



Application Checklist for Speech-Language Pathologists

Required Professional Experience

(US Graduates)

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

Items 1- 4 are required for issuance of the temporary license.

1. Application

- Please remember to submit a 2x2 passport quality photograph.

2. Fees

- Please submit a check or money order to the Board in the amount of \$60.00, made payable to SLPAHADB.

3. Fingerprints - DOJ and FBI clearances must be received prior to issuance of temporary license

- **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
 - **Please note:** one (1) check or money order in the amount of \$109 (\$60 licensing fee and \$49 fingerprint card processing fees) may be submitted. Please make check or money order payable to SLPAHADB.

4. Clinical Practicum/University Recommendation

Items 5-6 must be submitted within 30 days of issuance of your temporary license.

5. Transcripts – Graduate Programs only

- Must be sent directly to the Board from the universities. The Board does not accept transcripts electronically.
- Master's Degree for Speech-Language Pathology applicants.

6. Photocopy of Degree

- Please send a photocopy of the degree, not an original, if not posted on transcript.

Item 7 can be submitted anytime during the experience

7. National Exam Score

- Effective 09/01/2014 minimum passing score of 162 – SLP
- Must have been taken within the last five years.
- Must be sent electronically to the Board from Praxis.

Item 8 must be submitted at the end of each experience

8. RPE Verification Form

- Submit a separate verification form for each public school year.
- Provide a school calendar for each school year.
- Letter from the school district defining the dates and hours of the summer session.

Item 9 is to be completed after eligibility

9. Permanent/Full Licensure Application

- No additional fees are required.



**SPEECH-LANGUAGE PATHOLOGY
 REQUIRED PROFESSIONAL EXPERIENCE (RPE) APPLICATION
 TEMPORARY LICENSE
 \$60.00**

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.

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? 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 SPEECH-LANGUAGE PATHOLOGY OR AUDIOLOGY.			
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

YES NO

10. Have you taken the Educational Testing Service/National Teacher Examination (NTE) (The Praxis series) in speech-language pathology within the previous 5 years? Must have been completed in the United States.	<input type="checkbox"/> <input type="checkbox"/>
11. Have you completed any portion of your CFY/RPE in another state?	<input type="checkbox"/> <input type="checkbox"/>
12. Have you ever been licensed to practice speech-language pathology in any state or country? If yes, what state(s) or country? _____	<input type="checkbox"/> <input type="checkbox"/>

A YES answer to any of the questions below (13 through 18), requires you to complete and submit the Conviction and Discipline Reporting Form.

YES NO

13. 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"/>
14. Have you had any pending investigations by any state or federal agencies against you?	<input type="checkbox"/> <input type="checkbox"/>
15. Have you been denied a license to practice speech-language pathology, audiology, hearing aid dispensing, or any other healing arts profession, in any state or country?	<input type="checkbox"/> <input type="checkbox"/>
16. 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"/>
17. 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"/>
18. 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.

PART B – To be completed by the RPE Supervisor

Refer to Title 16, California Code of Regulations, Section 1399.153.3 for supervisor's responsibilities.

19. FULL LEGAL NAME OF SUPERVISOR:	LAST	FIRST	MIDDLE
STREET ADDRESS:			
CITY, STATE, ZIP CODE:			
20. BUSINESS TELEPHONE:	LICENSE NUMBER:		
21. EMAIL ADDRESS:			
22. PROPOSED START DATE:			
AS SOON AS APPROVED _____ FUTURE DATE: _____			
Professional services can only start upon the issuance of the RPE temporary license.			
23. NUMBER OF RPE EMPLOYMENT HOURS PER WEEKS:			
_____ 30-40 (FULL-TIME) _____ 15-29 (PART-TIME)			
24. LIST OF PLACE(S) WHERE FUNCTIONS WILL BE PERFORMED: (DO NOT PROVIDE CONTRACT AGENCY NAME AND ADDRESS)			
_____ FACILITY OR SCHOOL NAME (DO NOT USE ABBREVIATIONS) ADDRESS CITY, STATE, ZIP CODE			
_____ FACILITY OR SCHOOL NAME (DO NOT USE ABBREVIATIONS) ADDRESS CITY, STATE, ZIP CODE			
_____ FACILITY OR SCHOOL NAME (DO NOT USE ABBREVIATIONS) ADDRESS CITY, STATE, ZIP CODE			
25. IS THE SETTING(S) LISTED IN QUESTION #22 A PUBLIC SCHOOL?			
YES _____ NO _____			
IF YES, IS THE RPE:			
_____ A SALARIED EMPLOYEE OF THE SCHOOL PUBLIC OR COUNTY OFFICE OF EDUCATION.			
_____ PAID BY A CONTRACT AGENCY AND PLACED IN THE PUBLIC SCHOOL.			
26. SUPERVISION:			
_____ THE RPE WILL BE WORKING FULL-TIME AND I AGREE TO PROVIDE EIGHT HOURS A MONTH DIRECT SUPERVISION. FOUR OF THE EIGHT WILL BE IN SCREENING, THERAPY, AND EVALUATION.			
_____ THE RPE WILL BE WORKING PART-TIME AND I AGREE TO PROVIDE FOUR HOURS A MONTH DIRECT SUPERVISION. TWO OF THE FOUR WILL BE IN SCREENING, THERAPY, AND EVALUATION.			

