Wisconsin Department of Safety and Professional Services

Office Location: 4822 Madison Yards Way
Madison, WI 53705
Phone Number: (608) 266-2112

LicensE Portal: License.wi.gov
Email: dsps@wisconsin.gov
Website: http://dsps.wi.gov

HEARING AND SPEECH EXAMINING BOARD

APPLICATION FOR TEMPORARY LICENSE TO PRACTICE SPEECH-LANGUAGE PATHOLOGY

APPLICANT: Complete this section and submit directly to your supervisor for completion. Form must be returned directly from the supervising speech-language pathologist to the Department. An applicant for temporary licensure must submit a completed application for full licensure, together with submission of all required forms and required fees. A temporary license is required prior to commencing work at a clinical fellowship in Wisconsin.

Last Name | **First Name** | **MI** | **Former / Maiden Name(s)**

$10.00 non-refundable temporary license fee is required. Applicant must pay $10.00 fee online via applicant's LicensE account.

☐ **I have taken the National Certification Examination for Speech-Language Pathology and am awaiting results.**

☐ **I have taken and passed the National Certification Examination for Speech-Language Pathology.**

☐ **I am scheduled to take the next available National Certification Examination for Speech-Language Pathology on:** ___/___/_____ **Date**

ATTESTATION OF APPLICANT: I declare that I am the person referred to on this form and that all information required to be completed by me (the applicant for a credential), is complete and accurate to the best of my knowledge and belief. Furthermore, I declare that after completing the information that was required by me (and only that information) the form was forwarded to the relevant third-party for completion of the information asked of them. I also declare that to the best of my knowledge the completed form was provided to the Department of Safety and Professional Services by the relevant third-party (and not by me, the applicant). Finally, I declare that I understand that failure to provide the requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential may result in credential application processing delays; denial, revocation, suspension, or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. By signing below, I am signifying that I have read and understand the above declarations.

Applicant Signature (If unable to provide a digital signature, please print and sign form.) | ___/___/_____ **Date** | **Application Number**

SUPERVISING SPEECH-LANGUAGE PATHOLOGIST: Complete this section for the above-named applicant and return directly to the Department using the LicensE Third-Party* Upload Portal at license.wi.gov. You will need the application number shown above. (*For form completion purposes, the term "Third-Party" refers to any non-applicant or non-DSPS individual or entity submitting required documentation in support of a credential application.)

AFFIDAVIT: I wish to request that a temporary license to practice Speech-Language Pathology in the State of Wisconsin be issued to the above listed applicant. I am aware that a temporary license may be issued for a period not to exceed 18 months and may be renewed once for 18 months or longer, at the discretion of the Board.

ATTESTATION OF THIRD-PARTY PROVIDING INFORMATION RELATED TO APPLICANT: I declare, on behalf of the third-party asked to provide information related to the applicant identified on this form, that the information provided is true and correct to the best of my knowledge and belief. I further declare that after completing the form I, or other third-party staff, will provide the completed form directly to the Wisconsin Department of Safety and Professional Services for review. By signing below, I am signifying that I have read, understand, and have complied with the above declarations.

Signature of Supervisor (If unable to provide a digital signature, print and sign form.) | ___/___/_____ **Date** | **WI License Number**

Printed Name of Supervisor | **Title of Supervisor**

Agency/Department/Employer

Name of Physical Work Location

Address of Physical Work Location (number/street) | (city) | (state) | (zip code)