

Department of Health and Human Services  
 Division of Public Health - Licensure Unit  
 P.O. Box 94986 - Lincoln, Nebraska 68509-4986  
 Telephone #: 402-471-2299

**APPLICATION FOR REGISTRATION AS AN AUDIOLOGY ASSISTANT OR A  
 SPEECH-LANGUAGE PATHOLOGY ASSISTANT**

Check below the type of registration that you are requesting: (Please print or type application)

- Audiology Assistant
- Speech-Language Pathology Assistant

**SECTION A - Personal Information:** (All applicants for registration must complete this section.) **This section is public information and will be display on the INTERNET <http://www.nebraska.gov/LISSearch/search.cgi>**

**NOTE: All mailings from this office will be sent to the address you indicate below – If you change your address, you must advise this office.**

1	Legal Name:	First:	Middle/MI:	Last:
	Maiden Name	Name:	Other names you are known as (AKA)	
2	Present Address	Street/Box/Route:		
		City:	State:	Zip:

**Additional information requested: (This information is not displayed on the internet) Submit evidence of age, i.e.;** driver's license, birth certificate, marriage license, school transcript, US State ID card, Military ID, or other similar documentation. A birth certificate or passport will satisfy the requirement for proof of age and proof of U.S. citizenship.

3	Date of Birth:	Month/Day/Year	Place of Birth: City/State or Country		
4	Check the Appropriate Box(s):	<input type="checkbox"/> Social Security Number (SSN);		SSN#	
		<input type="checkbox"/> Alien Registration Number ("A#"); or		A#	
		<input type="checkbox"/> Form I-94 (Arrival-Departure Record) number		I-94#	
If you have both a SSN and an A# or I-94 number, you must report both. <a href="#">Neb. Rev. Stat. § 38-123 mandates disclosure of your social security number to DHHS. Although your number is not public information, DHHS may disclose it for child support enforcement purposes and to the Nebraska Department of Revenue.</a>					
5	Phone #: (optional)	Fax #: (optional)	E-Mail Address: (optional)		

**SECTION B – REGISTRATION FEE: \$60** Make payable to the "Licensure Unit"  
**All registrations expire one year from date of issuance**

**SECTION C – CONVICTION AND LICENSURE INFORMATION (all applicants must complete this section) Failure to disclose any such conviction or disciplinary action, regardless of when the action occurred, could result in disciplinary action, including, but not limited to, payment of a civil penalty.**

Answer each of the following questions by placing an **X** in the appropriate box (yes or no) and completing the information requested. All 'yes' responses **MUST** be explained in detail and you must submit the requested documentation.

#	Question	Yes	No	Type of Crime or Licensure Action	Date of Action	Name of Court/Entity Taking action
1	Have you ever been convicted of a misdemeanor or felony?	<input type="checkbox"/>	<input type="checkbox"/>			

If you answered YES to the question above, you must submit the following documents with your application:

- Copy of the court record(s), which includes charges and disposition;
- Written explanation of the events leading to the conviction(s) (what, when, where, why) and a summary of actions you have taken to address the behaviors/actions related to the conviction(s);
- All addiction/mental health evaluations and proof of treatment, if the conviction(s) involved a drug and/or alcohol related offense and if treatment was obtained and/or required;
- A letter from your probation officer addressing probationary conditions and current status, if you are currently on probation.

**The following questions relate to a credential that you hold or have held in health services, health related services or environmental services in Nebraska or another jurisdiction.**

		Yes	No			
2	Are you credentialed in any state?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what State(s) are you credentialed in?	What type of credential do you hold?	
3	Has your credential ever been denied, refused renewal, limited, suspended, revoked or had other disciplinary measures taken against it?	<input type="checkbox"/>	<input type="checkbox"/>	Type of Credential Action	Date of Action	Name of Entity taking Action
4	Have you ever been denied the right to take an examination?	<input type="checkbox"/>	<input type="checkbox"/>	Please Explain:		

If you answered YES to any of the questions above, you must request the following documents be sent directly to this office:

- Certification of your credential in another state
- Official Documents from the State Board in which the disciplinary action was taken

**SECTION D - Education** - All applicants must complete this section and provide an official transcript from the accredited college

<b>Part 1:</b> Associate's Degree	Name of Program:			
	College:			
	Location:			
	Date Completed:			
<b>Part 2:</b> Bachelor's Degree	Name of Program:			
	College:			
	Location:			
	Date Completed:			
<b>Part 3:</b> Proof of education equivalent to an associate's degree or a bachelor's degree	Name of Program:			
	College:			
	Location:			
	Date Completed:			

**SECTION E – Training:** Applicants must have supervisor complete and submit the **Affidavit of Completion of Aural Rehabilitation Training** (Attachment A1) if you will be providing aural rehabilitation.

Will you be providing aural rehabilitation?  Yes  No

**SECTION F – Supervision:** An Audiology/Speech-Language Pathology assistant must be supervised by a licensed audiologist or speech-language pathologist.

Has audiologist or speech-language pathologist submitted an application for certification of supervision?	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>
If yes, name of supervising audiologist or speech-language pathologist: _____		
If no, will an application for certification of supervision be forthcoming?	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>

**SECTION G – PRACTICE PRIOR TO CREDENTIAL:** An individual who practices prior to issuance of a credential is subject to assessment of an Administrative Penalty of \$10 per day up to \$1,000, or such other action as provided in the statutes and regulations governing the credential.

1	Have you practiced as an audiology or speech-language pathology assistant in Nebraska before submitting the application?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	If yes, what are the actual number of days you practiced in Nebraska and what is the business name, location and telephone number of the practice	# of days: _____
		Name of business: _____
		City: _____
		Telephone #: _____

**SECTION H - ATTESTATION**

For the purpose of complying with Neb. Rev. Stat. §§ 38-129, I attest as follows:

**Please check the appropriate box below:**

- I am a citizen of the United States; **or**
- I am an alien lawfully admitted into the United States who is eligible for a credential under the Uniform Credentialing Act; **or**
- I am a non- immigrant lawfully present in the United States who is eligible for a credential under the Uniform Credentialing Act.

**Application Attestation:** I further attest that:

1. I have read the application or have had the application read to me;
2. All statements on the application are true and complete;
3. I am of good character; and
4. I have not committed any act that would be grounds for denial under Neb. Rev. Stat. § 38-178 and/or 38-179.  
If you have committed any act(s), you must provide an explanation of all such act(s).

**See note below for information on documentation that must be submitted.**

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTE:** The applicant **must submit** the following documentation:

1. Age: Evidence of at least 19 years of age (i.e.: driver's license, birth certificate, marriage license, school transcript, US State ID card, Military ID, or similar documentation);
2. Other Credentialing Info: If you hold or have held a credential to provide health services, health-related services, or environmental services in Nebraska or in another jurisdiction, you must have the licensing agency submit to the Department a certification of your credential;
3. Disciplinary Action: If you have had any disciplinary actions taken against your credential, you must submit a copy of the disciplinary action(s), including charges and disposition;
4. Conviction Information: If you have been convicted of a felony or misdemeanor, you must submit:
  - (a) A copy of the court record, which includes charges and disposition;
  - (b) Explanation from the applicant of the events leading to the conviction (what, when, where, why) and a summary of actions you have taken to address the behaviors/actions related to the convictions;

- (c) All addiction/mental health evaluations and proof of treatment, if the conviction involved a drug and/or alcohol related offense and if treatment was obtained and/or required; and
  - (d) A letter from the probation officer addressing probationary conditions and current status, if you are currently on probation;
5. Citizenship/Lawful Presence Information: You must submit a copy of at least one of the following documents:  
Any of the following documents provide proof of United States Citizenship:
- (1) A U.S. Passport (unexpired or expired);
  - (2) A birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal;
  - (3) An American Indian Card (I-872);
  - (4) A Certificate of Naturalization (N-550 or N-570);
  - (5) A Certificate of Citizenship (N-560 or N-561);
  - (6) Certification of Report of Birth (DS-1350);
  - (7) A Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240);
  - (8) Certification of Birth Abroad (FS-545 or DS-1350);
  - (9) A United States Citizen Identification Card (I-197 or I-179);
  - (10) A Northern Mariana Card (I-873);
- Any of the following documents provide proof of lawfully admitted/present in the United States:
- (1) A Green Card, otherwise known as An Alien Registration Receipt Card (Form I-551), both front and back of card
  - (2) An unexpired foreign passport with an unexpired Temporary I-551 stamp bearing the same name as the passport;
  - (3) A document showing an Alien Registration Number ("A#"). An Employment Authorization Card/Document is not acceptable; or
  - (4) A Form I-94 (Arrival-Departure Record);
6. Education: An official college/university transcript.
7. Fee: The required fee.

Any documents written in a language other than English must be accompanied by a complete translation into the English language. The translation must be an original document and contain the notarized signature of the translator. An individual may not translate his/her own documents.

