Speech—Language Pathology License Application Packet

Contents:

Important Social Security Number Information:

If you have a Social Security Number, the law requires you to disclose it on your application for a professional or occupational license. 42 U.S.C. § 666(a)(13); RCW 26.23.150. It will be used under the state's child support enforcement program to locate individuals for purposes of establishing paternity and establishing, modifying, and enforcing support obligations. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. If you do not have a Social Security Number, you are still eligible to apply for and obtain a credential if you meet the requirements. Please see the Declaration of No Social Security Number Form. Please call the Customer Service Center at 360-236-4700 if you have questions.

In order to process your request:

Mail your application with initial documentation and your check money order payable to:

Department of Health
Hearing and Speech
P.O. Box 1099
Olympia, WA 98507-1099

Send other documents not sent with or initial application to:

Hearing and Speech Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email **civil.rights@doh.wa.gov.**

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Application Instructions Checklist

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be printed clearly in ink. It is your responsibility to submit the required forms.

☐ **Application Fee**. This fee is non-refundable. You can check the fee page for current fees.

☐ **Select if the following applies:**
Spouse or Registered Domestic Partner of Military Personnel

☐ **1. Demographic Information:**
Social Security Number: You must list your social security number on your application. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. Please see the Declaration of No Social Security Number Form. Please call the Customer Service Center at 360-236-4700 if you do not have one.

National Provider Identifier Number (NPI): The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.

Legal Name: List your full name, first, middle, and last.

Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, date and year of your birth.

Address: List the address we should use to send any information on your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change. See WAC 246-12-310.

Phone, Fax and Cell Numbers: Enter your phone, fax and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Place of Business: Enter your place of business name and address.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See WAC 246-12-300.

☐ **2. Personal Data Questions:**
All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer "yes" to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. Other License, Certification, or Registration:**
List all states, including Washington, where credentials are or were held. Attach additional completed pages if you need more space. You must also print the Verification Form and provide it to each state or jurisdiction that you have listed, requesting that they complete and submit the form directly to the Department of Health.

☐ **4. Agent Registration (Contact Person)**
Pursuant to RCW 18.35.230, each license holder shall name a registered agent to accept service of process for any violation of this chapter or rule adopted under this chapter. This registered agent can be the owner or manager of the business, your attorney or someone who will accept the responsibility of receiving legal documents should you not be available to accept them.

☐ **5. Education:**
List in date order all graduate school(s) attended, major, month, and year the degree was granted. Please request official transcripts be sent directly from your college or university to the Department of Health. If you need more space, attach a sheet of paper.

☐ **6. Professional Experience:**
Beginning with current employment, list all activities and account for all periods of time from graduation to the present time. A resume will not substitute for completion of the application. If you need more space, attach a sheet of paper.

☐ **7. Applicant's Attestation:**
You must sign and date this for us to process the application.

Licensure Requirements:

You may apply for licensure as a speech–language pathologist by completing the following requirements:

☐ Application and fee;

- [ ] Have a master's degree or the equivalent, or a doctorate degree or the equivalent, from a program at a board-approved institution of higher learning, which includes completion of a supervised clinical practicum experience as defined by rules adopted by the board;
- [ ] You must provide:
  - Official transcripts which must indicate your degree and the date granted. The transcripts must come directly from your college or university to the Department of Health; **and**
  - Postgraduate professional work experience; **and**
  - Pass the nationally recognized speech-language pathology examination and provide the department a copy of your examination scores;

    Or
  - Official verification of the American Speech and Hearing Association (ASHA) Clinical Competency Certifications (CCCs) sent directly from ASHA;
- [ ] Complete the Jurisprudence Examination:
  Study the Washington State speech language pathologist laws
  (RCW 18.35 and WAC 246-828).
- [ ] Out-of-State Credential Verification form be completed by each state where you hold or have held a credential. The state will complete its portion of the verification form and mail it directly to Washington State.

Interim Permit Requirements:

You may apply for an interim permit as a speech–language pathologist by completing the following requirements:

- [ ] Application and fee;
- [ ] Have a master's degree or equivalent, or a doctorate degree or the equivalent, from a program at a board-approved institution of higher learning, which includes completion of a supervised clinical practicum experience as defined by rules adopted by the board;
  Official Transcripts: Your transcripts must indicate the degree and date conferred. The transcripts must come directly from your college or university to the Department of Health.
- [ ] Complete the Interim Jurisprudence Examination:
  Study the Washington State speech language pathologist laws
  (RCW 18.35 and WAC 246-828).
- [ ] Practice under the supervision of a Washington State licensed speech-language pathologist;
- [ ] Acknowledgement of Responsibility form to be completed by your supervisor;
- [ ] Out-of-State verification form to be completed by each state(s) where you hold or have held a credential. The state will complete its portion of the verification form and mail it directly to Washington State.

