KANSAS DEPARTMENT FOR AGING & DISABILITY SERVICES
VERIFICATION OF OUT-OF-STATE LICENSURE

APPLICANT: This form may be copied. Complete the information in Part 1. Send a copy of this form to the licensure agency in each state in which you are currently licensed or have ever been licensed. This includes states in which you have held a license designated is APermanent,@ AActive,@ AProvisional,@ ATemporary,@ AInactive,@ and/or AAssistant@ or AAide.@ The state licensure agency will complete Part 2 and return it directly to the Department.

PLEASE TYPE OR PRINT LEGIBLY

PART 1 – APPLICANT

Name_____
Last First MI Other last name used

Name Which Appeared on License_____

Date of Birth_____/_____/_____ Social Security Number_____

State in Which License Issued_____License Number_____

License Title_____ Issue Date____/____/____ Expiration Date ____/____/____

_____ _____
Applicant=s Signature Date

PART 2 - LICENSURE AGENCY

The above-named individual has made application for licensure in Kansas as a Speech-Language Pathologist or Audiologist. Before any further consideration is taken with this application, we need the information requested on this form. Please complete Part 2 and return it to the address provided on the back of the form.

Applicant Name to Which License Was Issued_____

Do your records verify the information provided in Part 1? _____yes _____no

If no, please explain_____

_____

Was your state the state of original licensure? _____yes _____no

If no, according to your records, which state was the state of original licensure?_____

Is the license presently current and valid?_____yes _____no

The license was obtained by:

____Examination ____ASHA CCC ____Grandfathering ____Endorsement of License Issued by_____
(State)

Did the applicant meet the following requirements in obtaining the license?

_____yes _____no At lease a master=s degree in Speech-Language Pathology or Audiology

_____yes _____no A clinical practicum of at least 375 hours, of which at least 250 were obtained at graduate level

_____yes _____no A supervised postgraduate professional experience of the equivalent of at least nine months of full-time employment (also known as Clinical Fellowship Year)

_____yes _____no A passing score of at least 600 on the NTE Specialty Area Test in Speech-Language Pathology or Audiology of the Educational Testing Service

Is the applicant in good standing with your agency at this time? _____yes _____no

If no, please explain_____

_____

(Over)

According to your records, has the applicant ever been disciplined by your agency or any other state licensure agency?

_____yes _____no

If yes, date of disciplinary action_____ City, County, State_____

Conduct/Finding determined to be basis for action_____

_____

Disciplinary gency/Authority_____

Resolution of disciplinary action_____

Date of resolution_____

NOTE: PLEASE SEND A COPY OF THE RECORD OF ANY DISCIPLINARY ACTION LISTED ABOVE

Additional Comments_____

_____

_____

(Place state or board Seal here)

_____
Name

_____
Title

_____
Agency

_____
Address

_____
Telephone

_____
Signature

Please return completed form to:

HEALTH OCCUPATIONS CREDENTIALING
612 S KANSAS AVENUE
TOPEKA KS 66603-3404