STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

AUDIOLOGY LICENSURE

VERIFICATION OF OUT-OF-STATE LICENSED OR CERTIFIED WORK EXPERIENCE

PROFESSIONAL EMPLOYMENT AREA: AUDIOLOGY

CANDIDATE'S NAME: _____

ADDRESS _____

PLACE OF EMPLOYMENT BEING VERIFIED: _____
NAME

_____
NO. & STREET CITY STATE ZIP CODE

TO BE COMPLETED BY THE EMPLOYMENT SUPERVISOR:

SUPERVISOR'S NAME:_____
LAST FIRST MIDDLE

PLACE OF EMPLOYMENT_____
NAME

ADDRESS:_____
NO. & STREET CITY STATE ZIP CODE

LICENSE/CERTIFICATE NO.: _____ STATE: _____ DATE ISSUED: _____

ARE YOU CERTIFIED BY ASHA?_____IF YES, DATE OF CERTIFICATION_____

BUSINESS TELEPHONE:_____

INCLUSIVE DATES OF CANDIDATES EMPLOYMENT: FROM:_____/_____/_____ TO_____/_____/_____

HOURS PER WEEK CANDIDATE WORKED: _____ WEEKS PER YEAR_____

PLEASE WRITE YOUR EVALUATION OF THE CANDIDATE ON THE REVERSE SIDE OF THIS FORM CONCERNING THE CANDIDATE'S ABILITY TO FUNCTION COMPETENTLY WITHOUT SUPERVISION AND THE CANDIDATE'S CONFORMANCE WITH ACCEPTED STANDARDS OF PROFESSIONAL PRACTICE.

_____ _____
DATE SIGNATURE

THANK YOU FOR YOUR ASSISTANCE.

THIS VERIFICATION SHOULD BE SUBMITTED BY THE SUPERVISOR DIRECTLY TO:

DEPARTMENT OF PUBLIC HEALTH
AUDIOLOGIST LICENSURE
410 CAPITOL AVE., MS# 12APP
P.O. BOX 340308
HARTFORD, CT 06134-0308