DEPARTMENT OF HEALTH

Affirmation
Clinical Fellowship or Doctoral Externship License
Speech Language Pathologist (SLP)/Audiologist (Aud)

EMPLOYMENT INFORMATION

Employer/ Facility Name: Please provide the name of the facility where you work (do not include the name of the staffing agency).

Street Address | City | State | ZIP

Employer/Facility Phone | Fax

Employment Start Date (mm/dd/yyyy) | Position Title

Will you be dispensing hearing instruments during your fellowship or externship? ☐ No ☐ Yes

AUDIOLOGY APPLICANTS ONLY: I understand that I must pass the practical exam for hearing instrument dispensing before I am eligible for full audiologist licensing.

Applicant Signature | Date

APPLICANT AFFIRMATION: *I hereby make application for Clinical Fellowship/Doctoral Externship Licensing. I have completed the Master's or doctoral degree educational requirements for licensing as described in Minnesota Statutes, Section 148.515, Subd. 2 and Subd. 3. I understand that as a Clinical Fellowship/Doctoral Externship licensee I must practice under the supervision of a speech-language pathologist or audiologist who is licensed by the State of Minnesota or who holds a current certificate of clinical competence from the America Speech-Language hearing Association(ASHA) or current board certification from the American Board of Audiology (ABA).* I understand that Clinical Fellowship/Doctoral Externship licensing expires eighteen months from issuance and that to continue using a protected title after the expiration of Clinical Fellowship/Doctoral Externship licensing I must apply for and obtain either 1) a renewal of my Clinical Fellowship/Doctoral Externship licensing or 2)full licensing status as a speech-language pathologist or audiologist.*

By signing below, I certify that:

- I have read and will comply with the requirements of Minnesota Statute Section 148.5161
- I have read and will comply with the requirements of Minnesota Statutes, sections 148.511 to 148.5198
- I am not the subject of a pending investigation or disciplinary action for speech-language pathology or audiology practice in this or any other state or by the American Speech-Language Hearing Association (ASHA), and;
- I have not been the subject of a disciplinary action for speech-language pathology and or audiology practice in this or any other state or by the American Speech-Language hearing Association (ASHA) and or/American Board of Audiology.

I understand that approval of Clinical Fellowship/Doctoral Externship license and status as a Clinical Fellowship/Doctoral Externship licensee creates no rights to or expectation of approval of the Minnesota Department of Health for a license as a Speech-Language Pathologist and/or Audiologist

I have read and understand the instructions for this application process.

Applicant Signature | Date

SLP/AUD TEMPORARY CLINICAL FELLOWSHIP DOCTORAL EXTERNSHIP - AFFIRMATION

PART II: To be completed by applicant's supervisor only.

Please print and sign clearly in blue ink.

Last Name	First Name	Middle
Supervisor's MN License #	Employment Name	
Street Address	City State	ZIP
Telephone Number	Employer Telephone Number	
Fax Number	Supervisor's Email Address	
Date Supervisor Started Employment (mm/dd/yyyy)	Hearing Instrument Dispenser (HID) Certification # (if Certified)	

The Speech-Language Pathology and Audiology Advisory Council at the Minnesota Department of Health recommends that the supervisor has at least one year of experience. Please carefully read the "Supervisor Affirmation" Statement provided below.

SUPERVISOR AFFIRMATION. *I certify that I am a licensed speech-language pathologist or audiologist in the State of Minnesota or that I hold a current certificate of clinical competence from the American Speech- Language Hearing Association (ASHA) or current board certification by the American Board of Audiology (ABA)* and will be the supervisor of the applicant who has applied for Clinical Fellowship/Doctoral Externship license. I have read Minnesota Statutes, Section 148.5161 and will provide supervision consistent with subdivision 3. I understand that Clinical Fellowship/Doctoral Externship licensing expires within 18 months of issuance. Furthermore, I understand that I am a responsible supervisor for the above applicant until the Minnesota Department of Health receives my written and signed statement that I wish to cease supervision or until expiration of Clinical Fellowship/Doctoral Externship licensing*

Supervisor's Signature	Dater