



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
OFFICE OF HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243

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

INSTRUCTIONS FOR LICENSURE AS A SPEECH PATHOLOGIST OR AUDIOLOGIST LICENSURE APPLICATION

UNDERSTANDING THE APPLICATION PROCESS

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

1. All application fees are non-refundable.
2. All documents and fees required to be submitted must be mailed directly to:

**Board of Communication Disorders and Sciences
665 Mainstream Dr
Nashville, TN 37243**
3. 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.
4. 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.
5. Absent any complicating factors, the average application approval time is four to 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 or emails of the initial determination.
6. Applications that are deficient sixty (60) days after receipt of the initial deficiency letter will be closed.
7. **You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. Tenn. Code Ann. §36-5-1301(a), as authorized by 42 U.S.C. §405 (c) (2)(C)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that the Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.**

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

IMPORTANT: You must have a Tennessee License from the Board in your possession before you may lawfully practice as either a Speech Pathologist or Audiologist.

Provided below is a checklist containing all the things you must do to receive consideration for issuance of a Tennessee license to practice speech pathology/audiology. **NOTE: All submissions must be executed and dated less than one (1) year before receipt or they will be rejected by the Board.**

All applicants must submit the following:

1. ____ Completed application
2. ____ Fee: One Hundred Sixty Dollars (\$160)
3. ____ Transcript – Official transcript sent directly to the Board from Graduate school (transcript issued to student is NOT acceptable)
4. ____ Verification of licensure from each state(s) in which you hold or have ever held a license.
5. ____ Original passport photograph taken within the preceding 12 months (Passport photograph only, no copies).
6. ____ Tennessee Jurisprudence Exam on the rules and statutes of the Board (Will be sent to you by email after receipt of your application). Please allow approximately two (2) weeks from the date of this email for your application to be reviewed.
7. ____ Certified birth certificate or a notarized photocopy of a certified birth certificate
8. ____ All applicants must complete the Declaration of Citizenship form found at: <http://tn.gov/assets/entities/health/attachments/PH-4183.pdf>
9. ____ Criminal Background Check (<http://tn.gov/health/article/CBC-instructions>)
10. ____ Mandatory Profile Questionnaire found at: (<http://tn.gov/assets/entities/health/attachments/PH-3585.pdf>)

If applying by Certificate of Clinical Competence the following additional information is required:

1. ____ Official verification sent directly to the Board from ASHA verifying that your CCC has been awarded.
2. ____ Letter of recommendation (Moral Character). The letter must be signed and on the signatory's letterhead.

If applying by Reciprocity the following additional information is required:

1. ____ Official copy of licensure requirements from the state(s) in which you are currently licensed.
2. ____ Copy of your renewal certificate with expiration date and certification number from another state or foreign country.

If applying by Criteria the following additional information is required:

1. ____ Verification of successfully completed practicum of at least four hundred (400) clock hours (One thousand eight hundred twenty [1820] hours for Audiology)
2. ____ Verification of successful completion of nine (9) months full-time or eighteen (18) months half-time professional employment (CFY)
3. ____ Proof of current passing score, set by ETS, on the Praxis Examination in your field. Must be sent directly to the Board from ETS. Use code 8188 on the Praxis website for this.
4. ____ Letter of recommendation (Moral Character). The letter must be signed and on the signatory's letterhead.

EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for all educational institutions you have attended beyond junior high or middle 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

CLINICAL PRACTICUM/INTERNSHIP

List the location, dates and hours of supervised practicum(s) in speech pathology, which includes a minimum of four hundred (400) clock hours of supervised, direct clinical practice. For audiology one must have one thousand eight hundred twenty (1820) clock hours of supervised, direct clinical practice.

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

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):

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

LICENSURE INFORMATION

Are you or have you ever been licensed in this profession in another state? YES NO
_____ _____

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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 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/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