Attached is an application to register a Speech Language Pathologist Assistant with the Tennessee Board of Communication Disorders and Sciences. The rules regarding SLPA can be found at [http://share.tn.gov/sos/rules/1370/1370-01.20160622.pdf](http://share.tn.gov/sos/rules/1370/1370-01.20160622.pdf), beginning on page 22, Rule 1370-01-.14.

Carefully read the rules and complete the application for each Assistant to be registered. The licensee supervising the assistant must also include a Written Plan of Training which shall be signed by both the Licensee and the Assistant.

**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.

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 of the initial determination. Repeated phone calls and/or emails will only slow the process further.

6. 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.
APPLICATION INSTRUCTIONS FOR REGISTRATION AS A SPEECH LANGUAGE PATHOLOGIST ASSISTANT (SLPA)

Provided below is a checklist for your personal use and convenience containing all the things you must submit before your application for Tennessee Registration to practice as a speech pathology assistant can be considered.

NOTE: All submissions must be executed and dated less than one (1) year before receipt or they will be rejected by the Board.

The following documentation is required:

1. ___ Completed application
2. ___ Fees: Thirty Dollars ($30.00)
3. ___ Passport style photo taken within the last 12 months
4. ___ Transcript: Official transcript showing completion of 60 college-level semester credit hours sent directly to the Board from school, (transcript issued to student IS NOT acceptable).
5. ___ Proof of completion of 100 fieldwork hours. If you have received less than 100 hours, please indicate this on the application.
6. ___ Written plan of training from the Supervising Speech Language Pathologist (Signed by both the Supervisor and Assistant)
7. ___ Criminal Background Check (http://tn.gov/health/article/CBC-instructions)
8. ___ Declaration of Citizenship form (http://tn.gov/assets/entities/health/attachments/PH-4183.pdf)

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.

IMPORTANT: You must have a Tennessee registration from the Board in your possession before you may lawfully practice as a Speech Language Pathology Assistant.
THIS IS FOR A: ___ Temporary Registration – I have completed ______ hours toward the required 100 hours of fieldwork experience, and will need a temporary registration to complete the remaining hours.

___ Full Registration

Name: ____________________________________________

Last First Middle Maiden

Social Security Number: __________ - ________ - ______

Date of Birth: __________________________

Current Home Mailing Address: __________________________________________

Current Practice Name and Address: _______________________________________

Phone (Home): ____________________________ (Work): ____________________________

Gender: Female _____ Male _____

Race: ____________________________

U.S. Citizen: Yes _____ No _____

Entitled to live and work in the U.S.: Yes _____ No _____

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 _____

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:

______________________________________________________________________________

______________________________________________________________________________
SLPA Primary Supervisor: _________________________________ TN License Number: __________
(Supervisor must be 2 years post-CFY) (PRINT NAME)

SLPA Alternate Supervisor: ________________________________ TN License Number: __________
(Supervisor must be 2 years post-CFY) (PRINT NAME)

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

LICENSURE INFORMATION

Have you ever previously applied for an SLPA registration in Tennessee?   Yes ____ No ____

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? Yes ____ No ____

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.

<table>
<thead>
<tr>
<th>STATE</th>
<th>PROFESSION</th>
<th>LICENSE NUMBER</th>
<th>CURRENT STATUS</th>
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APPLICATION – Page 2 of 7
EMPLOYMENT STATUS

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.

<table>
<thead>
<tr>
<th>Company/Employer:</th>
<th>Name of Supervisor</th>
<th>Address: (City, and State)</th>
<th>Position:</th>
<th>Duties:</th>
<th>Dates From: To:</th>
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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.]

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)
I, _______________________________________, of __________________________________________,
(Name)      (City)     (State) 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 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
SLPA SUPERVISION REGISTRATION FORM

SLPA Registrant Name:

_______________________________________________________________________________________________

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<th>First</th>
<th>Middle</th>
<th>Maiden</th>
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Name of Primary Supervisor:  
(PRINT NAME) Last First Middle

_____________________________________________________________________

TN License Number of Primary Supervisor  
(Supervisor must be 2 years post-CFY)

Primary Supervisor Address: ________________________________

_____________________________________________________________________

Phone: ___________________________ Email address: ___________________________

I, ____________________________________________ have agreed to provide required and appropriate supervision to  
______________________________________________, registrant for SLPA.

Signature of Primary Supervisor ___________________________ Date ___________________________

Name of Alternate Supervisor:  
(PRINT NAME) Last First Middle

_____________________________________________________________________

TN License Number of Alternate Supervisor  
(Supervisor must be 2 years post-CFY)

Alternate Supervisor Address: ________________________________

_____________________________________________________________________

Phone: ___________________________ Email address: ___________________________

Signature of Alternate Supervisor ___________________________ Date ___________________________