UTAH DEPARTMENT OF COMMERCE
Division of Professional Licensing

☐ **Speech-Language Pathologist**
☐ **Audiologist**

APPLICANT INFORMATION

Full Legal Name: _____
First *Middle* *Last*

All Previous Legal Names: _____

Other DOPL Licenses Held: _____

SSN: _____ **Date of Birth:** _____ **Gender:** ☐ Male ☐ Female

Address: _____
Street Address (including Apt/Unit/Ste #) and/or PO Box

_____
City *State* *ZIP Code*

Phone: _____ **Email:** _____
Note: All Division notices and communication will be sent to this email

Please Select ONE:

☐ I am a United States citizen OR a non-citizen of the United States who is lawfully present.
☐ I am a foreign national not physically present in the United States.
☐ None of the above, please explain: _____

Driver License or State ID Card _____
State of Issue *License Number* *Expiration Date*

NOTE: If you do not hold a US Driver License or a US State ID, you must present a legible copy of your current and valid government issued document(s) showing evidence of lawful presence in the United States.

AFFIDAVIT AND RELEASE

1. I certify that I 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 all supporting document(s) are true and correct, 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, organizations, governmental agencies, or any others not specifically listed, which are set forth directly or by reference in this application, to release to the Division of Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division 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 I am applying, and that failure to do so may result in civil, administrative, or criminal sanctions.
5. I certify that I do not currently pose a direct threat to myself, to my clients, or to the public health, safety or welfare because of any circumstance or condition.
6. I understand that I am responsible to update the Division of any changes relating to my license/certification/registration.

Signature of Applicant: _____ Date: _____

QUALIFYING QUESTIONNAIRE

Do not leave any question blank.

DOPL may request additional documentation if the information submitted is insufficient.

1. ☐ Yes ☐ No Have you EVER had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, resigned, or surrendered while under investigation, or otherwise **disciplined in any way**?

2. ☐ Yes ☐ No Do you CURRENTLY have **any criminal action active or pending**?

3. ☐ Yes ☐ No WITHIN THE PAST 10 YEARS, have you pled **guilty** to, **no contest** to, entered into a **plea in abeyance,** or been **convicted** of **a misdemeanor** in any jurisdiction?

4. ☐ Yes ☐ No Have you EVER pled **guilty** to, **no contest** to, entered into a **plea in abeyance**, or been **convicted** of a **felony** 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 2, 3, or 4 you must submit the following for EACH and EVERY incident:

- personal account of the incident
- police report(s)
- court record(s)
- 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.

NOTE:

- **DISCLOSE** charges that were later held in abeyance, diverted, reduced, or dismissed.
- **DISCLOSE** motor vehicle offenses such as driving while impaired or intoxicated. But you do not need to disclose minor traffic offenses such as parking or speeding violations.
- You do **not need to disclose** juvenile offenses, unless you were tried as an adult.
- **DISCLOSE** if you are restricted from possession, purchase, transfer, or ownership of a firearm or ammunition (even if your restriction is based on a non-reportable juvenile conviction).
- You do **not need to disclose** legally expunged or sealed criminal history incidents.

For more information, see DOPL's criminal history FAQs.

PROFESSIONAL LICENSES

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

Profession: _____ **License Number:** _____

Issuing State: _____ **License Status:** _____ **Issue Date:** _____

Profession: _____ **License Number:** _____

Issuing State: _____ **License Status:** _____ **Issue Date:** _____

If you identified a license above, please answer the following:

☐ Yes ☐ No After obtaining the license(s) above, have you engaged in at least one year of experience in the jurisdiction where the license was issued?

Note: If you answer yes to the question above, please see the checklist at the end of this application or our website for instructions on applying by endorsement.

MEDICAL QUALIFYING QUESTIONNAIRE

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

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.

1. Have your rights, privileges, and/or participation ever been denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by:

☐ Yes ☐ No	a hospital or health care facility
☐ Yes ☐ No	Medicaid, Medicare or any other state or federal health care payment reimbursement program
☐ Yes ☐ No	the Federal Drug Enforcement Administration or any state drug enforcement agency
☐ Yes ☐ No	malpractice insurance coverage
☐ Yes ☐ No	other entity: _____

2. Have you ever been permitted to resign or surrender any rights, privileges and/or participation while under investigation or while action was pending against you from:

☐ Yes ☐ No	a hospital or health care facility
☐ Yes ☐ No	Medicaid, Medicare or any other state or federal health care payment reimbursement program
☐ Yes ☐ No	the Federal Drug Enforcement Administration or any state drug enforcement agency
☐ Yes ☐ No	malpractice insurance coverage
☐ Yes ☐ No	other entity: _____

3. Is any action pending against you now by:

☐ Yes ☐ No	a hospital or health care facility
☐ Yes ☐ No	Medicaid, Medicare or any other state or federal health care payment reimbursement program
☐ Yes ☐ No	the Federal Drug Enforcement Administration or any state drug enforcement agency
☐ Yes ☐ No	malpractice insurance coverage
☐ Yes ☐ No	other entity: _____

4. ☐ Yes ☐ No Have you been named as a defendant in a malpractice suit?

