Washington State Department of Health
Hearing and Speech Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Professional Reference Request

To be completed by post-graduate supervisor. Please be advised upon receipt of written request, this form will become a public document.

Applicant Demographics:

First Name	Middle	Last Name
Credential # (If available)	Date of Birth	
Supervisor Name	Supervisor Credential #	
Organization	Position	
Address		
City	State	Zip Code

To be completed by the supervisor:

The above named applicant has applied for license as an Audiologist/Speech Language Pathologist in the state of Washington. We would appreciate your completion of this reference form and return directly to the above address.

Dates of post-graduate supervision From (mm/dd/yyyy) _____ To (mm/dd/yyyy) _____

Total number of hours of post-graduate audiology/speech pathology work you supervised during the entire post-graduate professional work experience (this should be a number and not a percentage): _____

Applicants are required to have thirty-six weeks of full-time professional experience or part-time equivalent.

Comment on the applicant's professional judgment, responsibility, integrity and relationships with professional peers and clients:

Is there any other information about the candidate which you believe should be provided to the Board of Hearing and Speech? ☐ Yes ☐ No

If yes, please explain:

Signature _____ Date (mm/dd/yyyy) _____