



State of Alaska
 Department of Commerce, Community and Economic Development
 Division of Corporations, Business and Professional Licensing
AUDIOLOGY/SPEECH-LANGUAGE PATHOLOGY SECTION
 PO Box 110806, Juneau, AK 99811-0806
 Phone: (907) 465-2550 ★ Fax: (907) 465-2974
 E-mail: license@alaska.gov
 Website: *ProfessionalLicense.Alaska.Gov/AudiologistAndSpeechLanguagePathologists*

SPEECH-LANGUAGE PATHOLOGIST ASSISTANT REGISTRATION APPLICATION PACKET

In accordance with AS 08.11.042(a), a “person may not practice as a speech-language pathologist assistant in the state without registration” under AS 08.11.

GENERAL INSTRUCTIONS

If you received this application other than directly from the division or its official website, the application may be outdated or not an official version. To ensure you have the official version, please contact the division. Please read the application and all the instructions carefully. It is the applicant's responsibility to completely and accurately fill out the application and submit all required supporting documents. It is also the applicant's responsibility to request official transcripts and original verifications of licensure to be sent to this office. If the supporting documents show a name other than the one on the application (e.g., because of marriage, divorce, or any other reason), include an explanation and a certified true copy of the document that supports that change.

All documents must be originals or certified true copies of the original documents. To obtain a certified true copy, take the original documents and the photocopies to a notary public so s/he can compare each original document to its copy. Write or type "true copy of the original" on the photocopy and have the notary attest to its authenticity by including the notary's signature and seal. Documents of not larger than 8-1/2" x 11" are preferred.

APPLICATION FOR REGISTRATION

The following documents and fees must be on file with the division before the file will be reviewed:

1. APPLICATION - completed, signed, and notarized. An applicant with a “Yes” answer to one or more professional conduct questions must submit a separate written, signed, and dated explanation, and provide copies of any supporting documents.
2. FEES - Make check or money order payable to the State of Alaska.
 Nonrefundable application fee . . . \$250 Speech-Language Pathologist Assistant registration fee . . . \$225
3. EDUCATION – An official transcript of an associate of applied science degree in disabilities with a speech-language support emphasis from an accredited education institute or a bachelor’s degree in speech-language pathology from an accredited institution.
4. TRAINING – Satisfactory proof of the applicant having successfully completed 100 hours of field work supervised by a licensed speech-language pathologist (p. 3). This information should be documented with your transcript.
5. LICENSE VERIFICATION - Verification of licensure form (p. 4) from each U.S. state in which the applicant holds or has held a license to practice as a speech-language pathologist assistant. Make additional photocopies of the form, if necessary.
6. RELEASE - Completed Authorization for Release of Records form (p. 5).

OTHER FEES

Wall certificate (suitable for framing), with initial application or subsequent written request.....	\$20
Duplicate license fee (with written request)	\$ 5
Verification of licensure to another state (with written request).....	\$20
Returned check fee.....	\$20
Address change (must be in writing).....	no fee

GENERAL INFORMATION

APPLICATION PROCESSING - The amount of time it takes to process the application varies, depending on when all complete and correct documents and fees are received by the division. If the application is incomplete, the applicant will be notified of incomplete and/or incorrect documents and fees. When complete and correct, all supporting documents have been received, and all fees have been paid, a registration will be issued and mailed with an accompanying cover letter with further information about Alaska statutory requirements. If the application is not approved for licensure, a written explanation of the basis of that denial and information on how to appeal the decision will be provided.

SOCIAL SECURITY NUMBERS – AS 08.01.060 and 08.01.100 require that a U.S. Social Security Number be on file with the division before a professional license is issued or renewed. If you do not have a U.S. Social Security Number, please complete the Request for Exception from Social Security Number Requirement form located at www.commerce.alaska.gov/occ OR contact the division for a copy of the form.

PAYMENT OF CHILD SUPPORT AND STUDENT LOANS – If the Alaska Child Support Enforcement Division has determined that you are in arrears on child support, or if the Alaska Commission on Postsecondary Education has determined you are in loan default, you may be issued a nonrenewable temporary license valid for 150 days. Contact Child Support Services at (907) 269-6900 or the Postsecondary Education office at (907) 465-2962 or 1-800-441-2962 to resolve payment issues.