I, the RPE applicant, have discussed the plan for supervision with this supervisor and agree to its implementation and will not provide professional services until I have been issued a RPE temporary license. I further certify under penalty of perjury under the laws of the State of California that all statements made in the application are true and correct. Any misrepresentation may be caused for denial of my license.

APPLICANT'S SIGNATURE: _____ DATE SIGNED: _____

I, the RPE supervisor, have discussed the plan for supervision with the RPE applicant and hereby accept professional and ethical responsibility for his or her performance. I understand that professional services cannot be rendered until a RPE temporary license has been issued. I further certify under penalty of perjury under the laws of the state of California that all statements made in Part B are true and correct.

SUPERVISOR'S SIGNATURE: _____ DATE SIGNED: _____

REQUIRED PROFESSIONAL (RPE) TEMPORARY LICENSE

✦ Duties and Responsibilities of Applicant ✦

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

- 1) I have read and understand the excerpts of the laws and regulations, included with my application, pertaining to the responsibilities of an RPE temporary 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 may be verified at any time at the Board's website.*
- 3) I understand that my work plan can be 36 weeks for speech-language pathology of full-time professional experience (defined as 30-40 hours per week) with eight hours of direct supervision per month or 72 weeks for speech-language pathology of part-time professional experience (defined as 15-29 hours per week) with four hours of direct supervision per month.
- 4) If there is a break in professional experience due to a medical reason, it is my responsibility to notify the Board of the exact dates of the absence. I will not receive credit for the break in professional experience.
- 5) At the time of termination of supervision, I will ensure that my supervisor completes the RPE Verification form. I understand that it is my responsibility to submit the verification form within 10 days of completion.

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 SLP California license or my teaching credential is renewed in a timely manner. Failure to do so could result in a loss of credit for professional experience by the RPE.
- 3) I agree to provide eight hours direct supervision per month for each full-time RPE (defined as 30-40 hours per week) and four hours direct supervision per month for each part-time RPE (defined as 15-29 hours per week).
- 4) I will not supervise more than three RPE's at any one time pursuant to California Code of Regulations Section 1399.153.4.
- 5) I will immediately notify the RPE 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 RPE and the professional experience required.
- 7) I will ensure that the extent, type, and quality of the clinical work performed is consistent with the training and professional experience of the RPE and shall be accountable for the assigned duties performed by the RPE.
- 8) At the time of termination of supervision of the RPE, I will complete the RPE verification form. I will submit the original signed form to the Board within 10 calendar days of termination of supervision.
- 9) I have completed the initial six hours of continuing professional development in supervision training and will complete three hours every four years thereafter.

SIGNATURE OF SUPERVISOR

PRINT FULL LEGAL NAME OF SUPERVISOR

LICENSE NO. or
CREDENTIAL NO.

Date



SPEECH-LANGUAGE PATHOLOGY REQUIRED PROFESSIONAL EXPERIENCE CLINICAL PRACTICUM/UNIVERSITY RECOMMENDATION

Instructions:

- Any corrections to this form must be crossed out and initialed.
- This form is for use only by current graduate students who are/have:
 - from an approved California training program;
 - enrolled in their final semester of study in Speech-Language Pathology;
 - being recommended by their university for the RPE temporary license.
 - secured employment and have identified their RPE supervisor;

APPLICANT INFORMATION:

1. Name Last	First	Middle Initial
2. Social Security Number:	3. Official Graduation Date:	4. Date Of Birth: (MM/DD/YY)

UNIVERSITY & TRAINING PROGRAM DIRECTOR INFORMATION:

5. College or University:
6. Program Director Name:

VERIFICATION OF CLINICAL PRACTICUM:

	YES	NO
7. The applicant has completed a minimum of 300 clock hours of supervised clinical experience in direct client/patient contact.	<input type="checkbox"/>	<input type="checkbox"/>
8. The applicant has completed the hours while engaged in graduate study.	<input type="checkbox"/>	<input type="checkbox"/>
9. The applicant has gained knowledge & experience with individuals from culturally/linguistically diverse backgrounds and with clients/patients of all ages.	<input type="checkbox"/>	<input type="checkbox"/>
10. The applicant has been supervised by individual(s) who hold current/valid licensure in speech pathology or ASHA certification.	<input type="checkbox"/>	<input type="checkbox"/>
11. The amount of supervision was appropriate to the student's level of knowledge, experience & competence, and was sufficient to ensure the welfare of the clients.	<input type="checkbox"/>	<input type="checkbox"/>
12. The applicant is enrolled in the final semester of a graduate program in Speech-Language Pathology at an approved California university training program or ASHA approved program.	<input type="checkbox"/>	<input type="checkbox"/>

VERIFICATION OF UNIVERSITY RECOMMENDATION:

	YES	NO
13. The applicant is scheduled to graduate within the next 75 days and will graduate at the end of term (pending completion of final requirements).	<input type="checkbox"/>	<input type="checkbox"/>
14. The applicant is being recommended by the university training program for a RPE temporary license.	<input type="checkbox"/>	<input type="checkbox"/>

I certify that all academic and practicum information listed on this form was completed according to the State of California or ASHA licensure requirements.

 Signature of Current Training Program Director

 DATE



PRAXIS EXAMINATION INFORMATION

All applicants must submit a passing score on the required specialty examination. Your Praxis examination **must** be taken in the United States.

Effective September 1, 2014, the minimum passing score for Speech-Language Pathology is 162.

These examinations are offered at several sites throughout California and the United States, according to an annual schedule set by the Education Testing Service (ETS). When filing for the Praxis please, arrange to have a copy of your score sent electronically to the Board using the following Reporting Code: **R8544**. Applications may be obtained from:

The Praxis Series
Educational Testing Service
P.O. Box 6051
Princeton, NJ 08541-6051
(609) 771-7395

The examination may be taken anytime within the 5 year period prior to filing an application for permanent licensure or it may be taken while the Required Professional Experience (temporary license) is being completed. It takes approximately 6 weeks for ETS to process and send out scores, it is not recommended that you wait until the end of your RPE to sit for the examination. There are no limits on the number of times the examination may be taken.



REQUIRED PROFESSIONAL EXPERIENCE VERIFICATION FORM

INSTRUCTIONS AND IMPORTANT INFORMATION:

- This form must be completed and submitted within 10 business days after end date of experience, change in time base or end of supervision.
- Full-time and part-time experiences cannot be combined on the same form.
- Any corrections to this form must be crossed out and initialed by the Supervisor.
- Do **NOT** use white out or correction tape on this form.
- Do **NOT** fax or email this form to the Board.
- **SCHOOL SETTINGS:** Separate verifications and school calendars are required for each school session; including summer school.

PART A: RPE INFORMATION

1. FULL LEGAL NAME:	LAST	FIRST	MIDDLE
2. RPE LICENSE NUMBER			
3. STREET ADDRESS:			
CITY, STATE, ZIP CODE:			
4. EMAIL ADDRESS:			

PART B: SUPERVISOR INFORMATION

5. FULL LEGAL NAME OF SUPERVISOR:	LAST	FIRST	MIDDLE
6. SPEECH-LANGUAGE PATHOLOGY LICENSE NUMBER <u>OR</u> CLEAR CREDENTIAL NUMBER			
7. STREET ADDRESS:			
CITY, STATE, ZIP CODE:			
8. EMAIL ADDRESS:			

PART B: SUPERVISOR INFORMATION (Cont'd)

9. LOCATION(S) WHERE EXPERIENCE WAS OBTAINED:	
(A) _____ FACILITY OR SCHOOL NAME	CHECK ONE: <input type="checkbox"/> SCHOOL SETTING <input type="checkbox"/> OTHER

ADDRESS	CITY, STATE, ZIP CODE

(B) _____ FACILITY OR SCHOOL NAME	CHECK ONE: <input type="checkbox"/> SCHOOL SETTING <input type="checkbox"/> OTHER

ADDRESS	CITY, STATE, ZIP CODE
10. HOURS WORKED PER WEEK:	
11. DATE OF EXPERIENCE: (Must reflect only the dates AFTER the applicant was approved to start) MM/DD/YYYY	
START: / /	END: / /
12. WILL THE APPLICANT CONTINUE TO WORK UNDER YOUR SUPERVISION? If no supervision, RPE cannot practice until permanent license is issued.	
<input type="checkbox"/> YES <input type="checkbox"/> NO	
13. SUPERVISION: (Check One)	
<input type="checkbox"/> The RPE worked FULL-TIME, (30-40 hours per week) and I provided eight (8) hours of direct supervision per month. Four (4) of the eight (8) hours were in screening, therapy and evaluation.	
<input type="checkbox"/> The RPE worked PART-TIME, (15-29 hours per week) and I provided four (4) hours of direct supervision per month. Two (2) of the four (4) hours were in screening, therapy and evaluation.	
<input type="checkbox"/> The RPE worked less than fifteen (15) hours per week.	
14. PERFORMANCE OF RPE APPLICANT: (Check One)	
<input type="checkbox"/> SATISFACTORY <input type="checkbox"/> UNSATISFACTORY	
COMMENTS: (OPTIONAL)	

