State of Utah
DIVISION OF OCCUPATIONAL & PROFESSIONAL LICENSING

160 East 300 South, P.O. Box 146741
Salt Lake City, Utah 84114-6741
Telephone (801) 530-6628
www.dopl.utah.gov

☐ **Speech Language Pathologist** *($70.00 Non Refundable Application Fee)*

☐ **Audiologist** *($70.00 Non Refundable Application Fee)*

☐ **Temporary SLP/Audiologist** *($120.00 Non Refundable Application Fee)*

(Note: Microsoft Word users can fill in the blanks, print the form and save it for their records)

Please list your full legal name as it appears on your driver's license, Social Security Card, etc.		
Last Name:	First Name:	Middle Name:
Social Security Number: - -	Maiden Name:	

I certify under penalty of perjury that:

☐ I am a citizen of the United States and I have a valid US Driver License or US State ID.
License/State ID Number: _____ State: __

☐ I am a citizen of the United States currently living outside the United States and do not have a valid US Drivers License or US State ID. Please attach a legible copy of your valid passport or other documentation to verify you are a legal citizen of the United States.

☐ I am a non-citizen of the United States, who is lawfully present in the United States and I have a valid US Drivers License or US State ID.
License/State ID Number: _____ State: __

☐ I am a non-citizen of the United States, who is lawfully present in the United States and I do not have a valid US Drivers License or US State ID. Please attach a legible copy of your current and valid government issued document showing evidence of authorization to work in the United States.

☐ I am a foreign national not physically present in the United States.

Mailing Address:			
City:		State:	ZIP:
☐ Male ☐ Female	Date of Birth:	Phone #:	E-Mail:

List all other licenses, registrations, or certifications issued by any state which you now hold or have ever held in any profession. *(Use additional sheets if necessary.)*

Profession:	Issuing State:	
License Number:	License Status:	Issue Date:
Profession:	Issuing State:	
License Number:	License Status:	Issue Date:
Profession:	Issuing State:	
License Number:	License Status:	Issue Date:

DO NOT WRITE IN THIS SECTION - FOR DIVISION USE ONLY

License/Certificate Number: _____

Date License/Certificate Approved: ___/___/_____

Approved By: _____

Date License/Certificate Denied: ___/___/_____

Denied By: _____

Reason for Denial/Other Comments: _____

QUALIFYING QUESTIONNAIRE

Read thoroughly, and answer the questions. Do not leave any question blank.

(*Note: If you have formally expunged a criminal record you do not need to disclose that criminal history.*)

☐ Yes ☐ No	1. Have you ever applied for or received a license, certificate, permit, or registration to practice in a regulated profession under any name other than the name listed on this application?
☐ Yes ☐ No	2. Have you ever been denied the right to sit for a licensure examination?
☐ Yes ☐ No	3. Have you ever had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, or disciplined in any way?
☐ Yes ☐ No	4. Have you ever been permitted to resign or surrender your license, certificate, permit, or registration to practice in a regulated profession while under investigation or while action was pending against you by any health care profession licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
☐ Yes ☐ No	5. Are you currently under investigation or is any disciplinary action pending against you now by any licensing agency?
☐ Yes ☐ No	6. Have you ever had hospital or other health care facility privileges denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
☐ Yes ☐ No	7. Have you ever been permitted to resign or surrender hospital or other health care facility privileges, while under investigation or while action was pending against you by any licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
☐ Yes ☐ No	8. Is any action related to your conduct or patient care pending against you now at any hospital or health care facility?
☐ Yes ☐ No	9. Have you ever had rights to participate in Medicaid, Medicare, or any other state or federal health care payment reimbursement program denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
☐ Yes ☐ No	10. Have you ever been permitted to resign from Medicaid, Medicare, or any other state or federal health care payment reimbursement program while under investigation or while action was pending against you by any licensing agency, hospital, or other health care facility, or criminal or administrative jurisdiction?
☐ Yes ☐ No	11. Is any action pending against you now by Medicaid, Medicare, or any other state or federal health care payment reimbursement program?
☐ Yes ☐ No	12. Have you been named as a defendant in a malpractice suit?
☐ Yes ☐ No	13. Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitations, restrictions or conditions imposed by any malpractice carrier?
☐ Yes ☐ No	14. Have you ever had any malpractice insurance coverage denied, conditioned, curtailed, limited, suspended, or revoked in any way?
☐ Yes ☐ No	15. If you are licensed in the occupation/profession for which you are applying, would you pose a direct threat to yourself, to your patients or clients, or to the public health, safety, or welfare because of any circumstance or condition?
☐ Yes ☐ No	16. Have you ever been declared by any court of competent jurisdiction incompetent by reason of mental defect or disease and not restored?
☐ Yes ☐ No	17. Have you been terminated, suspended, reprimanded, sanctioned, or asked to leave voluntarily from a position because of drug use or abuse within the past five (5) years?
☐ Yes ☐ No	18. Have you ever had a documented case in which you were involved as the abuser in