REGISTRATION TERM – Registrations are issued for a two-year period. However, all speech-language pathologist assistant registrations expire September 30 of even-numbered years regardless of the date of issuance, except registrations issued within 90 days of the expiration date are issued to the next biennial expiration date. One renewal notice will be mailed at least 30 days before registration expiration to the last known address of record.

ADDRESS OR NAME CHANGE - In accordance with 12 AAC 02.900, it is the applicant's/licensee's responsibility to notify the division, in writing, of changes of address or name. Name and address change notification forms are available on the division's website. The address of record with the division will be used to send renewals and all other official notifications and correspondence. The name appearing on the registration must be your current legal name.

ABANDONMENT - Under 12 AAC 02.910, an application is considered abandoned when 12 months have elapsed since correspondence was last received from or on behalf of the applicant. An abandoned application is denied without prejudice and the application fee is forfeited. At the time of abandonment, the division will send notification to the last known address of the applicant, who has 30 days to submit a written request for a refund of registration and other fees paid. If no request for refund is received, all fees are forfeited.

DENIAL OF APPLICATION – Please be aware that the denial of an application of licensure may be reported to any person, professional licensing board, federal, state or local government agency, or other entity making a relevant inquiry or as may be required by law.

STATUTES AND REGULATIONS – The complete set of statutes and regulations for this program is available on the division's website at www.commerce.alaska.gov/occ. If you are unable to download the statutes and regulations, please contact the division and request a copy by mail.



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AUD

For Division Use Only

SPEECH LANGUAGE PATHOLOGIST ASSISTANT REGISTRATION APPLICATION

Please fill out each section. Write "N/A" if not applicable.

Nonrefundable application fee - \$250
 Registration fee - \$225

Part I: PERSONAL IDENTIFICATION INFORMATION

Type or Print Legibly

Full Legal Name (Last, First, Middle)	Last	First	Middle
Other Names Used (nick names, maiden name)			
Legal Name Changes (Provide copies of changes)			
Date of Birth	Mo _____ Day _____ Year _____	Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address	Street/PO Box	City	State Zip Code
Residence Address	Street/PO Box	City	State Zip Code
Telephone	Work:	Home:	

EMAIL AGREEMENT: By choosing to receive correspondence on any matter affecting my license or other business with the Alaska Division of Corporations, Business and Professional Licensing, I agree to maintain an accurate email address through the MY LICENSE web page. I understand that failure to check my email account or to keep the email address in good standing may result in an inability to receive crucial information, potentially resulting in my inability to obtain or maintain licensure.

Email Address:

- Send my Correspondence by Email
 Send my Correspondence by US Mail

SOCIAL SECURITY NUMBER: AS 08.01.100 requires you to provide your United States Social Security Number. It is considered confidential information and will not be publicly disclosed; it may be used to verify inter-state licensure.

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Part II: EDUCATION/GRADUATE EDUCATION

List accredited college or university attended where associate of applied sciences or bachelor's degree in speech-language pathology was received. Please have official transcripts sent DIRECTLY to the Division.

Name of School	Location	From (Mo/Yr)	To (Mo/Yr)	Degree/Date Awarded
Name of School	Location	From (Mo/Yr)	To (Mo/Yr)	Degree/Date Awarded

Part III: PROFESSIONAL ACTIVITIES

List all current and previous speech-language pathology assistant licenses held in any municipality, state, territory, or country. If none, write N/A. Ensure verifications are sent to the Division directly from the governing body.

Municipality/State/Territory/Country	License Number	Date of Issue	Status	Exam or Reciprocity
Municipality/State/Territory/Country	License Number	Date of Issue	Status	Exam or Reciprocity

Part IV: PROFESSIONAL FITNESS

In responding to the questions in Parts IV below, please check the appropriate box next to each question. A "Yes" response to a question does not automatically result in a denial of license application. For each "Yes" response to any question, you must provide an explanation and documentation. Provide your explanation on a separate sheet of paper labeled with your name, and signed by you; include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. When in doubt about your response, disclose and provide the explanation requested. Documentation includes copies of court orders, charging documents, board or license actions, etc.

WHEN IN DOUBT, DISCLOSE AND EXPLAIN!

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Have you been convicted of a crime or are you currently charged with committing a crime? For purposes of this question, "crime" includes a misdemeanor, felony, or a military offense, including, but not limited to, a conviction involving driving under the influence (DUI) or driving while intoxicated (DWI), driving without a license, reckless driving, or driving with a suspended or revoked license. "Convicted" includes having been found guilty by verdict of a judge or jury, having entered a plea of guilty, nolo contendere or no contest, or having been given probation, a suspended imposition of sentence, or a fine..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had a professional license denied, revoked, suspended, or otherwise restricted, conditioned, or limited or have you surrendered a professional license, been fined, placed on probation, reprimanded, disciplined, or entered into a settlement with a licensing authority in connection with a professional license you have held in any jurisdiction including Alaska and including that of any military authorities or is any such action pending?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Within the past five years, have you experienced, or been diagnosed with, or been treated for, bipolar disorder, schizophrenia, paranoia, psychotic disorder, substance abuse, depression (except for reactive or situational depression), or any other mental or emotional illness?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Within the past five years, have you been or are you addicted to, excessively used, or misused alcohol, narcotics, barbiturates, or habit-forming drugs?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Within the past five years, have you had, or do you have a physical disability which may impair or interfere with your ability to practice speech-language pathology?..... | <input type="checkbox"/> | <input type="checkbox"/> |

All information submitted with this application is considered public information unless required by state or federal law to remain confidential. If additional information of a confidential nature is required, you will be notified in writing. Licensee information, including mailing addresses, is available on the division's website at www.commerce.alaska.gov/occ/ under "License Search."

I certify that the information in this application is true and correct to the best of my knowledge. I further certify that all credentials and supporting documents supplied by me are true and correct. I understand that any false information or falsification of documents may result in failure to obtain, or subsequent revocation of, a license to practice speech-language pathology in Alaska.

Sign Here 

Signature of Applicant

SUBSCRIBED AND SWORN TO before me on _____ (date).

Notary Public, State of _____

(NOTARY SEAL)

Signature of Notary Public

My Commission Expires: _____



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VERIFICATION OF 100 HOURS OF FIELD WORK
(For applicants who completed hours through a university program)

Part I

Instructions to Applicant: Type or print the information needed to complete Part I of this form. Forward the form to the registrar of the college or university where you earned your degree. The information requested below must be officially verified by the college or university. It is the applicant's responsibility to request all necessary verifications and pay all applicable fees. Upon completion of Part II, the college or university must return the form directly to the State of Alaska.

Name Last First Middle Maiden/Other

Mailing Address City State ZIP Code

Daytime Phone #: Birthdate

Signature Date Signed

PLEASE DO NOT DETACH

Part II

Instructions to Registrar: Please provide the information requested below, and return the form directly to the Division of Corporations, Business and Professional Licensing at the address at the top of the page. The verification is not to be returned to the applicant. In lieu of this form, the State of Alaska will accept a verification letter on college or university letterhead that provides approximately the same information.

This form may be attached to the transcript of the student who requests that a transcript be sent to the division as part of his/her speech-language pathologist assistant application requirements.

I hereby certify that Applicant's Name graduated from

Name of College or University on Month Day Year with a

degree (include major/minor).

As a part of the degree program, the above-referenced student successfully completed 100 hours of fieldwork supervised by a licensed speech-language pathologist, as evidenced by the following:

Class Name:

Number of Hours:

Supervisor: SLP license #:

COMMENTS:

SEAL OF COLLEGE OR UNIVERSITY

Signature of Registrar Date

Phone Number:



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VERIFICATION OF SPEECH-LANGUAGE PATHOLOGIST ASSISTANT LICENSE OR REGISTRATION

Part I

Instructions to Applicant: Type or print the information needed to complete Part I of this form. Forward a verification to each jurisdiction where you previously were or currently are licensed or registered to practice as a speech-language pathologist assistant. The information requested below must be officially verified by the agency or board that issued the license. The blank form may be photocopied for additional requests. It is the applicant's responsibility to request all necessary verifications and pay all applicable fees. Upon completion of Part II, the licensing agency will return the form directly to the State of Alaska.

