



ARKANSAS BOARD EXAMINERS FOR SPEECH –LANGUAGE PATHOLOGY AND AUDIOLOGY
 4815 West Markham Street, Slot 72
 Little Rock, Arkansas 72205
 Office: (501) 537-9151
 Website: www.abespa.com • Email: abespa@arkansas.gov

LICENSE VERIFICATION REQUEST

I, _____ hereby authorize and request the State Board of _____ to furnish the Arkansas Board of Examiners in Speech-Language Pathology and Audiology documents, records or other information regarding charges or complaints filed against me, formal or informal, pending or closed, and to include any other pertinent licensure information.

Signature of Applicant _____	License Number _____	Issue Date _____
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Full name of Applicant _____	Date of Birth _____	Social Security Number _____
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Other Names Used in Obtaining Licensure

Current Address (Street, City, State, and Zip Code)

The following section must be completed by an official of the State Board and returned directly to the Arkansas Board of Examiners in Speech Language Pathology and Audiology.

State of _____	Full Name of Licensee _____
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Licensure Status _____	License Number _____	Issue Date _____
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License Current <input type="checkbox"/> Yes <input type="checkbox"/> No	License in Good Standing <input type="checkbox"/> Yes <input type="checkbox"/> No
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Has the applicant ever been the subject of complaints or charges received by a disciplinary authority in your state? If yes, attach details.
 Yes No

Has the applicant ever been notified or requested to appear before any licensing or disciplinary authority in your state? If yes, attach details.
 Yes No

Has the applicant ever been warned, censured, or disciplined in any manner by a licensing or disciplinary authority in your state? If yes, attach details.
 Yes No

Has any application by the above applicant ever been denied? If yes, attach details.
 Yes No

Comments, if any

Board Seal	Signature and Title _____	Date _____
	State Board _____	