



Print, complete, and mail this form to ASHA at the address listed below.

This is a new address

ASHA ID: _____

Name: _____ Previous Name(s) Used: _____

Address: _____
Street City State Zip

Daytime Phone: _____ Evening Phone: _____

E-mail: _____

- I am on short-term disability (a copy of my social security determination letter or letter from my doctor is attached)
- I am on long-term disability (a copy of my social security determination letter or letter from my doctor is attached)

Your medical documentation must include a statement that you are unable to provide clinical services or supervise the provision of clinical services and include an approximate date range indicating when you were first unable to work and when you will be able to return to work. You are not required to disclose the nature of the disability.

My signature below provides the assurance that I have read and agree to abide by all of the following requirements:

1. I affirm that the information provided on this affidavit is accurate.
2. I affirm that, during the time of my inactive certification status, I will not provide or supervise clinical services. Clinical services are defined as evaluation and treatment of persons with speech-language and/or hearing impairments, whether such services are provided in elementary or secondary schools, in private practice, or in free-standing community clinics, rehabilitation centers, hospitals, nursing homes, or other facilities.
3. I affirm that I abide by the Code of Ethics of the American Speech-Language-Hearing Association.
4. I affirm that I understand my CCC Inactive status may be made available to the public.
5. I affirm that I understand that the CCC Inactive status of disability waives the requirement to pay annual certification fees during the time I am on the Inactive status.
6. I affirm that I will cease using the designation CCC-A and/or CCC-SLP and will instead use the designation CCC-A Inactive and/or CCC-SLP Inactive.

Signature _____ Date _____