HEALTH OCCUPATIONS PROGRAM
Speech Language Pathology and Audiology
P.O. Box 64882, St. Paul, Minnesota 55164-0882
Telephone: (651) 201-4200
Fax: (651) 201-3839
Email: health.slpa@state.mn.us

Instructions and Application for Speech Language Pathologist

Method 3, Meet all requirements for certifications(s) but do not have certification

If you do not currently hold a CCC or board certification you may qualify for licensing under Minnesota Statutes, 148.515 if you have met every requirement that American Speech Hearing Association (ASHA) requires for certification. Please note that as of July 1, 2017, our application process has changed. Please follow the instruction provided below.

INSTRUCTIONS

To obtain your Speech Language Pathologist (SLP) license in the State of Minnesota, complete all the requirements below and submit the required application, supportive documentation and application fee to the address above.

☐ Print this document and use the instructions as a check list.

☐ Complete the attached application for licensing as a speech language pathologist/audiologist and remember to:

☐ Answer every numbered question or statement in the application. Incomplete applications will be returned.

☐ If something does not apply to you, please write "N/A" in the space provided for a response.

☐ Each question in the application must be answered fully, truthfully, and accurately. Intentionally submitting false or misleading information to the Commissioner is cause for denial of licensing or disciplinary action by the Commissioner.

☐ If you need additional space to answer a question, go to page 10 of the application and use the space provided. You may include additional sheets of paper to respond to a question. If additional sheets are used, please specify the number of the question you are responding to, sign and date each page, and include it with the rest of the application packet

☐ Sign the Records Waiver Authorization and Release.

☐ Complete, sign, and date the application forms within 30 days of submission.

☐ Contact the educational institution from which you received your degree. Request that the educational institution send an official transcript to you in a sealed/unopened envelope. DO NOT open the transcript when you receive it. Mail the unopened sealed transcript to the Minnesota Department of Health with your application.

☐ Contact the institution where you completed your supervised clinical training. Supervised clinical training is complete while one is a student. Have the appropriate person(s) at the institution sign and date Form A. **Please note that there is a separate Form A for SLP's to complete and a separate Form A for Audiologists (AUD) to complete.**

☐ Contact the organization where you completed your supervised post-graduate clinical fellowship or doctoral internship experience. Supervised post graduate clinical experience is completed after graduation. Have the appropriate person at the organization sign and date Form B**. Please note that there is a separate Form B for SLP's to complete and a separate Form B for AUD'S to complete.**

☐ Print, complete and send the **Verification of Credential Form (PDF)** to each state in which you hold or have held SLP/AUD license. Please mail the form on page 11 and 12 of this application to request verification from other states. When you receive the forms back from other states, DO NOT open the envelope(s). Mail the unopened/sealed envelope(s) containing the verification(s) with your completed application and fee. This form is required for applicants if you have ever held a license or certification or registration in another state or jurisdiction.

If the state licensing agency will only send electronic verification please request that they send the verification to health.slpa@state.mn.us. Please indicate the name(s) of the state licensing agency and provide the date(s) that you requested the electronic verification(s).

Name of state licensing agency; Date verification was requested:

Name of state licensing agency: Date verification was requested:

☐ Provide a copy of your score report showing a passing score on the National Examination in Speech-Language Pathology or Audiology (NESPA)

☐ Enclose check or money order made payable to "Treasurer: State of Minnesota" for the application fee. All fees are nonrefundable. Minnesota Statute 148.5194, Subd.5. Please see the fee schedule on the last page of this application.

Please see the fee schedule on the last page of this application.

☐ Make a copy of the application for your records. **DO NOT open sealed envelopes from educational Institutions and verifications from other states or jurisdictions.**

☐ Mail completed original application, supporting documents in sealed/unopened envelope(s), and application fee to the address provided at the top of the instruction page.

HOW IS THE APPLICATION PROCESSED?

1. When MDH receives your application and fees, your check or money order is deposited immediately.
2. When we receive your application we will begin the review process.
3. If the application is completed as instructed, the processing time will be within 30 business days after we receive all forms and supporting documents.

   If the application, fee and supporting documents are not included with the application as instructed it may take longer to process your application.

WHAT HAPPENS NEXT?

