



Application to Become an Associate of the American Speech-Language-Hearing Association

1. Personal Information

Title: Miss Mr. Mrs. Ms.
First Name: _____ Middle Name: _____
Last Name: _____ Previous Name: _____
Mailing Address: _____
City: _____ State/Province: ____ Zip/Postal: _____ - _____
Phone/Cell Number: _____ E-mail Address: _____

Check one.

- I am applying as a speech-language pathology Associate.
 I am applying as an audiology Associate.

2. Employment Status

NOTE: Though your state may use different terms, such as technician, aide, associate or other title, the use of “assistant” throughout this application is meant to include all titles of support personnel in audiology or speech-language pathology.

Check one.

- I am employed as a speech-language pathology assistant or as an audiology assistant. **Note:** If you are employed, you **must** complete Section 5a.
 I am **not** currently employed as a speech-language pathology assistant or as an audiology assistant. **Note:** If you are **not** employed, you **must** complete Section 5b.

3. Licensure, Registration or Certification Status

Check one.

- I am licensed, registered or certified to work as a speech-language pathology assistant or as an audiology assistant.

State issuing license, registration or certificate: _____

License, registration or certification number, if applicable: _____

- I am **not** licensed, registered or certified to work as a speech-language pathology assistant or as an audiology assistant.

4. Qualifications

Check one.

- My education or training background meets the requirements of my state for speech-language pathology assistants or audiology assistants.
 My state does not set education requirements for speech-language pathology assistants or audiology assistants.

What is the highest level of education you have **completed**?

- Bachelor's degree Associate's degree
 High school diploma Course or other relevant training

Area of degree (e.g., Communication Sciences & Disorders (CSD), SLPA, Biology, Psychology, etc.): _____

Name of course or other relevant training: _____

5. One Verifying Signature Required

5a. If you are employed as a speech-language pathology assistant or as an audiology assistant, you must obtain the signature of the ASHA-certified professional who supervises your work.

NOTE TO SUPERVISING SPEECH-LANGUAGE PATHOLOGIST OR AUDIOLOGIST: By signing this application you are verifying that you supervise this applicant in accordance with *ASHA Guidelines for the Training, Use and Supervision of Speech-Language Pathology Assistants or Support Personnel in Audiology: Position Statement and Guidelines*, and that in your opinion, this applicant is qualified to perform the assigned tasks of either a speech-language pathology assistant or an audiology assistant.

Signature of Supervising Speech-Language Pathologist or Audiologist _____ Date _____

First Name: _____ Last Name: _____
Employer: _____
City: _____ State/Province: _____
ASHA ID NUMBER: _____(optional)

5b. If you are **not** employed as a speech-language pathology assistant or as an audiology assistant, you must obtain the signature of the program director or instructor of your speech-language pathology or audiology training or education program.

NOTE TO PROGRAM DIRECTOR OR INSTRUCTOR: By signing below, you are verifying that this applicant has received training from you toward becoming a speech-language pathology assistant or audiology assistant, and that, in your opinion, this applicant is qualified to perform either the assigned tasks of a speech-language pathology assistant or an audiology assistant.

Signature of Program Director _____ Date _____

First Name: _____ Last Name: _____
Employer: _____
City: _____ State/Province: _____
ASHA ID NUMBER: _____(optional)

6. One Verifying Signature Required

As an ASHA Associate, I will agree to:

- Perform my job solely within the appropriate scope of responsibilities described in the *ASHA Guidelines for the Training, Use and Supervision of Speech-Language Pathology Assistants or Support Personnel in Audiology: Position Statement and Guidelines*.
- Perform only those tasks assigned by a supervising speech-language pathologist or audiologist.
- Work only under the supervision of an ASHA certified speech-language pathologist or audiologist.
- Adhere to all applicable state (province) laws and rules regulating the professions listed above.

I, _____, have read and agree to the above. Further, I agree that the information provided on this application is true and accurate.

Signature of Applicant _____ Date _____

Payment Information

Method of Payment

Payment by Check

Fees enclosed (\$75).

(Payment must be made in US dollars. Make checks payable to **ASHA**. Payments are not refundable and must be paid in full at the time of application.)

Payment By Credit Card

Please charge \$75 to my:

Visa

MasterCard

Discover

Credit Card Number

____/_____
Expiration Date (MM/YYYY)

Signature

Mail your completed application and dues payment to:

American Speech-Language-Hearing Association
PO Box 1160 #210
Rockville, MD 20849

We cannot process incomplete applications. If you have questions about this application, contact the ASHA Action Center at **800-498-2071** or **actioncenter@asha.org**.