**SALARY SUPPLEMENT**

**FOR**

**CERTIFICED AUDIOLOGISTS AND SPEECH-PATHOLOGISTS**

**Please review the laws listed below for eligible reimbursement for Certified Audiologist and Speech-Pathologist Teachers. If the application is not complete and the applicant information cannot be verified by the Kentucky Department of Education, the application will be returned to you for completion. Print or type clearly on the application.**

**KENTUCKY DEPARTMENT OF EDUCATION**

Salary Supplement Application 20 \_\_ - 20 \_\_

**Certified Audiologists and Speech Language Pathologist**

* The following Certified Audiologists and Speech-Language Pathologists is employed by the district and hold either a certificate of clinical competence issued by the [American Speech Language Hearing Association](https://www.asha.org/certification/cert-verify/) or board certified from the [American Board of Audiology](https://members.audiology.org/cvweb/cgi-bin/memberdll.dll/info?wrp=find-an-audiologist.htm).

Please submit by email to Jana Cox; jana.cox@education.ky.gov **Applications must be submitted by May 1st to KDE**

**District Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ District Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Employee Name(as listed in the ASHA or ABA Directory) | Include expiration date of Certificate of Clinical Competence issued by American Speech-Language Hearing Association  | Include expiration date of American Board of Audiology  | **AND** | Include expiration date of valid KY Teaching Credential issued by EPSB | Include expiration date oflicense issued by KY Bd of Speech Language Pathology and Audiology (Exp Date) | Amount Requested(not to exceed $2,000) |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

TOTAL FUNDS REQUESTED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***I certify that the above named employee(s) have qualified and have been paid a salary supplement for the qualified speech language pathologist or audiologists and we (district name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ request reimbursement under KRS 157.397.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Superintendent’s Signature***  ***Date***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Document Prepared by***

 ***Date***

***Contact name & Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**(Continued from page 1 if needed) Page 1**

**KENTUCKY DEPARTMENT OF EDUCATION**

Salary Supplement Application 20 \_\_ - 20 \_\_

**District Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ District Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Employee Name(as listed in the ASHA or ABA Directory) | Include expiration date of Certificate of Clinical Competence issued by American Speech-Language Hearing Association | Include expiration date of American Board of Audiology | **AND** | Include expiration date of valid KY Teaching Credential issued by EPSB | Include expiration date oflicense issued by KY Bd of Speech Language Pathology and Audiology (Exp Date) | Reimbursement Amount Requested(not to exceed $2000) |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

***I certify that the above named employee(s) have qualified and have been paid a salary supplement for the qualified speech language pathologist or audiologists and we (district name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ request reimbursement under KRS 157.397.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Superintendent’s Signature***  ***Date***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Document Prepared Date***

***Contact Name & Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***