LOUISIANA BOARD OF EXAMINERS FOR SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY
Towne Park Centre
37283 Swamp Road. Suite 3B
Prairieville, LA 70769
Office: (225) 313-6358 Toll Free: (800) 246-6050
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REGISTRATION FOR TELEHEALTH

I hereby apply for Telehealth Registration in the area of audiology and/or 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 Louisiana R.S. 37:1271. I hereby submit the $50.00 fee in the form of a cashier's check, money order, or credit card payment, to "LBESPA". I understand that the fee will be retained by the Board should my registration be rejected. I understand that any registration issued to me will be valid for up to one year, and it is my responsibility to renew annually before June 30th. **Initial and reinstatement registration applications are subject to query through the National Practitioner DataBank. Denial or abandonment of the telehealth registration application is subject to reporting to the National Practitioner DataBank. A registration application is considered abandoned after one year.**

In accordance with state law, individuals may not begin to practice in Louisiana until the registration has been approved by the Louisiana Board of Examiners for Speech-Language Pathology and Audiology.

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

Your registration 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: ☐ Initial Telehealth Registration ☐ Telehealth Reinstatement #_____

(ALL FIELDS REQUIRED)

1. Name_____
(print name as you wish it to appear on your registration certificate)

2. Home Address _____ Phone (_____)_____

City and State_____ ZIP _____

County_____Email Address _____

3. List the state where you currently hold an active and unrestricted professional license.
Home State:_____ Attach copy of **current** license.

4. Have you ever possessed a professional license issued by another state licensing authority?
If yes, please submit a Verification of License for each entity. ☐ Yes ☐ No
List other state(s):_____

5. Employer:_____

Employer's Address_____

City and State_____ ZIP_____

Phone (____)_____

6. Years employed is the field of Audiology or Speech-Language Pathology (circle one) _____

7. Date of Birth

Month	Day	Year

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

			■			■				

9. Citizenship:
   a. Are you a United States Citizen? ☐ YES ☐ NO
   b. If NO, attach notarized statement with supporting documentation and check applicable status described below:
      ☐ 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 U. S. under 8 U.S.C.A. §1182(d)(5) for less than one year.

10. Military (Act 276 of the 2012 Regular Session of the Louisiana Legislature and HCR 74 of the 2015 Regular Session of the Louisiana Legislature)
    Are you currently an active member of the military? ☐ YES ☐ NO
    Are you the spouse of an active military member?

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

12. 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

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

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

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

16. Have you received training on the following practice parameters:
    a. The telehealth equipment to be used? ☐ YES ☐ NO
    b. Delivery of services via telehealth, including methodologies? ☐ YES ☐ NO
    c. Protection of client information including authentication and encryption methods? ☐ YES ☐ NO

17. Current and previous work settings. Check all that apply.
    ☐ School
    ☐ Medical
    ☐ Private practice
    ☐ University
    ☐ Other: _____
    ☐ Part Time (<30 hours/week) ☐ Full Time (>30 hours/week)

18. Settings in which you plan to deliver telehealth. Check all that apply.
    ☐ School
    ☐ Medical
    ☐ Private practice
    ☐ University
    ☐ Other: _____
    ☐ To be determined
    ☐ Part Time (<30 hours/week) ☐ Full Time (>30 hours/week)

19. ASHA or AAA Number: _____
    **Please provide a copy of your ABA and/or ASHA certification card with this registration application.

EDUCATION/TRAINING

**PLEASE LIST HIGHEST DEGREE AWARDED IN AUDIOLOGY OR SPEECH-LANGUAGE PATHOLOGY*

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

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 _____

County/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 registration application withdrawn, must notify the Board in writing within one year of the Board's receipt of the application.

_____ _____

Signature of Applicant **Date**

Sworn to before me this Month_____ Day _____ Year_____

_____

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: