For Board Use Only - - Audiologist Application

Date Application received_____ Application Fee $_____CK# _____

Date Provisional License issued_____ Provisional License Number_____

Date Permanent License issued_____ Permanent License Number_____

Child Support Data Bank Date Checked_____

BOARD OF HEARING AID DISPENSERS AND AUDIOLOGIST
810 North Main #298, Spearfish, SD 57783 (605) 642-1600

APPLICATION FOR LICENSE TO PRACTICE

AUDIOLOGY

Type of license requested for Audiology: _____ ($200.00 Application fee)

Applicant's Name:_____
(Last) (First) (Initial) (Maiden)

Mailing Address:_____
(Street or P.O. Box) (City) (State) (Zip)

Home Telephone: (_____) _____

Date of Birth:_____ Social Security Number:_____

Email Address:_____

Race (please circle one): White Black or African American American Indian or Alaskan Native
Asian Native Hawaiian or Other Pacific Island Not Listed or Prefer Not to Answer Not Applicable

Gender (please circle one): Male Female Prefer Not to Answer Not Applicable

Ethnicity (please circle one): Hispanic Non-Hispanic Prefer Not to Answer Not Applicable

Business Name:_____
(Firm Name) (Telephone Number)

_____
(Street and P.O. Box if any) (City) (State)
(Zip) list both street and P.O. Box

Employing Facility:_____
(Firm Name) (City) (State)

Employer Business Type: (please circle one): Unknown Individual Partnership Corporation
Association LLC LLP Other

I am employed: Full Time _____ Part Time_____

Have you ever been licensed in another state?_____ Which state(s)_____

Have you ever been Licensed in South Dakota?_____ Dates?_____

*Please contact the board office(s) in the state(s) and request they submit a license verification on your past or current

license. They will need to mail or email the verification **direct from their office** to the South Dakota Board of Hearing Aid Dispensers and Audiologists at the address listed on the front page of this application or it may come by email to office@sdlicensing.com

Do you have ASHA certification? ☐ Yes ☐ No
If yes, please have ASHA send the Board office proof of certification.

If no, please supply verification of your one-year supervised practicum to the Board office on the Practicum Verification Form as well as request your Praxis scores directly from the testing service.

Please have official college transcripts sent directly to the Board of Hearing Aid Dispensers and Audiologists by the registrar of the college/ university **for your highest degree only.**

Name and Location of Accredited College	Date of Attendance From To	Degree and Date Granted

EMPLOYMENT RECORD FOR LAST 5 YEARS

Employer Name and Address	Date of Employment	Your Position	Supervisor's Name

PERSONAL REFERENCES

	Name	Street Address	City & State	Zip
1.				
2.				
3.				

1. Have you ever been convicted, plead no contest/nolo contendere, plead guilty to, or been granted a deferred judgment or suspended imposition of sentence or had a prosecution deferred with respect to a felony?
☐ Yes ☐ No

2. Have you ever been convicted, plead no contest/nolo contendere, plead guilty to, or been granted a deferred judgment or suspended imposition of sentence, or had prosecution deferred with respect to a misdemeanor other than a class 2 misdemeanor traffic offense? *It is the applicant's responsibility to confirm whether the infraction is a class 1 or class 2 misdemeanor. ☐ Yes ☐ No

Please Note*: if you answered yes to 1 or 2, provide a personal statement detailing the nature of the crime, whether you think the crime relates to your practice, and description of rehabilitation efforts. You must also submit copies of charges or citations and ALL communications (to and from) the citing agency AND the court of jurisdiction, including evidence of completion/compliance with court requirements. You must attach all communications for a violation to the signed and dated explanation of the violation. Please put correct correspondence in chronological order (most recent first). If you have more than one violation, please do the same for each violation.* **This does not include records that have been sealed, expunged, or pardoned.**

3. To your knowledge, has a complaint ever been filed against you, or a company owned by you, with the ASHA Board of Ethics, AAA Board of Ethics, the Federal Trade Commissioner or any other state licensure board?
☐ Yes ☐ No
If yes, give complete details on a separate sheet, including copies of the court's judgement and any written decisions in that case.

4. Has any state rejected your application or revoked your professional license or certificate?
☐ Yes ☐ No
If yes, give complete details on a separate sheet.

5. SDCL 25-A-56 prohibits the issuance of a license of any state regulated license if an applicant owes $1,000 or more in past due child support. Do you owe $1,000 or more in past due child support?
☐ Yes ☐ No

6. Is your spouse an active-duty member of the armed forces? ☐ Yes ☐ No
If yes, was your spouse subject to military transfer to South Dakota? ☐ Yes ☐ No
If yes, did you leave employment to accompany your spouse to South Dakota? ☐ Yes ☐ No

By applying for licensure to the South Dakota Board of Hearing Aid Dispensers and Audiologist, I:

*Authorize Board representatives to consult with others who have been associated with me and/or who may have information regarding my competence and qualifications.

*Consent to Board representatives' inspection of all records and documents that may be material to an evaluation of my professional qualifications and competence to carry out the privileges I request, of my physical and mental health status and of my professional and ethical qualifications.

*Release from any liability all Board representatives for their acts performed in good faith and without malice in connection with evaluation of me and my credentials.

*Release from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to the South Dakota Board of Hearing Aid Dispensers and Audiologists in good faith, and without malice concerning my competence, professional ethics, character, physical and mental health, emotional stability, and other qualifications for staff appointment and clinical privileges.

declare and affirm under the penalties of perjury that this application has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

_____
Applicant's Signature

_____
Print Name as it is to appear on license

_____
Date

NOTORIZATION

The applicant_____, having appeared before me and being identified as the same individual by the appropriate identification, being sworn, deposes and says that he/she is the person who executive this application; that the statements herein contained are true in every respect; that he/she has not suppressed any information that might affect this application.

Subscribed and sworn before me this_____day of_____,_____

My commission expires_____

_____ (Seal)
Signature of Notary Public