New Mexico Regulation and Licensing Department
BOARDS AND COMMISSIONS DIVISION
Speech-Language Pathology, Audiology & Hearing Aid Dispensing Practices Board
Toney Anaya Building ▪ PO Box 25101 ▪ Santa Fe, New Mexico 87504
(505) 476-4622 ▪ Fax (505) 476-4545 ▪ www.rld.state.nm.us

2017 Renewal Application
Speech-Language Pathologist

Name:_____

Address:_____

City, State, Zip:_____

License Number: _____

Issue Date:_____ **Expiration Date:**_____

E-mail Address: _____

Home Phone: _____ Work Phone: _____

RENEWAL INFORMATION:

House Bill 19 has required licensees of the Speech-Language Pathology, Audiology & Hearing Aid Dispensers Practices Board to complete a mandatory questionnaire to renew your license. This is MANDATORY and your license WILL NOT BE RENEWED WITHOUT IT which may result in late fees assessed if not returned with your renewal application to the board office by January 30, 2017.

To renew your license to practice as a **SPEECH-LANGUAGE PATHOLOGIST** in New Mexico, complete, sign and return this renewal form along with the $170.00 renewal fee

- All renewals must be post marked no later than January 30, 2017.
- Licenses expire January 30, 2017 and you cannot practice with an expired license.
- Renewals postmarked during the grace period of January 31, 2017 thru March 31, 2017 will require a $75.00 late fee! **NO EXCEPTIONS**.
- If your License renewal is not postmarked by March 31, 2017, you will need to reapply for licensure and meet all applicable requirements.

MANDATORY SURVEY

New Mexico License Number: _____

CURRENT WORK STATUS (Select all that apply)

- ☐ Practice in New Mexico
- ☐ Practice Medicine in another state: ☐ TX ☐ CO ☐ AZ ☐ Other
- ☐ Permanently or Temporarily Inactive in New Mexico
- ☐ Retired, but maintain an active license
- ☐ Retired and do not maintain an active license
- ☐ Current Resident of Fellowship Training

CURRENT ACTIVITIES

How many weeks per year do you practice in NM? _____

How many hours per week do you practice in NM? _____

For you practice in New Mexico, approximately what percent of your time was spent on the following activities (percentage of all selected activities should total 100%)

	Direct Patient Care
	Teaching/Precepting
	Research
	Healthcare Administration

	Other, please specify:_____

For Direct Patient Care, approximately what percent of your time was spent in the following types of facilities (percentage should total 100%)

	Hospital/Inpatient
	Outpatient/Clinic
	Mobile Services
	Other, please specify:_____

LOCATION OF EDUCATION AND TRAINING

	New Mexico	Other U.S. state or Canada	Foreign country	Not Applicable
Location of the high school from which you graduated:	☐	☐	☐	☐
Location of the undergraduate college or university from which you graduated:	☐	☐	☐	☐
Location of the licensure training from which you graduated:	☐	☐	☐	☐
Location of primary specialty training:	☐	☐	☐	☐
Location of secondary specialty training:	☐	☐	☐	☐

PRACTICE SPECIALTY(IES) IN WHICH YOU SPEND MOST OF YOUR PROFESSIONAL TIME

Primary Specialty:
% Patient care time for primary specialty: _____

Secondary Specialty:
% Patient care time for secondary specialty: _____

TRAINING AND CERTIFICATION

	Yes	No
Completed accredited residency programs for primary specialty?	☐	☐
Board certified/Certificate of Added/Special Qualifications for primary specialty?	☐	☐
Completed accredited residency programs for secondary specialty?	☐	☐
Board certified/Certificate of Added/Special Qualifications for secondary specialty?	☐	☐

HOSPITAL ADMITTING PRIVILEGES

Number of hospitals in New Mexico at which you have admitting privileges

☐None ☐One ☐Two ☐Three or more

REIMBURSEMENT: PAYMENT SOURCES

Primary source of payment for patient care (**select top 3**):

☐Medicare
☐Medicaid
☐Tricare/VA/HIS
☐Private Insurance
☐Self-pay
☐Bad Debt/Charity
☐Other
☐Do Not Know or Not Applicable

☐Other:_____

% of patients with Medicare as their primary payer: _____
% of patients with Medicaid as their primary payer: _____
% of patients with Tricare/VA/HIS as their primary payer: _____
% of patients with Private Insurance as their primary payer: _____
% of patients with Self-pay as their primary payer: _____
% of patients with Bad Debt/Charity as their primary payer: _____
% of patients with Other as their primary payer: _____

Provide an approximate monetary value for the **uncompensated** patient care you provided during the last year for **emergency** services: | |

Provide an approximate monetary value for the **uncompensated** patient care you provided during the last year for **non-emergency** services: | |

PATIENT CARE PRACTICE LOCATIONS

For PRIMARY location of patient care:

PRIMARY patient care street address:	
PRIMARY patient care city/town:	
PRIMARY patient care state:	
PRIMARY patient care 5-digit zip code:	
Weekly PRIMARY patient care hours:	
Weekly PRIMARY number of patients:	

For SECONDARY location of patient care:

SECONDARY patient care street address:	
SECONDARY patient care city/town:	
SECONDARY patient care state:	
SECONDARY patient care 5-digit zip code:	
Weekly SECONDARY patient care hours:	
Weekly SECONDARY number of patients:	

PRACTICE SETTINGS

What best describes your PRIMARY location practice?

