APPLICATION FOR REGISTRATION as a SPEECH-LANGUAGE PATHOLOGY AIDE
or
REINSTATEMENT of a SPEECH-LANGUAGE PATHOLOGY AIDE REGISTRATION

GEORGIA STATE BOARD OF SPEECH-LANGUAGE PATHOLOGY/AUDIOLOGY
237 Coliseum Drive, Macon, Georgia 31217
Phone (404) 424-9966 * Board of Speech Pathology and Audiology | Georgia Secretary of State (ga.gov)

Please read the instructions carefully and be familiar with the laws and rules governing the practice of Speech-Language Pathology/Audiology in the State of Georgia. Visit the web site for information.

****Important****
The Board cannot process incomplete applications. If any item is missing, incomplete or incorrect, your application cannot be reviewed by the Board. Please review this application before you submit it to ensure that all information and documentation is complete and correct. Please mail in a 9 X 12, or larger, envelope with pages unfolded and unstapled. Incomplete applications result in delayed processing. Incomplete applications are void and withdrawn after sixty (60) days pursuant to administrative policy.

The following checklist is an important part of your application. Please use this checklist to ensure that you submit a COMPLETE application.

The **$50.00 non-refundable** application fee payable to **Georgia State Board of Speech-Language Pathology/Audiology** must be included with application.

(Application fee includes a $10 mail in application processing fee)

Checks returned for insufficient funds will be assessed a service charge pursuant to O.C.G.A. §16-9-20

PLEASE NOTE:

***The Training program CANNOT begin until the application for registration has been approved by the Board*.**

Once approved by the Board, you will be notified in writing that practice as an aide may begin following completion of the training program.

Supervisor must submit verification (Form D – Page 8) that the training was completed satisfactorily within 30 days of applicant's employment. Employment date will be the same as the approval date to begin the training program

☐ **APPLICATION**: The application must be mailed to the Board's office at the address listed above, along with your FEE. All questions must be answered. Any question answered "yes" requires further documentation to be submitted. Attach copies of official court documents and an explanation if you have had any criminal convictions or charges, or sanctions by another state licensing board. Approval of licensure is at the Board's discretion.

☐ **EDUCATIONAL REQUIREMENTS**: The applicant must submit a copy of the high school diploma, GED Certificate or college transcript. If applying to reinstate a lapsed or revoked SLPA Georgia registration, and this information was previously provided, you do not have to submit verification again.

☐ **JOB DESCRIPTION**: A job description listing the specific duties of the Speech-Language Pathology Aide.

☐ **SUPERVISOR'S DUTIES**: The supervisor must retain two years of documentation of the indirect or direct supervisory activities. This documentation may be requested by the Board.

FOR BOARD USE ONLY		FOR BOARD USE ONLY
Amount Submitted _____		Certificate Number _____
Date _____		Date Issued _____
Receipt # _____		Applicant No. _____

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APPLICATION FOR INITIAL REGISTRATION AS A
SPEECH-LANGUAGE PATHOLOGY AIDE (or REINSTATEMENT)

Non-Refundable application fee **$50.00** *(includes a $10 application processing fee)*
***(PLEASE check only one box)*:**

☐ **NEW SLPA Registration - NEVER** been registered or issued a registration # as an SLPA issued by the Georgia Board

☐ **REINSTATEMENT** of a lapsed **Registration** - Prior registration #: SLPA00_____
(Refer to Board rule 609-6-.01)

Name _____
Last First Middle

Name as shown on exam records or transcripts (If different)

_____
Last First Middle

Physical Address _____
(P.O. Box NOT Acceptable) Number and Street Apt. No City/State Zip

Mailing Address (if different): _____
(P.O. Box Acceptable) Number and Street Apt. No City/State Zip

Email Address _____
(PLEASE PRINT CLEARLY)
Acknowledgement of your application will be sent by email. Also, if further information is needed, email is the most efficient way for Board staff to contact you so that your application can be processed in the most efficient manner. Your email address will not be shared with any third party.

_____ _____ _____
Telephone Number Day Telephone Number Evening ***E-Mail Address

_____/_____/_____ Male ( ) Female ( ) _____
**Social Security Number Date of Birth

Please provide a current, valid e-mail address as the Board staff communicates with applicants and licensees primarily via e-mail. Your e-mail address will NOT be shared with anyone.

****(This information is authorized to be obtained and disclosed to state and federal agencies pursuant to O.C.G.A. §§ 19-11-1 & 20-3-295, U.S.C.A §§ 551, 20 & 1001)***

☐ **Please check this box if you are a military spouse or a transitioning service member of the United States armed forces (including the National Guard).**

OTHER LICENSURE/REGISTRATION

☐ **Yes** ☐ **No** Have you ever been licensed or registered in GA or any other state or jurisdiction as a Speech-Language Pathologist or Audiologist or Speech-Language Pathology Aide? **If "yes," complete below.**

☐ **SPEECH-LANGUAGE PATHOLOGIST**_____
State License # Expiration Date

☐ **AUDIOLOGIST**_____
State License # Expiration Date

☐ **SPEECH LANGUAGE PATHOLOGY AIDE**_____
State License # Expiration Date

PROFESSIONAL BACKGROUND: ANSWER "YES" OR "NO" TO THE FOLLOWING QUESTIONS. IF "YES," TO 1 THROUGH 7, ATTACH A DETAILED EXPLANATION.

☐ **Yes** ☐ **No** 1. Are you unable to practice safely because of use of alcohol or other drugs?

☐ **Yes** ☐ **No** 2. Have you been denied registration, professional licensure, or renewal because of a license disciplinary proceeding?

☐ **Yes** ☐ **No** 3. Have you ever had a license or registration for a Speech-Language Pathology Aide, Speech-Language Pathologist, Audiologist, or any other profession revoked, suspended, or annulled or otherwise disciplined, including by private order?

☐ **Yes** ☐ **No** 4. Have you been subject to disciplinary action or had your membership revoked by any professional organization?

☐ **Yes** ☐ **No** 5. Have you been convicted of any criminal offense?

☐ **Yes** ☐ **No** 6. Have you ever been arrested or convicted of a felony, misdemeanor (other than a minor traffic violation), crime involving moral turpitude, or a crime violating federal or state law relating to controlled substances or dangerous drugs? (DWI and DUI are not minor traffic violations.) For purposes of this question, a "conviction" includes a finding of verdict of guilty, plea of guilty, a plea of nolo contendere, or first offender treatment, and also includes adjudication of guilt or sentence withheld or not entered on the charge (s). NOTE: The answer to this question is "YES" if an arrest or conviction has been pardoned, expunged, dismissed or deferred, you pled & completed probation under First offender and/or your civil rights have been restored and/or you have received legal advice that the offense will not appear on your criminal record. You must also print and submit the **"Background Consent Form"** or processing of your application may be delayed.

If "yes," please include a certified copy of the court records and final disposition from the court with your application. In the event the file no longer exists, you must submit documentation from the court stating that fact. Also include a personal letter of explanation regarding each incident.

☐ **Yes** ☐ **No** 7. Have you been the defendant in a malpractice suit and either entered into a settlement agreement or paid court awarded expenses?

☐ **Yes** ☐ **No** 8. Have you previously applied for the same registration for which you are currently applying?
If "yes" name under which application was submitted: _____

9. If applying to reinstate a lapsed or revoked Georgia Board SLPA registration, please explain why the license lapsed and what you have been doing since the lapse; where you have you been employed and your job duties.

_____

_____

_____

AFFIDAVIT OF APPLICANT

I hereby swear and affirm that all information provided in this application is true and correct to the best of my knowledge and belief. I further swear and affirm that I have read and understand the current state laws and rules and regulations of the Georgia State Board of Speech Language Pathology and Audiology (SLPA) and I agree to abide by these laws and rules, as amended from time to time.

By signing this application, electronically or otherwise, I hereby swear and affirm one of the following to be true and accurate pursuant to O.C.G.A. § 50-36-1:

1) _____ I am a United States citizen 18 years of age or older.

NOTE: In addition to this form, ***PLEASE SUBMIT A COPY OF YOUR CURRENT SECURE AND VERIFIABLE DOCUMENT(S)*** ***such as driver's license, passport, or document as indicated on the listing of acceptable documents on the site www.sos.ga.gov/plb)****. Failure to do so will result in delayed application processing.*

2) _____ I am not a United States citizen, but I am a legal permanent resident of the United States 18 years of age or older, or I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act 18 years of age or older with an alien number issued by the Department of Homeland Security or other federal immigration agency. **Please submit a copy of your current immigration document(s) which includes either your Alien number or your I-94 number and, if needed, SEVIS number.** See list of acceptable documents on the site www.sos.ga.gov/plb

In making the above attestation, I understand that any failure to make full and accurate disclosures may result in disciplinary action by the Georgia State Board of SLPA and/or criminal prosecution.

My signature below certifies that all information on this application is complete and correct to the best of my knowledge and belief. I acknowledge that all statements made on this application concerning my qualifications and training are subject to verification by the Georgia State Board of Examiners for Speech-Language Pathology and Audiology. I understand that as a Speech-Language Pathology Aide I may only provide those services authorized by the Georgia State Board of Examiners for Speech-Language Pathology and Audiology.

_____ _____

Date **Signature of applicant**

Sworn to and subscribed before me this

_____day of_____, 20____. My commission expires: _____

_____ Notary Seal

Notary Public

SPEECH-LANGUAGE PATHOLOGY AIDE SUPERVISOR

INSTRUCTIONS

- **Complete all sections below.**
- **Be sure to submit with this application also:**

A completed Form B - Description Proposed Speech-Language Pathology Aide Training (Page 6)
A completed Form C - Plan of Supervision for the Speech-Language Pathology Aide (Page 7)

NAME OF SPEECH LANGUAGE PATHOLOGY AIDE APPLICANT:

NAME OF SUPERVISOR: _____
First *Middle* *Last*

Current Georgia Speech-Language Pathology License # SLP_____

EMPLOYMENT OF SUPERVISOR

Employer_____

Name of Facility_____

Street Address_____

City/State/Zip Code_____

SPEECH LANGUAGE PATHOLOGY AIDES WORKSITE(S):

_____

_____

OTHER PERSONS SUPERVISED

☐ Yes ☐ **No** Are you (the Supervisor) supervising other Speech-Language Pathology Aides or PCET's? **If "yes," provide name/s and registration/temporary permit #'s below:**

SPEECH AIDES/PCET's: _____

_____

(Refer to Board rules: Only a total of 2 SLPA's and 2 PCET's may be supervised by a single SLP at any given time)

AFFIDAVIT OF SUPERVISOR

This is to certify that in accordance with Chapter 609-6-.01(b) (2) (I – iv) of the Rules of the Georgia State Board of Examiners of Speech-Language Pathology and Audiology, I attest that a minimum of 40 hours of training will occur prior to supervision of the above-named Speech-Language Pathology Aide, and I accept full and complete responsibility for the speech-language activities and services of the Aide.

_____ _____

Date **Signature of Supervisor**

GEORGIA STATE BOARD OF EXAMINERS OF SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY
237 Coliseum Drive, Macon, Georgia 31217-3858
(478) 207-2440 (Telephone) * (866) 888 - 7127 (Fax)
www.sos.ga.gov/plb/speech

DESCRIPTION OF PROPOSED SPEECH-LANGUAGE PATHOLOGY AID TRAINING
FORM B

INSTRUCTIONS:

- This form is to be completed **by the Supervisor** of the Speech-Language Pathology Aide applicant.
- This form is to be submitted with the Application for Speech-Language Pathology Registration to the Board office at the above address.
- Please feel free to duplicate this form if additional space is needed.

NAME OF SLP AIDE APPLICANT: _____	**NAME OF SUPERVISOR:** _____

SPECIFIC TASK	DIAGNOSIS	AGE RANGE	SPECFIC TRAINING	# OF HOURS

PLAN OF SUPERVISION FOR SPEECH-LANGUAGE PATHOLOGY AIDE
FORM C

INSTRUCTIONS:

- This form is to be completed by the Supervisor of the Speech-Language Pathology Aide applicant.
- This form is to be submitted with the Application for Speech-Language Pathology Registration to the Board office at the above address.
- Please feel free to duplicate this form, if additional space is needed**.**
- The Supervisor should retain documentation of indirect and direct supervision
- Upon request, this documentation must be sent to the Board for review during registration renewal audits
- See Chapter 609-6-.01 of the Rules of the Georgia State Board of Examiners of Speech-Language Pathology and Audiology for further information.

NAME OF SLP AIDE APPLICANT	**NAME OF SUPERVISOR**

DATE ACTIVITIES START:

INDIRECT SUPERVISORY ACTIVITIES

ACTIVITY	FREQUENCY	DURATION	COMMENTS/RELIABILITY/ACCURACY

DIRECT SUPERVISORY ACTIVITIES

ACTIVITY	FREQUENCY	DURATION	COMMENTS/RELIABILITY/ACCURACY

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SPEECH-LANGUAGE PATHOLOGY AIDE
TRAINING VERIFICATION STATEMENT
FORM D

INSTRUCTIONS

- This form is to be completed and signed by the Speech Language Pathology Aide Supervisor within 30 days **after completion** of the training program and submitted to the Board office.

***The training program CANNOT begin until the application for registration has been approved by the Board*.**
Once approved by the Board, you will be notified in writing that practice as an aide may begin following completion of the training program.

Supervisor must submit verification that the training was completed satisfactorily within 30 days of applicant's employment. Employment date will be the same as the approval date to begin the training program.

NAME OF SPEECH-LANGUAGE PATHOLOGY AIDE:

NAME OF SUPERVISOR:

DATE SPEECH-AIDE STARTED THIS EMPLOYMENT:

AFFIDAVIT OF SUPERVISOR

I, the undersigned, verify that the above-named Speech-Language Pathology Aide **completed** the described speech-language pathology training that was submitted with the initial application for aide registration.

_____ _____
Date **Signature of Supervisor**