



Speech Pathologist

2023-001 - \$150

2023-006 - \$10

Audiologist

2024-001 - \$150

2024-006 - \$10

**STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
665 MAINSTREAM DR
NASHVILLE TN 37243**

BOARD OF COMMUNICATION DISORDERS AND SCIENCES
(615) 253-6061-or 1-800-778-4123

**APPLICATION INSTRUCTIONS FOR LICENSURE AS A
SPEECH PATHOLOGIST OR AUDIOLOGIST
LICENSURE APPLICATION SHEET**

Provided below is a checklist containing all the things you must do to receive consideration for issuance of a Tennessee license to practice speech pathology/audiology. **NOTE: All submissions must be executed and dated less than one (1) year before receipt or they will be rejected by the Board.**

Personal resumes are not acceptable and will not be reviewed.

A criminal background check is required for all methods of licensure. For instructions to obtain a criminal background check, [click here](#) or go to the Noteworthy section of the Board's website.

A mandatory Practitioner Profile Questionnaire is required for all methods of licensure. For instructions to obtain a Mandatory Practitioner Profile Questionnaire, [click here](#).

If applying by Certificate of Clinical Competence

The following documentation is required:

1. _____ Completed application
2. _____ Fee: One Hundred Sixty Dollars (\$160)
3. _____ Transcript – Official transcript sent directly to the Board from Graduate school (transcript issued to student is NOT acceptable) (See Attachment I)
4. _____ Official verification sent directly to the Board from ASHA verifying that your CCC has been awarded
5. _____ Verification of licensure from each state(s) in which you hold or have ever held a license. (See Attachment II)
6. _____ Original, signed and notarized passport photograph taken within the preceding 12 months. (Passport photograph only, no copies)
7. _____ Letter of recommendation (Moral Character). The letter cannot be from a relative
8. _____ Mandatory Profile Questionnaire (<http://health.state.tn.us/Downloads/PH-3585.pdf>)
9. _____ Certified photocopy of birth certificate or a notarized copy of a certified birth certificate
10. _____ All applicants must complete the attached Declaration of Citizenship form and have it notarized.
11. _____ Criminal Background Check (<http://health.state.tn.us/CBC/index.htm>.)
12. _____ A copy of the legal document that changed your name (Marriage Certificate or Divorce Decree). IF APPLICABLE
13. _____ Tennessee Jurisprudence Exam on the rules and statutes of the Board (Will be sent to you after receipt of your application)

If applying by Reciprocity:

The following documentation is required:

1. _____ Completed application
2. _____ Fee: One Hundred Sixty Dollars (\$160)
3. _____ Verification of licensure from each state(s) in which you hold or have ever held a license (See Attachment II)
4. _____ Official copy of licensure requirements from the state(s) in which you are currently licensed
5. _____ Original, signed and notarized passport photograph taken within the preceding 12 months (Passport photograph only, no copies)
6. _____ Copy of your under-graduate and graduate transcripts
7. _____ Copy of your renewal certificate with expiration date and certification number from another state or foreign country
8. _____ Mandatory Profile Questionnaire (<http://health.state.tn.us/Downloads/PH-3585.pdf>)
9. _____ Certified photocopy of birth certificate or a notarized copy of a certified birth certificate
10. _____ All applicants must complete the attached Declaration of Citizenship form
11. _____ Criminal Background Check (<http://health.state.tn.us/CBC/index.htm>.)
12. _____ A copy of the legal document that changed your name (Marriage Certificate or Divorce Decree). IF APPLICABLE
13. _____ Tennessee Jurisprudence Exam on the rules and statutes of the Board (Will be sent to you after receipt of your application)

If applying by Criteria:

The following documentation is required:

