

## **Speech—Language Pathology License Application Packet**

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### **Important Social Security Number Information:**

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, please read, complete, and return this [form](#) with your application.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

### **In order to process your request:**

**Mail your application with initial documentation and your check or money order payable to:**

Department of Health  
Hearing and Speech  
P.O. Box 1099  
Olympia, WA 98507-1099

**Send other documents not sent with initial application to:**

Hearing and Speech Credentialing  
Credentialing  
P.O. Box 47877  
Olympia, WA 98504-7877

### **Contact us:**

360-236-4700

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## Application Instructions Checklist

**Important background check Information:** Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be printed clearly in ink. It is your responsibility to submit the required forms.

**Application Fee.** This fee is non-refundable. You can check the [fee page](#) for current fees.

**Select if the following applies:**  
Spouse or Registered Domestic Partner of Military Personnel

**1. Demographic Information:**  
**Social Security Number:** You must list your social security number on your application. Please call the Customer Service Center at 360-236-4700 if you do not have one.

**National Provider Identifier Number (NPI):** The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.

**Legal Name:** List your full name, first, middle, and last.

**Definition of legal name:** “Legal name” is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

**Birth date:** Provide the month, date and year of your birth.

**Birth place:** Provide the city, state and country where you were born.

**Address:** List the address we should use to send any information on your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change. See [WAC 246-12-310](#).

**Phone, Fax and Cell Numbers:** Enter your phone, fax and cell numbers, if you have them.

**Email:** Enter your email address, if you have one.

**Other Name(s):** Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See [WAC 246-12-300](#).

**2. Personal Data Questions:**

All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

**3. Other License, Certification, or Registration:**

List all states, including Washington, where certifications/licenses/registrations are or were held. If you need more space, attach a sheet of paper.

**4. Agent Registration (Contact Person)**

Pursuant to [RCW 18.35.230](#), each license holder shall name a registered agent to accept service of process for any violation of this chapter or rule adopted under this chapter. This registered agent can be the owner or manager of the business, your attorney or someone who will accept the responsibility of receiving legal documents should you not be available to accept them.

**5. Education:**

List in date order all graduate school(s) attended, major, month, and year the degree was granted. Please request official transcripts be sent directly from your college or university to the Department of Health. If you need more space, attach a sheet of paper.

**6. Professional Experience:**

Beginning with current employment, list all activities and account for all periods of time from graduation to the present time. A resume will not substitute for completion of the application. If you need more space, attach a sheet of paper.

**7. AIDS Education and Training Attestation:**

AIDS affidavit must be initialed and dated. AIDS training may include self-study, direct patient care, courses, or formal training required by [WAC 246-12-260](#). Course content can be found in [WAC 246-12-270](#). If AIDS education was included in your professional education or training, an additional course is not required.

**8. Applicant’s Attestation:**

You must sign and date this for us to process the application.

## Licensure Requirements:

You may apply for licensure as a speech–language pathologist by completing the following requirements:

- Application and fee;
- Have a master’s degree or the equivalent, or a doctorate degree or the equivalent, from a program at a board-approved institution of higher learning, which includes completion of a supervised clinical practicum experience as defined by rules adopted by the board;
- You must provide:
  - Official transcripts which must indicate your degree and the date granted. The transcripts must come directly from your college or university to the Department of Health; **and**
  - Postgraduate professional work experience; **and**
  - Pass the nationally recognized speech-language pathology examination;

**Or**

  - Official verification of the American Speech and Hearing Association (ASHA) Clinical Competency Certifications (CCCs) sent directly from ASHA;
- Complete the **Jurisprudence Examination**:  
Study the Washington State speech language pathologist laws ([RCW 18.35](#) and [WAC 246-828](#)).
- Four hours of HIV/AIDS education and training; and
- Out-of-State Credential Verification form be completed by each state where you hold or have held a credential. The state will complete its portion of the verification form and mail it directly to Washington State.

