CLINICAL PRACTICUM VERIFICATION FORM

SOUTH DAKOTA BOARD OF HEARING AID DISPENSERS & AUDIOLOGISTS
810 North Main Street #298
Spearfish, SD 57783
Ph. 605-642-1600

If you do not hold a current ASHA Certification, this form must accompany each application for an Audiology License. Please return with your completed application.

INSTRUCTIONS FOR THE APPLICANT: Have your supervisor or clinical program director complete section 2 to verify your clinical practicum/externship. Attach the completed form to your application, if possible. Your supervisor or clinical program director must sign the form before a notary public.

Section I – To Be Completed by Applicant

Applicant Name: _____
(Last) (First) (M.I.) (Maiden)

Applicant Address: _____
(Mailing Address) (City) (State) (Zip)

Applicant Phone Number: (_____)_____

Applicant Email Address: _____

Signature:_____ Date:_____
Audiologist Applicant (mm/dd/yyyy)

INSTRUCTIONS FOR THE SUPERVISOR OR CLINICAL PROGRAM DIRECTOR: The person named above is applying for an audiologist license in South Dakota. Please complete section 2 to verify the applicant completed the clinical practicum pursuant to SDCL 36-24-17.3 (4) under your supervision or direction, and sign before a notary public. You may return the completed form to the applicant to submit with their application or separately to the board office.

Section II – To Be Completed by Supervisor

Supervisor Name: _____
(Last) (First) (M.I.)

Business Address:_____
(Mailing Address) (City) (State) (Zip)

Phone #: (_____)_____

Email Address: _____

Audiology License No.: _____ State of License: _____

Clinical Practicum Start Date (mo/yr): _____ Clinical Practicum End Date (mo/yr): _____

Length of Training (months): _____ Total Hours: _____

Position Held: _____

Name of Training Institution: _____

Address of Training
Institution:_____
(Address) (City) (State) (Zip)

Brief Summary of the duties that the applicant performed during the clinical practicum:

_____

_____

_____

_____

_____

Attestation and Notarization

I do hereby attest that:

1. I supervised or directed the clinical observation and clinical practicum of the individual stated above;
2. The clinical practicum experience was obtained from a regionally accredited educational institution or its cooperating programs

Signature:_____ Date:_____
Signature of Supervisor or Clinical Program Director (mm/dd/yyyy)

The supervisor or clinical program director _____, having appeared before me and being identified as the same individual by the appropriate identification, being sworn, deposes and says that he/she is the person attesting to the information in section 2 of this application; that the statements herein contained are true in every respect; that he/she has not suppressed any information that might affect this application.

Subscribed and sworn before me this _____day of _____,

My commission expires

_____ (SEAL)
Signature of Notary Public