

### **State of New Hampshire**

## OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION DIVISION OF LICENSING AND BOARD ADMINISTRATION

Allied Health Professionals 7 Eagle Square, Concord, NH 03301-4980 Phone: 603-271-2152

#### APPLICATION FOR REINSTATEMENT OF LICENSURE OR CERTIFICATION

\$110.00: Certification Reinstatement for Speech Language Assistant only

\$220.00: All other professions Make check payable to: Treasurer, State of New Hampshire

# If a question does not apply to you mark the space with N/A this includes but is not limited to "maiden & aliases" and your "Place of employment"

What profession are you app	olying for?			
Name:				
last	first	middle initial	maiden & alis	ases
Home physical address	(Street #, City, State	and Zip)	-	
Home phone # or personal c	ell phone #:			
Home mailing address	(Street # or P.O. B	ox #, City, State and Zip)	I	
Place of employment name	(if any)			
Place of employment mailin	g address (Street # or P	.O. Box #, City, State and	d Zip)	
Place of employment phone	#:	<u></u>		
If you answer Yes to any o	-	v, attach a detailed repo	ort of the relevant	
circumstances on a separa	ie sneet. <u>mave you:</u>		Yes	No
Been found guilty or entered	l a plea of no contest to	any felony or misdemean	nor?	
Been the subject of any disc	iplinary action by any p	professional licensing autl	nority?	_
Been denied a license, or oth	ner authorization to practice.	ctice in any state or jurisd	liction?	
Surrendered a license or oth Disciplinary charges?	er authorization to prac	tice in order to avoid or s	ettle	
PLEASE DO NOT WRITE I	BELOW THIS LINE			
FOR OFFICE USE ONLY	: Date received	check #	amount	
License/Certificate #				

E-mail address at which you wish to receive correspondence:							
Other State(s) licensing information			n you are curr	ently or			
have previously been licensed to pra-	ctice, enclose additiona	l sheet if necessary:					
STATE:	DATE LICENSE WAS HELD	IS LICENSE CURRENT?	IF EXPI REASO	/			
Which of the addresses listed ca (Choose only one)	n the Board make a	vailable to various p	ublic entitie	es?			
Home mailing address: Place	ee of Employment Mail	ing Address: N	one:				
			Yes	No			
Do you have any reason to believe that y proceeding, settlement agreement or con professional licensing board of any state							
Has any malpractice claim been made ag	gainst you?						
Have you, for disciplinary reasons, been limited, suspended or revoked from any hospital, healthcare institution or setting	of the following settings:		?				
Have you ever been denied the privilege professional licensure?	of taking an examination	required for					
Have you any physical, mental or emotion which could negatively affect your ability							
Do you engage in any remedial undertak Question above which could itself negat for which you seek licensure?							
Have you committed any act(s) that wou profession for which you are applying?	ald violate the laws and/or	rules that govern the					
NOTEIf the answer to any of the		oove are "yes", please :	attach a deta	<u>iled</u>			
report of the relevant circumstanc	e on a separate sheet.						
Pursuant to RSA 125:25-C do you hat Therapeutic service(s) company(s)?  If you answer "yes" you must atta	•		Yes	No			

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### **Personal Affidavit**

staple				
2x2 passport photograph				
in this				
space				
State of	tate of County or City of			
I acknowledge that knowin under RSA 641:2, I. I certiful form and in the documents and accurate to the best of the rules of the Board and particular to the best of the rules of the Board and particular to the best of the rules of the Board and particular to the best of the rules of the Board and particular to the best of the Board and particular to the Board and particular to the best of the Board and particular to the Board and pa	fy that the information I hat I have personally submy knowledge and belief.	ive provided on all printed to support m I also certify that I led, I will abide by t	parts of the application y application is complete have read the statute and hem.	
Applicant's printed name		Applicant's Sign	ature	
Date	_			
Sworn to, before me, and subs	scribed in my presence this _	day of	20	
N. Dili (I. ii. Ci. D				
Notary Public / Justice of the P	eace	My commission	expires	
		(seal or stamp)		

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#### **BOARD ACTION SIGN OFF PAGE**

ATION APPROVAL:
Date:
Date:
ΓΙΟΝ APPROVAL:
Date:
Date:

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