



Applicants requesting a full/reciprocal license may submit either documentation of completing the experience signed by the supervisor OR a Certificate of Clinical Competence.

**EXAMINATION**

TEMPORARY LICENSE

Have you taken and passed the NTE Specialty Area Test in Speech-Language Pathology or Audiology? **Y/N**

Request that ETS send the results to the department. The department's score recipient code is 7272.

FULL/RECIPROCAL LICENSE

Applicants for a full/reciprocal license may submit verification of passing score OR Certificate of Clinical Competence.

**LICENSE IN ANOTHER STATE**

List all states in which you have ever held a speech-language pathology and/or audiology license:

State: \_\_\_\_\_ State: \_\_\_\_\_ State: \_\_\_\_\_  
State: \_\_\_\_\_ State: \_\_\_\_\_ State: \_\_\_\_\_

For each state, complete Part I of the "Verifications of License" form, request that the state board complete Part II and return to KDHE.

**DISCIPLINARY ACTION**

●This information is required under Kansas law: K.S.A. 65-6506(d)(1) and K.S.A. 65-6508(g)

Has any license, certification, or registration issued by Kansas or another state or entity been denied, refused for renewal, suspended, revoked or subjected to any other disciplinary action? Y/N

If YES, please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been convicted of a crime by any court (including Kansas), or any federal court of the United States? Y/N

If YES, please indicate:

Date of conviction: \_\_\_\_\_

City, County and State of conviction: \_\_\_\_\_

Crime of which convicted: \_\_\_\_\_

I do hereby attest that the information supplied in this application and any attachment is accurate and complete to the best of my knowledge. I do hereby give permission to the board to verify any information provided in this application and attachments. I understand that the application fee is non-refundable should I not meet licensure qualifications.

\_\_\_\_\_  
Signature of Applicant Date

**^ PLEASE NOTE: YOUR SIGNATURE MUST BE NOTARIZED**

SUBSCRIBED AND SWORN TO before me, the undersigned authority,  
on this \_\_\_\_\_ day of \_\_\_\_\_, 201\_\_\_\_\_  
\_\_\_\_\_  
(Notary Public Signature)  
My appointment expires: \_\_\_\_\_

Submit applications, supporting documents and fee to:

**Health Occupations Credentialing  
1000 SW Jackson, Suite 200**

Topeka, KS 66612-1365