1. _____ Completed application
2. _____ Fee: One Hundred Sixty Dollars (\$160)
3. _____ Transcript – Official transcript sent directly to the Board from Graduate school (transcript issued to student is NOT acceptable) (See Attachment I)
4. _____ Verification of successfully completed practicum of at least four hundred (400) clock hours (One thousand eight hundred twenty [1820] hours for Audiology)
5. _____ Verification of successful completion of nine (9) months full-time or eighteen (18) months half-time professional employment (CFY)
6. _____ Letter of recommendation from the Director of training program from which the academic training and practicum were obtained
7. _____ Verification of a minimum score of six hundred (600) on the National Teacher Examination in Speech Pathology and one hundred seventy (170) for Audiology sent directly to the Board from N.T.E.
8. _____ Verification of licensure from each state(s) in which you hold or have ever held a license (See Attachment II)
9. _____ Original, signed and notarized passport photograph taken within the preceding 12 months (Passport photograph only, no copies)
10. _____ Letter of recommendation (Moral Character) The letter cannot be from a relative
11. _____ Mandatory Profile Questionnaire (<http://health.state.tn.us/Downloads/PH-3585.pdf>)
12. _____ Certified photocopy of birth certificate or a notarized copy of a certified birth certificate
13. _____ All applicants must complete the attached Declaration of Citizenship form
14. _____ Criminal Background Check (<http://health.state.tn.us/CBC/index.htm>.)
15. _____ A copy of the legal document that changed your name (Marriage Certificate or Divorce Decree). IF APPLICABLE
16. _____ Tennessee Jurisprudence Exam on the rules and statutes of the Board (Will be sent to you after receipt of your application)

UNDERSTANDING THE APPLICATION PROCESS

If an address change occurs at any time, you MUST notify the Board office, in writing, immediately.

1. All application fees are non-refundable.
2. All documents and fees required to be submitted must be mailed directly to:

**Board of Communication Disorders and Sciences
665 Mainstream Dr
Nashville, TN 37243**

3. Allow fourteen (14) working days for information mailed to our office to be received and placed in your file. The Board asks that you please give the Board office every consideration in this matter.
4. If necessary documentation has not been received when your application has been received by the Board office, an initial deficiency letter will be sent to you by mail.
5. Absent any complicating factors, the average application processing time is six weeks. Once the application is completed, your file will be promptly reviewed and an initial certification determination made. You will be promptly notified by letter of the initial determination.
6. Applications that are deficient sixty (60) days after receipt of the initial deficiency letter will be closed.

Thank you for your cooperation. We will make every effort to expedite your application in an efficient manner.

IMPORTANT: You must have a Tennessee License from the Board in your possession before you may lawfully practice as either a Speech Pathologist or Audiologist.



**STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
665 MAINSTREAM DR
NASHVILLE TN 37243**

A. Speech Pathology	
2023-001	\$150.00
2023-006	\$10.00
B. Audiology	
2024-001	\$150.00
2024-006	\$10.00

BOARD OF COMMUNICATION DISORDERS AND SCIENCES

LICENSURE ALTERNATIVES

[PLEASE TYPE OR PRINT LEGIBLY]

CHECK TYPE OF LICENSE DESIRED: Speech Pathology Audiology

Dispense/Sell hearing aids Y N

A. Speech Pathologist

B. Audiologist

Certificate of Clinical Competence

Certificate of Clinical Competence

Reciprocity

Reciprocity

Criteria

Criteria

PERSONAL INFORMATION

PLEASE PRINT IN INK

Name:

Last	First	Middle	Maiden
------	-------	--------	--------

Social Security Number: _____ - _____ - _____ Date of Birth: _____

You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. Tenn. Code Ann. §36-5-1301(a), as authorized by 42 U.S.C. §405 (c) (2)(C)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that the Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.

Mailing Address: _____

County (TN applicants only): _____
 Phone (Home) _____
 Office: _____

Place of Birth: _____

U.S. Citizen: Yes No
**All applicants must complete the attached
 Declaration of Citizenship Form**

E-Mail: _____

Do you wish to receive notification, including renewal notification, from the Department of Health via email? Yes No

Sex (optional-for statistical purposes only) Female Male

EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for all educational institutions you have attended beyond junior high or middle school. Use the back of this page if you need additional space.

From: _____	To: _____		
Mo/Yr	Mo/Yr	Educational Institution	Degree Awarded
From: _____	To: _____		
Mo/Yr	Mo/Yr	Educational Institution	Degree Awarded
From: _____	To: _____		
Mo/Yr	Mo/Yr	Educational Institution	Degree Awarded
From: _____	To: _____		
Mo/Yr	Mo/Yr	Educational Institution	Degree Awarded

Practicum (400 clock hours of supervised, direct clinical practice; 1820 hours for Audiology). Give dates and brief description:

EMPLOYMENT STATUS

Are you currently employed? Yes _____ No _____ If yes, give name and address of primary

<u>DATES</u>	<u>LOCATION</u>	<u>POSITION & DUTIES</u>
From: _____ To: _____		
Mo/Yr Mo/Yr	(City) (State)	
From: _____ To: _____		
Mo/Yr Mo/Yr	(City) (State)	
From: _____ To: _____		
Mo/Yr Mo/Yr	(City) (State)	

Do you have more than one employer? Yes _____ No _____ (if yes, list names addresses and job title)

<u>NAME</u>	<u>ADDRESS</u>	<u>JOB TITLE</u>
-------------	----------------	------------------

Do you engage in private practice? Yes _____ No _____ (If yes, give location)

LICENSURE INFORMATION

(Please complete and submit this page with your application. If no other state licenses are held, please mark "N/A" in each section.)

List below ALL States, Countries, or Provinces in which you have ever been or are currently licensed, permitted or certified as a Speech Pathologist/Audiologist. Additional pages may be added if necessary. Submit a copy of licensure verification form to all such states, countries or provinces regarding such licensure, certification or permit. Use the back of this page if you need additional space.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List below ALL states, countries or provinces in which you hold or have ever held a license, certification, or permit as a health professional other than a Speech Pathologist/Audiologist. Submit a copy of licensure verification form to all such states, countries or provinces regarding such licensure, certification or permit. Use the back of this page if you need additional space.

STATE	NUMBER/PROFESSION	DATE ISSUED	CURRENT STATUS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the affirmative, attach an explanation on a separate sheet. In support of your explanation, the final documents or orders from the issuing states, courts, and/or agencies must be submitted along with this application. For the purpose of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:
 - a. The cognitive capacity to make appropriate diagnosis (if necessary), exercise reasoned judgment, and to learn and keep abreast of development in the field.
 - b. The ability to communicate those judgments and information to clients and other health care providers, with or without the use of aids or devices, such as voice amplifiers.
 - c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. **"Medical Condition"** includes physiological, mental or psychological disorders, such as, but not limited to: orthopedic, visual, speech and/or hearing impairment, cerebral palsy, epilepsy, muscular dystrophy, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.
3. **"Chemical Substances"** is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
4. **"Currently"** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.
5. **"Illegal Use of Controlled Substances"** means the use of controlled substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

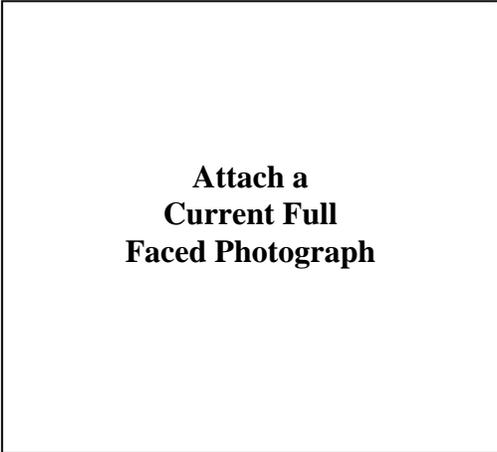
QUESTIONS	YES	NO
Do you currently have a medical condition which in any way impairs or limits your ability to practice as a Speech Pathologist/Audiologist with reasonable skill and safety?	—	—
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program?	—	—
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting, or the manner, in which you have chosen to practice?	—	—
(If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether conditions should be imposed or whether you are not eligible for licensure.)		
Do you currently use chemical substances?	—	—
If yes, do they in any way limit your ability to practice speech pathology/audiology with reasonable skill and safety?	—	—
Are you currently engaged in the illegal use of controlled substances?	—	—
If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaged in illegal use of controlled substances?	—	—
Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?	—	—
If you have ever held or applied for a license or certificate to practice as a Speech Pathologist/Audiologist in any state, county, or province, was or has it ever been denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	—	—
If you have ever had staff privileges at any hospital or health care facility, have they ever been revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	—	—
Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?	—	—
Have you ever been rejected or censured by a Professional Association?	—	—
In relation to the performance of your professional services in any profession:		
a. Have you ever had a final judgment rendered <u>against</u> you?	—	—
b. Have you ever had settlement of any legal action rendered <u>against</u> you?	—	—
c. Are there any legal actions pending <u>against</u> you or to which you are a party?	—	—
If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	—	—