	any incident of verbal, physical, mental, or sexual abuse?
☐ Yes ☐ No	19. Are you currently using or have you recently (*within 90 days*) used any drugs (*including recreational drugs*) without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state of federal law?
☐ Yes ☐ No	20. Do you currently have any criminal action pending?
☐ Yes ☐ No	21. Have you pled guilty to, no contest to, entered into a plea in abeyance or been convicted of a misdemeanor in any jurisdiction within the past ten (10) years? Motor vehicle offenses such as driving while impaired or intoxicated must be disclosed but minor traffic offenses such as parking or speeding violations need not be listed.
☐ Yes ☐ No	22. Have you ever pled guilty to, no contest to, or been convicted of a felony in any jurisdiction?
☐ Yes ☐ No	23. Have you, in the past ten (10) years, been allowed to plea guilty or no contest to any criminal charge that was later dismissed (*i.e. plea-in-abeyance or deferred sentence*)?
☐ Yes ☐ No	24. Have you ever been incarcerated for any reason in any federal, state or county correctional facility or in any correctional facility in any other jurisdiction or on probation/parole in any jurisdiction?
	**If you answered "yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached. If you answered "yes" to Questions 20, 21, 22, 23, or 24 you must submit a complete narrative of the circumstances that occurred for EACH and EVERY conviction, plea in abeyance, and/or deferred sentence. You must also attach copies of all applicable police report(s), court record(s), and probation/parole officer report(s).** If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available. **If you have formally expunged a criminal record as evidenced by a court order signed by a judge, you do not need to disclose that criminal history. Expungement orders must be sent to the Bureau of Criminal Identification and the FBI to enable the expungement to be completed and the criminal history eliminated from the records.** **A "Yes" answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.**

AFFIDAVIT and RELEASE AUTHORIZATION

1. I certify that am qualified in all respects for the license for which I am applying in this application.
2. I certify that to the best of my knowledge, the information contained in the application and its supporting document(s) is free of fraud, forgery, misrepresentation, omission of material fact; is truthful, correct, and complete; discloses all material facts regarding the applicant; and that I will update or correct the application as necessary, prior to any action on my application.
3. I authorize all persons, institutions, organization, schools, governmental agencies, employers, references, or any others not specifically included in the preceding characterization, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division of Occupational and Professional Licensing to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.
4. I understand that it is the continuing responsibility of applicants and licensees to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which you are applying, and that failure to do so may result in civil, administrative, or criminal sanctions.

Signature of Applicant: _____ Date of Signature: ___ /___ /_____

AUDIOLOGY
CLINICAL EXTERNSHIP SUPERVISION REQUEST

PART 1 - TO BE COMPLETED BY THE APPLICANT

Last Name:	First Name:	Middle Name:	
Mailing Address:			
City:		State:	ZIP:

PART 2 - TO BE COMPLETED BY THE SUPERVISING AUDIOLOGIST:

Last Name:	First Name:		
Business Address:			
City:		State:	ZIP:
Speech Audiologist License Number:		Issuing State:	

I hereby certify I am a licensed Audiologist in good standing in the state of Utah and have practiced full-time as an Audiologist and have not been disciplined during the past five years. I meet the qualifications set forth in the Audiologist Licensing Act Rule to act as a supervising Audiologist, and I will supervise the clinical externship practice of the above named applicant. I understand I must be available for consultation with the person being supervised by personal face-to-face contact, or direct voice contact by telephone, radio or some other means, without regard to whether I am at the same premises as the person being supervised. I certify the applicant named above will be under my supervision while practicing in a clinical externship program and will be in compliance with all Utah laws and rules. I understand I may not supervise more than two individuals at the same time.

Signature of Supervising Audiologist : _____

Date of Signature: ____/____/____

SPEECH LANGUAGE PATHOLOGY
CLINICAL FELLOWSHIP SUPERVISION REQUEST

PART 1 - TO BE COMPLETED BY THE APPLICANT

Last Name:	First Name:	Middle Name:	
Mailing Address:			
City:		State:	ZIP:

PART 2 - TO BE COMPLETED BY THE SUPERVISING SPEECH LANGUAGE PATHOLOGIST:

Last Name:	First Name:		
Business Address:	City:	State:	ZIP:
Speech Language Pathologist License Number:		Issuing State:	

I hereby certify I am a licensed Speech Language Pathologist in good standing in the state of Utah and have not been disciplined for any unprofessional or unlawful conduct within two years of the start of any supervision of a clinical externship program. I meet the qualifications set forth in the Speech Language Pathology and Audiology Licensing Act Rule to act as a supervising Speech Language Pathologist, and I will supervise the clinical fellowship practice of the above named applicant. I understand I must have authorized the work to be performed by the person being supervised, and be available for consultation with the person being supervised by personal face-to-face contact, or direct voice contact by telephone, radio or some other means, without regard to whether I am located on the same premises as the person being supervised and can provide any necessary consultation within a reasonable period of time and personal contact is routine. I certify the applicant named above will be under my supervision while practicing in a clinical fellowship program and will be in compliance with all Utah laws and rules. I understand I may not supervise more than two individuals at the same time.

Signature of Supervising Speech Language Pathologist : _____

Date of Signature: ____/____/____

SPEECH LANGUAGE PATHOLOGY or AUDIOLOGY
VERIFICATION OF COMPLETION OF CLINICAL FELLOWSHIP/EXTERNSHIP

PART 1 - TO BE COMPLETED BY THE APPLICANT

Last Name:	First Name:	Middle Name:
Mailing Address:		
City:	State:	ZIP:
Telephone:	Email Address:	
Dates of Clinical Fellowship: From:	To:	
Approximate Number of Hours Applicant Worked Per Week:	Total Hours Worked:	
Nature of Applicant's Duties:		

PART 2 - TO BE COMPLETED BY THE SUPERVISING SPEECH LANGUAGE PATHOLOGIST OR AUDIOLOGIST:

Last Name:	First Name:		
Business Address:	City:	State:	ZIP:
Speech Language Pathologist License Number:	Issuing State:		
Inclusive Dates of Supervision: From:	To:		
Approximate Number of Hours Applicant Worked Per Week:	Total Hours Worked:		
Nature of Applicant's Duties:			

I do hereby certify the applicant has completed the Clinical Fellowship/Externship for licensure as a Speech Language Pathologist or Audiologist. ☐ Yes ☐ No

I further certify the applicant:

☐ is qualified and competent to practice as a licensed Speech Language Pathologist or Audiologist.

☐ is not qualified and competent to practice as a licensed Speech Language Pathologist or Audiologist.

If applicant is not qualified, please explain the nature of the problem and recommendation for becoming qualified. (*Use additional sheets if necessary.)*

I further certify the information contained in the application is truthful, correct and complete, and discloses all material facts regarding the applicant. I understand it is unlawful and punishable as a Class A misdemeanor to apply for or obtain a license or to otherwise deal with DOPL through the use of fraud, forgery, or intentional deception, misrepresentation, misstatement or omission.

Signature of Speech Language Pathologist or Audiologist Supervisor: _____

Date: ____/____/____

SPEECH LANGUAGE PATHOLOGIST OR AUDIOLOGIST

Temporary Speech Language Pathologist or Audiologist Licensure Checklist *(Applications with incomplete attachments will not be considered and may be denied.)*	
☐	Complete all sections of the application and attach the necessary supporting documentation
☐	If applying as an **Audiologist** submit: • a letter from an accredited university or college, verifying the applicant is currently enrolled in a Doctoral of Audiology program and has completed course work primarily in the field of audiology; and • a completed "Clinical Externship Supervision Request" form. If applying as a **Speech Language Pathologist** submit: • a Masters Degree in Speech Language Pathology. • a completed "Clinical Fellowship Supervision Request" form.
☐	Include a **$120.00** non-refundable application-processing fee, made payable to "DOPL". Fee is comprised of a **$50.00** Temporary licensure fee, and a **$70.00** application fee for full licensure.

Speech Language Pathologist or Audiologist Licensure Checklist *(Applications with incomplete attachments will not be considered and may be denied.)*	
☐	Complete all sections of the application and attach the necessary supporting documentation
☐	If licensed in another state as a Speech Language Pathologist or Audiologist, submit a verification of licensure.
☐	Submit documentation showing a passing score ASHA Certificate of Clinical Competence. *To request information to obtain ASHA certification as a Speech Language Pathologist or Audiologist, call (301) 296-5700.*
☐	Transcripts documenting you are the legal holder of a: • Masters Degree if applying for licensure as a Speech-Language Pathologist. • Doctoral Degree if applying for licensure as an Audiologist.
☐	Include $70.00 Non Refundable Application Fee.

1. **Social Security Number:** Your social security number is classified as a private record under the Utah Government Records Access and Management Act. If an SSN is not provided, the application is incomplete and may be denied.

2. **Address of Record:** The address you provide on this application will be your address of record. You are responsible to directly notify DOPL of any change to your address of record.

3. **Laws and Rules:** You are required to understand Utah laws and rules pertaining to your practice as an Online Facilitator. The following laws and rules are available on the Internet at www.dopl.utah.gov:

4. **Acceptable Forms of Payment:** Licensure fees can be paid by check or money order, made payable to "DOPL." Cash and debit/credit cards (*American Express, MasterCard, and Visa*) are also accepted in person at DOPL's main office – but not over the telephone.

5. **Send Complete Application to:**

By U.S. Mail	Division of Occupational & Professional Licensing P.O. Box 146741 Salt Lake City, Utah 84114-6741
By Express Mail or In Person	Division of Occupational & Professional Licensing 1st Floor Lobby 160 E 300 S Salt Lake City UT 84111-2305

6. **Telephone Numbers:** (801) 530-6628
(866) 275-3675 – Toll-free in Utah