

PROCEDURES FOR REGISTRATION

Speech Pathology Clinical Fellowship Year (CFY) or Audiology Clinical Extern (ACE)

All supervising licensees must register any and all **Clinical Fellows or Clinical Externs** working under their supervision with the Board on a registration form. Registration must be made by the supervising licensee before or within ten (10) days of retaining each Clinical Fellow.

An applicant for registration as a **Clinical Fellow or Clinical Extern** shall successfully complete a minimum of four hundred (400) clock hours of supervised clinical experience (practicum) with individuals having a variety of communication disorders, as required by ASHA. The experience shall have been obtained through an accredited college or university which is recognized by ASHA. The applicant shall cause the Department Chair or other program head to provide directly to the Board's Administrative Office a letter attesting to the standards of the Practicum and the applicant's successful completion, and the number of clinical hours achieved.

CFY: An applicant for registration as a **Clinical Fellow (CFY)** shall cause a graduate transcript to be submitted directly from the educational institution to the Board's Administrative Office. The transcript must show that graduation with at least a Master's or Doctorate level degree has been completed and must carry the official seal of the institution.

ACE: An applicant for registration as an **Audiology Clinical Extern (ACE)** shall cause a letter to be submitted directly from the educational institution to the Board's Administrative Office. The letter must show that the applicant has successfully completed sufficient academic course work to engage in outside supervised clinical practice

PERIOD OF EFFECTIVENESS CFY:

Clinical fellowships are effective for a period of no less than nine (9) months and no more than one (1) year.

The clinical fellowship's period of effectiveness for applicants for licensure who are awaiting national certification and subsequent Board review of their application for licensure may be extended for a period not to exceed three (3) additional months. Such extension will cease to be effective if national certification or Board licensure is denied. At all times while awaiting national certification results and until licensure is received, clinical fellows shall practice only under supervision as set forth in rule 1370-01-.10(1).

Application for licensure or a three (3) month extension of the clinical fellowship should be made thirty (30) days before the expiration of the clinical fellowship registration.

Supervising licensees may only supervise three (3) Registered Clinical Fellows concurrently or two (2) Registered Speech Assistants concurrently. They cannot supervise more than a total of three concurrently.

PERIOD OF EFFECTIVENESS ACE:

Audiology Externships are effective for a period of no less than fifteen (15) continuous months.

The Audiology Externship's period of effectiveness for applicants for licensure who are awaiting national certification and subsequent Board review of their application for licensure may be extended for a period not to exceed four (4) additional months. Such extension will cease to be effective if national certification or Board licensure is denied. At all times while awaiting national certification results and until licensure is received, clinical fellows shall practice only under supervision as set forth in this rule.

Application for licensure or a four (4) month extension of their Audiology Externship should be made thirty (30) days before the expiration of their Audiology Externship registration.

Supervising licensees may only supervise two (2) Registered Audiology Externs concurrently.

UNDERSTANDING THE APPLICATION PROCESS

If an address change occurs at any time, you **MUST** notify the Board office in writing immediately.

1. All documents required to be submitted must be mailed directly to:

**Board of Communication Disorders and Sciences
665 Mainstream Dr
Nashville, TN 37243**

We cannot accept faxed or emailed applications.

2. Please allow fourteen (14) working days for information mailed to our office to be received and placed in your file. The Board asks that you please give the Board office every consideration in this matter.
3. If necessary documentation has not been received when your application has been received by the Board office, an initial deficiency letter will be sent to you by mail or email.
4. All applicants must complete the Declaration of Citizenship form found at and have it notarized:
<http://tn.gov/assets/entities/health/attachments/PH-4183.pdf>
5. All applicants must complete a criminal background check. The instructions can be found at:
<https://www.tn.gov/health/health-professionals/criminal-background-check.html>
6. Absent any complicating factors, the average application processing time is six weeks. Once the application is completed, your file will be promptly reviewed and an initial certification determination made. You will be promptly notified by letter of the initial determination.
7. Applications that are deficient sixty (60) days after receipt of the initial deficiency letter will be closed.

Thank you for your cooperation. We will make every effort to expedite your application in an efficient manner.