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC

AFFIDAVIT AND RELEASE

I, _____, of _____, being duly sworn
(Applicant's Name) (City) (State)

and identified as the person referred to in this application, attests to the truth of each statement made in said application. I further swear that I have read and understand the law and the rules and regulations, which were enclosed in the application packet, and agree to abide by them in the practice of Speech Pathology/Audiology in the State of Tennessee. I also attest that the attached photo below is of me, taken within the last 6 months.



I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary which may include a full Board interview.

RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice Speech Pathology/Audiology.

AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications;

RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character and other qualifications for certification.

ACKNOWLEDGE that I, as an applicant for certification, have the burden of producing adequate information for a proper evaluation of my professional, ethical and other qualifications and for resolving any doubts about such qualifications.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE **DATE**

Sworn before me this _____ day of _____, 20_____.

NOTARY PUBLIC Affix seal here

My Commission Expires:_____

ATTCHMENT I



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
665 MAINSTREAM DR
NASHVILLE, TN 37243
BOARD OF COMMUNICATION DISORDERS AND SCIENCES
(615) 253-6061 or 1-800-778-4123

EDUCATION VERIFICATION

APPLICANT: Supply the information requested on this page and then mail this entire form to the school at which you completed your Speech Pathology/Audiology educational program. **NOTE:** Many schools require a fee, so you may wish to contact the institution before mailing this form so that you can attach their fee.

TO WHOM IT MAY CONCERN:

I am applying for a certificate or permit to practice Speech Pathology/Audiology in the State of Tennessee. The Board of Communication Disorders and Sciences requires verification of educational attainment. Please forward an original transcript showing degree awarded and bearing the institution's official seal to the Board address below.

Applicant's Full Name:

(Last) (First) (Middle/Maiden)

Applicant's Address: _____

Applicant's Social Security Number: _____ - _____ - _____

Applicant's Student Identified Number: _____

Year of Graduation: _____

Degree Conferred: _____ Date Degree Conferred: _____

Please forward an original graduate transcript bearing the institutions official seal to:

**TENNESSEE BOARD OF COMMUNICATION DISORDERS AND SCIENCES
665 MAINSTREAM DR
NASHVILLE, TN 37243**

Thank you for your cooperation and prompt response.

Applicant's Signature

Date

ATTCHMENT II



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
665 MAINSTREAM DR
NASHVILLE, TN 37243

BOARD OF COMMUNICATION DISORDERS AND SCIENCES
(615) 253-6061 or 1-800-778-4123

VERIFICATION FROM OTHER STATE CERTIFICATION BOARDS

APPLICANT: Please provide the information requested and then mail one form to the certification board in EACH state where you hold or have ever held a certificate/license/permit to practice any profession. (Copies of this form can be used). **NOTE:** Some states require a fee for providing clearance information. To expedite your application, you may wish to contact the applicable state(s).

TO BE COMPLETED BY APPLICANT

I, the undersigned applicant, was granted a (circle one) license/certificate/permit to practice _____ with (check one) license/certificate/permit number _____ on _____ in the State of _____. The Tennessee Board of Communication Disorders and Sciences requests that I submit evidence of the current status of that license in your state. You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Board of Communication Disorders and Sciences.

Applicant's Signature Date

Applicant's Typed or Printed Name

TO BE COMPLETED BY ADMINISTRATIVE OF STATE CERTIFICATION BOARD

Name in full as it appears on license/certificate/permit:

(First) (M.I.) (Last)

License/Certificate/Permit Number: _____ Profession: _____

Date Issued: _____ Date of Expiration: _____

Basis of Issuance:
(Check One) () CCC from ASHA () Reciprocity () Other, Specify _____

The license is currently active and registered? Yes _____ No _____

Is there any derogatory information on file? Yes _____ No _____ If yes, Please attach supporting documentation

Authorized Signature Title Date



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DR
NASHVILLE, TN 37243

DECLARATION OF CITIZENSHIP
MUST ACCOMPANY ALL APPLICATIONS FOR INITIAL LICENSURE OR REINSTATEMENT OF LICENSURE

The "SAVE Act" requires Tennessee Department of Health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that every adult applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.