## Interim Permit Requirements:

You may apply for an interim permit as a speech–language pathologist by completing the following requirements:

- Application and fee;
- Have a master’s degree or equivalent, or a doctorate degree or the equivalent, from a program at a board-approved institution of higher learning, which includes completion of a supervised clinical practicum experience as defined by rules adopted by the board;  
**Official Transcripts:** Your transcripts must indicate the degree and date conferred. The transcripts must come directly from your college or university to the Department of Health.
- Complete the **Jurisprudence Examination**:  
Study the Washington State speech language pathologist laws ([RCW 18.35](#) and [WAC 246-828](#)).
- Practice under the supervision of a Washington State licensed speech-language pathologist;
- Acknowledgement of Responsibility form to be completed by your supervisor;
- Four hours of HIV/AIDS education and training; and

- Out-of-State verification form to be completed by each state(s) where you hold or have held a credential. The state will complete its portion of the verification form and mail it directly to Washington State.

**You must complete the following during your interim permit period prior to licensure as an Speech Language Pathologist.**

See [WAC 246-828-045](#) and [WAC 246-828-04503](#).

- The Professional Reference Request form to be completed by your postgraduate supervisor;
- Speech Language Pathologist Interim Permit Supervision Documentation Form, that needs to be sent in at the end of each three month time period.

**Other Information:**

You will be mailed a letter regarding the deficiencies of your application if the application is incomplete.

- The initial license will expire on your birthday unless the initial license is issued within 90 days of your next birthday.
- Licenses must be renewed every year on your birthday as provided in Chapter [246-12 WAC, Part 2](#). A courtesy renewal notice will be mailed to your address on record. You must keep your address current with us. Any renewal postmarked or presented to the department after midnight on the expiration date is late.
- Information regarding the hearing and speech program is available on our [website](#).

**Continuing Education Requirements:**

Speech-language pathologists must complete a minimum of 30 hours of continuing education every three years.

The required continuing education must be obtained during the period between renewals. For more information on the continuing education requirement, please see [WAC 246-828-510](#) and [246-12 WAC, Part 7](#).

**For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:**

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly.

Documents to submit with your application should include the following:

- A copy of your spouse's or registered domestic partner's military transfer orders to Washington State.
- One of the following:
  - A copy of your marriage certificate to show proof of marriage; or
  - A copy of a state's declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

Date  
Stamp  
Here

Revenue: 0216020000

## Speech–Language Pathologist License Application

**Please indicate which you are applying for:**     Speech–Language Pathologist Endorsement License  
 Speech–Language Pathologist License         Speech–Language Pathologist Interim Permit

**Select if the following applies:**     Spouse or Registered Domestic Partner of Military Personnel

### 1. Demographic Information

<b>Social Security Number (SSN)</b> (If you do not have a SSN, see instructions)	<b>National Provider Identifier Number (NPI)</b> (Enter 10 digit number)	<input type="checkbox"/> Male <input type="checkbox"/> Female
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Name	First	Middle	Last
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Birth date (mm/dd/yyyy)	<b>Place of birth</b>		
	City	State	Country

Address

City	State	Zip Code	County
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Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)
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Email address

Mailing address if different from above address of record

City	State	Zip Code	County
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Country

**Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.**

Have you ever been known under any other name(s)?     Yes     No    If yes, list name(s):

Will documents be received in another name?     Yes     No    If yes, list name(s):

## 2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation.....

**“Medical Condition”** includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

- 1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.  
1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

**Note: If you answered “yes” to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.**

**The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.**

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain.....

**“Currently”** means within the past two years.

**“Chemical substances”** include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?.....

4. Are you currently engaged in the illegal use of controlled substances?.....

**“Currently”** means within the past two years.

**Illegal use of controlled substances** is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

**Note: If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.**

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ..

**Note: If you answered “yes” to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.**

**To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.**

## 2. Personal Data Questions (cont.)

Yes No

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
- a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? .....
  - b. Diverted controlled substances or legend drugs? .....
  - c. Violated any drug law? .....
  - d. Prescribed controlled substances for yourself? .....
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? .....
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? .....
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? .....
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? .....
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)? .....

## 3. Other License, Certification, or Registration

List **all** states where credentials are or were held. Attach additional pages if you need more space.

State/Jurisdiction	Profession	Type of Credential	Certificate or License		Credential is	
			Yr Issued	Number	Active	In-active

An "Out of State Credential Verification" form is enclosed and must be sent to each state listed above. Enter your full name and birth date at the top of the form so the state may identify you. Also contact each state board listed for any fees they might charge you for processing the verification form.