While you're waiting for your SLP License approval letter, you can see if you've been issued a license on our **Health Occupations Program Credential Lookup** database. This database is updated daily. Your name will appear on our database the day after your license has been issued.

Instructions and Application for Speech Language Pathologist

Mail completed application forms, supporting documents, and fee to the address provided on page 1 of the instructions.

MINNESOTA GOVERNMENT DATA PRACTICE ACT NOTICE. This notice is given pursuant to Minnesota Statutes, §13.04, Subd. 2, and §13.41, Subd. 2. The Commissioner of the Minnesota Department of Health (Commissioner) will use information provided in this application to determine if you meet Minnesota Statutes §§148.511 to 148.5198 requirements for licensing. You are not legally required to supply the requested information. However, FAILURE TO PROVIDE INFORMATION OR THE SUBMISSION OF FALSE OR MISLEADING INFORMATION MAY DELAY THE PROCESSING OF YOUR APPLICATION OR MAY BE GROUNDS FOR DENYING YOUR APPLICATION. All data, except your name and address, submitted by you or on your behalf are considered private until you are licensed. "Private" data is data that is not public and is accessible to you. When you become licensed, the application data except your social security number becomes public. Information submitted to the Commissioner in this licensing application may, in some circumstances, be disclosed to other persons or entities including the Minnesota Department of Health and its staff, the Speech Language Pathologist and Audiologist Advisory Council, staff of the Attorney General's office; and persons whom they contact including any person to whom the Commissioner must refer the application or parts thereof for verification purposes or for otherwise determining your qualifications, and to persons you designate. In addition, if the matter of your license becomes contested and thereby results either in a contested case hearing or litigation, the data submitted by you or on your behalf may also become accessible to the Minnesota Office of Administrative Hearings, appropriate courts, and those associated with such proceedings, and thereby become public data.

Please print and use blue ink.

Do you or have you previously held a Temporary or Full Credential in state of Minnesota as either a Speech Language Pathologist (SLP) or Audiologist (AUD)?

Yes☐ No☐ If Yes, please provide your credential number: _____

If your Full SLP or AUD license is lapsed/expired DO NOT use this application.

My application is for licensing as (check one only): SLP ☐AUD☐ Dual☐

If applying for audiology or dual licensing: Did you take and pass the Hearing Instrument Dispenser Practical examination? Yes☐ Date_____ No ☐

Applicant Information

1. Name

(Last Name) (First Name) (Middle Name)

2. Check one: Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ If you check Dr. you must provide a copy of your Doctorate transcript.

3. Date of Birth Female: ☐ Male☐

4. Social Security Number (S.S. # is required by MN Statute 270.72, Subd.4):_____

5. Cell Phone: Home Phone:

Applicant Information continued

6. Email Address:

7. Home Address:

Include Home street number, street name, city, state, zip code – PO Box address is not acceptable.

8. Please designate the address at which you will receive correspondence from the Department regarding your license and which will be public information. (Chose One) Home☐ Employer☐

9. Have you ever used another legal name under which records may be filed concerning your application, including your education, training or experience? Yes☐ No☐

If yes, please list name(s) used:

10. Did you complete any part of the clinical fellowship or doctoral externship in Minnesota?

Yes☐ No☐

If yes, indicate dates:

(month/day/year – month/day/year)

List the name and complete address of each employer for whom you have practiced as an SLP or AUD in the last six years. List your current employer first. You must list all employment dates as shown (month/day/year) List all your current employers as well as any previous employment as an SLP for the past six years. Use page 10 and additional sheets if necessary.

11. Name of employer/facility: Telephone:

(Please provide the name of the facility where you work. Do not include the name of the staffing agency)

Facility address:

(Include street number, street name, city, state and zip code)

Fax Number:

Month/day/year-month/day/ Year:

If you are currently working at this location please provide month/day/year – current

12. Name of employer/facility: Telephone:

(Please provide the name of the facility where you work. Do not include the name of the staffing agency)

Facility address:

(Include street number, street name, city, state and zip code)

Fax Number: SLP☐ AUD☐

Month/day/year-month/day/ year:

If you are currently working at this location please provide month/day/year – current

SLP/AUD Practice Related Questions

13. Do you hold or have you ever been issued a credential as a speech Language pathologist or audiologist in another state?