In order to comply with federal statutes, the Board of Communications Disorders and Sciences is obligated to inform each applicant or licensee from whom it requests a social security number that disclosing such number is mandatory in order for this Board to comply with the requirements of the federal Healthcare Integrity and Protection Data Bank and/or the National Practitioner Data Bank. If the Board is required to make a report about one of its applicants or licensee to either or both of these data banks, it must report that individual's social security number. This application will not be complete if the social security number is omitted. The number will be used for identification purposes and for such purposes as are allowed by the state and federal law.

IMPORTANT: You must have a registration from the Board in your possession before you may lawfully practice in a Speech Pathology Clinical Fellowship or Audiology Clinical Externship.



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH LICENSURE AND REGULATION
665 Mainstream Dr
Nashville, TN 37243
<http://tn.gov/health/topic/CDS-board>

BOARD OF COMMUNICATION DISORDERS AND SCIENCES
(615) 741-5735 or 1-800-778-4123

APPLICATION for CLINICAL FELLOWSHIP YEAR (CFY) or AUDIOLOGY CLINICAL EXTERNSHIP (ACE)

_____ CFY

_____ ACE

Name: _____

Last

First

Middle

Maiden

Current Home Mailing Address:

Current Practice Name and Address: *

*If you have no practice address, notify the Board of your practice address within 30 days of obtaining a practice address. If you have multiple practice address, please attach an additional page listing all practice addresses.

Phone (Home): _____

(Work): _____

U. S. CITIZEN: Yes _____ No _____ Entitled to Live and Work in the U.S.: Yes ___ No ___

All applicants must complete the Declaration of Citizenship form and have it notarized.

Social Security Number: _____ - _____ - _____

Date of Birth: _____

E-Mail: _____

Do you wish to receive notifications, including renewal notification, from Department of Health via email? Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office. **Yes** _____ **No** _____

Gender: Female _____ Male _____ Race: _____

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? (If yes, please provide proof of status.) **Yes** _____ **No** _____

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? (If yes, please provide proof of same.) **Yes** _____ **No** _____

Have you ever been known by any other names besides what is listed above? **Yes** _____ **No** _____

If yes, please state in full every other name by which you have been known, the reason therefore, and inclusive dates so known:

EDUCATIONAL INFORMATION

Please provide the following information for all educational institutions you have attended beyond high school. Use the back of this page if you need additional space.

From: _____ To: _____
Mo/Yr Mo/Yr Educational Institution Degree Awarded

From: _____ To: _____
Mo/Yr Mo/Yr Educational Institution Degree Awarded

From: _____ To: _____
Mo/Yr Mo/Yr Educational Institution Degree Awarded

From: _____ To: _____
Mo/Yr Mo/Yr Educational Institution Degree Awarded

Masters Degree Awarded By: _____ **Degree Date:** _____

Doctoral Degree University: _____ **Degree Date (or anticipated)** _____

Practice Site for CFY/ACE: _____

Practice Address: _____

CFY/ACE Supervisor: _____
(Supervisor must be 2 years post-CFY/ACE)

TN License Number: _____
(If ASHA certified only, must include copy of ASHA card)

LICENSURE INFORMATION

Have you ever previously applied for a speech pathology or audiology license in Tennessee? Yes ____ No ____

If you have an NPI number, please provide _____

YES NO

Are you or have you ever been licensed in this profession in another state? _____
-

Are you or have you ever been licensed in any other profession in Tennessee or another state? _____
-

List below **ALL STATES, COUNTRIES, OR PROVINCES IN WHICH YOU HAVE EVER BEEN OR ARE CURRENTLY LICENSED, PERMITTED, OR CERTIFIED.** Additional pages may be added if necessary. Request that verification of licensure be submitted directly to the Board's Office from each state.

STATE	PROFESSION	LICENSE NUMBER	CURRENT STATUS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

EMPLOYMENT STATUS

Are you currently employed? Yes _____ No _____ If yes, give name and address of primary employer:

Do you engage in private practice? Yes _____ No _____ (If yes, give location): _____

Have you ever held a job in a healthcare profession? Yes: _____ No: _____

Please complete your entire healthcare employment history starting with the most current position first. Use the back of this page, if you need additional space. Dates of employment must be included.

