# CERTIFICATE OF CLINICAL COMPETENCE
# MEDICAL CIRCUMSTANCES
# INACTIVE AFFIDAVIT

**Instructions**

- Print, complete, and submit this form by one of the following methods:
  ***E-Mail**: cccmaintenance@asha.org  ***Mail**: ASHA
  2200 Research Blvd. #313
  Rockville, MD 20850

**Please provide current, accurate information:**

ASHA ID: _____ Check here if this is a new address

Name: _____ Previous Name(s) Used: _____

Address: _____
Street City State Zip

Phone: _____ E-mail: _____

**I have a medical circumstance, or I am the primary caregiver for someone who has a medical circumstance, that prevents me from working in the audiology or speech-language pathology profession. Evidence documenting my inability to work in the professions, such as a letter from a doctor, the Medical Documentation form, or a Social Security Administration determination letter, is included.**

Medical documentation must have been completed no more than 12 months prior to the submission of this form. This documentation must include a statement that you are unable to provide clinical services or supervise the provision of clinical services but does not need to disclose the nature of the medical circumstance.

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

1. The information provided on this affidavit is accurate.
2. 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 will continue to abide by the Code of Ethics of the American Speech-Language Hearing Association.
4. I understand my CCC Inactive status may be made available to the public.

5. I understand that I am exempt from the professional development requirement of the certification maintenance standard during the time I am on Inactive status.
6. I understand that I may be eligible for a waiver of the annual membership dues and/or certification fees during the time I am on Inactive status if I have been a Certified Member for at least 5 years.
7. 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 during the time I am on Inactive status.
8. I will notify ASHA of my intent to return to clinical practice and regain Active certification status by completing and submitting the Return to Active Certification form. I understand that I will need to provide evidence of 10 certification maintenance hours (CMHs) that were completed no more than 12 months prior to the submission of the Return to Active Certification Form.
9. I understand that I cannot be on Inactive certification status for more than 4 years. If my Inactive status exceeds 4 years, I understand my certification will be retired and I will need to apply for reinstatement of the CCC-A and/or CCC-SLP in order to regain Active certification status.

Signature _____ Date _____

# CERTIFICATE OF CLINICAL COMPETENCE
# MEDICAL DOCUMENTATION FORM

**Please provide current, accurate information:**

Individual's Name: _____ ASHA ID: _____

☐ The individual named above has a medical circumstance that prevents her/him from working in the audiology or speech-language pathology profession.

☐ The individual named above is the primary caregiver for someone who has a medical circumstance that prevents her/him from working in the audiology or speech-language pathology profession.

Health Care Provider: _____ Facility: _____

Address: _____

Street City State Zip

Phone: _____

My signature below affirms that the individual named above has a medical circumstance, or is the primary caregiver for someone who has a medical circumstance, that prevents her/him from working in the audiology or speech-language pathology profession.

Health Care Provider's Signature _____ Date _____/_____/_____