5. ☐ Yes ☐ No Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitation, restrictions or conditions imposed by any malpractice carrier?

If you answered **"Yes"** to question 4 you must submit a complete narrative of the circumstances and a National Practitioner Data Bank report outlining all professional liability claims made against your license and any settlements paid by or on your behalf. *NPDB website: http://www.npdb.hrsa.gov.*

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.

Verification of Clinical Fellowship/Externship

APPLICANT INFORMATION

To be completed by the applicant.

Full Legal Name: _____
First *Middle* *Last*

Mailing Address: _____
Street/PO Box *City* *State/Zip*

License Number: _____ **State of Issue:** _____

EXPERIENCE INFORMATION

To be completed by the supervisor.

Name of Establishment: _____

Name of Supervisor: _____ **License Number:** _____

Establishment Address: _____
Street/PO Box *City* *State/Zip*

Telephone Number _____ **Email:** _____

Dates of Supervision: _____ to _____
MM/DD/YYYY *MM/DD/YYYY*

Approximate Number of Hours Worked Per Week: _____ **Total Hours Worked:** _____

Describe the applicant's duties: _____

_____

_____

I hereby certify that the applicant has completed the Clinical Fellowship/Externship for a Speech Language Pathologist or Audiologist as outlined in 58-41-5(1d) and (4d).

I further certify that the applicant is qualified and competent to practice as a(n):

- ☐ Speech Language Pathologist
- ☐ Audiologist
- ☐ Speech Language Pathologist/Audiologist

Signature of Supervisor: _____ **Date:** _____

APPLICATION CHECKLIST AND INSTRUCTION

This checklist is for your convenience; you do not need to include it with your application.
NOTE: Incomplete applications will be denied.

Your application is classified as a public record and may be available for inspection by the public, except with regard to the release of information which is sub-classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other law.

ALL APPLICANTS

All Speech Language Pathology or Audiology Applicants are required to complete the following items to complete the application:

- ☐ $70.00 non-refundable application processing fee, made payable to "DOPL". ***NOTE:*** *If you are applying for both a SLP and Audiologist license with a single application, only one application fee is required.*
- ☐ Supporting documentation for any "yes" answers provided on either the "Qualifying Questionnaire" or "Medical Qualifying Questionnaire" (Pages 2 and 3).
- ☐ Official transcripts documenting completion of:
  - Doctoral Degree in Audiology if applying for an Audiologist license
  - Master's Degree in Speech Language Pathology if applying for SLP

APPLICANTS HOLDING ASHA CERTIFICATION

If applying for Initial Licensure and you hold a current ASHA Certification, in addition to the items required for all applicants, you must submit:

- ☐ Documentation of your current ASHA Certification

APPLICANTS WITHOUT ASHA CERTIFICATION

If applying for Initial Licensure and you do not hold a current ASHA Certification, in addition to the items required for all applicants, you must submit:

- ☐ Documentation of passing a Nationally Standardized Examination, in accordance with ASHA.
- ☐ Verification of Clinical Fellowship/Externship. See page 4 of this application.
  Audiologist Applicants Only: If you received your AuD from an accredited school, this information may be verified on your transcripts. If so, you do not need to complete the form.

LICENSURE BY ENDORSEMENT

If you are currently licensed in *good standing* in a jurisdiction deemed equivalent to a Utah license and have at least one year of licensed experience, you may apply for **Licensure by Endorsement**. *In addition* to the items required by all applicants, you must submit the following:

- ☐ Official verification, showing active licensure in good standing for at least one year, from a jurisdiction designated by the Division as equivalent to Utah in the same classification as the license being sought. Please see our website for additional information regarding approved states.
  NOTE: If your state is not deemed equivalent for purposes of endorsement, you may be able to use experience gained outside of this state to document meeting the requirements for initial licensure.

Submit the above items with your completed application to:

In person or via express delivery:
Division of Professional Licensing
Heber M Wells Building, 1st Floor Lobby
160 E 300 S
Salt Lake City, UT 84111

US Postal Service:
Division of Professional Licensing
PO BOX 146741
Salt Lake City, UT 84114-6741