<u>Company/Employer:</u>	<u>Name of Supervisor</u>	<u>Address: (City, and State)</u>	<u>Position:</u>	<u>Duties:</u>	<u>Dates</u> <u>From: To:</u> <u>Mo./Yr. Mo./Yr.</u>	
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If you answer “yes” to any of the questions in this part, you must supplement your affirmative response with a thorough explanation on a separate page. **IN SUPPORT OF YOUR EXPLANATION, THE FINAL DOCUMENTS OR ORDERS FROM THE ISSUING STATES, COURTS, AND/OR AGENCIES MUST BE SUBMITTED ALONG WITH THIS APPLICATION.** Additional information may be requested and/or required before a licensure decision may be made. For the purposes of these questions, the following phrases or words have the following meanings:

1. **“Ability to practice your profession”** is to be construed to include all of the following:
 - a. The cognitive capacity to make appropriate clinical diagnoses, exercise reasoned medical judgments, to learn, and keep abreast of medical developments;
 - b. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
 - c. The physical capability to perform professional tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. **“Medical Condition”** includes physiological, mental or psychological conditions including, but not limited to: orthopedic, visual, speech and/or hearing impairments, emotional or mental illness, specific learning disabilities, drug addiction, and alcoholism.
3. **“Minor Traffic Offense”** generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.
4. **“Chemical substances”** is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
5. **“Currently”** does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.
6. **“Illegal use of illicit or controlled substances”** means the use of substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.

- | | YES | NO |
|--|-------|-------|
| 1. Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated by ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice? | _____ | _____ |
| 2. Do you currently use any chemical substances which in any way impair or limit your ability to practice your profession with reasonable skill and safety? | _____ | _____ |

If so, please list: _____

[If you receive such ongoing treatment or participate in such a monitoring program, the Council will make an individual assessment of the nature, the severity and the duration of the risks associated with an ongoing medical conditions so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are ineligible for licensure.]

YES NO

3. At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances? _____
4. Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of illicit or controlled substances? _____
5. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or other diagnosis of a predatory nature? _____
6. Have you ever held or applied for a license, privilege, registration or certificate to practice as a hearing aid dispenser in any state, country, or province, that has been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action? _____
7. Have you ever had staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action? _____
8. Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, voluntarily surrendered or otherwise disciplined or surrendered under threat of restriction or disciplinary action? _____
9. Have you ever been convicted (including a nolo contendere plea or guilty plea) of a felony or misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended? _____
10. Have you ever been rejected or censured by a professional association or society? _____
11. In relation to the performance of your professional services in any profession:
 - a. Have you ever had a final judgment rendered against you; _____
 - b. Have you ever entered into any settlement of any legal action; or _____
 - c. Are there any legal actions pending against you or to which you are a party? _____
12. Have you ever held a license, registration, privilege or certificate in any profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action in any jurisdiction? _____
13. My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state) _____

AFFIDAVIT AND RELEASE

I, _____, of _____, being duly
(Name) (City) (State)

sworn and identified as the person referred to in this application, attest to the truth of each statement made in said application. I further attest that I have read and understand the law and the rules and regulations regarding the practice of my profession, which are posted on the Board’s internet site and/or were provided to me by the Board office, and agree to abide by them in the practice of Speech Pathology or Audiology in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary which may include a full Board interview.

RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice Speech Pathology/Audiology.

AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications;

RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character and/or other qualifications for certification.

ACKNOWLEDGE that I, as an applicant for certification, have the burden of producing adequate information for a proper evaluation of my professional, ethical and other qualifications and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE

DATE

CFY/ACE SUPERVISOR REGISTRATION FORM

CFY/ACE Registrant Name:

Last First Middle Maiden

Name of Supervisor: _____

Last First Middle Maiden

TN License Number of Supervisor

ASHA Certification Number

Practice Name: _____

Practice Address: _____

Phone: _____ **Email address:** _____

I, _____ have agreed to provide required and appropriate supervision to _____, registrant for CFY/ACE, at _____ for the period of _____

(location) (city and state)

_____ to _____
(Month/Day/Year) (Month/Day/Year)
Full Time _____ **Part Time** _____

Supervisor Signature: _____ **Date:** _____

Please return completed form to: Tennessee Board of Communications Disorders and Sciences
665 Mainstream Dr
Nashville, TN 37243