



## APPLICATION FOR RENEWAL OF PROVISIONAL LICENSE

FORM SPA-5

Speech-Language Pathologist     
  Speech-Language Audiologist

<b>1. APPLICANT DATA</b> <span style="float: right;">☞ Print clearly or type the following information.</span>					
NAME	Last	First	Middle	Home Telephone:	Business Telephone:
MAILING ADDRESS	Street and Number		Apt #	Email Address: _____	
	City	State	Zip Code	Date of Birth:	
License Number: _____      Expiration Date: _____					
<b>2. APPLICANT HISTORY – GENERAL</b>					
A. Have you been convicted of a crime, pled nolo contendere, or had adjudication of guilt withheld since your last application to the Department? <span style="float: right;"><input type="checkbox"/> yes <input type="checkbox"/> no</span> <b>If YES, provide the date, jurisdiction, offense, disposition, and attach a copy of the court disposition.</b>					
B. Have you completed your nine (9) months of professional employment? <span style="float: right;"><input type="checkbox"/> yes <input type="checkbox"/> no</span> <b>If YES, you are not eligible to renew your provisional license.</b>					

Department of Health  
 Division of Medical Quality Assurance  
 Board of Speech-Language Pathology and Audiology  
 4052 Bald Cypress Way BIN# C06, Tallahassee, FL 32399-3256  
 Telephone: (850) 245-4161

**FORM SPA-5**

License Number: \_\_\_\_\_

**CERTIFICATION**

I hereby authorize all hospitals, institutions, or organizations, personal physicians, employers (past or present), business and professional associates (past or present), and all government agencies and instrumentalities (local, state, federal, or foreign) to release to the Department of Health any information, files, or records requested by the Department in connection with the processing of this application. I further authorize the Department to release to the organizations, individuals, and groups listed above any information, which is material to my application.

I understand that it is my duty and responsibility as an applicant for licensure to supplement my application after it has been submitted if and when any material change in circumstances or conditions occur which might affect the Board's decision concerning my eligibility for examination or licensure. Chapter 455.213(1), F.S., requires such supplement. Failure to do so may result in disciplinary action by the Board including denial of licensure.

I have carefully read the questions in the foregoing application and have answered them completely without reservations of any kind, and I declare that my answers and all statements made by me herein are true and correct. Should I furnish any false information on this application, I hereby agree that such act shall constitute cause for denial, suspension, or revocation of any license to practice in the State of Florida the profession for which I am applying.

I hereby acknowledge receipt of Chapter 468, Part I, F.S., and related rules and further acknowledge that I have read these regulations. I understand that it is my responsibility to keep informed of any changes to Chapter 468, Part I, F.S. and related rules.

**I UNDERSTAND THAT I AM NOT PERMITTED TO PRACTICE THE PROFESSION FOR WHICH I AM APPLYING UNTIL I AM ISSUED A LICENSE OR CERTIFICATE TO PRACTICE THE PROFESSION.**

\_\_\_\_\_  
Print Applicant Name

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date