

SOUTH DAKOTA
BOARD OF HEARING AID DISPENSERS AND AUDIOLOGISTS
810 North Main #298 • Spearfish, SD 57783
(605) 642-1600

VERIFICATION OF AUDIOLOGY LICENSURE IN OTHER STATE

Part II

To the Applicant: Complete the top portion and back of this form and forward to the Licensing Authority/Regulatory Board in each state in which you were licensed or are currently licensed.

Full Name _____			
(Last Name)	(First Name)	(Middle)	(Maiden)
Mailing Address _____			
(Street or P.O. Box)	(City)	(State)	(Zip)
License/Certificate No.:	Date Issued:		Date Exp:

Part III

CERTIFICATE OF AUTHORIZED BOARD REPRESENTATIVE OF STATE BOARD ISSUING LICENSE

To the licensing authority/regulator Board: Please provide the information requested below and return directly to the Board address indicated at top of page.

I, an Authorized Board Representative of _____ hereby certify that the above
(State)
named applicant is/was licensed and is/was in good standing was granted State Certificate/License

Number _____ to practice audiology on _____,
(Date of initial licensure)

on the basis of:

- | | | |
|--------------------------|---------------------------|-------------------|
| _____ Exemption | _____ Written Examination | _____ Reciprocity |
| _____ Endorsement | _____ Oral Examination | _____ Other |
| _____ ASHA Certification | _____ Education | |

This license expired/will expire _____.

PLEASE SEND A COPY OF ALL TEST SCORES.

Any complaints and/or disciplinary actions? Yes No

Explanation of above if answer is yes: _____

Authorized Board Representative

(Seal)

(Signature)

(Please print name)

(Date)

(Over)

SOUTH DAKOTA BOARD OF HEARING AID DISPENSERS AND AUDIOLOGISTS
810 North Main #298
Spearfish, SD 57783
(605) 642-1600

**RELEASE AND WAIVER FOR
VERIFICATION OF AUDIOLOGY LICENSURE IN OTHER STATE**

Part I

Directions for Applicant:

Complete Part I and Part II of this form and forward a form to each state where you hold or have held a license to practice Audiology.

TO: _____
Name of State Board

Address Of State Board: _____
Mailing

City State Zip Telephone #

I am applying for a license in South Dakota to practice audiology. I was granted license # _____ by the State of _____.

The South Dakota Board of Hearing Aid Dispensers and Audiologists request that I submit verification that my license in the State of _____ is or was at time of licensure in good standing.

You are hereby authorized to release any information in your files, favorable or otherwise, directly to the South Dakota Board of Hearing Aid Dispensers and Audiologists. Your early attention is appreciated. I declare and affirm under the penalties of perjury that this application has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

Signature: _____

Print Name: _____

Date: _____

(OVER)