## 4. Agent Registration (Contact Person)

Pursuant to [RCW 18.35.230](#), each license holder shall name a registered agent to accept service of process for any violation of this chapter or rule adopted under this chapter. This registered agent can be the owner or manager of the business; your attorney; or someone who will accept the responsibility of receiving legal documents should you not be available to accept them.

The registered agent may be released at the expiration of one year after the license issued under this chapter has expired or been revoked if no legal action has been instituted against the license holder.

Name of Registered Agent \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## 5. Education

List in date order all of your educational preparation. Attach additional pages if you need more space.

Schools Attended Full Name, City and State	Degree Earned	Attendance Dates	
		Start (mm/yyyy)	End (mm/yyyy)

## 6. Experience

List in date order all of your professional experience and practice from date of graduation from professional college. Include the month/day/year. Attach additional pages if you need more space.

Name of Business	Total number of Months	Dates	
		Start (mm/yyyy)	End (mm/yyyy)

## 7. AIDS Education and Training Attestation

I certify I have completed the minimum of four hours of education in the prevention, transmission and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested. **I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.** If AIDS education was included in your professional education or training, an additional course is not required.

Applicant's Initials	Today's Date
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## 8. Applicant's Attestation

I, \_\_\_\_\_, declare under penalty of perjury under the laws of the state of  
Name of Applicant

Washington the following is true and correct:

- I am the person described and identified in this application.
- I have read [RCW 18.130.170](#) and [RCW 18.130.180](#) of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.
- I have read all laws and rules related to my profession.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated \_\_\_\_\_ By: \_\_\_\_\_  
mm/dd/yyyy Original Signature of Applicant

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Hearing and Speech Credentialing  
 P.O. Box 47877  
 Olympia, WA 98504-7877  
 360-236-4700

## Professional Reference Request

To be completed by post-graduate supervisor. Please print Clearly. Please be advised upon receipt of written request, this form will become a public document.

Supervisor	Organization	
Position		
Address		
City	State	Zip

\_\_\_\_\_, has applied for license as an Audiologist/  
 Speech Language Pathologist in the state of Washington. We would appreciate your completion of this reference form and return directly to the above address.

1. Relationship to Candidate:  Post-Graduate Supervisor  Other (specify) \_\_\_\_\_

Appropriate dates of this relationship: From \_\_\_\_\_ To \_\_\_\_\_

Percent of applicant's time spent in audiology/speech pathology work: \_\_\_\_\_

Title of applicant's position and name of organization: \_\_\_\_\_

2. Describe briefly the applicant's duties as you know them in the position listed above: \_\_\_\_\_

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3. Please comment on the applicant's professional judgment, responsibility, integrity and relationships with professional peers and clients: \_\_\_\_\_

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4. If you were a supervisor of the applicant's post-graduate work, please complete the following:

A. Dates of post-graduate supervision: From \_\_\_\_\_ To \_\_\_\_\_

B. Total number of hours of post-graduate audiology/speech pathology work you supervised (this should be a number and not a percentage): \_\_\_\_\_

C. Total number of hours of face to face supervision you provided (this should be a number and not a percentage): \_\_\_\_\_

Applicants are required to have thirty-six weeks of full-time professional experience or part-time equivalent.

5. Please check the areas in which you judge the candidate to be technically competent and able to meet reasonable standards in the profession of audiology/speech pathology. Please double-check what you regard as the applicant's specialty area(s):

Audiology  Speech Language Pathology  Medical  Education  Other \_\_\_\_\_

Do you feel the candidate is a credit to the profession of audiology/speech pathology?

Yes  No Please explain: \_\_\_\_\_

6. Do you have any reservations against recommending the applicant for certification in the state of Washington for independent practice?  Yes  No

If Yes, please comment specifically. Include any other information you consider relevant: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7. Is there any other information about the candidate which you believe should be provided to the Board of Hearing and Speech?  Yes  No If Yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I have carefully read the questions in the professional reference form. I have answered them completely, without Reservations of any kind, and I declare under penalty my answers and all statements made by me herein are true and correct.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Your Name (please print) \_\_\_\_\_ Phone \_\_\_\_\_

Highest degree earned \_\_\_\_\_

Licensed Audiologist  Yes  No State(s) \_\_\_\_\_ Yr. Cert. \_\_\_\_\_ Cert # \_\_\_\_\_

Licensed Speech Path  Yes  No State(s) \_\_\_\_\_ Yr. Cert. \_\_\_\_\_ Cert # \_\_\_\_\_



Hearing and Speech Credentialing  
P.O. Box 47877  
Olympia, WA 98504-7877  
360-236-4700

## Acknowledgment of Responsibility for Interim Permit Speech-Language Pathology Interim Permit or Audiology Interim Permit

### To the Supervisor:

Please review [RCW 18.35.060](#) and the Board of Hearing and Speech, Speech-Language Pathology, and Audiology interim permit rule [WAC 246-828-045](#).