You must complete the following during your interim permit period prior to licensure as an Speech Language Pathologist.
See WAC 246-828-045 and WAC 246-828-04503.

- ☐ The Professional Reference Request form to be completed by your postgraduate supervisor;
- ☐ Speech Language Pathology or Audiology Supervision form, that needs to be sent in at the end of each three month time period.

Other Information:

You will be mailed a letter regarding the deficiencies of your application if the application is incomplete.

- The initial license will expire on your birthday unless the initial license is issued within 90 days of your next birthday.
- Licenses must be renewed every year on your birthday as provided in Chapter 246-12 WAC, Part 2. A courtesy renewal notice will be mailed to your address on record. You must keep your address current with us. Any renewal postmarked or presented to the department after midnight on the expiration date is late.
- Information regarding the hearing and speech program is available on our website.

Continuing Education Requirements:

Speech-language pathologists must complete a minimum of 30 hours of continuing education every three years.

The required continuing education must be obtained during the period between renewals. For more information on the continuing education requirement, please see WAC 246-828-510 and 246-12 WAC, Part 7.

For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly.

Documents to submit with your application should include the following:

- A copy of your spouse's or registered domestic partner's military transfer orders to Washington State.
- One of the following:
  - A copy of your marriage certificate to show proof of marriage; or
  - A copy of a state's declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

Washington State Department of HEALTH

Date Stamp Here

Revenue: 0216020000

Speech–Language Pathologist License Application

Please indicate which you are applying for: ☐ Speech–Language Pathologist Endorsement License

☐ Speech–Language Pathologist License ☐ Speech–Language Pathologist Interim Permit

Select if the following applies: ☐ Spouse or Registered Domestic Partner of Military Personnel

1. Demographic Information

Social Security Number (SSN) (If you do not have a SSN, see instructions)	**National Provider Identifier Number (NPI)** (Enter 10 digit number)	☐ Male ☐ Female ☐ Prefer Not to Answer ☐ X

Name First Middle Last

Birth date (mm/dd/yyyy)

Address

City	State	Zip Code	County

Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)

Email address

Mailing address if different from above address of record

City	State	Zip Code	County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Place of Business Name

Address

City	State	Zip Code	County

Have you ever been known under any other name(s)? ☐ Yes ☐ No If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No If yes, list name(s):

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation. ☐ ☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

"Currently" means within the past two years.

"Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

"Currently" means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ☐ ☐

Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

Yes No

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
   a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? ☐ ☐
   b. Diverted controlled substances or legend drugs? ☐ ☐
   c. Violated any drug law? ☐ ☐
   d. Prescribed controlled substances for yourself? ☐ ☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? ☐ ☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? ☐ ☐
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? ☐ ☐
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? ☐ ☐
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)? ☐ ☐

3. Other License, Certification, or Registration

List **all** states where credentials are or were held. Attach additional pages if you need more space.

State/Jurisdiction	Profession	Type of Credential	Certificate or License		Credential is	
			Yr Issued	Number	Active	In-active

An "Out of State Credential Verification" form is enclosed and must be sent to each state listed above. Enter your full name and birth date at the top of the form so the state may identify you. Also contact each state board listed for any fees they might charge you for processing the verification form.

4. Agent Registration (Contact Person)

Pursuant to RCW 18.35.230, each license holder shall name a registered agent to accept service of process for any violation of this chapter or rule adopted under this chapter. This registered agent can be the owner or manager of the business; your attorney; or someone who will accept the responsibility of receiving legal documents should you not be available to accept them.

The registered agent may be released at the expiration of one year after the license issued under this chapter has expired or been revoked if no legal action has been instituted against the license holder.

Name of Registered Agent _____

Address _____

City _____ State _____ Zip _____

5. Education

List in date order all of your educational preparation. Attach additional pages if you need more space.

Schools Attended Full Name, City and State	Degree Earned	Attendance Dates	
		Start (mm/yyyy)	End (mm/yyyy)

6. Experience

List in date order all of your professional experience and practice from date of graduation from professional college. Include the month/day/year. Attach additional pages if you need more space.

Name of Business and Address	Total number of Months	Dates	
		Start (mm/yyyy)	End (mm/yyyy)

8. Applicant's Attestation

I,_____, declare under penalty of perjury under the laws of the state of
Name of Applicant

Washington the following is true and correct:

- I am the person described and identified in this application.
- I have read RCW 18.130.170 and RCW 18.130.180 of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.
- I have read all laws and rules related to my profession.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ By: _____
mm/dd/yyyy Original Signature of Applicant

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RCW/WAC and Online Website Links

RCW/WAC Links

Uniform Disciplinary Act, RCW 18.130

Administrative Procedure Act, RCW 34.05

Administrative Procedures and Requirements, WAC 246-12

Hearing and Speech Laws, RCW 18.35

Hearing and Speech Rules, WAC 246-828

Online

Board of Hearing and Speech, Web Page