



Washington State Department of

Health

Hearing and Speech Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Out of State Credential Verification

To Applicant:

Please complete this section. Forward this form to the jurisdiction of certification/license/registration for them to complete and return to the above address.

I, _____, am/was certified/licensed/registered in the state of _____,

as a _____, certificate/license/registration number: _____.

I have applied for a Washington State Hearing Aid Specialist License. I authorize the release of the information requested below to Washington State Hearing and Speech Credentialing.

Signature _____ Date _____

To the State Board:

Please provide a copy of the current statute under which the above-named applicant was certified/licensed/registered. Please return this completed form with the statute to the above address.

I hereby certify that _____ was granted

professional certificate/license number _____ to practice _____

in the state of _____ on the _____ day of _____, 20____ on the basis of: Yes No

Successfully passing the International Hearing Society Licensing Examination..... [] []

Successfully passing the required state constructed examination:

Written..... [] []

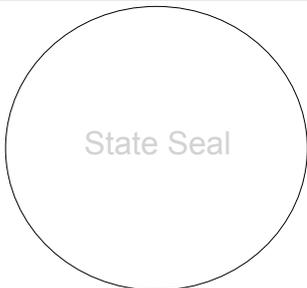
Practical..... [] []

Other (please explain): _____

Status of Certification/License/Registration: [] Active [] Inactive [] Expiration Date (mm/dd/yyyy) _____

Legal or Disciplinary Action?: [] Yes [] No

If yes, please explain below and provide any applicable documentation.



Signature of Verifier _____

Title of Verifier _____

Date _____