

Wisconsin Department of Safety and Professional Services

Office Location: 4822 Madison Yards Way
Madison, WI 53705
Phone Number: (608) 266-2112

LicensE Portal: [License.wi.gov](http://license.wi.gov)
Email: dsps@wisconsin.gov
Website: <http://dsps.wi.gov>

COSMETOLOGY EXAMINING BOARD

EMPLOYMENT VERIFICATION FOR COSMETOLOGIST APPRENTICE TRAINERS

APPLICANT: Complete top portion of this form and forward to past or present employer. Proper completion of this form is required for processing of the application. Failure to submit proper documentation of employment will delay processing of your credential application.

Last Name <input type="text"/>	First Name <input type="text"/>	MI <input type="text"/>	Former / Maiden Name(s) <input type="text"/>
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Cosmetologist License Number <input type="text"/>	Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>
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I hereby authorize the employer named below to provide the Department with the information requested below.

Applicant Signature:

Date: / /

(If unable to provide a digital signature print and sign form.)

PAST OR PRESENT EMPLOYER: Certify employment below and return directly to DSPS. The above listed applicant is required to have 2000 hours of practice as a licensed cosmetologist in order to supervise apprentices. Employer completing this section may email it to DSPSCREDBAC@wisconsin.gov.

Cosmetology Manager/Owner Name <input type="text"/>	Establishment License Number <input type="text"/>
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Establishment Name <input type="text"/>	Total Number of Hours Worked <input type="text"/>
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Employment Period (include month, day, and year) From: / / To: / /

I declare, as the Cosmetology Manager or Owner, the foregoing statements are true to the best of my knowledge and belief, and that I personally completed and signed this form.

Signature of Cosmetology Manager or Owner

(If unable to provide a digital signature print and sign form.)

Date

/ /

Email Address of Cosmetology Manager or Owner

License Number