Yes☐ No☐

If yes, please identify the state(s), the current status, the date(s) of issuance and any identification numbers(s) used in relation to your permit, license or other credential. Use page 10 and additional sheets if necessary.

State Type of Credential Status Original Date Issued Expiration Date ID Number

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State Type of Credential Status Original Date Issued Expiration Date ID Number

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State Type of Credential Status Original Date Issued Expiration Date ID Number

14. Do you hold or have you ever been issued a credential a teaching credential as a speech language pathologist in Minnesota or another state? Yes ☐ No☐ If yes, please identify the state(s), the current status, the date(s) of issuance and any identification numbers(s) used in relation to your permit, license or other credential. Use page 10 and additional sheets if necessary.

State Type of Credential Status Original Date Issued Expiration Date ID Number

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State Type of Credential Status Original Date Issued Expiration Date ID Number

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For each state or jurisdiction in which you hold or have held a credential as a speech-language pathologist and/or as an audiologist (including a teaching credential(s)) you must submit the Speech Language Pathologist/Audiologist Verification of Credential Form (PDF). This form is available on page 11 and 12 of this application packet. Mail the form to the state credentialing board or agency with any required fees, and request that they send the completed form directly to you in an unopened/sealed envelope. This letter should be left sealed/unopened and mailed to our office with your application and application fee. Copies and faxes of signatures are unacceptable. You may photocopy the verification of credential form, if additional forms are needed. If the verifying agency does not use the verification form, you must request a letter from the appropriate person in the state which provides the following information: your name, date of issuance of your credential, date of expiration of your credential, credential number, current status of your credential, and an affirmative statement about whether any discipline is pending or has been taken against you.

Note: applicants who are applying for licensing by reciprocity must request that the credentialing state also provide a copy of the state statute or administrative rules which describes the qualifications for your credential at the time your credential was issued. Please include the copy of the rules and/or statute with your application.

SLP/AUD Practice Related Questions

If the state licensing agency will only send electronic verification(s) please request that they send the verification to health.slpa@state.mn.us. Please indicate below the name(s) of the state licensing agency and provide the date(s) that you requested the electronic verification(s).

Name of state licensing agency: Date verification was requested:

Name of state licensing agency: Date verification was requested:

15. Is action being taken against you or has action ever been taken against you or your legal authorization to practice speech-language pathology or audiology in this or another state either through denial of application, revocation, suspension, restrictions, limitations, conditions, reprimand, civil penalty, or any other means(including Stipulations and Consent Orders and Determinations? Yes☐ No☐
If yes, please explain the reason for the action, action taken, and name the state, address of credentialing authority in possession of record, dates, and part or parties involved in the action, Use Page 10 and additional sheets if necessary.

16. Do you now hold or have you ever been issued a credential (e.g. a permit, registration, certification or license) to dispense hearing instruments in this or another state?

If yes, please identify the state(s), the current status, the date(s) of issuance and any identification numbers(s) used in relation to your permit, license or other credential. Use page 10 and additional sheets if necessary.

State	Type of Credential	Status	Original Date Issued	Expiration Date	ID Number
State	Type of Credential	Status	Original Date Issued	Expiration Date	ID Number

For each state in which you hold or have ever been issued a credential (e.g. a permit, registration, certification or license) to dispense hearing instruments (not including MN), you must submit a letter from the appropriate person in the state, which provides the following information: your name and date of birth, date credential issued, credential number, current status of your credential and a statement about any disciplinary action pending or taken against you, if any. Print, complete and send the **Verification of Credential Form (PDF)** to each state in which you hold or have held a dispenser permit, registration, certification or license. Please mail the form on page 11 and 12 of this application to request verification from other states. When you receive the forms back from other states, DO NOT open the envelope(s). Mail the unopened/sealed envelope(s) containing the verification(s) with your completed application and fee. This form is required for applicants if you have ever held a license or certification or registration in another state or jurisdiction.

17. Is action being taken against you or has action ever been taken against you or your legal authorization to dispense hearing instruments in this or another state either through denial of application, revocation, suspension, restrictions, limitations, conditions, reprimand, civil penalty, or any other means(including Stipulations and Consent Orders and Determinations?
Yes☐ No☐

If yes, please give a statement supplying full details including the crime(s) of which you were convicted, dates(s) name(s) and location of court(s) and case numbers(s). Use page 10 and additional sheets if necessary.

18. Have you been convicted within the last five years, of a felony or misdemeanor which relates to hearing instrument dispensing or which involved an essential element of dishonesty? Yes☐ No☐

If yes, please give a statement supplying full details including the crime(s) of which you were convicted, dates(s) name(s) and location of court(s) and case numbers(s). Use page 10 and additional sheets if necessary.

18. Have you ever been subject to a state or federal court order or judgement issued to manage your activities in dispensing hearing instruments? (Include conciliation court orders) Yes☐ No☐ If yes, please explain on page 10.

19. Have you ever violated a state or federal court order or judgment issued to manage your activities in dispensing hearing instruments? Yes☐ No☐ If yes, please explain on page 10.

20. Do you have any criminal charges pending against you? Yes ☐ No☐

21. Have you been convicted, within the last five years of a felony or misdemeanor which related to the practice of speech language pathology or audiology or which involved an essential element of dishonesty? Yes☐ No☐
If yes, provide a statement giving full details on page 10, including the crime(s) of which you were convicted, date(s), name(s) and location of court(s) and case numbers(s).

If you answered “yes” to questions 19-22 please explain on page 10 and use additional sheets if necessary.

Practice Related Questions A-P

Have you ever engaged in or aided or abetted another in engaging in any of the following acts or conduct whether or not you have been formally disciplined? **Applicants must answer “yes” or “no” to questions A-P**

A. Intentionally submitted false or misleading information to the Commissioner or the advisory council; Yes☐ No☐

B. Failed within 30 days, to provide information in response to a written request from the Commissioner or the advisory council; Yes☐ No☐

C. Performed services of speech language pathologist or audiologist in an incompetent or negligent manner; Yes☐ No☐

D. Violated, aided or abetted another person in violating any person in violating any provision of Minnesota Statute§§148.511 to 148.5198; Yes☐ No☐

E. Failed to perform services with reasonable judgement, skill, or safety due to the use of alcohol drugs or other physical or mental impairment; Yes☐ No☐

F. Failed to cooperate in an investigation conducted by the Health Department; Yes☐ No☐

G. Advertised in a manner that is false or misleading; Yes☐ No☐

H. Engaged in conduct likely to deceive, defraud, or harm the public; or demonstrated a willful or careless disregard for the health, welfare or safety of a client; Yes☐ No☐

I. Failed to disclose to consumer any fee splitting or any promise to pay a portion of a fee to any other professional other than fee for services rendered by that professional to the client; Yes☐ No☐

J. Engaged in abusive or fraudulent billing practices, including violations of federal Medicare and Medicaid laws, Food and Drug Administration regulations, or state medical assistance laws; Yes☐ No☐

K. Obtained money, property, or services from a consumer through use of undue influence, high pressure sales tactics, harassment, duress, deception or fraud; Yes☐ No☐

L. Performed services for a client who had no possibility of benefiting from the services; Yes☐ No☐

M. Failed to refer a client for medical evaluation or to other health care professionals when appropriate, or when client indicated symptoms associated with disease that could be medical or surgically treated; Yes☐ No☐

N. Used the term doctor of audiology, doctor of speech-language pathology, A.u.D. or SLP.D., without having obtained the degree from an institution accredited by the North Central Association of Colleges and Secondary Schools or the America Speech-Language-Hearing Association; Yes☐ No☐

O. Failed to comply with the requirements of section 148.5192 regarding supervision of speech-language pathologists assistants; Yes☐ No☐

P. If applying as an audiologist, failed to comply with the standards of practice for hearing instrument dispensing listed in 148.5195, subd. 3, (20); Yes☐ No☐

If you answered yes to any part of questions A-P please give full details on page 11 and additional sheets if necessary.

APPLICANT AFFIRMATION: The information I have provided in this application is true and accurate to the best of my knowledge and belief. I have read and will comply with the requirement of Minnesota Statutes, §148.5811 through 148.5198.

_____ _____

SIGNATURE DATE

RECORDS WAIVER AUTHORIZATION AND RELEASE

I HEREBY AUTHORIZE THE COMMISSIONER OF THE MINNESOTA DEPARTMENT OF HEALTH or the Commissioner's designee to obtain, and authorize the person to whom this authorization is presented to release, any and all information contained in the license, registration, permit or other credentialing records in this or any other state where I have practiced speech-language pathology or audiology or where I have dispensed or have authorization to dispense hearing instruments.