(To be completed by supervising audiologist or speech-language pathologist if additional training has been provided)

**AFFIDAVIT FOR COMPLETION OF  
AURAL REHABILITATION TRAINING FOR AUDIOLOGY OR SPEECH-LANGUAGE PATHOLOGY ASSISTANT**

I, \_\_\_\_\_ do hereby attest  
(Licensed Audiologist or Speech-Language Pathologist)

that \_\_\_\_\_ has satisfactorily  
(Audiology/Speech-Language Pathology Assistant)

completed additional training to provide aural rehabilitation covering the following areas:

1. Information concerning the nature of hearing loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Purposes and principles of auditory and visual training	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Maintenance and use of amplification devices	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Routine cleaning of devices	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Communication options for individuals with hearing loss, e.g., sign language	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Use of assistive technology	<input type="checkbox"/> Yes <input type="checkbox"/> No

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Audiologist or Speech Language Pathologist

Return this form to:

Nebraska Department of Health and Human Services  
Division of Public Health  
Licensure Unit  
P.O. Box 94986  
Lincoln, NE 68509-4986



NEBRASKA  
 Department of Health and Human Services  
 Division of Public Health - Licensure Unit  
 P.O. Box 94986 - Lincoln, Nebraska 68509-4986  
 Telephone #: 402-471-2299

**APPLICATION FOR CERTIFICATION OF SUPERVISION OF AN  
 AUDIOLOGY OR SPEECH-LANGUAGE PATHOLOGY ASSISTANT**

(This application must be completed by the supervising audiologist or speech-language pathologist.  
 The audiologist or speech-language pathologist may only **supervise two assistants**)

**SECTION A - Name of Audiology or Speech-Language Pathology Assistant**

Name:

Are you supervising other audiology or speech-language pathology assistants?     Yes     No

If yes, list name of assistant(s):

**SECTION B - Supervising Audiologist or Speech-Language Pathologist Information**

1 Name:

2 Present Address:

Street/PO/Route:

City:

State:

Zip:

3 Nebraska license number:

Audiologist:

Speech-Language Pathologist:

4 Area in which the Assistant is working:

Audiology

Speech-Language Pathology

**SECTION C - Practice Site(s)**

Location(s) where Audiology/SLP assistant will be working:

Facility Name

Street Address:

City:

State:

Zip:

Telephone – Optional:

Facility Name

Street Address:

City:

State:

Zip:

Telephone – Optional:

**CERTIFICATION FEE: One time fee of \$25**

Make payable to the "Licensure Unit"

License expires upon termination of the Audiology or Speech-Language Pathology Assistant

**SECTION D - Usage Plan** - All applicants must complete **The Audiology/Speech-Language Pathology Assistant Usage Plan**. Indicate which of the following duties the Audiology/SLP Assistant will perform.

**DUTIES:**

- |                          |  |
|--------------------------|--|
| <input type="checkbox"/> | (1) Implement programs and procedures designed by licensed audiologist(s) or speech-language pathologist(s).   |
| <input type="checkbox"/> | (2) Maintain records of implemented procedures which document a patient's responses to treatment.  |
| <input type="checkbox"/> | (3) Provide input for interdisciplinary treatment planning, inservice training and other activities directed by a <u>licensed</u> audiologist or speech-language pathologist.                  |
| <input type="checkbox"/> | (4) Prepare instructional material to facilitate program implementation as directed by a licensed audiologist or speech-language pathologist.  |
| <input type="checkbox"/> | (5) Follow plans developed by licensed audiologist(s) or speech-language pathologist(s) that provide specific sequences of treatments to individuals with communicative disorders or dysphagia |
| <input type="checkbox"/> | (6) Chart or log patient responses to the treatment plan   |
| <input type="checkbox"/> | (7) Provide aural rehabilitation.  |

Describe how you will use an alternate supervisor when you are unable to provide supervision and the method of supervision the alternate supervisor will use:

**SECTION E – AFFIDAVIT**

I, the undersigned, certify that I am the person referred to in this application and that the statements herein are true and complete. I further certify that the Audiology or Speech-Language Pathology Assistant named in this application will not perform the functions listed in Neb. Rev. Stat. §38-524 and will not perform aural rehabilitation unless s/he has the additional training required by Neb. Rev. Stat. §38-522. I also certify that I will be responsible for supervising the Audiology or Speech-Language Pathology Assistant and be responsible for all aspects of patient treatment if I am granted approval to supervise said assistant. I agree to provide an alternate supervisor in the event I am unable to supervise the Audiology or Speech-Language Pathology Assistant.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Supervisor)

**Attestation of the supervising audiologist or speech-language pathologist: I attest as follows:**

1. I will provide supervision for no more than two (2) audiology/speech-language pathology assistants;
2. I will provide direct onsite supervision for the first two (2) treatment sessions of each patient's care;
3. I will provide direct onsite supervision of at least twenty (20) percent of all subsequent treatment sessions per quarter;
4. I will provide a minimum of ten (10) hours of in-service training;
5. I will provide semi-annual performance evaluations and review them with the speech-language pathology assistant that I am supervising;
6. I will provide an alternate supervisor if I am unable to supervise the SLPA;
7. I will be responsible for all aspects of patient treatment; and
8. All statements in this application are true and complete.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Supervisor)