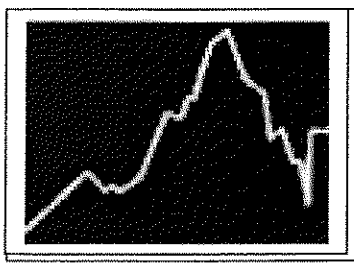

COMMONWEALTH OF VIRGINIA
Department of Health Professions
Board of Audiology and Speech Language Pathology

Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

E-Mail: AudBD@dhp.virginia.gov
Phone: (804) 367-4630
Website: www.dhp.virginia.gov

Application for Provisional Audiologist to Apply for FULL Audiology License

1. Legal Full Name (Please Print or Type)

Last	First	Middle	Maiden Name or Suffix

Have you ever been known by any other name [ ] Yes [ ] No? If yes, state, in full, every name by which you have been been known, the reason therefore, and dates so used. If name change was made by court order, enclose herein a certified copy of such order. _____

Address of Record (Mailing Address)	City	State	ZIP Code	Telephone No.
Publicly Disclosable Address	City	State	Zip Code	Telephone No.

ADDRESS: Virginia law allows persons regulated by boards within the Department of Health Professions to provide an alternative address for public disclosure if they want their address of record to remain confidential, used only for agency purposes. Health professionals may choose to provide a work address, a post office box, or a home address as the public address. If an alternative public address is not provided, the address of record will also be used as the public address and may be disclosed if specifically requested. Addresses of individuals **are not posted** on the "License Lookup" program available through the board's website.

List Virginia Provisional Audiology License Number

*Social Security No. or Virginia DMV No.	Date of Birth (Mo/Day/Yr)	E-mail Address

Graduation Date (Mo/Day/Yr)	Professional Degree	School	City	State

Print legal name as you wish it to appear on wall certificate:

2. A current and original certification letter from ABA or ASHA must be submitted directly to the board. **No copies or faxes.**

3. Official school transcripts confirming degree in audiology must be submitted directly to the board. **No copies or faxes.**

*In accordance with §54.1-116 Code of Virginia, you are required to submit your Social Security Number or your control number issued by the Virginia Department of Motor Vehicles. If you fail to do so, the processing of your application will be suspended and fees will not be refunded. This number will be used by the Department of Health Professions for identification and will not be disclosed for other purposes except as provided by law. Federal and state law requires that this number be shared with other state agencies for child support enforcement activities. In order to obtain a Virginia driver's license control number, it is necessary to appear in person at an office of the Department of Motor Vehicles in Virginia. A fee and disclosure to DMV of your Social Security Number will be required to obtain this number.

APPLICANTS DO NOT USE SPACES BELOW THIS LINE – FOR OFFICE USE ONLY

APPLICANT #	FEE	RECEIPT #	BASE STATE	ASHA/ABA	LICENSE #	ISSUE DATE

4. List all jurisdictions in which you have ever been issued a license (active, inactive, expired) to practice audiology and/or speech-language pathology. If more space is needed, please record on separate paper.

Jurisdiction	How Licensed	License #	Issue Date	Years of Practice	License Status

QUESTIONS MUST BE ANSWERED. If any of the following questions **(5-11)** are answered **yes**, explain and substantiate with documentation. Letters must be submitted by your attorney regarding malpractice suits.

5. List all professional practice in reverse chronological order for the last 36 months.

Began Date ____ ____ Month Year	Ended ____ ____ Month Year	Name of Practice/Address/Phone	Type of Practice

6. Have you ever been convicted of a violation of/or pled Nolo Contendere to any federal, state or local statute, regulation or ordinance, or entered into any plea bargaining relating to a felony or misdemeanor to include convictions for driving under the influence (DUI) and excludes traffic violations? Attach your original criminal history record, a certified copy of any final order, decree, or case decision by a court or regulatory agency with lawful authority to issue such order, decree, or case decision, and any other information you wish to considered with you application (i.e. information on the status of incarceration, parole, or probation, reference letters documentation of rehabilitation, etc.).	**YES** ____	**NO** ____
7. Have you ever had any of the following disciplinary actions taken against your license to practice Audiology and/or Speech Language Pathology? (a) suspension/revocation (b) probation (c) reprimand/cease and desist (d) had your practice monitored (e) monetary penalty? **If yes**, the regulatory agency authorized to take such action(s) must submit documentation of any disciplinary action taken against your license to include notices, orders, etc.	**YES** ____	**NO** ____
8. Are you currently under disciplinary investigation by any jurisdiction? **If yes**, give jurisdiction. _____	**YES** ____	**NO** ____
9. Have you had any malpractice suits brought against you in the last ten years? **If yes**, how many? _____ Provide details and documentation. Letters must be submitted by your attorney regarding malpractice suits.	**YES** ____	**NO** ____
10. Have you been physically or emotionally dependent upon the use of alcohol/drugs or treated by, consulted with, or been under the care of a professional for any substance abuse within the last two years? **If yes**, please provide a letter from the treating professional, on letterhead, to include diagnosis, treatment, prognosis and fitness to practice.	**YES** ____	**NO** ____
11. Do you have a physical disease, mental disorder, or any condition, which could affect your performance of professional duties? **If yes**, provide a letter from your treating professional, on letterhead, to include diagnosis, treatment, prognosis and fitness to practice.	**YES** ____	**NO** ____

12. AFFIDAVIT OF APPLICANT (THIS SECTION MUST BE NOTARIZED)

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents. I hereby authorize all hospitals, institutions, or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Virginia Board of Audiology and Speech-Language Pathology any information, files or records requested by the Board in connection with the processing of individuals and groups listed above, any information, which is material to my application and me. I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension, or revocation of my license to practice Audiology and/or Speech-Language Pathology in the Commonwealth of Virginia.

I have carefully read the laws and regulations related to the practice of my profession which are available on www.dhp.virginia.gov/aud/ and I fully understand that funds submitted as part of the application process shall not be refunded.

_____ _____

Signature of Applicant

City/County of _____ State of _____

Subscribed and sworn to before me this _____ day of _____ 20_____.

My Commission expires _____.

_____ _____

Signature of Notary Public

NOTARY SEAL