LOUISIANA BOARD OF EXAMINERS FOR SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY

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APPLICATION FOR LICENSE

I hereby apply for a license to practice Speech-Language Pathology within the State of Louisiana under the rules established by the Louisiana Board of Examiners for Speech-Language Pathology and Audiology and Act 892 of the 1995 Regular Session of the Louisiana Legislature. I hereby submit the $125.00 application fee in the form of a check, money order, or credit card payment, to "LBESPA". I understand that the fee will be retained by the Board should my application be rejected. I understand that any license issued to me will be valid for only one year, and it is my responsibility to renew annually before June 30th. **All initial and reinstatement applications are subject to query through the National Practitioner Data Bank. Denial or abandonment of the initial application is subject to reporting to the National Practitioner Data Bank. An application is considered abandoned after one year.**

All candidates for licensure must update and supplement the information and responses on this application if they change. Failure to supplement the information and responses provided on this application may result in denial or other appropriate action.

Your application is considered incomplete until all supporting documents and fees have been received by the Board office. Applications submitted via fax are unacceptable.

Check One: ☐ New License ☐ Reinstatement #__________

In accordance with state law, you may not begin work until the application has been received by the

In accordance with state law, individuals may not begin work until a completed application and application fee have been received by the Louisiana Board of Examiners for Speech-Language Pathology and Audiology. According to Rule 109. only initial applicants will receive a grace period. In addition, under certain conditions, military personnel and spouses may also be entitled to a grace period.

(ALL FIELDS REQUIRED)

1. Name____
(print name as you wish it to appear on your license)

2. Home Address ______________________________ Phone (______)______________
City and State______________________________ ZIP ______________
Parish______________________ Email Address ______________________

3. Driver's License Number:______________________________________

4. Are you employed in Louisiana in the field of Audiology or Speech-Language Pathology? ☐ Yes ☐ No
If yes, beginning date of employment ____________________
☐ Part Time (<30 hours/week) ☐ Full Time (>30 hours/week)
Employer ____
Employer's Address______________________________________
City and State______________________________ ZIP______________
Phone (____)____

5. Name, address, and email address can be requested by third parties to advertise continuing education opportunities. I allow only the following to be shared. If left unchecked, all data will be shared.
☐ Name & Address ☐ Email Address ☐ Opt out of data sharing

6. Is English your primary language? ☐ Yes ☐ No If no, are you proficient in English? ☐ Yes ☐ No

7. Years employed in the field of Speech-Language Pathology __________

8. Date of Birth

Month	Day	Year

9. Social Security Number (required by LRS 37:23)

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10. Citizenship
   (a) Are you a United States Citizen? ☐ YES ☐ NO
   (b) If NO to question 10(a) above, attach notarized statement with supporting documentation.
   Please check one of the following:
   ☐ A qualified alien (as defined in 8 U.S.C.A. § 1641).
   ☐ A nonimmigrant under the Immigration and Nationality Act (8 U.S.C.A. § 1101 et seq).
   ☐ An alien who is paroled into the United States under 8 U.S.C.A. § 1182(d)(5) for less than one year.

11. Military—Act 276 of the 2012 Regular Session and House Concurrent Resolution 74 of the 2015 Regular Session of the Louisiana Legislature
   (a) Are you currently an active member of the military? ☐ YES ☐ NO
   (b) Are you the spouse of an active military member? ☐ YES ☐ NO

12. Have you ever possessed a professional license or certificate issued by a state licensing authority? If yes, please submit a Verification of License for each entity. ☐ YES ☐ NO
   List State(s):____

13. Has any state licensing authority ever denied your application for licensure or renewal? If yes, attach notarized explanation. ☐ YES ☐ NO

14. Have you ever been the subject of disciplinary action (e.g. revocation, suspension, reprimand, fine, etc.) by a state licensing authority? If yes, attach notarized explanation. ☐ YES ☐ NO

15. Do you have any unresolved or pending complaint(s) or disciplinary action against you or your professional licensure? If yes, attach notarized explanation. ☐ YES ☐ NO

16. Have you ever voluntarily surrendered your professional license in any state? If yes, attach notarized explanation. ☐ YES ☐ NO

17. Have you ever been charged or convicted of any crime? If yes, attach notarized explanation. ☐ YES ☐ NO

18. To an extent that it impairs your functioning as a speech-language pathologist or audiologist, have you ever used or are you currently using drugs, chemical substances (including controlled substances obtained either with or without a valid prescription), or intoxicating liquors? If yes, attach notarized explanation. ☐ YES ☐ NO

19. Have you been treated for a drug or alcohol addiction or been a participant in an alcohol or drug treatment or rehabilitation program in which you were monitored or supervised? If yes, attach notarized explanation. ☐ YES ☐ NO

20. To an extent that it impairs your functioning as a speech-language pathologist or audiologist, have you ever been diagnosed with a mental or emotional disease or condition? If yes, attach notarized explanation. ☐ YES ☐ NO

21. Have you ever been adjudged mentally incompetent? If yes, attach notarized explanation. ☐ YES ☐ NO

EDUCATION OR TRAINING

University or College	City, State	Dates Attended	Degree & Date	Major

22. **Professional Employment** (Begin with most recent professional employment first.)

Dates of Employment (Mo., Day, Yr.)	Title of Position
From ____________________ To ____________________	____________________ ____________________

Name of Employer____________________

Physical Address of Work Location____________________

City and State ____________________

Name of Immediate Supervisor____________________

Supervisor Address ____________________

City and State ____________________

Description of work:____________________

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Date of Employment (Mo., Day, Yr.)	Title of Position
From ____________________ To ____________________	____________________ ____________________

Name of Employer____________________

Physical Address of Work Location____________________

City and State ____________________

Name of Immediate Supervisor____________________

Address____________________

City and State ____________________

Description of Work____________________

____

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Date of Employment (Mo., Day, Yr.)	Title of Position
From ____________________ To ____________________	____________________ ____________________

Name of Employer____________________

Physical Address of Work Location____________________

City and State ____________________

Name of Immediate Supervisor____________________

Address____________________

City and State____________________

Description of Work____________________

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AFFIDAVIT

NOTE: Any false or misleading information in, or in connection with, any application may be grounds for disciplinary action on the grounds of lack of good moral character.

State of ____

Parish/City of ____

The undersigned, being sworn, deposes and says that he/she is the person who executed this application; that the statements herein contained are true in every respect; that he/she has not suppressed any information that might affect this application; that he/she will conform to the ethical standards of conduct in his/her profession; and that he/she has read and understands this affidavit.

Check:

☐ I understand that an application that is not completed within one year from date of application, will be considered abandoned and is subject to reporting to the National Practitioner Data Bank. Individuals who wish to have their application withdrawn, must notify the Board in writing prior within one year of the board's receipt of the application.

____ ____________________________

Signature of Applicant **Date**

Sworn to before me this Month_________________________ Day __________ Year___________

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Signature of Notary Public **ID#**

Payments may be made via money order, cashier's check, or credit card. If you wish to pay via credit card, please complete the following information. A $3.00 processing fee will be added to all credit card purchases.

Card Type: ☐ Visa ☐ MasterCard ☐ Discover

Name on Card: ______________________________

Address, if different:______________________________

Card Number:

Expiration Date:

3-digit Security Code on Back: