ASHA
American Speech-Language-Hearing Association

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

1| APPLICANT PROFILE

Title: ❑ Miss ❑ Mr. ❑ Mrs. ❑ Ms.

First Name _____ Middle Name _____

Last Name _____ Previous Name _____

Mailing Address _____

City _____ State _____ Zip _____

Cell Phone #_____ Email _____

Check one.

❑ I am applying as an Audiology Assistant.

❑ I am applying as a Speech-Language Pathology Assistant.

2| EMPLOYMENT PROFILE

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 an audiology assistant or as a speech-language pathology assistant.
Note: *If you are employed, you **must** complete Section 5a.*

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

3| LICENSURE, REGISTRATION OR CERTIFICATION PROFILE

Check one.

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

State issuing license, registration, or certificate: _____

License, registration, or certification number, if applicable: _____

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

4| EDUCATION PROFILE

Check one.

❑ My education or training background meets the requirements of my state for audiology assistants or speech-language pathology assistants.

❑ My state does not set education requirements for audiology assistants or speech-language pathology assistants.

Please complete:

University/Institution: _____

Degree Type:

❑ Associate's degree Bachelors: ❑ BA ❑ BS Masters: ❑ MA ❑ MS

❑ High school diploma ❑ Course or other relevant training

Degree Area:

❑ Communication Sciences & Disorders (CSD) ❑ Audiology ❑ SLPA ❑ Speech-Language Pathology

❑ Other, please specify: _____

Name of course or other relevant training: _____

Degree Date (mm/dd/yy): _____

5 | REQUIRED SIGNATURE

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

NOTE TO SUPERVISING AUDIOLOGIST OR SPEECH-LANGUAGE PATHOLOGIST: By signing this application you are verifying that you supervise this applicant in accordance with the *Speech-Language Pathology Assistant Scope of Practice* or the *Audiology Assistants Overview* and that in your opinion, this applicant is qualified to perform the assigned tasks of either an audiology assistant or a speech-language pathology assistant.

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

_____ _____

ASHA ID NUMBER: _____

First Name: _____ Last Name: _____

Employer: _____

City: _____ State/Province: _____

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

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

Signature of Program Director **Date**

_____ _____

ASHA ID NUMBER: _____

First Name: _____ Last Name: _____

Employer: _____

City: _____ State/Province: _____

6 | PLEASE VERIFY: AS AN ASHA ASSISTANT, I WILL AGREE TO:

- Perform my job solely within the appropriate scope of responsibilities described in the *Speech-Language Pathology Assistant Scope of Practice* and the *Audiology Assistants Overview*.
- Perform only those tasks assigned by a supervising audiologist or speech-language pathologist.
- Work only under the supervision of an ASHA-certified audiologist or speech-language pathologist.
- 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

ASSISTANT MEMBERSHIP: JANUARY 1–DECEMBER 31

METHOD OF PAYMENT

Payment by Check

❑ Fees enclosed ($75).

(Payment must be made in U.S. 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
P.O. 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**.

Please DO NOT email any credit card payments.