I am a(n) _____
Healthcare Profession (Please Print) License number if applicable

Please Print Legibly

1. Name: _____
Last First Middle Maiden_
2. Mailing Address: _____
3. Phone Number: Home: (____)____-____ Office: (____)____-____ Fax: (____)____-____
4. I am a United States Citizen: ____Yes ____No. If you answered yes to this question please sign this form in the presence of a notary and return it with your application.
5. I am a foreign national not physically present in the United States ____Yes ____No. If you answered yes to this question please sign this form in the presence of a notary and return it with your application. No further documentation is required.
6. Applicants Claiming United States Citizenship **MUST** provide one of the following:
 - a) Tennessee Driver's License, or photo ID issued by Department of Safety.
 - b) A valid driver license or ID issued by another state provided its issuance requirements meet Department of Safety criteria.
 - c) An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not count.
 - d) A federally issued birth certificate.
 - e) A valid, unexpired U.S. passport.
 - f) A report of birth abroad of a U.S. citizen.
 - g) A certificate of citizenship.
 - h) A certificate of naturalization.
 - i) A U.S. citizen ID card.
 - j) Any successor document to #'s a-i above.
 - k) SSN that the entity or local health department may verify with the Social Security Administration in accordance with federal law.
7. If you checked "No" in question 4 please indicate from the list below which category applies to you: (circle one)
 - a) Permanent Residents
 - b) A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*).
 - c) Asylees who meet the qualifications set out in 8 U.S.C. 1158
 - d) Refugees who meet the qualifications set out in 8 U.S.C. 1157

- e) Persons who have been “paroled into the United States,” under 8 U.S.C. 1182(d)(5) or whose deportation has been withheld under 8 U.S.C. 1253.
- f) Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980
- g) Persons granted conditional entry into the U.S. under 8 U.S.C. 1153(a)(7) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity.
- h) An alien who has been “battered” or subjected to “extreme cruelty” by a parent or spouse as defined by 8 U.S.C. 1641(c), and also meets the qualifications set out 8 U.S.C. 1641(c)(1)(B). Under the circumstances set out in 8 U.S.C. 1641(c)(2) and (3), victims’ children, or the parents of children who are victims, may also apply for benefits as qualified aliens.

Applicants claiming **qualified alien status** (question 7 above), please submit two of the following forms of “documentation of identity and immigration status” as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status are listed below. (Note: If you can provide only one document, your status will be verified through the U.S. Department of Homeland Security’s SAVE program):

I-327 (Reentry Permit)

I-551 (Permanent Resident Card or “Green Card”)

I-571 (Refugee Travel Document)

I-766 (Employment Authorization Card)

Machine Readable Immigrant Visa (with Temporary I-551 language)

Temporary I-551 stamp (on passport or I-94)

I-94 (Arrival/Departure record)

Unexpired foreign passport

WT/WB Admission Stamp in unexpired foreign passport

I-20 (Certificate of Eligibility for Nonimmigrant F(1) student status– “student visa”)

DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

I affirm under the penalty of perjury that the above is true and correct.

Signed this ____ day of _____, 20__.

Signature

Sworn to before me this ____ day of _____, 20__.

NOTARY PUBLIC

AFFIX SEAL HERE

My Commission Expires: _____

If an applicant is discovered to be an unqualified alien, or otherwise ineligible for benefits under the Act, all recurring benefits provided to that applicant must be immediately terminated. Anyone who purposefully makes a false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status will be liable under the Tennessee Medicaid False Claims Act, or Tennessee’s False Claims Act. Any person who conspires to defraud the state or any local health department by securing a false claim allowed or paid to another person in violation of the Act may be liable under Tennessee’s False Claims Act. Upon discovery of an applicant’s false, fictitious, or fraudulent claim of U.S. citizenship, state governmental entities and local health departments must also file a criminal complaint with the United States Attorney.