

**ARKANSAS BOARD OF EXAMINERS IN
SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY**

APPLICATION FOR REGISTRATION AS
SPEECH-LANGUAGE PATHOLOGY ASSISTANT

PERSONAL (Print or Type)

1. NAME _____
(Last) (First) (Middle) (Maiden)

2. MAILING ADDRESS _____
(Street Number or Route Number or Box Number)

(City) (State) (Zip)

3. PHONE _____
(Area Code) (Number)

4. DATE OF BIRTH _____ AGE _____ SEX _____
SOCIAL SECURITY NUMBER: _____

5. ARE YOU A LEGAL RESIDENT OF ARKANSAS? _____ IF YES, COUNTY: _____

6. GIVE NAMES, ADDRESSES, AND DATES OF ISSUANCE OF ANY OTHER STATE PROFESSIONAL
LICENSE OR REGISTRATION, IF ANY:

7. HAS ANY LICENSE/REGISTRATION ISSUED BY ANY STATE BOARD EVER BEEN REVOKED OR
SUSPENDED? _____ IF YES, ATTACH DETAILED EXPLANATION

8. HAVE ANY DISCIPLINARY PROCEEDINGS BY A STATE BOARD BEEN INITIATED AGAINST YOU
AT ANY TIME? _____ IF YES, ATTACH DETAILED EXPLANATION

9. HAVE YOU, PREVIOUS TO THIS DATE, BEEN DENIED LICENSURE/REGISTRATION IN ANY
OTHER STATE? _____ IF SO, NAME THE LIC/REG AND
STATE(S) _____

10. HAVE YOU EVER BEEN CONVICTED OF ANY VIOLATIONS OF LAW (EXCEPT MINOR TRAFFIC
VIOLATIONS)? _____ IF YES, ATTACH DETAILED EXPLANATION

11. ARE THERE ANY CRIMINAL OR CIVIL SUITS PENDING AGAINST YOU? _____

12. ARE YOU BEING SUPERVISED UNDER ANY OTHER AGENCY? _____
IF YES, INDICATE AGENCY _____

13. LIST WHERE AND WHEN INITIAL TRAINING AS AN ASSISTANT WAS/WILL BE COMPLETED:

SUPERVISION

SLP SUPERVISOR'S NAME: _____ AR LIC. #: _____

WORK SITE: _____

SLP SUPERVISOR'S NAME: _____ AR LIC. #: _____

WORK SITE: _____

POST-SECONDARY EDUCATION

Name/Location of Institution

Degree & Major

Date(s)

PROSPECTIVE EMPLOYER NAME and ADDRESS:

EMPLOYMENT HISTORY

(List Current Position First)

Dates of Employment

Name and Address of Employer

From _____ to _____

From _____ to _____

From _____ to _____

From _____ to _____

AFFIDAVIT OF THE APPLICANT

I, the undersigned, do solemnly swear or affirm that I am the above applicant. I have read Act 826 and the Rules of the Board and am familiar with the requirements of both. I agree to abide by the rules and regulations of the Board. I understand that the fee submitted with this application is non-refundable. I understand that an original or certified copy of my transcript shall be sent to the board. I agree to be bound by the Code of Ethics of the State Board of Examiners in Speech-Language Pathology and Audiology.

State of: _____

County of: _____

(Signature of Applicant)

Subscribed and sworn to before me on this _____ day of _____
in the year _____.

Notary Public

My Commission expires _____
(Date)

(Seal)