

# Wisconsin Department of Safety and Professional Services

**Mail To:** P.O. Box 8935  
Madison, WI 53708-8935  
**FAX #:** (608) 251-3036  
**Phone #:** (608) 266-2112

**Ship To:** 4822 Madison Yards Way  
Madison, WI 53705  
**E-Mail:** [dspd@wisconsin.gov](mailto:dspd@wisconsin.gov)  
**Website:** <http://dspd.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.** An applicant for temporary licensure must submit a completed application form 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)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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:  /  /

**SUPERVISING SPEECH-LANGUAGE PATHOLOGIST: Complete this section and submit directly to DSPS: Supervisor may mail to the address above or fax or email with facility cover sheet or letter to: (608) 251-3036 or [DSPSCredHearingSpeech@wisconsin.gov](mailto:DSPSCredHearingSpeech@wisconsin.gov).**

**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.

**Signature of Supervisor (Print and Sign Form)**

**Printed Name of Supervisor**

/  /

**Date**

**Title of Supervisor**

**WI License #:**

**Agency/Department/Employer:**

**Name of Physical Work Location:**

**Address of Physical Work Location:**  
(number, street, city, zip code)

**APPLICATION FEES:** Please check applicable box. Make check payable to DSPS and attach to this application.

**Temporary License Fee \$10.00**

**For Receipting Use Only (154)**