Name Last First Middle Maiden/Other

Mailing Address City State ZIP Code

License # Birthdate

Signature Date Signed

PLEASE DO NOT DETACH

Part II

Instructions to Licensing Agency or Board: The above-named individual is applying for registration as a speech-language pathologist assistant in Alaska. Please provide the information requested below, and return the form directly to the Division of Corporations, Business and Professional Licensing at the address at the top of the page. The verification is not to be returned to the applicant. In lieu of this form, the State of Alaska will accept a standard computer verification that provides approximately the same information.

Licensee's Name as Shown on your Records:

License # Birthdate

Original Issue Date Current Expiration Date

Status: Current Inactive Lapsed Other

Licensed By: Exam (Date) Credentials Other, please specify:

Has there been any final disciplinary action taken against this licensee? Yes No

If yes, please provide a copy of the disciplinary action document.

List derogatory information, if any

(BOARD SEAL)

Board/Agency Name

Signature

Printed Name

Title

Date

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AUTHORIZATION FOR RELEASE OF RECORDS

To Whom It May Concern:

I, _____
(print name)

residing at _____
(print address)

authorize the Alaska Division of Corporations, Business and Professional Licensing and its investigators to examine my medical, dental, employment, and education records, and any records pertaining to litigation, suits, judgments and/or settlements, and any law enforcement records pertaining to me and discuss them with persons having possession of them. I also expressly permit and authorize the release of any and all such records pertaining to me to the Alaska Division of Corporations, Business and Professional Licensing and its investigators.

I authorize the division to discuss my records with persons or organizations which are considered appropriate by the division in connection with an official investigation, and to provide copies of my records to those persons or organizations considered appropriate by the division.

This release also applies to any documents or records which contain information pertaining to psychiatric, drug or alcohol evaluation, diagnosis, or treatment received by me and which were prepared or made in conjunction with, or under the authority or guidance of any local, state, or federal law which relates to psychiatric, drug or alcohol evaluation, diagnosis or treatment.

I request that upon presentation of this release, or a certified true copy of it, that you provide copies of those records to the division and/or its investigators, and/or representatives of the Office of the Attorney General of the State of Alaska.

This authorization is given expressly in connection with my application for initial issuance of a registration as a speech-language pathologist assistant. This authorization expires one year from the date of my signature below.

Signature: _____

Date: _____

Home Telephone: _____

Work Telephone: _____



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VERIFICATION OF 100 HOURS OF FIELD WORK
(For applicants who completed hours outside of a university program)

Part I

Instructions to Applicant: Type or print the information needed to complete Part I of this form. It is the applicant's responsibility to request all necessary verifications and pay all applicable fees. Hours must be completed under the supervision of a speech-language pathologist licensed in Alaska.

Name _____
Last First Middle Maiden/Other

Mailing Address _____
City State ZIP Code

Daytime Phone #: _____ Birthdate _____

Signature _____ Date Signed _____

PLEASE DO NOT DETACH

Part II

Instructions to Supervisor: Please provide the information requested below, and **return the form directly to the Division of Corporations, Business and Professional Licensing at the address at the top of the page.** The verification is not to be returned to the applicant.

I hereby certify that _____ has completed
Applicant's Name
_____ under my supervision.
Number of Hours

COMMENTS: _____

Signature of Supervisor

SLP License # Date

Phone Number



THE STATE
of **ALASKA**
Department of Commerce, Community, and Economic Development
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FOR DIVISION USE ONLY

State of Alaska
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Credit Card Payment Form

All major credit cards are accepted. For security purposes, do not email credit card information. Include this credit card payment form with your application.

Name of Applicant or Licensee: _____

Program Type: _____ License Number (if applicable): _____

I wish to make payment by credit card for the following (check all that apply):

AMOUNT

Application Fee: _____

License or Renewal Fee: _____

Other (name change, wall certificate, fine, duplicate license, exam, etc.):

1. _____

2. _____

TOTAL: _____

Name (as shown on credit card): _____

Mailing Address: _____

Phone Number: _____ Email (optional): _____

Signature of Credit Card Holder: _____

08-4438

Rev 12/26/18

Credit Card Payment Form (all major cards accepted)

CREDIT CARD INFO: Your payment cannot be processed unless all fields are completed!

<p>1. Account Number: _____</p> <p>2. Expiration Date: _____</p> <p>3. Billing ZIP Code: _____</p> <p>4. Security Code: _____</p>	<p>All four fields MUST be completed!</p> <p>This section will be destroyed after the payment is processed.</p>
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