DISCHARGED.			

ATTACH 2" x 2"
**PASSPORT QUALITY
 PHOTOGRAPH**
 (Must be an actual
 photograph, not a paper
 copy.)

Photographs must be taken
 within 60 days of the filing date
 of this application.

Print your full name on the back
 of the photograph.

PART A - Continued

A <u>YES</u> answer to any of the questions below (10 through 15), requires you to complete and submit the Conviction and Discipline Reporting Form.		YES	NO
10. Have you ever been the subject of a disciplinary action or have any <i>pending</i> disciplinary action taken or charges filed against any speech-language pathology, audiology, hearing aid dispensing, or other healing arts license? Include any disciplinary action taken by any other state or Federal Government entity? <i>This includes, but is not limited to suspension, revocation, probation, confidential discipline, consent order, letter of reprimand or warning, or any other restriction of actions taken against a license.</i>	<input type="checkbox"/>	<input type="checkbox"/>	
11. Have you had any pending investigations by any State or Federal agencies against you?	<input type="checkbox"/>	<input type="checkbox"/>	
12. Have you been denied a license to practice speech-language pathology, audiology, hearing aid dispensing, or other healing arts, in any state or country?	<input type="checkbox"/>	<input type="checkbox"/>	
13. Have you voluntarily surrendered a license to practice speech-language pathology, audiology, hearing aid dispensing, or other healing arts in another state or country?	<input type="checkbox"/>	<input type="checkbox"/>	
14. Have you been convicted of, or pled nolo contendere to any criminal offense, misdemeanor or felony of any state, the United States, its territories or a foreign country? <i>(This includes any citation, infraction, misdemeanor and/or felony, excluding violations of minor traffic laws not involving alcohol or drugs, which result in fines of \$300 or less. Note: Convictions that were later dismissed pursuant to Sections 1203.4, 1203.4a, or 1203.41 of the California Penal Code or equivalent non-California law must be disclosed. Convictions that were adjudicated in the juvenile court or convictions under California Health and Safety Code sections 11357(b),(c),(d),(e), or section 11360(b) that are two years or older should not be reported).</i> <i>You must also submit a certified copy of any court order dismissing a conviction pursuant to Penal Code sections 1203.4, 1203.4a, or 1203.41.</i>	<input type="checkbox"/>	<input type="checkbox"/>	
15. Are you required to register as a sex offender pursuant to section 290 of the Penal Code, or the equivalent in another state or territory, or military or federal law?	<input type="checkbox"/>	<input type="checkbox"/>	

I hereby certify under penalty of perjury under the laws of the State of California that all statements made herein are true in every respect and that misstatements or omissions of material facts may be cause for denial of this application, or for suspension or revocation of a license.

APPLICANT'S SIGNATURE: _____ DATE SIGNED: _____

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 your tax obligation is not paid.

SPEECH-LANGUAGE PATHOLOGY OR AUDIOLOGY AIDE LICENSE

✦ Duties and Responsibilities of Applicant ✦

Aide applicants and applicant's supervisor must read and sign this form under the penalty of perjury. Please submit with the completed Aide application.

- 1) I have read and understand the excerpts of the laws and regulations, included with my application, pertaining to the responsibilities of a speech-language pathology or audiology aide license holder.
- 2) My supervisor shall maintain a current license issued by the Board, during the time of my supervision. If my supervisor's license expires during the course of professional experience, I will immediately notify the board. *A supervisor's license can be verified at any time at the Board's website.*
- 3) I understand that I am required to have 100% direct supervision when assisting with patients.
- 4) I understand that any experience obtained as an aide shall not be creditable toward the supervised clinical experience required as a speech-language pathologist or audiologist.

APPLICANT SIGNATURE

PRINTED FULL LEGAL NAME OF APPLICANT

DATE

✦ Duties and Responsibilities of Supervisor ✦

- 1) I possess the following qualification to supervise an RPE applicant: a California SLP license; or (if employed by a public school) a clear, valid, teaching credential authorizing service in language, speech, and hearing issued by the Commission on Teacher Credentialing.
- 2) I agree to ensure that either my California licensee or my teaching credential is renewed in a timely manner.
- 3) I agree to provide 100% direct supervision to the aide when assisting with patients.
- 4) I will not supervise more than three aides at any one time pursuant to California Code of Regulations Section 1399.154.3.
- 5) I will immediately notify the aide of any disciplinary action, including revocation, suspension (even if stayed), probation terms, inactive licensure, or lapse in licensure that affects my ability or right to supervise.
- 6) I have read and understand the laws and regulations pertaining to the supervision of the aide.
- 7) I shall establish and complete a training program for a speech-language pathology or audiology aide 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.

SIGNATURE OF SUPERVISOR

PRINT FULL LEGAL NAME OF SUPERVISOR

LICENSE NUMBER OR CREDENTIAL NUMBER
(Please attach a copy of the front and back of your credential)

Date

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0437 Code assigned by DOJ Type of Application: (check one) Employment License, Certification, Permit Volunteer
Job Title or Type of License, Certification or Permit: Speech Pathologist Audiologist Speech Assistant Speech Aide Audiology Aide

PLEASE CIRCLE ONE

Agency Address Set Contributing Agency:

SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS BOARD

06187

Agency authorized to receive criminal history information

Mail Code (five-digit code assigned by DOJ)

2005 Evergreen Street, Suite 2100

N/A

Street No. Street or PO Box

Contact Name (Mandatory for all school submissions)

Sacramento

CA

95815

()

City

State

Zip Code

Contact Telephone No.

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

AKA's: _____
Last First

CDL No. _____

DOB: _____ SEX: Male Female

Misc. No. BIL - Applicant Must Pay At Site
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: 7700 SLP/AU
OCA No. (Agency Identifying No.)

Level of Service DOJ FBI

If resubmission, list Original ATI No. _____

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

THIS SECTION IS NOT APPLICABLE

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: _____ Date _____
Name of Operator

Transmitting Agency

ATI No.

Amount Collected/Billed

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(Please print)

Last

First

MI

AKA's:

Last

First

CDL No. _____

DOB: _____

SEX: _____

Male

Female

Misc. No. BIL -

Applicant Must Pay At Site

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Male

Female

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