Speech–Language Pathology Assistant Certification 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
P.O. Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:
Hearing and Speech Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:
360-236-4700
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 blue or black ink. It is your responsibility to submit the required forms.

☐ Application Fee. This fee is non-refundable. You can check the online fee page for current fees.

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

☐ Check appropriate box for certification:
WAC 246-828-617 (1) or WAC 246-828-617 (2)

☐ 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, day 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.

- If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.

- 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, or registrations are or were held. Attach additional pages if you need more space.

4. Education:
A BA, AA or certificate of proficiency from a board approved institution of higher education as defined in WAC 246-828-025 (1)(b). Please request official transcripts to be sent directly from the college or university to the Department of Health. If transcripts do not reflect 100 hours of clinical experience practicum, with at least 50 hours directly supervised, applicant must fill out work experience verification form as part of application per WAC 246-828-617 (1) or (2).

5. Experience:
List in date order all of your experience and practice from date of graduation from professional college. Attach additional pages if you need more space.

6. AIDS Education and Training Attestation:
Read the AIDS employment and training attestation. AIDS training may include self-study, direct patient care, courses, or formal training. A minimum of four hours is required. 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.

7. Applicant's Attestation:
You must sign and date this for us to process the application.

Additional Requirements:
Complete the Jurisprudence Examination:
Study the Washington State Speech-Language Pathology Assistant laws (RCW 18.35 and WAC 246-828).
**Continuing Education Requirements:**

Speech-Language Pathology Assistant 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.

**Other Information:**

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

- The application is considered incomplete if requested information is left blank. Write N/A or place a line through a section instead of leaving it blank.
- 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](#).
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Speech–Language Pathology Assistant Certification Application

Please indicate which you are applying for:

- Certification under [WAC 246-828-617 (1)]
- Certification under [WAC 246-828-617 (2)]

Select if the following applies:

- [ ] Spouse or Registered Domestic Partner of Military Personnel

1. Demographic Information

<table>
<thead>
<tr>
<th>Social Security Number (SSN)</th>
<th>National Provider Identifier Number (NPI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(If you do not have a SSN, see instructions)</td>
<td>(Enter 10 digit number)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>First</th>
<th>Middle</th>
<th>Last</th>
</tr>
</thead>
</table>

<table>
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<tr>
<th>Birth date (mm/dd/yyyy)</th>
<th>Place of birth</th>
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<td>City</td>
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<thead>
<tr>
<th>Address</th>
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<tbody>
<tr>
<td>City</td>
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<tr>
<td>State</td>
</tr>
<tr>
<td>Zip Code</td>
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<td>County</td>
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<th>Country</th>
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<th>Phone (enter 10 digit #)</th>
<th>Fax (enter 10 digit #)</th>
<th>Cell (enter 10 digit #)</th>
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<tr>
<th>Email address</th>
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<table>
<thead>
<tr>
<th>Mailing address if different from above address of record</th>
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<tr>
<td>City</td>
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<th>Country</th>
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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

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.

   If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.

   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.)

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? ................................................... F
   b. Diverted controlled substances or legend drugs? ....................................................................................... F
   c. Violated any drug law? .............................................................................................................................. F
   d. Prescribed controlled substances for yourself? .......................................................................................... F

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? .............................................................. F

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? ............ F

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? ............................................................................... F

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? ...................... F

11. Have you ever been disqualified from working with vulnerable persons by the Department
    of Social and Health Services (DSHS)? ...................................................................................................... F

3. Other License, Certification, or Registration

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

<table>
<thead>
<tr>
<th>State/Jurisdiction</th>
<th>Profession</th>
<th>Type of Credential</th>
<th>Certificate or License</th>
<th>Credential is</th>
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<td>Yr Issued</td>
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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. Education
List in date order all of your educational preparation. Attach additional pages if you need more space.

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<thead>
<tr>
<th>Schools Attended</th>
<th>Degree Earned</th>
<th>Attendance Dates</th>
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<tbody>
<tr>
<td>Full Name, City and State</td>
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5. 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.

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<thead>
<tr>
<th>Name of Business</th>
<th>Total number of Months</th>
<th>Dates</th>
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<td>Start (mm/yyyy)</td>
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6. 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.

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<th>Applicant’s Initials</th>
<th>Today’s Date</th>
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7. Applicant’s Attestation

I, ______________________________________, declare under penalty of perjury under the laws of the state of 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)
Out-of-State Credential Verification

To Applicant:

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

I, ________________________________, am/was certified/licensed/registered in the state of ________________, as a ________________________________, certificate/license/registration number: ____________________.

I have applied for a Washington State Speech-Language Pathology Assistant Certification. 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/registration number ________________ to practice ____________________
in the state of ________________ on the ______ day of ________________, 20 ____, on the basis of: __________________________________________

__________________________________________

Status of Certification/License/Registration: □ 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: __________________________________________
Speech-Language Pathology Assistant
Work Experience Verification
In accordance with WAC 246-828-617 (1) and (2)

Instructions To Applicant: Please fill out this section completely and include completed form with application. Please use one form for each employer.

I, __________________________________________ am applying for certification to practice as a speech-language pathology assistant in Washington State and authorize you to release information as required on this form. I authorize the Department of Health to contact my employer if further information is needed.

Signature of applicant: _________________________________________________________________________

Applicant's address: ___________________________________________________________________________

___________________________________________________________________________

Employer Name:  _____________________________________________________________________________

Employment Dates: ___________________________________________________________________________

Instructions To Employer: Please fill out the following sections completely.

By my signature below, I attest that the above-named applicant has completed supervised patient/client/student work experience within a one-year time frame under the supervision of a licensed speech-language pathologist or speech-language pathologist certified as an educational staff associate by the superintendent of public instruction.

1. During their employment, the applicant has completed:
   □ 100 or more hours, with at least 50 of those hours under direct supervision

   Or

   □ ________ hours, with ________ hours under direct supervision

2. The applicant was supervised by a speech-language pathologist:
   From: ________________ To: ________________ Number of hours: ________________

   From: ________________ To: ________________ Number of hours: ________________

   From: ________________ To: ________________ Number of hours: ________________

Employer signature: ______________________________________ Title: _________________________________

Printed Name: __________________________________________ Date: ________________________________

Employer’s mailing address: ___________________________________________________________________

Phone: ______________________________________________________________________________________
(This page intentionally left blank.)
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*