This authorization also allows the Commissioner or the Commissioner's designee to make summaries or photocopies of all or any portion of any records pertaining to my authority to practice speech-language pathology or audiology or to my dispensing of or authorization to dispense hearing instruments in this or any other state. A photocopy of this authorization may be considered to be as valid as the original.

Dated this _____ day of _____, _____ (year)

_____

Signature

_____

Name typed or printed

_____

Address (street address)

_____

City, State, Zip Code

Additional Information Page

Instructions:

Use this page to complete answers only when there isn't enough space following the questions on the previous application page. Include the question number with each answer you provided below. This page can be copied and used more than once if you need additional space for your answers. Please note: if you use this page to supply application related answers, you must sign and date the bottom of this page.

Signature: Date

Speech Language Pathologist or Audiologist Verification of Credential

APPLICANT INSTRUCTIONS: This form is provided to you to obtain verification of credential(s) you hold, or held, in this or another state. Credentials that must be verified are credentials in speech-language pathology, audiology, teaching, and hearing instrument dispensing. After completing Part I, you must send this form, including any required fees, to the agency in the state(s) which issued the other credentials you hold. **Do not send this form to the Minnesota Department of Health**. If you have any questions, please call 651-201-4200.

PART I. To be completed by Applicant

Applicant, please complete the top portion only and send this form to the Speech-Language Pathology or Audiology related board, or agency, in the state(s) from which you are or have been licensed or registered.

Applicant Name: _____

Address: _____

SSN: _____ Date of Birth: _____
(Voluntary)

I HEREBY AUTHORIZE the Commissioner of the MINNESOTA DEPARTMENT OF HEALTH or the Commissioner's designee to obtain, and authorize the person to whom this authorization is presented to release, any and all information contained in the license, registration, or other credentialing records in this or any other state where I hold or have held a credential as a speech-language pathologist or audiologist.

_____ _____
Signature of Applicant Date

PART II to be completed by the State board or agency

The individual listed above has applied for licensing in Minnesota as a Speech-Language Pathologist or Audiologist. We prefer that this form be completed, however, if a letter or other form is sent, it must contain all information requested in this form. **Please send this completed form, or the information requested, to the applicant.**

Name on credential, if different from above: _____
State: _____ License #/ File #: _____

Type of Credential: _____

Date of Original Issue: _____

Applicant's Registration/License is:

1. _____Current Expiration Date: _____

2. _____Inactive _____Expired

3. If inactive or expired, date licensed became inactive or expired: _____

   Explain: _____

DEPARTMENT OF HEALTH

Continued from other side

4. **Registration/License was obtained by:** _____ASHA Credential; ASHA #:_____

____Reciprocity; _____Grandfathering; _____Other

5. **Action taken or pending against applicant's registration/license:** _____No disciplinary action taken or pending; ___Disciplined; ___Suspended; ___Revoked; ___Invalid

6. **Is or was there any derogatory information concerning this applicant? ___Yes ___No**
If yes, please explain: _____

_____

COMMENTS:

I certify that the information contained in this Speech-Language Pathologist or Audiologist Verification of Credential is true in every respect in accordance with the records on file with:

_____

(State and Official Name of Board/Agency)

_____
Executive Officer/Official

SEAL

_____
Title

_____
Date

PLEASE RETURN THIS FORM TO THE APPLICANT IN A SEALED ENVELOPE. Applicants are required to send the sealed unopened envelope with their application.

NOTICE TO APPLICANTS: This notice is given pursuant to Minnesota Statutes, section 13.04, subdivision 2, and section 13.41, subdivision 2. The Commissioner of the Minnesota Department of Health will use information provided in your application to determine if you meet Minnesota Statutes, sections 148.511 through 148.198 requirements for licensing. You are not legally required to supply the requested information. However, FAILURE TO PROVIDE INFORMATION OR THE SUBMISSION OF FALSE OR MISLEADING INFORMATION MAY DELAY THE PROCESSING OF YOUR APPLICATION OR MAY BE GROUNDS FOR DENYING YOUR APPLICATION. All data, except your name and address, submitted by you or on your behalf are considered private until you are license. "Private" data is data that is not public and is accessible to you. When you become license the application data, except social security number, becomes public. Information submitted to the Commissioner in your license application may, in some circumstances, be disclosed to other persons or entities including the Minnesota Department of Health and its staff, the Speech-Language Pathologist and Audiologist Advisory Council and its staff; staff of the Attorney General's office; and persons whom they contact including any person to whom they contact including any person to whom the Commissioner must refer the application or parts thereof for verification purposes or for otherwise determining your qualifications, and to persons you designate. In addition, if the matter of your license becomes contested and thereby results either in a contested case hearing or litigation, the data submitted by you or on your behalf may also become accessible to the Minnesota Office of Administrative Hearings, appropriate courts, and those associated with such proceedings, and thereby become public data.

