Washington State Department of Health
Office of Customer Service
PO Box 47865
Olympia WA, 98504-7865
360-236-4700

Hearing and Speech Attestation

Name of Practitioner:	
Credential Type:	Credential Number:

I have completed the following:

- Continuing education, if required;
- I have properly calibrated testing equipment; and
- I am covered by a surety bond or maintain security in lieu of a surety bond per **RCW 18.35.240**.

I affirm the information I provided for the renewal of my credential is true and accurate to the best of my knowledge. In addition, if I have continuing education and/or other requirements due, I affirm I have met those requirements and I will provide documentation to the Department of Health upon request.

Signature of Practitioner:
Date:

Mail this document with your check or money order to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Documents without a check or money order:

Department of Health
Office of Customer Service
PO Box 47865
Olympia, WA 98504-7865

If you have any questions, please contact the Health Systems Quality Assurance Division, Customer Service Center.

Phone: 360-236-4700
Fax: 360-236-4818
Email: **hsqarenewalresearch@doh.wa.gov**