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 Permanent, Active, Provisional, Temporary, Inactive, and/or Assistant or Aide. 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 least 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  Address

___________________________________  ________________

Agency  Telephone

___________________________________

Signature

Please return completed form to:

HEALTH OCCUPATIONS CREDENTIALING
503 S KANSAS AVENUE
TOPEKA KS 66603