Form A Speech Language Pathologist (SLP) Licensing Application

This form is required for applicants applying for a SLP License by Method 3

Explanation: Licensing by Method 3 requires that an applicant may qualify for licensing by documenting completion of every requirement necessary to obtain a certification of clinical Competence CCC for Speech Language Pathology from the American Speech-Language Hearing Association (ASHA). The applicant must, in part document the completion of supervised clinical training by obtaining the signature of the appropriate person(s) in the institution(s) where the training occurred. The training must meet the requirements prescribed by ASHA or ABA.

Supervised Graduate or Doctoral Clinical Training Experience.

INSTRUCTIONS: Have the appropriate person(s) at the institution(s) where you completed your supervised clinical training sign and date this form. PLEASE NOTE: If more than one person is needed to attest to your required supervised clinical training please copy this form for each signature.

Applicant Name: School:

Supervisor Information

Supervisor Name: Title:

Name of Institution (Training site):

Address of training site:

(Include Street number, street address, city, state, zip code

Supervisor certification: By signing and dating this document, I certify that the above named application has completed the requirements of supervised clinical training.

Supervisors Signature: Date:

Send completed form to applicant

MDH-SLP Licensing
Health Occupations Program
PO Box 64882
Saint Paul MN 55164-0882

Form B: Speech Language Pathologist (SLP) Licensing Application

This form is required for applicants applying for a SLP License by Method 3

Explanation: Licensing by Method 3 requires that an applicant may qualify for licensing by documenting completion of every requirement necessary to obtain a Certification of Clinical Competence (CCC) for Speech Language Pathology from the American Speech-Language Hearing Association (ASHA). The applicant must, in part document the completion of supervised postgraduate clinical experience. (Clinical Fellowship or Doctoral Externship) by obtaining the signature of the appropriate person who can attest that the training occurred. The supervised postgraduate clinical experience must meet the requirements described in Minnesota Statute 148.5161, Subd.3.

Supervised Postgraduate Clinical Experience

This training requires supervision by a speech-language pathologist who is either licensed as such by the Minnesota Department of Health or holds a certificate of Clinical Competence (CCC) from the American Speech-Language-Hearing Association (ASHA). The training may not begin until the applicant completed the academic course work required by Minnesota Statute 148.515, subdivision 2. The Minnesota Statute requirements for the academic course work and clinical training are the same as ASHA requirements.

The Supervised training must include both on-site observation and other monitoring activities. On-Site observation must involve the supervisor, the clinical fellowship licensee or doctorial externship licensee, and the client receiving speech-language pathology services and must include direct observation by the supervisor of treatment given by the clinical fellowship licensee or doctoral externship licensee. Other monitoring activities must involve direct or indirect evaluative contact by the supervisor of the clinical fellowship licensee or doctorial externship licensee, may be executed by correspondence, and may include, but are not limited to, conferences with the clinical fellowship licensee or doctoral externship licensee, evaluation of written reports, and evaluations by professional colleagues, Other monitoring activities do not include the client receiving speech-language pathology services.

INSTRUCTIONS: Have the appropriate person(s) who can attest to your completion of supervised postgraduate clinical experience sign and date this form. PLEASE NOTE: If more than once person is need to attest to your required supervised post graduate clinical training, please copy this form for each signature.

Applicant Name: Clinical Site

Supervisor Information

Supervisor Name: Title:

Name of Clinical Training site:

Address of training site:

(Include Street number, street address, city, state, zip code

Supervisor certification: By signing and dating this document, I certify that the above named application has completed the requirements of supervised clinical training.

Supervisors Signature: Date:

Send completed form to applicant.