I declare under penalty of perjury under the laws of the State of California that I have discussed the foregoing with the applicant and that the statements made herein are true and correct, and I did not supervise more than two (2) other applicants obtaining their Required Professional Experience (RPE) during the same period of time. I further 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 verification, or for suspension or revocation of my license.

SUPERVISOR'S SIGNATURE

DATE

PRINT FULL LEGAL NAME OF SUPERVISOR



REQUEST FOR LIVE SCAN SERVICE

[Print Form](#)

[Reset Form](#)

Applicant Submission

A0437

ORI (Code assigned by DOJ)

License

Authorized Applicant Type

Speech Pathologist, Audiologist, Speech Assistant Speech Aide Audiography Aide

Type of License/Certification/Permit OR Working Title (Please circle one) (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:

SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS

06187

Agency Authorized to Receive Criminal Record Information

Mail Code (five-digit code assigned by DOJ)

2005 Evergreen Street, Suite 2100

Street Address or P.O. Box

Contact Name (mandatory for all school submissions)

Sacramento, CA 95815

City

State ZIP Code

Contact Telephone Number

Applicant Information:

Last Name

First Name

Middle Initial

Suffix

Other Name

(AKA or Alias) Last

First

Suffix

Date of Birth

Sex Male Female

Driver's License Number

Height

Weight

Eye Color

Hair Color

Billing Number

(Agency Billing Number)

Place of Birth (State or Country)

Social Security Number

Misc. Number

BIL-Applicant Must Pay At Site

(Other Identification Number)

Home Address

Street Address or P.O. Box

City

State

ZIP Code

Your Number: 7700 SLP/AU

OCA Number (Agency Identifying Number)

Level of Service:

DOJ

FBI

If re-submission, list original ATI number:
(Must provide proof of rejection)

Original ATI Number

Employer (Additional response for agencies specified by statute):

THIS SECTION IS NOT APPLICABLE

Employer Name

Mail Code (five digit code assigned by DOJ)

Street Address or P.O. Box

City

State

ZIP Code

Telephone Number (optional)

Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency

LSID

ATI Number

Amount Collected/Billed



REQUEST FOR LIVE SCAN SERVICE

[Print Form](#)

[Reset Form](#)

Applicant Submission

A0437

ORI (Code assigned by DOJ)

License

Authorized Applicant Type

Speech Pathologist, Audiologist, Speech Assistant Speech Aide Audiology Aide

Type of License/Certification/Permit OR Working Title (Please circle one) (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

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Sacramento, CA 95815

City

State ZIP Code

Contact Telephone Number

Applicant Information:

Last Name

First Name

Middle Initial

Suffix

Other Name

(AKA or Alias) Last

First

Suffix

Date of Birth

Sex Male Female

Driver's License Number

Height

Weight

Eye Color

Hair Color

Billing Number

(Agency Billing Number)

Place of Birth (State or Country)

Social Security Number

Misc. Number

BIL-Applicant Must Pay At Site

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Home Address

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Name of Operator

Date

Transmitting Agency

LSID

ATI Number

Amount Collected/Billed



REQUEST FOR LIVE SCAN SERVICE

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[Reset Form](#)

Applicant Submission

A0437

ORI (Code assigned by DOJ)

License

Authorized Applicant Type

Speech Pathologist, Audiologist, Speech Assistant Speech Aide Audiology Aide

Type of License/Certification/Permit OR Working Title (Please circle one) (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:

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State ZIP Code

Contact Telephone Number

Applicant Information:

Last Name

First Name

Middle Initial

Suffix

Other Name

(AKA or Alias) Last

First

Suffix

Date of Birth

Sex Male Female

Driver's License Number

Height

Weight

Eye Color

Hair Color

Billing Number

(Agency Billing Number)

Place of Birth (State or Country)

Social Security Number

Misc. Number

BIL-Applicant Must Pay At Site

(Other Identification Number)

Home

Address Street Address or P.O. Box

City

State

ZIP Code

Your Number: 7700 SLP/AU

OCA Number (Agency Identifying Number)

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