



# Arkansas Department of Health

Arkansas Board of Examiners in Speech-Language Pathology and Audiology  
4815 West Markham Street, Slot 72 • Little Rock, Arkansas 72205-3867 • (501) 537-9151 • Fax: (501) 682-9181

**Governor Sarah Huckabee Sanders**  
**Renee Mallory, RN, BSN, Secretary of Health**  
**Nathaniel Roe, MFA, MA, Director**

## APPLICATION FOR LICENSE

All candidates for licensure have an obligation to update and supplement the information and responses on this application if they change. Failure to supplement the information and response provided on this application may result in denial or other appropriate action. Your application will not be considered complete until all documents and fees have been received by the Board office.  
**ALL FIELDS REQUIRED**

### I am applying for:

**Name:**

(Legal First, Middle, Last)

**Home Address:**

**City and State:**

**Zip Code:**

**Email Address:**

**Phone:**

**Date of Birth:**

**Place of Birth:**

**Race/Ethnicity:**  Black or African American  Native American/Alaskan  Asian or Pacific Islander  
 Caucasian  Hispanic or Latin American  Other

**Social Security Number:**

**Gender:**

Have you ever held an Arkansas Speech-Language Pathology or Audiology License?  Yes  No

If yes, what is the license number?

Please list any state(s) in which you currently hold a professional license.

Do you hold current certification with American Speech-Language Hearing Association (ASHA)?  Yes  No

If yes, indicate area:  CCC-SLP  CCC-A

Account number as shown on your card:

***Please include a copy of your current ASHA card with your application***

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**Education**

University or College	City, State	Degree and Major	Date Awarded

Have you ever been the subject of disciplinary action (e.g., revocation, suspension, reprimand, fine, etc.) by a state licensing authority? If yes, attach explanation.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any unresolved or pending complaint(s) or disciplinary action against you or your professional licensure? If yes, attach explanation.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever voluntarily surrendered your professional license in any state? If yes, Attach explanation.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has any state licensing authority ever denied your application for licensure or renewal? If yes, attach explanation.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been charged or convicted of any crime, not including minor traffic offenses? If yes, attach explanation.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

First expected day of practice in Arkansas will be:

Current Employer:

Employer's Address:

City and State:

Zip Code:

**Affidavit of the applicant**

I hereby apply for a license to practice Speech-Language Pathology or Audiology within the State of Arkansas under the rules established by the Arkansas Board of Examiners in Speech-Language Pathology and Audiology and Ark. Code Ann. §17-100-101 et seq.§. I hereby submit the application fee in the form of a check or money order, made payable to "ABESPA". I understand that the fee will be retained by the Board should my application be rejected. I understand that the license issued to me will be valid for only one year, and it is my responsibility to renew annually before **June 30<sup>th</sup>**.

I, the undersigned do solemnly swear or affirm that I am the above applicant. I have read the above application and all statements contained therein or accompanying this application are true to the best of my knowledge and belief.

Signature of Applicant

Date

Payment Submitted:  Mailed In Cash/Check/Money Order     Electronically On ABESPA Website