☐Independent Practice
☐Group practice-Employee/Staff
☐Organizationally affiliated (ie University, or Health Plan staff)
☐Hospital-Inpatient
☐Hospital-Outpatient dept/satellite clinic
☐Hospital-Emergency room
☐Federal Qualified Health Clinic (FQHC)
☐Nursing home/Home Health agency
☐Private health center/clinic
☐Public/Non-profit community health center (non-FQHC)
☐Other licensed community clinic

- ☐ Military/VA health facility
- ☐ Indian Health Service clinic
- ☐ Locum tenens
- ☐ Multi-Specialty Practice-Employee/staff
- ☐ Nurse Managed Clinic
- ☐ Other (please specify): _____

What best describes your PRIMARY location practice size?

- ☐ Solo Independent Practitioner
- ☐ Solo Independent Practitioner + Intermediate
- ☐ Two Independent Practitioners
- ☐ Three or Four Independent Practitioners
- ☐ Five to Nine Independent Practitioners
- ☐ Ten or More Independent Practitioners

What best describes your SECONDARY location practice?

- ☐ Independent Practice
- ☐ Group practice-Employee/Staff
- ☐ Organizationally affiliated (ie University, or Health Plan staff)
- ☐ Hospital-Inpatient
- ☐ Hospital-Outpatient dept/satellite clinic
- ☐ Hospital-Emergency room
- ☐ Federal Qualified Health Clinic (FQHC)
- ☐ Nursing home/Home Health agency
- ☐ Private health center/clinic
- ☐ Public/Non-profit community health center (non-FQHC)
- ☐ Other licensed community clinic
- ☐ Military/VA health facility
- ☐ Indian Health Service clinic
- ☐ Locum tenens
- ☐ Multi-Specialty Practice-Employee/staff
- ☐ Nurse Managed Clinic
- ☐ Other (please specify): _____

What best describes your SECONDARY location practice size?

- ☐ Solo Independent Practitioner
- ☐ Solo Independent Practitioner + Intermediate
- ☐ Two Independent Practitioners
- ☐ Three or Four Independent Practitioners
- ☐ Five to Nine Independent Practitioners
- ☐ Ten or More Independent Practitioners

CURRENT PRACTICE CAPACITY

What describes your current patient care practice capacity?

- ☐ My practice is full: I cannot accept any new/additional patients
- ☐ My practice is nearly full: I can accept a few new/additional patients
- ☐ My practice is far from full: I can accept new/additional patients
- ☐ Not Applicable

MEANINGFUL USE OF HEALTH INFORMATION TECHNOLOGY (HIT) AND ELECTRONIC HEALTH RECORD (EHR) IN YOUR PRACTICE

Does your practice CURRENTLY have the following HIT/EMR capacity? (select all that apply)	
☐	Computerized Provider Order Entry (CPOE)
☐	E-Labs (Order, Retrieve and Store results)
☐	Create Registries (e.g. registry of patient with diabetes)
☐	Quality Reporting
☐	Record Demographics (e.g. patient race/ethnicity, insurance status)
☐	Patient access to electronic copy of health records
☐	E-Prescribing
☐	Patient timely access to labs, x-ray and other results
☐	Record Vital Signs (e.g. height, weight, blood pressure)
Does your practice PLAN TO HAVE IN THE NEXT YEAR? (select all that apply)	
☐	Computerized Provider Order Entry (CPOE)
☐	E-Labs (Order, Retrieve and Store results)
☐	Create Registries (e.g. registry of patient with diabetes)
☐	Quality Reporting
☐	Record Demographics (e.g. patient race/ethnicity, insurance status)
☐	Patient access to electronic copy of health records
☐	E-Prescribing
☐	Patient timely access to labs, x-ray and other results
☐	Record Vital Signs (e.g. height, weight, blood pressure)

REFERRAL DIFFICULTIES

Identify the specialties that you or your patients have the greatest difficulty scheduling/obtaining/arranging a timely appointment **when making referrals** (MARK UP TO 3 SPECIALTIES)

- ☐ Advanced practice certified chiropractor
- ☐ Social Worker
- ☐ Social Worker - Clinical Specialty
- ☐ Social Worker - Medical Specialty
- ☐ Social Worker - School Specialty
- ☐ Social Worker - Researcher
- ☐ Social Work - Community Organizer
- ☐ Social Work Administrator
- ☐ Dental Public Health
- ☐ Endodontic
- ☐ Oral and maxillofacial surgery
- ☐ Orthodontics and dento-facial orthopedics
- ☐ Oral pathology
- ☐ Pediatric dentistry
- ☐ Periodontology
- ☐ Acupuncturists
- ☐ Cardiology/Vascular Specialists
- ☐ Chiropractors
- ☐ Dermatology
- ☐ Diabetic Educators
- ☐ Gynecology (only)
- ☐ Endocrinology and Metabolism
- ☐ Primary Care - Internal Medicine, Family
- ☐ Practice, Pediatrics, Geriatrics

- [ ] Infectious Disease
- [ ] Mental Health Adult ,Child and Adolescent
- [ ] Nephrology
- [ ] Neurology
- [ ] Nutritionists
- [ ] Occupational /Rehabilation-Physiary
- [ ] Medicine
- [ ] Oncology/Hematology
- [ ] Orthotists/Prosthetics
- [ ] Pain Management
- [ ] Physical Therapy
- [ ] Rheumatology
- [ ] Other - _____

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RECRUITMENT EXPERIENCES

How would you describe your experience in recruiting:	Easy	Somewhat Difficult	Very Difficult	Not Known or Now Applicable
Physicians	☐	☐	☐	☐
Nurses	☐	☐	☐	☐
Nurse Practitioners	☐	☐	☐	☐
Physician Assistants	☐	☐	☐	☐
Other Health Professionals	☐	☐	☐	☐

DEMOGRAPHIC INFORMATION

Gender: ☐Male ☐Female

Hispanic, Latino or Spanish Origin: ☐Yes ☐No

Race (Select all that apply):

☐White or Caucasian
☐Black or African American
☐Native American or Alaska Native
☐Asian or Pacific Islander
☐Other: _____

NEAR FUTURE PRACTICE PLANS

In the next 12 months I plan to (select all that apply):

☐Retire from patient care
☐Significantly reduce patient care hours

- ☐ Move my practice to another geographic location in New Mexico
- ☐ Move my practice out of New Mexico
- ☐ None of the above

If you are retiring, moving or reducing patient care hours in the next 12 months, what are the factors that led to that decision? (select all that apply)

- ☐ Age
- ☐ Geographic preference
- ☐ Health
- ☐ Practice Environment
- ☐ Lack of Job Satisfaction
- ☐ Gross Receipts Tax
- ☐ Increasing Administrative/Regulatory Burden
- ☐ Reimbursement Issues
- ☐ Other: _____
- ☐ N/A

PROFESSIONAL LIABILITY INSURANCE INCREASE THRESHOLDS

At what percent increase in your annual liability insurance above your current level would you consider:

Retiring from patient care?	%
Significantly reduce patient care hours?	%
Moving practice out of state?	%

MEDICARE PAYMENT DECREASE THRESHOLDS

At what percent decrease to your Medicare payment level would you consider:

Retiring from patient care?	%
Closing practice to NEW Medicare patients	%
Closing practice to ALL Medicare patients	%
Significantly reduce patient care hours?	%
Moving practice out of state?	%

When billing for services:

- ☐ Submit billing through own license
- ☐ Submit billing through someone else's license
- ☐ Submit billing through Group/Hospital ID
- ☐ Do not know
- ☐ Other (please specify): _____

CONTINUING EDUCATION REQUIREMENTS:

Twenty (20) hours of continuing education in your field, taken within the renewal period of **January 31, 2015 through January 30, 2017**, is required.

NOTE: If you have been licensed less than 1 year, you are required to earn 1 hour of continuing education for each month you have been licensed.

You are not required to submit CEU certificates unless you are being audited by the Board.

ALL QUESTIONS MUST BE ANSWERED OR YOUR RENEWAL APPLICATION WILL BE CONSIDERED INCOMPLETE.

GIVE DETAILS OF ANY "YES" ANSWERS TO QUESTIONS 1 - 4 ON A SEPARATE SHEET OF PAPER. *If you have previously submitted information it is on file and duplicate information is not required*

1. Have you been convicted of a felony in the past 2 years? □ Yes □ No
2. Have you had any disciplinary action taken against you in any state? □ Yes □ No
3. Do you certify that you have completed the required number of continuing education hours? □ Yes □ No

RENEWAL FORMS WILL BE RETURNED IF NOT COMPLETE

I understand that if I falsify any part of my renewal form I will be subject to disciplinary action up to and including revocation of my license.

I certify that all of the information in this renewal form is correct to the best of my knowledge.

Signature _____ Date _____

Method of Payment: Make items payable to the NM SLPAHAD Board

□ Check □ Cashiers Check □ Money Order