To supervise a permit holder, you must be licensed in Washington State and in good standing for at least two years unless otherwise approved by the board.

You shall provide supervisory activities as outlined in [WAC 246-828-04503](#).

As supervisor, you are responsible for all acts of the interim permit holder in connection with speech-language pathology or audiology services during the postgraduate professional work experience. An audiologist or speech language pathologist licensed under chapter [18.35 RCW](#) may supervise up to four interim permit holders concurrently.

The supervisor must submit to the department, on a form provided by the department, documentation of supervision and progress during the postgraduate professional work experience, at the end of each three-month period.

Please review supervision delegation as outlined in [WAC 246-828-04505](#).

The supervisor of an interim permit holder who desires to terminate the responsibility as supervisor must immediately notify the department in writing of the termination. The supervisor is responsible for the interim permit holder until the notification of the termination is received by the department.



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### Please complete the following documentation and return to the Department of Health Acknowledgment of Responsibility—to be completed by Supervisor

I, \_\_\_\_\_, a licensed Speech Language  
Pathologist Name of Supervisor

or Audiologist in the state of Washington with license number \_\_\_\_\_,

acknowledge that I will take full responsibility for all acts of \_\_\_\_\_  
Name of Interim Permit Holder

in connection with speech-language pathology or audiology services provided while under my supervision.

Signature of Supervisor \_\_\_\_\_

Date \_\_\_\_\_

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Hearing and Speech Credentialing  
 P.O. Box 47877  
 Olympia, WA 98504-7877  
 360-236-4700

## Out-of-State Credential Verification

### To the Applicant:

Please complete this section. Forward this form to the jurisdiction of certification/license for them to complete and return to the above address.

I, \_\_\_\_\_, am/was certified/licensed in the state of \_\_\_\_\_,

as a \_\_\_\_\_, certificate/license number: \_\_\_\_\_.

I have applied for a Washington State Speech-Language Pathologist License. I authorize the release of the information requested below to Washington State Hearing and Speech Credentialing.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### To the State Board:

Please provide a **copy of the current statute** under which the above named applicant was certified/licensed. Please return this completed form with the statute to the above address.

I hereby certify that \_\_\_\_\_ was granted

professional certificate/license number \_\_\_\_\_ to practice \_\_\_\_\_

in the state of \_\_\_\_\_ on the \_\_\_\_\_ day of, 20 \_\_\_\_ on the basis of:

Successfully passing the National Examination in Speech-Language Pathology. ....  Yes  No

Successfully passing the required state constructed examination. ....  Yes  No

Written .....  Yes  No

Practical .....  Yes  No

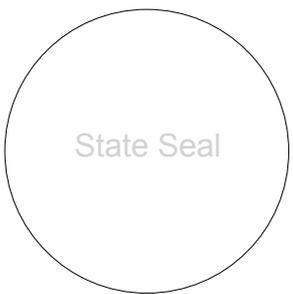
Other (please explain): \_\_\_\_\_

**Status of Certification/License:**  Active  Inactive  Expiration Date

**Legal or Disciplinary Action?:**  Yes  No

If yes, please explain below and provide any applicable documentation.

\_\_\_\_\_  
 \_\_\_\_\_



Signature of Verifier \_\_\_\_\_

Title of Verifier \_\_\_\_\_

Date \_\_\_\_\_

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## **RCW/WAC and Online Website Links**

### **RCW/WAC Links**

[Uniform Disciplinary Act, RCW 18.130](#)

[Administrative Procedure Act, RCW 34.05](#)

[Administrative Procedures and Requirements, WAC 246-12](#)

[Hearing and Speech Laws, RCW 18.35](#)

[Hearing and Speech Rules, WAC 246-828](#)

### **Online**

[AIDS Training Resources, Reference Page](#)

[Board of Hearing and Speech, Web Page](#)